



CHILD PROTECTION TEAM
 Boston Medical Center, Department of Pediatrics

24 Hour Consultant
 BMC pager 638-5795 #7336
 To make appointments in clinic
 617-414-7425
 Fax consults and 51As to our confidential fax
 617-414-3648

Services:

- Provides 24 hr consultation for child protection questions, notifications, and requests for follow-ups
- Tracks reviews and collects data on all 51As filed by BMC staff
- Provides training and education to staff regarding child abuse and neglect: reporting, assessment, responding to caregivers, treatment referrals.
- Serves as a resource for discussing complex cases

Child Protection Team:
 Betsy McAlister Groves LICSW, Co-Director
 Cindy Moore PNP, Clinician
 Irene Tien MD, Co-Director and Medical Director
 Patsy Natanagara LMHC, Clinician

The Team also includes representatives from the hospital general counsel, the Department of Social Services, social work, physician and nursing representatives from the pediatric emergency department, pediatric primary care, adolescent primary care, inpatient pediatrics, pediatric subspecialties, and child psychiatry.

CHILD ABUSE MAY INCLUDE

- Physical Abuse
- Sexual Abuse
- Neglect/Failure to Thrive
- Medical Neglect
- Emotional Abuse
- Munchausen by Proxy

WHAT IS ABUSE/NEGLECT?

The non-accidental commission or omission of any act by a caregiver upon a child under the age of 18 which causes, or creates a substantial risk of, physical or emotional injury; or any sexual contract between a caregiver and a child under the care of that individual. Caregivers may include teachers, daycare providers, school bus drivers, for example.

RED FLAGS FOR CHILD ABUSE/NEGLECT

The following potential indicators of abuse are not all-inclusive but are intended to help guide the health-care professional in assessing children for abuse.

HISTORICAL INDICATORS

- Injuries inconsistent with the history or for which no history is given.
- Delay in seeking treatment for an injury or illness for which there is an inadequate or implausible explanation. Be cognizant of immigration issues that may contribute to delayed care.
- Significant injuries in a young child that are blamed on a young sibling or pet.
- Disclosure by the child that he/she has been physically, emotionally, or sexually abused by a caregiver.
- Frequently missed health care appointments that can reasonably be expected to result in additional injury to or illness in the child.
- Non-developmentally normal sexualized behavior.
- Injuries due to inadequate supervision.
- Intentional withholding of food, shelter, or clothing.

EXAM INDICATORS

- Traumatic intracranial injuries, except epidural hematomas, in young children for which there is no plausible mechanism.
- Long bone fractures in pre-ambulatory children.
- Rib or metaphyseal fractures in young children.
- Bruising in pre-ambulatory children.
- Bruising in ambulatory children in areas not usually associated with normal activities (eg. inner arms, inner thighs, buttocks, behind the ears, pinnae, trunk)
- Laceration of the inferior or superior frenulums of the lips.
- Hematoma of the tragus of the ear.
- Scars in the shape of objects
- Diagnosis of a sexually transmitted disease.

WHAT TO DO IF MALTREATMENT IS SUSPECTED

1. Ask detailed questions
2. Complete physical evaluation and assess safety
3. Complete detailed documentation
4. File a 51 A if appropriate
5. Make appropriate referrals

1. ASK DETAILED QUESTIONS

Who Should Be Interviewed:

- Parents should be interviewed out of earshot of the child/children.
- Adolescents should be given the option of interview with or without parent
- Children should not be interviewed unless it is necessary to collect information important to medical evaluation and treatment.

How To Conduct Interview:

- Conduct the interview in the patient's/caregiver's first language when possible. Use interpreter services as needed.

- Conduct the interview in a quiet and private space.
- Obtain the history of the events through open-ended statements, such as "Tell me why you are here."
- Avoid leading questions.
- Remain calm and sensitive.
- Screen for domestic violence.
- Minimize the number of interviews.
- If it is necessary to interview the child, a stair-step approach that becomes progressively more directed, is recommended. Utilize the least directed method of questioning as possible:
 - Request a narrative
 - Set the scene and request elaboration
 - Ask direct, but open-ended questions (with multiple possible answers)

2. PHYSICAL EXAM & EVALUATION

- Physical examination should be performed in an age appropriate fashion.
- Minimize the number of examinations and examiners.

Physical abuse pearls:

- Complete a careful examination of all of the skin.
- Examine areas of the body that are often overlooked: behind the ears, pinnae of the ears, frenulums of the lips, posterior neck, inner arms and thighs, buttocks, and external genitalia.
- Consultation with pediatric ophthalmology is recommended for a direct ophthalmic exam of the retina in **ALL** children under 3 years who may have been physically abused.
- For children under 2 years of age in whom physical abuse is suspected or identified, a skeletal survey should be performed.
- For infants, a head CT scan should be considered if: they are <6mos old, there is a fracture, facial bruising, witnessed shaking or slamming, the child has fractures of various ages on skeletal survey.

Sexual abuse pearls

- Adolescents should be given as much decision-making power as possible during the evaluation.
- If the last episode of sexual abuse occurred within the preceding 72 hrs, a rape kit should be performed.
- Under no circumstances should a pre-pubescent girl undergo a speculum examination nor should her hymenal area be touched unless she is under general anesthesia.
- See Table for AAP and CDC guidelines on evaluation for STDs in sexually abused children; Consultation with pediatric ID and the CPT should occur to discuss individual cases

Neglect pearls

- Measurements of weight, height, and head circumference, when applicable, should be recorded on a growth chart.
- Detailed history surrounding the neglect issue is key.

Table: AAP and CDC recommendations for evaluating sexually abused children for STDs		
	AAP Recommendations	CDC Recommendations
1. How do we decide which children should have an STD evaluation?		
	The decision is made on a case-by-case basis. Perform STD screening for the following:	The decision is made on a case-by-case basis; situations where there is a high risk for STDs and a strong indication for testing include the following:
	<ul style="list-style-type: none"> • A perpetrator with a known STD or high risk for STD • Multiple perpetrators • Patient or family preference • A postpubertal patient • Patient with signs or symptoms of an STD or an infection that can be transmitted sexually • Prevalence of STDs in the community is high • STDs in siblings, other children, or adults in the household 	<ul style="list-style-type: none"> • A suspected offender is known to have an STD or to be at high risk for STDs (e.g., multiple sex partners or a past history of STDs) • The child has symptoms or signs of an STD or an infection that can be transmitted sexually • There is a high prevalence of STDs in the community • There is (1) evidence of genital or oral penetration or ejaculation or (2) STDs in sibling or other children or adults in the household
	All children examined for STDs are evaluated for <i>Chlamydia trachomatis</i> , <i>Neisseria gonorrhoeae</i> , syphilis, human immunodeficiency virus (HIV), bacterial vaginosis, and <i>Trichomonas vaginalis</i>	
2. When should the STD evaluation take place?		
	Obtain specimens at initial evaluation For syphilis: serologic testing at time of abuse and 6, 12, and 24 weeks later For HIV: test at time of abuse and 6, 12, and 24 weeks later	Obtain specimens at initial evaluation If abuse took place <2 weeks before, repeat evaluation at 2 weeks after sexual contact; store initial serum specimen for testing if a later specimen is positive At 12 weeks after sexual contact, test for

		<i>Treponema pallidum</i> , HIV, or hepatitis B
3. What specimens should be sent and what tests should be performed?		
<i>N. gonorrhoeae</i>	Rectal, throat, vaginal, and/or endocervical specimens for culture; urethral specimen in boys	Pharyngeal, anal, vaginal specimens for culture, urethral specimen in boys if there is no discharge (meatal specimen if there is discharge)
<i>C. trachomatis</i>	Rectal and urethral or vulvovaginal specimens for culture	Anal, vaginal specimens for culture in girls, and urethral specimen in boys (only if there is a discharge)
<i>T. pallidum</i>	Darkfield microscopy examination of chancre fluid if present; serologic tests	Serologic tests
HIV	Serologic test of abuser (if possible); serologic test of child	Serologic tests
Hepatitis B	Serologic tests of abuser	Serologic tests
Herpes simplex	Culture of lesion	-----
Bacterial vaginosis	Wet mount and culture of vaginal swab specimen	Wet mount of vaginal swab specimen
Papillomavirus	Biopsy of lesion	-----
<i>T. vaginalis</i>	Wet mount and culture of vaginal swab specimen	Wet mount and culture of vaginal swab specimen
Pediculosis capitis	Examine for eggs, nymphs, and lice	-----

3. DETAILED DOCUMENTATION

Adequate documentation of the initial evaluation of a potentially abused child is critical to the appropriate, effective, and efficient investigation and treatment of the child. Consultation with a social worker and/or the child protection team should be sought if more guidance in this area is necessary.

History
Demographic information about the child's parents and caretakers:

- full names, dates of birth, and addresses- include all people living with the child and who takes care of the child.

Detailed history elements pertinent to concerns of child abuse

- Mechanism of injury
- Alleged perpetrator of abuse (include full name, age, address, relation to child)
- Timing of abuse
- Other children potentially at risk
- Disclosures of abuse by other children

- When and how the current abuse was disclosed by the child, if applicable.

- What agencies are involved in the case, if any (eg. DSS, police, district attorney, CAC)
- Use quotes from the child and family members as much as possible.

Physical examination

- Be as detailed and objective as possible, using non-medical language
- Use diagrams to describe your findings whenever possible.
- Describe the demeanor of the child and caregiver in an objective fashion

Assessment and Plan

- Summarize your history and physical examination
- Document any consultations you requested.
- Document whether you filed a report with CPS and any other agencies you may have notified.
- Specifically address your assessment of the child's safety and if you have any concerns for child abuse.

You do not need to be sure that a child is abused to document that you have concerns for abuse.

- Outline your safety and medical plan for the child.
- Photographs may be taken by hospital personnel preparing a 51A report to DSS of areas of trauma visible on a child who is the subject of the report without the consent of the child's parents or guardians.
- Photographs should be marked with the name of the subject, date, time, identity of the person taking the photograph and should be sent to DSS together with the 51A report. Duplicates should be taken and kept in the medical record.

4. FILING A 51A

All 51As must be reported initially with a phone call to DSS and then follow up with the written form which should be mailed or faxed to DSS within 24 hours of the telephone report.

DSS Hotline 1-800-792-5200
Please fax BMC 51A's to the CPT's confidential fax machine, at **617-414-3648**.

5. MAKE APPROPRIATE REFERRALS
BMC CARE CLINIC
Call **617-414-7425** for an appointment

Guidelines for referral

IMMEDIATE REFERRAL (should be seen immediately)

Sexual Abuse

- Acute assaults where rape kits are necessary to collect physical evidence (<72hrs for children under 13 years, <100hrs for children 13 years or older)
- Children with acute genital or anal symptoms secondary to the assault

Physical Abuse

- Acutely injured children with life-threatening or extensive injuries
- Any children with suspected abuse who demonstrates symptoms of head injury, abdominal injury, even when there are no external signs of injury, fracture, burns to face, genitals, hands or if significant in size or severity

Neglect/Failure to Thrive

- Children with impending starvation, such as lethargy, swollen hands or feet, distended abdomen, dizziness, rapid heart rate, or rapid breathing
- Children appearing dehydrated. Signs of dehydration may include dry mouth, sunken eyes, or parched skin

URGENT REFERRALS (should be seen within 24 hours)

Sexual Abuse

- Children with a history of abuse **AND** vaginal or penile discharges
- Children who have been found to have acute genital or anal injuries at other health care facilities, where the rape kit has already been done at the other facility.

Physical Abuse

- Children with bruising or abrasions where immediate medical care is not needed but where medical documentation is needed.

SEMI-URGENT REFERRAL (should be seen within 7 days)

Sexual Abuse

- Children without physical symptoms who report sexual abuse that occurred greater than 72 hours prior to disclosure or discovery of abuse

Physical Abuse

- Children with a HISTORY of physical abuse in the past who need physical examinations to look for old injuries, old fractures, or scars.

ROUTINE REFERRAL (should be seen within 3 weeks)

Sexual Abuse

- Cases where sexual abuse is a CONCERN, but NO SPECIFIC DISCLOSURES have been made.
- Cases where children have been evaluated by another health provider who reports evidence of old genital or anal scarring from sexual abuse. Referral to the CARE clinic will allow for photo documentation of injuries or for a second opinion

Physical Abuse

- Cases where the child has been examined or treated at another facility, and where injuries have been previously documented, when a second opinion is needed from a child abuse specialist.

Munchausen Syndrome by Proxy/Medical Neglect:

- All cases, after DSS has collected complete medical records that can be used to document the diagnosis.

OTHER RESOURCES

Advocacy & Legal Services
BMC Family Advocacy Program: (617) 414-7430
BMC Family Help Desk: (617) 414-4349
Greater Boston Legal Services: (617) 371-1234
Legal Advocacy & Resource Center: (800) 342-5297
Volunteer Lawyers Project: (617) 423-0648; (800) 342-9092
Youth Advocacy Project: (617) 445-5640
www.neighborhoodlaw.org legal info for MA residents.

Child Abuse Evaluation
BMC AAC (Adolescent Aftercare Clinic) (617) 414-3796
BMC Child Protection Team: (617) 638-5795, pager #7336

Boston Children's Hospital CPT (617) 355-7979
DSS reporting abuse/neglect: (800) 792-5200

Domestic Violence & Sexual Assault
Boston Area Rape Crisis Center: (617) 492-RAPE
BMC Child Witness to Violence Project: (617) 414-7425
CH Project AWAKE *support for DV victims*: (617) 355-4760
Jane Doe, Inc. *coalition against DV & SA*: (617) 248-0922
National Battered Women's Line *24 hr*: (800) 799-SAFE
SafeLink *statewide multilingual 24 hr hotline*: (877) 785-2020
Statewide Shelter Hotline: (800) 992-2600
Survivor Assistance Hotline: (877) 627-7700
Victims of Violence Program Community Crisis Response Team: (617) 498-1180

Sexual and Reproductive Health
ABCD Family Planning (617) 357-6000
BMC Project Baby (617) 414-6012
BMC Women's Resource Center (617) 414-2262

Mental Health Sexual Abuse Evaluations
BMC Child Psychiatry Trauma Clinic (617) 414-5245
Family Services of Greater Boston, Glenda Alderman (617) 523-6400, x5879
Massachusetts Society for the Prevention of Cruelty to Children (617) 983-5800
Boston Children's Hospital (617) 355-7979
Trauma Center, Rona Sandberg (617) 782-6460, x231

Evaluation and Treatment after Trauma
BMC Child Psychiatry Trauma Clinic (617) 414-5245
BMC Good Grief Program *for children* (617) 414-4005
Boston Cares *for injured youth*: (617) 563-8142
Children's Advocacy Center, Sharman Nathanson (617) 619-4339
Family Services of Greater Boston, Glenda Alderman (617) 523-6400, x5879 or x5926
Trauma Center, Rona Sandberg (617) 782-6460, x231
Victims of Violence Program: (617) 498-1180
Child Witness to Violence (617) 414-7425

Criminal Justice
Children's Advocacy Center
Coordinator of Victim Services for Child Abuse Unit, Susan Goldfarb JD (617) 619-4276
Child Abuse/DV Issues, Susan Hoye, (617) 619-4290
SAIN coordinator, Emily Rivera (617) 619-4300
District Attorney's Office, Suffolk County (617) 619-4300
Sexual Assault Unit, Boston Police (617) 343-4400

Parental Support
MA SIDS Program: (800) 641-7437
Parental Stress Hotline *24 hr*: (800) 632-8188