Vermont Child Abuse and Neglect: Guidelines and Resources for Healthcare Professionals

The heart and science of medicine.

THE University of Vermont Children's Hospital

Contents

Introduction

There are standardized national guidelines for the work-up of child maltreatment; however, there are also regional practices and state laws that need to be taken into account when evaluating a child for maltreatment. The guidelines outlined in this manual are meant to standardize the medical approach to identification, work-up, and treatment of child maltreatment for children who live in Vermont and upstate New York.

When there is a sufficient evidence base for recommendations, they are incorporated into these guidelines. When there is not a sufficient evidence base for recommendations, local expert guidance forms the basis for these guidelines.

This resource is intended to give professionals an understanding of standards of care in the evaluation and work-up of child maltreatment and to help providers recognize when it is appropriate to transfer patients to a higher level of care. Additionally, these guidelines are intended to provide a level of transparency for everyone involved in the process.

CHILD SAFE PROGRAM

University of Vermont Medical Center

802-847-2700

https://www.uvmhealth.org/medcenter/Pages/Departments-and-Programs/Child-Safe-Program.aspx#TabOne

The Child Safe Program identifies, treats and supports children who are suspected to have experienced or are at risk of experiencing abuse and neglect. This program is staffed by a board-certified child abuse physician, nurse practitioner, pediatric forensic nurse and social worker. The Child Safe Program conducts multidisciplinary evaluations of children in the hospital and in the Child Safe Clinic on an urgent and routine basis. The Child Safe Program is also available for consultative and educational services throughout Vermont and upstate New York.

The Child Safe Program would like to extend its gratitude to the numerous professionals in the medical, legal, mental health, advocacy and child welfare fields who have taken the time to review these guidelines and offer their feedback.

The Child Safe Program at UVM Medical Center (UVMMC)

Evaluating a child for abuse or neglect is not easy. Every case poses unique challenges. Completing these evaluations should be a team effort that draws on all available resources and expertise. Working as a team ensures that we are making the best decision for the child and family. The Child Safe Program at UVMMC is committed to being a part of this team.

Services

- Evaluation of children who are admitted to UVMMC with concerns for child maltreatment
- Contact through the provider access line at UVMMC (802-847-2700)
- Availability to discuss acute or chronic concerns of child maltreatment
- Secure photo sharing
- Recommendations for work-up and management of maltreatment
- Case conferences on inpatient and complex cases
- EPIC referral to the "Child Protection Team" (for medical providers)
- Shared email (childprotectionteam@uvmhealth.org) available for less urgent consults
- Answers to specific consult questions
- Recommendations for medical assessment of child victim and other children in the home
- Ability to participate in multidisciplinary team meetings
- Education pertaining to all topics of child abuse and neglect

Child Safe Clinic

- Comprehensive exam for non-acute concerns of child maltreatment
- Detailed history from the current caregivers, review of prior records, conversation with child about the events
- Detailed physical exam (which may include colposcopy to evaluate acute and healed injuries, evaluation for STIs)
- Recommendations for follow-up care, including mental health and advocacy

Note: Consultation with the Child Safe Program does not replace consultation with other pediatric specialists (trauma, surgery, neurosurgery, dental, gynecology, etc.)

Reporting Child Maltreatment Guidelines

The decision to report suspected child maltreatment can be difficult, but failure to recognize signs can have serious consequences for children. If you suspect a child is being abused or neglected, you are mandated to report your concerns to Child Protective Services within 24 hours from when you become aware of the concern. The Child Safe Program is available to answer questions and offer consultative services to help mandated reporters understand and organize their concerns, as well as navigate through all the steps in reporting.

The Family Services Division within the Department for Children and Families (DCF) is Vermont's designated child welfare agency.

Since Vermont borders New York, New Hampshire and Massachusetts, many children cross state lines either to access medical care or to live with parents who reside in two different states. It is helpful to know that there are both similarities and differences in the child protective systems in different states. All of Vermont's bordering states also have centralized reporting systems that are staffed 24/7.

Things that may be different in other states include:

- Name of the agency (CPS, DCYF, DSS are all common abbreviations for designated child protection agencies)
- Protocols that guide when an in-person, after-hours emergency response occurs
- Time frame for the child protection agency to make contact with the family
- Coordination with law enforcement
- Availability of preventive services for reports that don't rise to the level of intervention by child protection

Note: If a child is in immediate danger, call 911 or local police prior to making the child protection report.

YOU CAN REACH THE VERMONT CHILD PROTECTION HOTLINE AT 1-800-649-5285.

For more information about reporting to Vermont DCF, please visit:
https://dcf.vermont.gov/fsd/report

YOU CAN REACH THE NEW YORK CHILD PROTECTION HOTLINE AT 1-800-342-3720.

For more information about reporting to New York Child Protective Services, please visit:
https://ocfs.ny.gov/main/cps/default.asp

YOU CAN REACH THE MASSACHUSETTS CHILD PROTECTION HOTLINE AT 1-800-792-5200.

For more information about reporting to Massachusetts services, please visit:
https://www.mass.gov/how-to/report-child-abuse-or-neglect

YOU CAN REACH THE NEW HAMPSHIRE CHILD PROTECTION HOTLINE AT 1-800-894-5533.

For more information about reporting to New Hampshire services, please visit:
https://www.dhhs.nh.gov/dcyf

Tips for Mandatory Reporting for Medical Providers

Preparing ahead of time and making an effective report can be just as important as making the decision to report concerns of abuse or neglect. The following are some helpful hints to keep in mind before making the call. Providing all of the relevant information to DCF/CPS allows them to make more accurate child safety decisions. It is often helpful and important to talk as a multidisciplinary team to better understand the concerns of the whole team.

- **Gather as many family demographics as you can, including:**
  - DOB of child, parents' names and phone numbers, race/ethnicity of patient and immediate family members, custodial arrangement, primary living arrangement, physical address, siblings' names and dates of birth.
- **Be specific about your concerns of abuse or neglect:**
  - Provide a clear statement about what your concern is and what prompted you to make the call; articulate the harm (short-term and long-term) you're concerned about. For example: Child has an unexplained skull fracture, child disclosed sexual abuse, family is not following through on recommended medical care.
  - Explain the medical recommendations and next steps (child is being admitted, child is being discharged, further medical work-up is being done, appointment is being rescheduled, etc.).
- **Share relevant information about family circumstances:**
  - Family resources or natural supports that you're aware of
  - Interventions that have been attempted to address the concern
  - Current location of the child
  - Whether or not the family knows that you've decided to report*
- **Share relevant information about other social concerns the family may be experiencing and how you've become aware of those concerns:**
  - Substance use, mental health concerns, safety concerns (weapons in the home, aggressive animals), domestic violence and any other factors you think would be important

***All efforts should be made to be transparent with the family about your role as a mandated reporter and decision to report unless doing so places the child in greater danger. If you are unsure whether or not telling the family may place the child in greater danger, you are encouraged to discuss this with the intake worker at the child protection hotline.**

After you make a report of abuse or neglect, supervisors will review the allegations and compare with policy to make a decision regarding acceptance for intervention.

Importance of Social Work Evaluation/Safety Assessment

Every child presenting with a concern for child maltreatment warrants a comprehensive social work evaluation. If this is not available, consider transfer to a higher level of care.

A social worker evaluation can provide:

1. Additional information and history regarding concerns of abuse.
2. A skilled patient and family safety/risk assessment
3. Assistance in determining level of concern for abuse
4. Making a report to CPS/ DCF
5. Resources and family support
6. Discharge planning and coordination

The following information will be gathered in a social work evaluation:

- Are there protective caregivers?
- Do the caregivers have supports?
- Does the person of concern have access to the child?
- Is there any previous or current CPS/DCF involvement. If current, who is the assigned caseworker?
- Are there other children in the home or at risk?
- Are there any issues with visitation?
- Is there concern for domestic violence?
- Is there concern for manipulation or coercion of the child or children in the home?
- Is there concern for caregiver impairment?
- Is the child at risk for self-harm or harming others?
- Other child/youth vulnerabilities/ protective factors?
- What are the current custody orders or visitation guidelines?

If immediate safety concerns are identified, contact the child protection hotline while the patient is still present in your facility, to relay those concerns.

Note: If you are recommending transfer to another facility for further work-up, consider safety issues when determining the best mode of transportation. If the child is being transferred by private vehicle, it is advised that the transferring facility reach out to the accepting facility and alert them to follow up with Child Protective Services if the child does not show up as planned.

Bias in Child Abuse Identification, Reporting and Work-Up, and Special Populations

According to 2018 national data from KIDS COUNT, Black children comprised approximately 14 percent of the population, yet 23 percent of children in foster care were Black. Once in the system, Black children are more likely to languish in foster care, less likely to be reunited with their families and more likely to age out of the system without permanent connections.

This disparity starts at the decision point of reporting and continues throughout the entirety of child protection involvement. It is essential that professionals in this field be aware of this disproportionality and be willing to think critically about what's influencing their decision to report, as well as whether or not to pursue a work-up for child abuse.

Bias in Child Maltreatment

As providers, we must acknowledge bias occurs in this work. However, we know abuse can happen in any family. Decision-making based on personal biases can lead to differences in reporting, work-ups and outcomes for children. Recognizing bias and health care's role in perpetuating bias is important in addressing the problem. A standardized approach in medicine, especially in cases of child maltreatment, will reduce bias and the impact of bias on patient care while providing evidence-based, child-focused care. Continuous self-assessment and vigilance is essential in ensuring that decisions are made based on clinical findings.

THERE ARE SEVERAL POPULATIONS THAT ARE MORE VULNERABLE TO MALTREATMENT AND BIAS. THESE INCLUDE:

Patients with Differing Abilities

Understand that pediatric patients with differing abilities may have unique physical, sensory, cognitive, developmental or mental health needs. These children, depending on their challenges, may be at greater risk for abuse.

- Assess a victim's level of ability and need for assistance during the exam process.
- Provide reasonable accommodations.
- Communicate directly with pediatric patients, even when interpreters, intermediaries or guardians are present.
- Recognize that the exam may take longer to perform.

Native Americans

Native American patients may have unique cultural or language needs. Recognize that native tribes may have their own laws and regulations, as well as their own police, prosecutors, advocates, courts and service providers to address maltreatment. American Native/Alaska Native women and children are of central and primary importance to the family and the community.

- Be mindful that sexual violence against a Native woman or child may be seen as an assault on both the individual and the community.
- Be mindful of historical trauma.
- Identify any agencies outside DCF/CPS that may be responsible for child welfare in this population.

Patients who are LGBTQIA+

- Be aware that youth identifying as LGBTQIA+ are at high risk for abuse.
- Always refer to pediatric patients by their preferred name and pronouns, even when speaking to others. If unsure of what name or pronoun to use, ask the patient.
- Treat the knowledge that the person is LGBTQIA+ as protected medical information subject to all confidentiality and privacy rules.
- Be aware that caregivers and companions of pediatric patients identifying as LGBTQIA+ may not know the patient's gender identity or sexual orientation.

Patients who are Male

Adolescent males are less likely to report abuse, and when abuse is identified they are often considered to be either partly or fully responsible. Sexual abuse is under-recognized and underreported in males.

- Help male pediatric patients understand that male sexual assault is not uncommon and that the assault is not their fault. Many male pediatric patients focus on the sexual aspect of the assault and overlook other elements such as coercion, power differences and emotional abuse. Broadening their understanding of sexual assault may reduce their self-blame.
- Because some male pediatric patients may fear public disclosure of the assault and the stigma associated with male sexual victimization, consider emphasizing the scope of confidentiality of patient information during the exam process.

Offer male pediatric patients assistance in considering how friends and family members will react to the fact that they were sexually assaulted (e.g., by a male offender or a female offender). Research tells us that male pediatric patients are less likely than females to seek and receive support from family members and friends, as well as from advocacy and counseling services.

Cultural/Religious Considerations

Child maltreatment and discipline is viewed differently in different cultures. Asking about various cultural practices/beliefs may help provide context for certain injuries or circumstances surrounding injuries. **However**, regardless of cultural norms, abusive injuries or situations that place a child in danger need to be reported to DCF/CPS.

- Make every effort to use an interpreter/cultural ambassador when English is not the primary language.

Examinations and Custody Concerns

Although it is not common, there are times when concerns for abuse are used as a tool in custody disputes.

- Repeated child maltreatment interviews and exams of children for vague concerns can be harmful.
- Consider engaging a multidisciplinary team that includes the medical home, law enforcement, child welfare and prosecutors to assess the family situation, the veracity of the reports, and the actual need for ongoing exams.
- Bear in mind that with all concerns of repeated maltreatment (such as repeat sexual assault exams), the primary concern is to ensure the well-being of the child, not to meet the custody needs of the parent.

A WORD ABOUT CHAPERONES...

Always refer to your institutions policy regarding chaperones. Consider the use of a medical chaperone in cases of child abuse and neglect. Suggested resource: AAP Policy Statement-Use of Chaperones During the Physical Examination of the Pediatric Patient.

Tips for Obtaining Medical History in Child Abuse Cases

There are times when you will be the first person to complete a medical assessment with a child who is presenting with a primary concern of abuse. The role of the medical provider in the evaluation/work-up of abuse is to assess whether there are injuries or exposures that need medical attention and to reassure the child that they are not at fault and are healthy. The role of the medical provider is **not** to determine who may have perpetrated the abuse or what the intent may have been. A medical history gathering is not a forensic interview. Gathering medical history from the parents and/or the child is done to identify any potential important medical concerns. If a child reports detailed information about the abuse, it is best to ask open-ended questions (e.g. “tell me more about that”) and document the child’s statements verbatim.

If English is not the language the family speaks at home, it is important to use a professional (non-familial) interpreter for all interactions with the family.

Medical History from Caregiver

All efforts should be made to speak with a parent or caregiver separately from the child to obtain an understanding of the circumstances surrounding the suspected maltreatment. This information may be obtained by the health care provider or a designated member of the team (nurse, social worker).

GENERAL DOCUMENTATION

- Person(s) who accompanied patient and their relationship to patient
- Sources of information
- Police report if filed: police department, case number, assigned detective and contact information
- DCF/CPS report if filed: intake number, district office, assigned worker and contact information
- Who was present when history of the event was obtained
- Any safety concerns identified (weapons in the home, concern for domestic violence, etc.)

CURRENT MEDICAL HISTORY

- A detailed timeline of the events leading up to the concerns/symptoms, including when the child was last in normal state of health
- Physical symptoms or signs noted by parent or caregiver
- Behavioral changes such as anxiety, sleep disturbance, toileting problems
- Action the parent or guardian took after noting concerns/symptoms

PAST MEDICAL HISTORY

- Birth history (delivery type, gestational age)
- Feeding history (breast, bottle, supplemented, etc.)
- A detailed developmental history, including motor development, communication, learning disabilities, special education
- Active and significant past medical problems
- Medication history
- Allergies

SOCIAL HISTORY

Social work involvement in cases of child maltreatment is recommended and can add details to the social history.

- Household composition: adults and children (include ages) in each household the child resides in
- Other caregivers for child and settings that child spends time in
- Whether or not the caregivers who are present have ongoing or immediate safety concerns for the child or themselves
- Family stressors and supports
- Current or past DCF/CPS involvement with the family
- Other children who may be at risk

FAMILY MEDICAL HISTORY

- History of early hearing or vision loss, multiple broken bones, easy bleeding, significant dental issues or precocious puberty
- History of mental health diagnoses and/or substance use disorder

REVIEW OF SYSTEMS

- A comprehensive review of systems with a pediatric focus, including recent or intercurrent illness, recent vomiting, fussiness or inconsolability.

Note: Clear documentation in cases where child abuse is in the differential diagnosis is a critical aspect of providing effective patient care. Where there is a concern for non-accidental trauma, specifically document the concern. Use quotation marks, attribute remarks to child or adult, and record impressions, but identify them as such. Avoid qualifiers such as, "This is a nice family that..."

Medical History from Child

If a child is verbal, it is preferred that the child talk to the medical provider with the parent or caregiver out of the room. It is important to keep questions open-ended and to follow up statements with "tell me more about that." Avoid leading questions ("Did mommy hit you?").

Timelines for children may be difficult to ascertain due to developmental age and/or trauma. They may not be able to distinguish "before" or "after" or "first" and "then".

OBTAINING HISTORY FROM THE CHILD

Help to put the child at ease by initiating neutral conversation. Use this conversation to do a developmental assessment of the child's speech. Is the child able to give a free narrative of an event ("What happened at school today?" or "What happened at your last birthday?")?

Ask open-ended questions ("Why did your parent bring you here today?"). Avoid yes or no questions and multiple-choice questions. Allow space during the interview and exam for the child to ask questions and bring up conversation that he/she may want to discuss. If a child is reluctant to speak, it may be best to defer the history taking.

- Start the exam by saying, "In order for me to be able to take care of you, I need to ask you some questions about why you are here today."

Allow the child to fully answer each question before asking another.

- Encourage free narrative. Understand that free narrative will give the most accurate report. Yes or no questions may result in more, but less accurate, information.
- Do not introduce new information, such as actions ("Did he do...?") in questions.
- Referring to prior statements by the child is acceptable ("You told me he did...").

EXAMPLE QUESTIONS APPROPRIATE FOR YOUNGER CHILDREN: TELL ME ABOUT...

- Any ouchies or booboos you have?
- Anything bothering you today?
- Anything you would like to talk to me about today?
- Why are you here today?

EXAMPLE QUESTIONS APPROPRIATE FOR OLDER CHILDREN:

- Tell me why your mom/dad/guardian brought you here today?

CHILD FORENSIC INTERVIEWS

In Vermont, the Department for Children and Families and/or law enforcement typically arranges child forensic interviews. This takes place after a report of child abuse or neglect has been called in to and accepted by the DCF Centralized Intake (1-800-649-5285). Ideally, forensic interviews occur at the local Children's Advocacy Center (CAC), an area designed to create a feeling of safety and security for children. CACs provide a space where professionals can work together to minimize the need for multiple interviews with a child.

Participation in a forensic interview is child led, and assent is required.

CHILD SAFE - TIME OUT USING BEST PRACTICE

Pre-Reporting Time-Out: Have we checked our BIASEs?
e.g. what are your cultural beliefs aroud family norms and child safety? would you report this case in all situations?

Are there opportunities for the medical community to EDUCATE and SUPPORT the family that would help alleviate the concerns?
e.g. have we solicited information from other team members?

Do we have enough SITUATIONAL AWARENESS to make a report?
e.g. have we solicited information from other team members?

Have we been TRANSPARENT with the family about our concerns and/or making a report?

Physical Child Abuse Clinical Guidelines: Bruising

Overview

Bruising is the most visible sign of child abuse and may be the only outward indication of additional injuries to a child. Bruising in a child is considered a sentinel injury. Sentinel injuries are minor injuries with major significance. A sentinel injury in an infant may appear minor but can be a precursor to ongoing or escalating abuse. Any bruising on a child must be evaluated in the context of the child's developmental level. A thorough history and physical will help in determining whether a bruise is concerning for abuse. A comprehensive skin exam (undressed) is necessary.

Note: Bruises cannot accurately be aged.

ACCIDENTAL BRUISES	ABUSIVE BRUISES
• Tend to occur over bony prominences (e.g., spine) • Matches the mechanism provided in the history • Makes sense in the context of the developmental stage of the child	• Unexplained or poorly explained cause of injury provided • Not consistent with child's developmental level and capabilities • Unexplained/poorly explained bruising on a child who is not ambulating • Bruising to the torso, ears and neck • Bruising to genitalia • Patterned bruises (e.g., handprint, looped cord)

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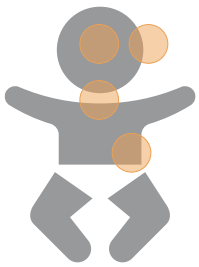
When Bruises Are Signs of Child Abuse

If any of the following are seen on a baby or child, contact your pediatrician.

4 Months

Age

Bruising on a baby younger than 4 months



Body Bruising

Bruising on the torso, ears, neck, face (jaw line, cheeks, eyelids) on a child up to age 4

Patterns

Bruising that shows a pattern (slap, loops, grip marks) on a child at any age

Assessment

Important considerations when evaluating children with soft tissue injuries:

- Those who don't cruise rarely bruise.[1]
- TEN-4 FACES-p Decision Rule[2]:
  - Any bruise on a child 4.99 months of age and younger, without a witnessed accident, is highly concerning for abuse
  - Any bruise in the TEN region (torso including genitals and buttocks, ears and neck) in a child 5 months to 4 years of age without a witnessed accident is highly concerning for abuse
  - Any injury in the FACES locations is highly concerning for abuse
    - **F**—Frenulum
    - **A**—Angle of the jaw/neck
    - **C**—Cheek
    - **E**—Eyelid
    - **S**—Sclera/subconjunctival hemorrhages
  - Patterned bruising is highly concerning for abuse
- Document bruising as descriptively as possible including shape, size (with a measuring tool), location and any other notable characteristics.

Work-Up

- Perform a thorough history and physical with special attention to age/developmental abilities of infant/child, consistency of history provided, presence of other injuries, and whether there has been a delay in seeking care.
- If you are concerned about child maltreatment, then consultation with the Child Safe Program is strongly recommended.
- Photo documentation of all injuries is warranted (see section on Photo Documentation Guidelines).
- Social work evaluation in all cases of concern about child maltreatment is highly recommended.
- For children under 2 years of age, a skeletal survey (see Child Safe Program: Protocol for Skeletal Survey) should be completed and read by a pediatric radiologist.

- For children > 2 years of age, a skeletal survey may be warranted in certain situations and circumstances, including nonverbal and immobile child
- Labs (CBC, PT, PTT, VW Factor antigen/activity, Factor VIII, Factor IX levels)
- If bruising is in abdominal area, AST/ALT and UA looking for hematuria and consider further trauma work-up including a Pediatric Surgical consult
- Head imaging in children ≤ 6 months of age or in any children with altered level of consciousness (see section on Abusive Head Trauma)

Siblings or other children in the household should be evaluated by a medical provider for a complete physical exam to document any external injuries or other stigmata of abuse.

Follow-Up

- In most instances, a child will need a follow-up skeletal survey two weeks after the initial skeletal survey. The skull and pelvis are often not included in the follow-up exam.
- If you are unsure whether a mark is a bruise or a birthmark, scheduling a follow-up visit within a week or so to evaluate any changes in appearance of the lesion can be helpful.
- Children who experience ear bruising/injuries should be referred for a formal hearing evaluation.

Special Considerations

Not all bruising is abusive. There are mimics, including:

- Congenital dermal melanocytosis/slate gray spots
- Hematologic conditions (von Wilebrand disease, factor deficiencies, vitamin K deficiency)
- Cultural practices (moxibustion, coining)
- Phytophotodermatitis
- Suction injuries or “hickeys”

Strongly consider consulting pediatric trauma services if more extensive injuries are suspected.

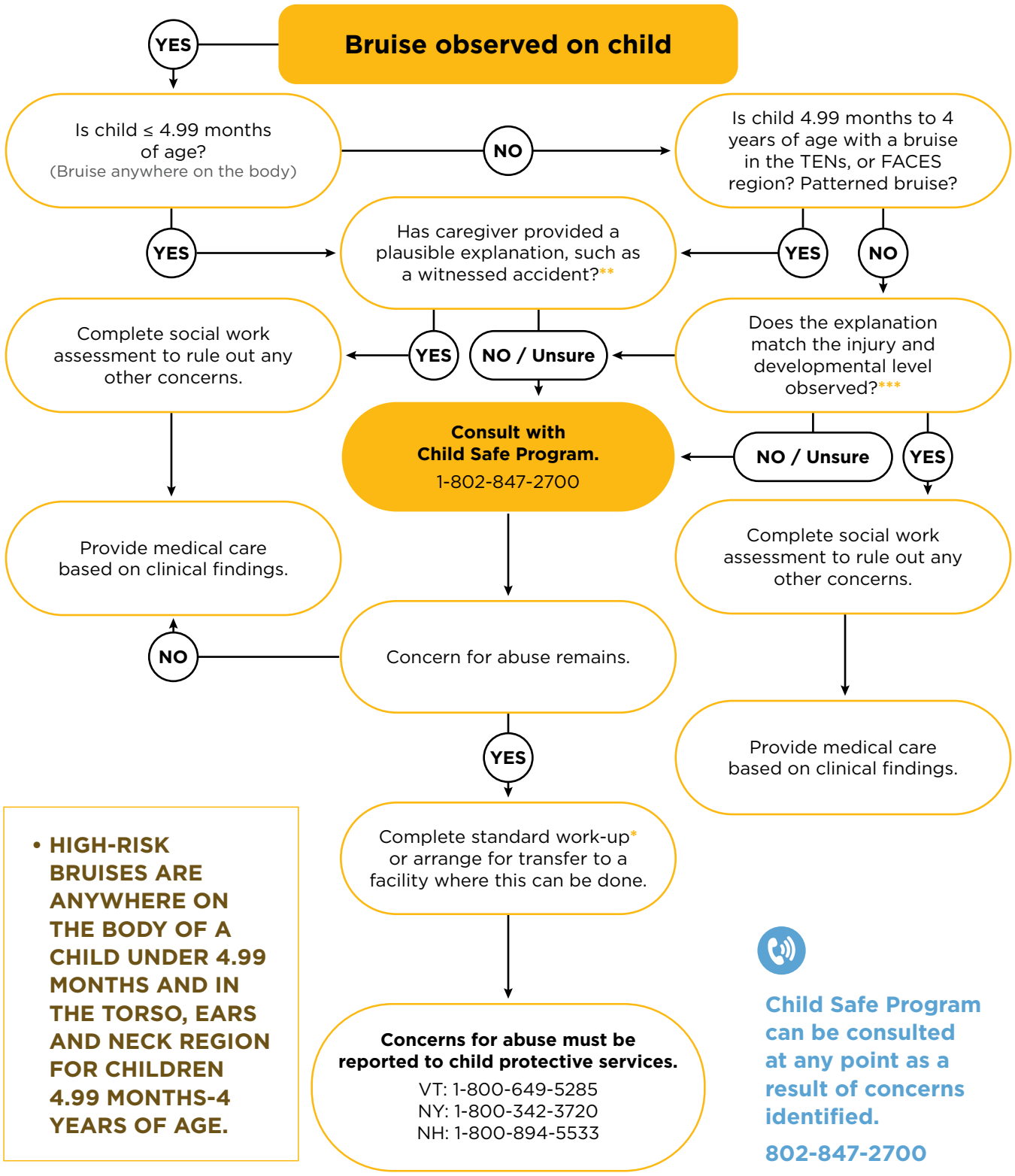
Other Injuries

- Lips and frenula are common sites of abusive injuries. Other sites include the posterior pharyngeal space and jaw.

Bite marks may be suspected when injuries are noticed in an elliptical, ovoid or horseshoe-shaped pattern. Bite marks may have an area of central bruising due to a suctioning force. Animal bites tend to cause puncture wounds (cat bite) or tear or crush tissue (dog bites), whereas human bites cause abrasions or lacerations.

Note: Subconjunctival hemorrhages in infants are not caused by coughing, constipation or vomiting and are considered a sentinel injury.

Decision Tree for High-Risk Bruising



- **HIGH-RISK BRUISES ARE ANYWHERE ON THE BODY OF A CHILD UNDER 4.99 MONTHS AND IN THE TORSO, EARS AND NECK REGION FOR CHILDREN 4.99 MONTHS-4 YEARS OF AGE.**

Child Safe Program can be consulted at any point as a result of concerns identified.

802-847-2700

*Standard work-up includes a skeletal survey at UVMMC, DHMC or Albany Medical Center

**When there is any question about the plausibility of the explanation or mechanism of injury it is strongly recommended to move to consult with the Child Safe Program

Physical Child Abuse Clinical Guidelines: Skeletal Injuries/Fractures

Overview

Fractures are the second most common injury of abuse. Any fracture in a child must be evaluated in the context of the child's development and the explanation provided by caregivers. Fractures can occur both in isolation and with other injuries. A complete and thorough history and physical will help in determining level of work-up and possible additional injuries. Fractures can be occult and may not have any overlying injury associated with them.

Assessment

SPECIFICITY OF FRACTURES IN ABUSE:

HIGH SPECIFICITY	MODERATE SPECIFICITY	COMMON BUT LOW SPECIFICITY
• Classic metaphyseal lesions ("corner," "chip" or "bucket handle" fractures • Rib fractures (especially posterior) • Scapular and sternal fractures	• Multiple fractures • Fractures of different ages or stages of healing • Epiphyseal separations • Vertebral body fractures • Digital fractures	• Subperiosteal new bone formation • Clavicle fractures • Long bone fractures • Skull fractures[3]

- Rib fractures in infants often do not have any external signs of injury including overlying bruising of fractures.
- Classic metaphyseal lesions (CMLs), also known as "corner fractures" or "bucket handle fractures," are highly concerning for abuse and suggest a twisting, jerking or wrenching of an extremity. (Kleinman, 2009)

Skeletal surveys are the standard of care for young children with a concern for non-accidental trauma, and for their siblings.	**This skeletal survey should not be considered an "elective" procedure.**	**Obtaining a skeletal survey should occur as close in time to identification of injury as possible and read by a pediatric radiologist.**

Work-Up

- A thorough history and physical should be performed, with special attention to plausibility of injury based on age/developmental abilities of infant/child, consistency of history provided, presence of other injuries, and whether there has been a delay in seeking care.
- Complete skin exam, head-to-toe
- If you are concerned about child maltreatment, then consultation with the Child Safe Program is strongly recommended.
- Consideration of an underlying bone disorder (e.g., rickets) is warranted, and routine bone labs are recommended. An underlying bone disorder may or may not be apparent on skeletal survey.
- Social work evaluation in all cases of concern about child maltreatment is highly recommended.
- If cutaneous injuries are noted, photo documentation is warranted (see section on Photo Documentation Guidelines).

≤ 2 YEARS OF AGE	≥ 2 YEARS OF AGE
• Skeletal survey at UVMMC, Dartmouth, or Albany • Labs (PTH, 25-OH Vit D, Ca, Mag, Phos, Alk Phos) • Head imaging in children ≤ 6 months of age or in older children with altered level of consciousness (see section on head imaging)	• Skeletal survey may be warranted in certain situations and circumstances including children with medical complexity and/or children who have distracting injuries • Labs (PTH, 25-OH Vit D, Ca, Mag, Phos, Alk Phos) • Head imaging strongly encouraged if injury includes the head (see section on head imaging)

Children ≤ 2 years of age should have a skeletal survey (see Child Safe Program: Protocol for Skeletal Survey) completed and read at a pediatric center, and children ≤ 6 months of age should have head imaging.

Fractures of abuse can be subtle and not detected on initial X-rays. In cases where high suspicion of fractures exists, other imaging modalities may be indicated, e.g., CT scans.

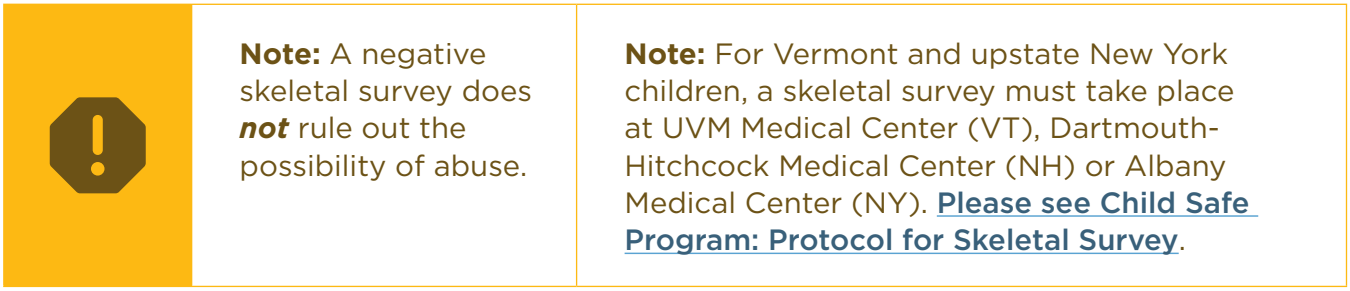
Siblings or other children in the household of suspected abuse pediatric patients should be evaluated by a medical provider, including getting a complete physical exam to document any external injuries.

Special Considerations

Rare disorders, such as osteogenesis imperfecta, rickets, Menkes disease or other metabolic bone disorders, may cause unexplained fractures. If you are considering a work-up for a bone disorder, consultation with a pediatric geneticist is advised.

COMMON NON-ABUSE-RELATED FRACTURES IN CHILDREN:

- Birth-related fractures typically result from breech, large for gestational age instrumented or traumatic deliveries. The most common birth-related fractures are of the clavicles. Rib fractures are not common birth injuries, nor are they commonly the result of CPR.
- Toddler fractures, non-displaced spiral fractures of the long bones, are common accidental injuries in ambulating children.
- Skull fractures in and of themselves are not specific for abuse and can result from accidental short falls.

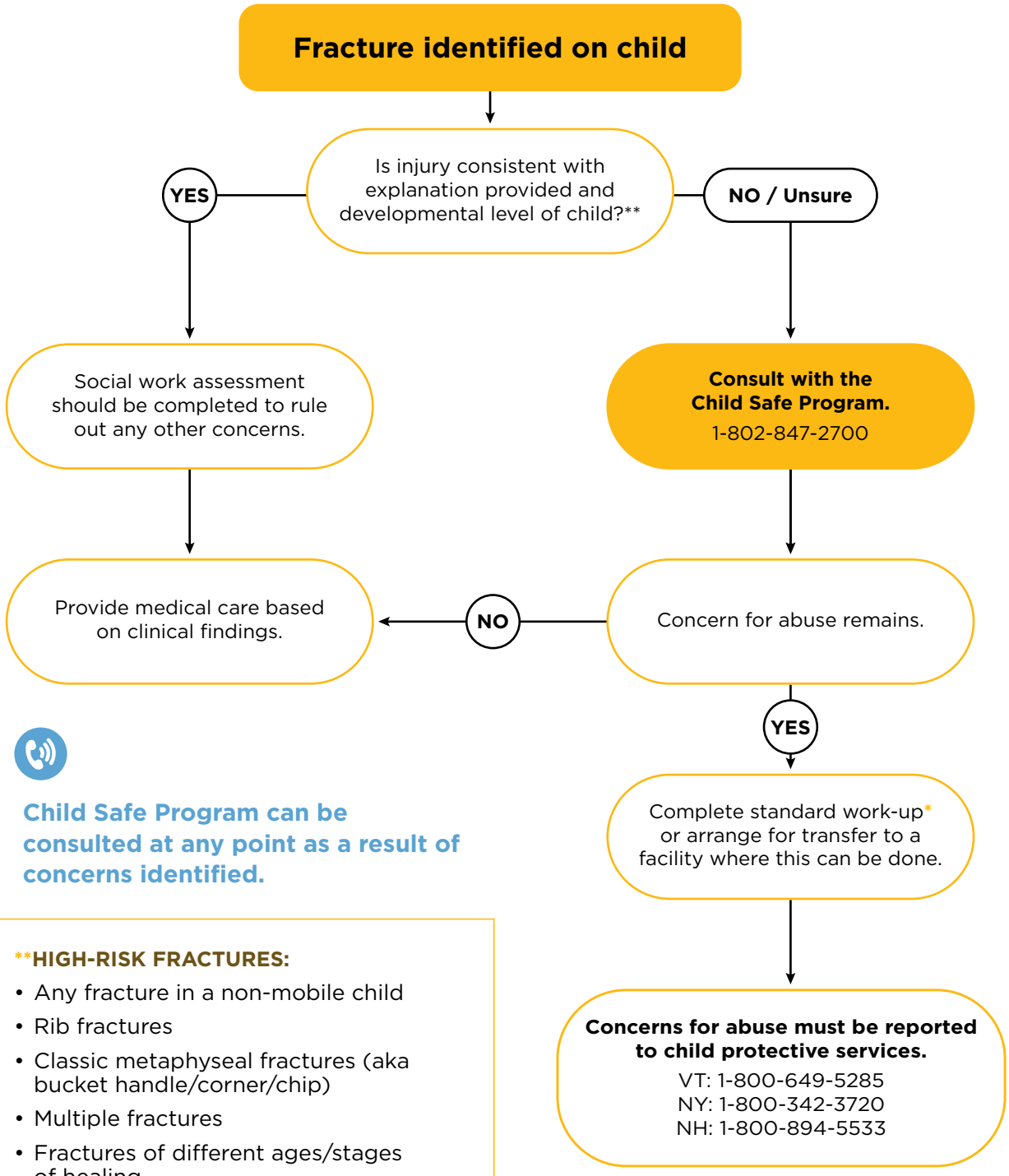


Follow-Up

- Children need a two-week follow-up skeletal survey to detect any fractures that may not have been seen on initial X-ray. It is preferable for the follow-up skeletal survey to occur at the same facility where the initial skeletal survey took place. Head and pelvis X-Rays are often not included.

Evaluating Young Children With Fractures for Child Abuse:Clinical Report

Decision Tree for Skeletal Injuries



Child Safe Program can be consulted at any point as a result of concerns identified.

****HIGH-RISK FRACTURES:**

- Any fracture in a non-mobile child
- Rib fractures
- Classic metaphyseal fractures (aka bucket handle/corner/chip)
- Multiple fractures
- Fractures of different ages/stages of healing
- Scapular and sternal fractures

*Standard work-up includes a skeletal survey at UVMMC, DHMC or Albany Medical Center

**When there is any question about the plausibility of the explanation or mechanism of injury it is strongly recommended to consult with the Child Safe Program

Child Safe Program: Protocol for Skeletal Survey

OVERVIEW

The Child Safe Program at UVM Children's Hospital follows the guidelines outlined in the AAP Policy statement "Diagnostic Imaging of Child Abuse."[4] The AAP and ACR recommend obtaining this comprehensive radiological exam for any child younger than 2 years of age with a fracture that is concerning for abuse, and for that child's close contacts.[5] Children with medical complexity or children who have distracting injuries regardless of age may warrant a skeletal survey. A follow-up survey is typically scheduled two weeks after the initial survey to track healing and ensure that no additional injuries are present.

For Vermont and upstate New York children, a full skeletal survey must take place at UVM Medical Center (VT), Dartmouth-Hitchcock Medical Center (NH) or Albany Medical Center (NY).

Indication: Skeletal surveys are indicated for all children younger than age 2 and in older children, in certain circumstances (nonverbal, immobile) with concerns for physical abuse.

Any children under the age of 2 years who are cared for by the person(s) of concern, should also undergo a skeletal survey.

PHYSICAL EXAM FINDINGS THAT ARE CONCERNING AND MAY PROMPT A SKELETAL SURVEY INCLUDE:

- *Any* injury to a young, pre-ambulating child
- Injuries to multiple organ systems
- Injuries in different stages of healing
- Patterned injuries
- Injuries to non-bony or other unusual locations (torso, ears, neck, face, upper arms)
- Significant unexplained injuries
- Additional evidence of child abuse

EDUCATION

Questions regarding skeletal surveys should be directed to Child Safe Program staff.
Email: childprotectionteam@uvmhealth.org

Caregivers should receive the handout **What to Expect When Your Child Needs to Have a Bone Survey.**

SCHEDULING

Ideally, all pediatric skeletal surveys are performed as close to the time of injury as possible. Skeletal surveys are scheduled during regular business hours (8 am-3:30 pm, Monday through Friday) when the pediatric radiologist and the full complement of trained staff, including the child life specialist, are available.

To coordinate the survey, contact the Child Safe Program at 802-847-8200.

Note: Sibling evaluation, follow-up exams and remote history of injury are non-emergent skeletal surveys that can occur on an outpatient basis and be scheduled ahead of time.

MEDICATIONS

Caregivers can be advised that over-the-counter analgesics may be indicated for patients with suspected injuries, administered ideally half an hour prior to the exam.

Physical Child Abuse Clinical Guidelines: Abusive Head Trauma

Overview

Abusive head trauma is the most lethal form of child abuse. It can include cerebral, spinal, retinal and other extracranial injuries. These injuries can result in death or permanent neurological impairments. One-third of abusive head trauma injuries are missed during initial work-up in the emergency department.[6]

Abusive head trauma is the most appropriate and inclusive diagnostic term for children who suffer from inflicted head injury. Abusive head trauma does not presume a specific mechanism of injury; it encompasses whiplash, shaken baby and impact injuries.

Assessment

- Abusive head trauma should be considered in all infants presenting with vague or ill-defined complaints including brief resolved unexplained event (BRUE).
- Acute clinical signs include scalp swelling, bruising to face or other parts of the body, inconsolability, loss of appetite, vomiting, altered sleep patterns, seizures, alteration or loss of consciousness, cardiorespiratory compromise and/or arrest and death.
- Late clinical signs include feeding difficulties, sensory deficits, motor impairments and macro- or microcephaly.

Work-Up

- A thorough history and physical should be performed, with special attention to the caregiver's explanation of the child's presenting illness. Attempt to ascertain when the child was last in his or her normal state of health.
- The physical exam should include careful measurement and plotting of head circumference, vital signs and visual inspection of the entire body. Particular attention should be placed on bruises in non-mobile children, or in the TEN (Trunk, Ears, Neck) regions for older children. Observe for oro-pharyngeal injuries including the frenula, and subjunctival hemorrhages.
- If you are concerned about child maltreatment, then consultation with the Child Safe Program is strongly recommended.
- Social work evaluation in all cases of concern for child maltreatment is highly recommended.
- Recommended imaging in suspected cases of abusive head trauma includes:
  - Children younger than 6 months of age or neurologically altered
    - Neuroimaging* and a complete skeletal survey
  - Children older than 6 months of age
    - **Based on clinical exam** neuroimaging and
    - Complete skeletal survey (up to 2 years of age)

*In selected patients, a trauma-focused MRI may be considered instead of a CT scan.

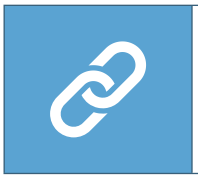
- In most cases of suspected abusive head trauma, the preferred neuroimaging is computed tomography (CT).
- 3D CT reformatting to evaluate for skull fractures should be routine in all cases of suspected abusive head trauma.
- In some instances, magnetic resonance imaging (MRI) may be used in the initial evaluation of abusive head trauma. Specific pediatric protocols to limit the amount of time and necessity for sedation are recommended.
- Formal dilated ophthalmology exam should be performed for children found on neuroimaging to have subdural hemorrhages concerning for abusive head trauma.
- Labs (CBC, coagulation studies including PT/PTT, Factor XII, Factor IX, DIC panel and comprehensive metabolic panel).
- Transfer child to UVM Medical Center, Dartmouth-Hitchcock Medical Center or Albany Medical Center for complete evaluation with a child abuse physician.

Special Considerations

- Consult Pediatric Neurosurgery in cases of abusive head trauma.
- Neuro Imaging should be considered as screening for abuse in siblings under 6 months of age.
- Consideration for other medical causes of intracranial hemorrhage may warrant additional lab work or imaging.
- Consider abusive head trauma in children being worked up for macrocephaly.
- Siblings of children with suspected abuse are also at risk. We recommend that all children in the household are seen by a medical provider.

Follow-Up

- Pediatric Neurosurgery follow-up
- If retinal hemorrhages are found on initial eye exam, pediatric ophthalmology follow-up is indicated
- Consult Pediatric Endocrinology as indicated
- Developmental monitoring



Abusive Head Trauma in Infants and Children: Technical Report

Physical Child Abuse Clinical Guidelines: Burns

Overview

Burn injuries, whether accidental or abusive, are some of the most visible signs of trauma. Determination of the cause of burns requires a careful multidisciplinary team approach. The pattern and healing of the burn can reveal a lot about the mechanism of injury.

Burn principles:

- Scalding liquid typically has a trickle-down drip pattern in which the burn becomes less intense as the liquid runs down and dissipates.
- Pull-down or splash burns typically have a "triangular" appearance, with the area of greatest burn injury occurring at the area of immediate skin contact.
- Clothing or other coverings can attenuate the burn and leave a distinct burn pattern.

Assessment

INDICATORS OF CONCERN FOR ABUSE FROM HISTORY AND PHYSICAL EXAM FINDINGS

AREAS HIGHLY CONCERNING FOR ABUSIVE INJURY	PATTERNS OF INJURY CONCERNING FOR ABUSE	OTHER FINDINGS CONCERNING FOR ABUSE OR NEGLECT
• Hands • Feet • Genital region • Buttocks	• Large surface area of burn • Uniform degree of burn • Full-thickness burn • Presence of sharply delineated burn margin • Symmetrical burns • Absence of burn in areas of skin flexion • Sparing of skin with surrounding burn secondary to contact with cooler surfaces (donut burn) • Scald injury without splash/drip marks	• Infected burns • Chronic burns • Burns in various stages of healing • Burn appears older than stated history • Concomitant cutaneous injuries

Work-Up

- A thorough history and physical should be performed, with special attention to the history of injury based on age/developmental abilities of infant/child, consistency of history provided, presence of other injuries, and whether there has been a delay in seeking care.
- If you are concerned about child maltreatment, then consultation with the Child Safe Program is strongly recommended.
- Social work evaluation in all cases of concern about child maltreatment is highly recommended.
- A skeletal survey is recommended in all cases of suspected abuse-related burns in children and close contacts under 2 years of age.
- Photo documentation of all injuries is warranted (see Photo Documentation Guidelines). Special attention should be paid to documenting the margins of the burns. Additionally, follow-up photos should be taken to document progression of burn and healing.

Special Considerations

- There are many mimics of burns, including those from cultural practices (e.g., cupping, coining), phytophotodermatitis, chemical burns (e.g. nail glue) and laxative-induced buttock burns.
- Much of the work in child maltreatment and burns requires a close evaluation by child protective services and law enforcement, including a scene evaluation.
- In cases of scald/hot water burns, a scene investigation can provide important information.

Follow-Up

- Follow-up care with burn specialist
- Physical therapy
- Mental health support

Prototype Triage Tool for Diagnosis of Intentional Scalds

INTENTIONAL SCALD MUST BE EXCLUDED	INTENTIONAL SCALD SHOULD BE CONSIDERED	INTENTIONAL SCALD UNLIKELY
Physical Features	**Physical Features**	**Physical Features**
MECHANISM • Immersion		**MECHANISM** • Spill injury • Flowing water injury
AGENT • Hot tap water		**AGENT** • Non-tap water (hot beverage)
PATTERN • Clear upper limits • Scald symmetry (extremities)	**PATTERN** • Uniform scald depth • Skin fold sparing • Central sparing buttocks	**PATTERN** • Irregular margin and burn depth • Lack stocking distribution
DISTRIBUTION • Isolated scald buttock/ perineum • +/- lower extremities • Isolated scald lower extremities	**DISTRIBUTION** • Glove and stocking distribution • 1 limb glove/stocking	**DISTRIBUTION** • Asymmetric involvement lower limbs • Head, neck and trunk or face and upper body
CLINICAL FEATURES • Associated unrelated injury • History incompatible with examination findings • Co-existing fractures	**CLINICAL FEATURES** • Previous burn injury • Neglect/faltering growth • History inconsistent with assessed development	
HISTORICAL/SOCIAL FEATURES • Passive, introverted, fearful child • Previous abuse • Domestic violence • Numerous prior accidental injuries • Sibling blamed for scald	**HISTORICAL/SOCIAL FEATURES** • Trigger, such as: Soiling/ enuresis/misbehaviour • Differing historical accounts • Lack of parental concern • Unrelated adult presenting child • Child known to social services	

EVIDENCE WORKSHEET FOR HOT WATER BURNS

A

Case No.
Present Date:
Suspect's Name:
Victim's Name:
Incident Location:
Address:
City/State/Zip:

B

Water Heater Temperature Measurement	
Electric Water Heater	**Gas Water Heater**
Brand	Brand
Capacity	Capacity
Upper plate temp	Temperature setting
Lower plate temp	

C

Incident Location Measurements: 0 Bathtub 0 Basin/Sink 0 Other	
Inside Width	Inside Depth to drain
Inside Length	Height of Rim from Floor
Inside Depth to faucet handles:	Construction/ Material

D

Running Water Temperature			
HOT		**COLD**	
Seconds	**Degrees**	**Seconds**	**Degrees**
0			
5		Running water temperature (full hot and cold)	
10			
20		Seconds:	Peak Temp:

EVIDENCE WORKSHEET FOR HOT WATER BURN (Cont)

E

Full Tub: Standing Hot Water in Incident Location, 5 Inches Deep
temperature measured in middle of tub at water mid-depth

FILL TIME

Inches	minutes/seconds	Minutes	Degrees
1		0	
2		5	
3		10	
4		15	
5		20	
		25	
		30	

F

_____ ran a tub of water on my request. Results: Depth 5 inches. One minute after water off: Temperature _____ degrees Fahrenheit.

Investigator #1 _____

Investigator #2 _____

Physical Child Abuse Clinical Guidelines: Strangulation

Overview

Strangulation is the impeding of normal breathing or circulation of the blood by applying pressure on the throat or neck or by blocking the nose or mouth of an individual. Strangulation can be a serious, life-threatening risk to the short- and long-term health of a child. Children who have been strangled are at high risk for additional abusive injuries.

Note: Currently, there is no standardized work-up for children who have experienced strangulation. Work-up for children who have been strangled depends on their presentation and specific symptoms.

Physical evidence of strangulation is not always obvious. Strangulation results in vessel occlusion (carotid, jugular) and/or airway occlusion (tracheal). While clinical exam findings may be noted, the child's disclosure offers the most reliable insight into what may have happened. Equally important is the child's disclosure and/or interpretation of event(s).

Assessment

Cognitive and developmental differences may make it difficult for a child to effectively describe a strangulation event. Given the varied presentation of children who have been strangled, it is important to ask directly whether a child has been strangled in a developmental appropriate way. Ask about the senses: What did they see, hear, feel, or smell.

Assess for:

- Linear or circumferential ligature marks
- Petechiae (usually above the level of compression): Areas to observe include periorbital, post auricular, face, neck, conjunctivae and oral mucosa
- Facial edema, swelling, congestion
- Facial bruising, abrasions and lacerations
- Blood in mouth or nose
- Vertical abrasions on the neck caused by the child's defensive attempt to relieve the obstruction
- voices changes
- pain of head and neck

See diagram from the Strangulation Institute for a visual representation of injuries to observe for: https://www.strangulationtraininginstitute.com

Work-Up

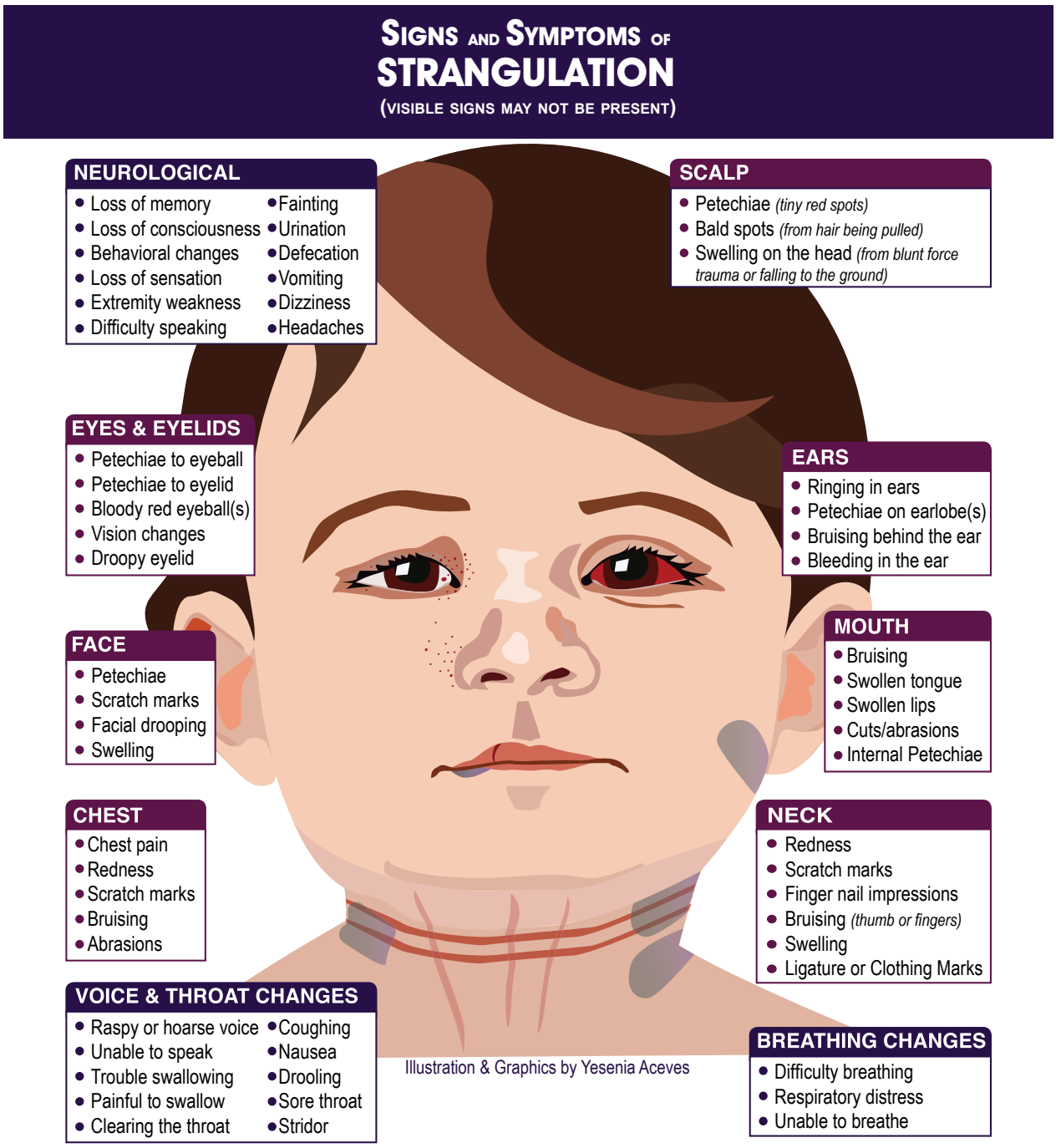
Direct radiologic evidence of strangulation is rare. Rarely is imaging necessary in the pediatric patient with suspected strangulation. In children there is no standardized approach to imaging. In circumstance where a child is symptomatic or has distracting injuries, CT or MRI may be useful to fully evaluate.

Most children who have been strangled will have either minor or no physical findings. Close attention to any overt or subtle symptoms of strangulation is crucial. If questioning whether imaging will be beneficial, consider contacting Child Safe.

Special Considerations

Onset of symptoms may be delayed; therefore, close follow-up in cases of strangulation is important. Children with any symptoms should be seen immediately by a medical provider.

Signs and Symptoms of Strangulation



Source: *Strangulation in Intimate Partner Violence, Chapter 16, Intimate Partner Violence. Oxford University Press, Inc. 2009.*

TRAINING INSTITUTE on STRANGULATION PREVENTION

strangulationtraininginstitute.com

v 10.5.2017

Child Sexual Abuse Clinical Guidelines

Overview

Child sexual abuse is the most underreported type of abuse. It is estimated that one in four girls and one in 13 boys experience child sexual abuse. In most situations, the circumstances around the sexual abuse are unclear, including whether it is acute or non-acute. Lack of clarity can be influenced by several factors, including partial disclosures, developmental level, sense of safety, age of the child, and the manipulation tactics or grooming by an offender. A child's disclosure of sexual abuse should be believed, and the child should be reassured that it is OK to talk about it.

Note: Sexual abuse of children is rarely physically violent. In the large majority (up to 97 percent) of children who are seen for concern of sexual abuse, the physical exam is normal. However, a normal or non-specific exam ***does not rule out*** sexual abuse.

Note: A huge preponderance of sexual assault in boys are not reported.

It is important to note that:

- National guidelines indicate that all children with concern for sexual abuse should be offered a medical forensic exam.[7]
- A medical forensic exam is best completed by a nurse or physician with specific training.
- A decision to obtain a medical exam should not depend on disclosure of "penetration."
- Child sexual abuse includes many acts, not limited to "penetration".
- Penetration is often understood differently by children (i.e. between buttocks).
- Children often disclose the abuse weeks or months after the abuse event, and their disclosure may be vague or incomplete.
- Physical injuries to the genital or anal regions usually heal within a few days.
- Sexualized behavior in and of itself is not a specific indicator of sexual abuse.

THE EXAM

The role of the medical provider in the evaluation/workup of sexual abuse is to determine whether there are injuries or exposures that need medical attention, and to reassure the child that he or she is not at fault and is healthy. **It is not to figure out when, where or how the assault occurred and who was the offender.** A medical interview, not a forensic interview, should be conducted to identify any potential important medical concerns. If the child reports detailed information about the assault, you can ask open-ended questions and document the child's statements verbatim.

A comprehensive evaluation of child sexual abuse is an interdisciplinary effort that includes a medical evaluation, a social work evaluation, a forensic interview, forensic evidence collection, a child welfare/law enforcement investigation and support through Children's Advocacy Centers. In Vermont, the Child Safe Program collaborates with the Vermont Forensic Nursing Program (https://www.vermontsane.org) to coordinate medical forensic care of pediatric patients.

Consent for Care of Minors Related to Sexual Abuse

In Vermont, children under age 18 can provide consent for a sexual assault exam and treatment. The patient's assent must be sought for all aspects of a sexual assault exam and treatment. The patient, of any age, has the right to accept or decline any part of the medical exam. Force or coercion is never used to "complete" the exam.

In general, the parent or legal guardian should be notified of the care needs for a patient younger than 18 years of age. If someone other than the parent or legal guardian brings in a child for care, the parent or guardian should be contacted to provide information and assent. If the patient feels it would be unsafe to tell the parent or guardian, consult the hospital social work team and DCF.

Note: If a child is incapacitated and unable to give consent or assent for a medical forensic examination , seek a higher level of authorization (e.g. hospital legal consult) before performing forensic evidence kit collection or an invasive genital exam.

Confidentiality

It is not always possible to guarantee absolute confidentiality from parents or legal guardians. The minor should be counseled and assisted in informing parents/guardians of the concern. In Vermont, any concern for child sexual abuse in a child less than 18 years old must be reported to DCF (1-800-649-5285) regardless of the relationship between the child and the perpetrator. Vermont DCF will coordinate with law enforcement as appropriate.

Validate and discuss who has access to the minor's medical record. For safety planning purposes, it may be important to know who has access to healthcare information.

Assessment

TRIAGE

The first step for the health care provider with concern for child sexual abuse is to determine whether it is an ***acute*** or ***non-acute*** issue. This determination will guide care, whether a child needs to be seen emergently in an emergency department for an exam with evidence collection or be referred to the Child Safe Program or primary care setting for a non-acute exam.

QUESTIONS TO ASK

- What are the reasons for concern?
- Has the child made a disclosure of sexual contact, or was there a witness to an abusive event?
- When was the last time the patient was in the presence of the person of concern?
- Does the child have any symptoms such as pain, difficulty urinating, discharge or bleeding?

Children are often brought to an emergency department or primary care provider owing to parental concern about sexual abuse. It is important to clarify the presenting concern and understand the events that prompted the worry (e.g., large vaginal opening or contact with a suspected offender). The screening exam includes a brief history from the adult(s) and a physical exam to rule out acute injury (bruises, abrasions, lacerations) anywhere on the body, including the external genital–anal area.

Note: Sexual exploration or play between similar-age peers without force or coercion is common.[8]

>4 years age difference, coercion or manipulation, and persistence of behavior are concerning signs.

Prematurely attributing findings to sexual abuse can have significant consequences for the child, the family and other individuals.

Note: The diagnosis of sexual abuse should be made only with expert consultation.

Types of Exams: Acute versus Non-Acute

These guidelines include information suited for the acute and non-acute exam. The type of exam will vary according to patient needs, the medical setting and the expertise of the examiner.

Consultation with the Child Safe Program can help in determining which exam is most appropriate.

ACUTE EXAM **offer exam if any answer is "YES" AND abuse/exposure occurred ≤ 120 hours**		**NON-ACUTE EXAM** **may schedule later exam if any answer is "YES"**	
Witnessed event	YES	≥ 120 hours since contact with person of concern	YES
Clear disclosure from child	YES	Non-specific behavior changes (e.g., resisting diaper changes, new onset enuresis)	YES
Acute genital injury	YES	Child displays concerning sexual behaviors	YES
Child discloses or is suspected of being a victim of human trafficking	YES	Concerning but non-specific exam findings	YES
Need for emergency contraception	YES		
Need for HIV PeP	YES		
Extreme parent or child anxiety*	YES		
REFER: Have patient seen by Pediatric Forensic Nurse Examiner		REFER: Schedule an outpatient appointment	

*In an effort to understand the parent/child anxiety, consultation with Child Safe Program, Social Worker, or local Child Advocacy Center may be necessary.

Work-Up

OBTAIN COMPREHENSIVE MEDICAL HISTORY

Obtain history from parent and child separately if child is older than 4 years. A detailed history is best obtained by the medical team, with social work and pediatric forensic nursing included when available.

PHYSICAL EXAM

A head-to-toe exam should be performed on all patients, with the immediate external genital exam being the last portion. Injuries (bruises, abrasions, lacerations) should be noted in writing as well as on a traumagram. An external genital exam should be done by the treating physician upon initial exam to ensure there is no acute issue or alternative diagnosis that would negate the need for a forensic exam.

Note: If bruising is noted in a child under 4 years of age, refer to TEN-4 FACES-p Bruising Clinical Decision Rule.

GENITAL EXAM

The purpose of the genital exam is to ensure there is no obvious, acute injury that requires medical attention. Findings may fall into three general categories:

- Normal genital exam with no acute injuries.
- Acute injuries, described by type, size and location. Acute injuries may require the involvement of pediatric surgery, urology and/or gynecology.
- Abnormal or atypical findings with clear written description of what is seen and locations (e.g., genital discharge, odor, irritation, warts, ulcerative lesions, anatomical variants).

The standard of care in pediatric sexual abuse cases is video documentation to capture the dynamic aspects of prepubescent female genitalia and for expert peer review.

Note: Remember Normal is Normal. A "normal" exam does not rule out sexual abuse or prior penetration. It does not mean the child is lying. A normal exam does not exonerate the alleged perpetrator.

Forensic Evidence Collection

In Vermont, collection of forensic evidence within 120 hours of a sexual assault is recommended. Forensic specimens are not processed within the hospital, but stored following the chain of custody and transferred to law enforcement. All evidence is evaluated by the Vermont Forensic Laboratory within approximately six months. Medical providers will not be informed of the forensic evidence findings.

Note: If the history is concerning, it may be best to "err on the side of evidence collection" even if the timeline is not definitive. Discussion with Pediatric Forensic Nurse Examiner or Child Safe Team can be helpful.

Medical Management of Child Sexual Abuse

ACUTE FINDINGS

For acute injuries, a consult with pediatric surgery/gynecology/urology may be warranted.

Note: In the prepubescent patient, speculuum exams should not be performed without sedation.

Pregnancy Testing and Emergency Contraception

Evaluate for pregnancy in all females of possible childbearing age (Sexual Maturity Rating 3 >). Females can become pregnant before their first known menstrual period.

TOXICOLOGY SCREENING

If the patient's history or symptoms indicate the possibility that drugs were used to facilitate the assault, complete toxicology screening. History or symptoms may include memory loss or lapse, disheveled or missing clothing, dizziness or intoxication. Refer to section: Ingestion/Poisoning. In the older pediatric patient, discuss the need for a Drug Facilitated Sexual Assault testing kit with a Forensic Nurse. This is an evidentiary testing mechanism that affords privacy for the patient. It does not replace hospital laboratory testing when results are necessary for immediate medical decision-making.

SEXUALLY TRANSMITTED INFECTIONS

Identification of sexually transmitted infections (STIs) past the neonatal period requires thoughtful consideration of sexual abuse. While vertical transmission and transmission from inanimate objects is possible with certain STIs, the possibility of sexual abuse must be considered given its high incidence. Testing results should be interpreted with care. Use only tests with high specificities to avoid the potential legal and psychosocial consequences of a false-positive diagnosis.

It is important to keep in mind that STIs are not common in sexually abused children of prepubertal age. The need to test children for STIs should be evaluated on an individual basis, and it should be evidence-based and done in accordance with the latest recommendations of the Centers for Disease Control and Prevention.

CDC 2021: https://www.cdc.gov/std/treatment-guidelines/sexual-assault-children.htm

Usually if the circumstances warrant forensic evidence collection, STI testing should be completed as well.

Note: In prepubertal children, prophylactic treatment is not recommended until STI testing has been completed AND confirmed.

According to the CDC (2021), consider the following to indicate a high risk for transmitted infection, warranting consideration for prophylaxis:

- There is a disclosure of penetration or evidence of recent or healed penetrative injury to the mouth, genitals and/or anus.
- The child has been abused by a stranger.
- The suspected assailant is known to have an STI or to be at high risk of STIs.
- A sibling, another child or an adult in the household or child's immediate environment has an STI.
- The child lives in an area with a high rate of STIs in the community.
- The child has symptoms of STIs.
- A low threshold for obtaining STI testing is encouraged. If the threshold for obtaining STI testing has been met, testing should be completed for ***all*** STIs.

WHEN STI TESTING IS INDICATED

HIV:

The risk of HIV transmission from a positive source in a single act of receptive vaginal intercourse is estimated to be one per 1,000. The risk of transmission from a positive source in a single act of anal receptive intercourse is one per 200. The risk from penile–oral or vaginal–oral is extremely low.

HIV testing should be done in all children with concerns for sexual abuse in whom STI collection is indicated. Rapid HIV 1/2 antigen and antibody 4th-generation testing is preferred. Follow-up testing at 3 and 6 months is recommended.

The decision to recommend HIV prophylaxis depends on local epidemiology and a case-by-case assessment of risk factors of the assailant and details of contact. The risk for the pediatric patient is often difficult to calculate, since details about the assailant's risk factors and HIV status are usually unknown.

HIV PEP (post exposure prophylaxis) may be indicated when both of the following are true:

- Sexual contact was within the prior 72 hours.
- There was probable body fluid to mucosa contact.

And any one of the following is true:

- Contact was by a man at high risk (especially a man who has sex with men).
- There was more than one offender.
- There was penile–anal penetration.
- The victim has grossly identifiable genital or anal injury skin disruption.
- The family has a high concern for HIV infection, after discussion of low relative risk.

Gonorrhea and chlamydia:

Urine, separate oral/anal swabs if mucosal contact is suspected.

Nucleic acid amplification test performed on "dirty catch" urine specimen is a good screening test. A positive result should prompt repeat testing by a second, alternative technology, NAAT. The lab should retain the specimen for future testing.

Note: Urethral swabs are not recommended.

Note: Do not insert swabs past the hymen in a prepubertal female.

Trichomonas:

Send "dirty urine" for PCR/NAAT. POC tests for T. vaginalis have not been validated for prepubertal children. Positive tests should be confirmed.

HSV 1 or 2:

Herpes virus is fairly common in the United States and rarely specific for sexual abuse. Routine testing for HSV is not recommended unless lesions are present. If testing use polyester swab and send in viral culture media for PCR.

Syphilis:

Syphilis serologies should be collected.

Hepatitis B & C:

Hepatitis B & C testing is indicated in children for whom STI collection is indicated. For Hepatitis B, surface antibody, surface antigen and core antibody are recommended. For Hepatitis C, antibody testing is recommended. Follow-up testing at 3 and 6 months is recommended.

HPV:

Consider HPV vaccination at > 9 years of age if the series is incomplete. There is data indicating that children who are survivors of sexual abuse are at increased risk of future unsafe sexual practices at an earlier age.[9]

Genital Warts:

Human papilloma virus (HPV) causes genital warts. The cause of genital warts is very difficult to determine, especially when a child is young. A thorough evaluation should be completed. The older the child, the more concerning genital warts are for sexual abuse.

NON-SEXUALLY TRANSMITTED DISEASES

Vulvovaginitis is common in prepubertal girls and is usually due to irritation or infection with a non-sexually transmitted organism. If there is a vaginal discharge, swab the posterior fourchette and send for routine wound culture and gonorrhea culture.

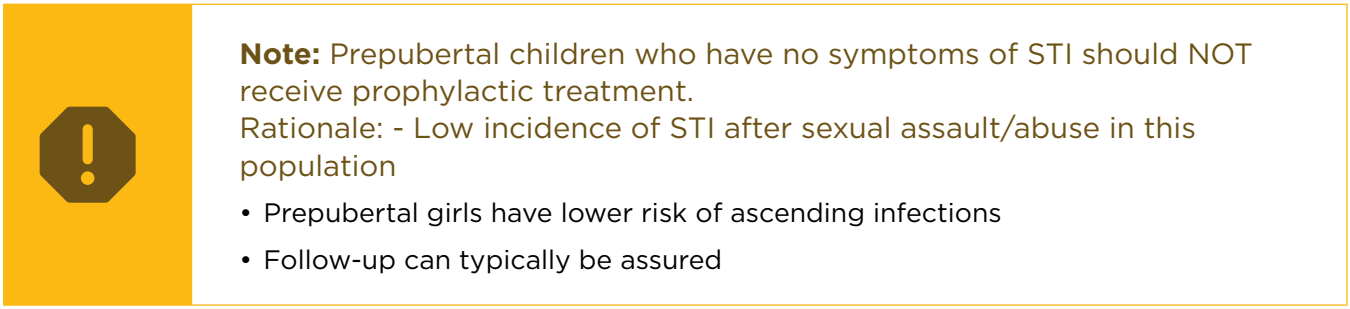
Candida vulvovaginitis is uncommon in girls who are out of diapers and prepubertal. Vaginal discharge or irritation should not be assumed to be candida and inappropriately treated with anti-fungal creams.

STI Testing Guidelines

CONDITION/ INFECTION	INITIAL LAB TESTS	PROPHYLAXIS/ TREATMENT**	FOLLOW-UP TESTING
Pregnancy	**Urine or serum hCG** All females ≥ 12 ≤ 12 yrs with menarche SMR > 3 without menarche	Prophylaxis within 72 hours	Repeat testing in 1-2 weeks
HIV	**HIV ½ Antigen and Antibody, 4th generation**	Post-Exposure prophylaxis within 72 hours if concerning contact. Obtain CBC, Hepatic Function Panel before treatment. Obtain Center for Crime Victim's Services voucher to cover the cost of medication. Vouchers can be obtained via Forensic Nursing Programs.	Retest at 6 weeks and <3 months
Gonorrhea/ Chlamydia	**Nucleic Acid Amplification Testing (NAAT)** • A random voided, non-clean catch specimen • Oral pharynx & rectal NAAT swabs • Vaginal swab for girls is not necessary, but can be used if unable to obtain urine *Cervical specimens NOT recommended for prepubertal girls	**Prepubescent** – withhold treatment until tests results confirmed **Post pubertal** – test, then offer treatment	Retest in 2 weeks
Trichomonas (T. Vaginalis)	**Urine NAAT** * Should NOT be limited to girls with vaginal discharge	**Prepubescent** – if patient is asymptomatic, withhold treatment until tests results confirmed **Post pubertal** – test, then offer treatment *Consider medicating for nausea if providing treatment.*	n/a

CONDITION/ INFECTION	INITIAL LAB TESTS	PROPHYLAXIS/ TREATMENT**	FOLLOW-UP TESTING
Syphilis	Serology	No prophylaxis available	Retest at 6 weeks and <3 months
Hepatitis B	**Surface antibody, antigen & core antibody**	No treatment if the patient has been previously vaccinated. Provide Hep B vaccine if: Pt. is unvaccinated and offender status is unknown, If pt. unvaccinated and offer is known to be infected, offer HBIG within 24 hours of exposure (preferred).	Retest at 6 weeks and <3 months
Hepatitis C	**Relex to HCV, RNA by PCR** Note: Obtain if risk factors identified (e.g. prevalence >0.1%, offender with history of HIV infection, or injecting drugs	As indicated	Retest at 6 weeks and <3 months
HPV	Assess vaccination status *Survivors may be at risk for future unsafe sex practices.	Complete vaccination if ≥ 9 years of age	Follow -up vaccines per schedule
HSV 1 or 2	**NAAT or PCR swab** * Routine testing not recommended. If lesions present- complete testing	As indicated	n/a
Bacterial Vaginosis (BV)	**Wet Mount** Test for BV if discharge is present	As indicated	n/a

** History, PE findings guide treatment decisions. Use Shared decision-making with family. See treatment guidelines at CDC (Table of Contents - STI Treatment Guidelines (cdc.gov)) or Pediatric Red Book Infectious Disease or consult with Child Protection Team.



Note: Prepubertal children who have no symptoms of STI should NOT receive prophylactic treatment.
Rationale: - Low incidence of STI after sexual assault/abuse in this population

- Prepubertal girls have lower risk of ascending infections
- Follow-up can typically be assured

FOLLOW-UP MEDICAL CARE

A follow-up medical visit or check-in by the medical home provider or Child Safe Program is recommended one to three weeks after the initial exam. Also:

Review with patient and parent

- Acute exam findings
- Medical lab results
- Current physical symptoms
- Emotional well-being (sleep disorders, anxiety, depressive symptoms, flashbacks)
- Concerns for safety and legal issues
- Contact with community supports (child protection, law enforcement, school and mental health care)
- Concerns regarding STIs and HIV prophylaxis management

Physical exam

- Individualize exam, depending on history and symptoms
- Check for resolution of injury
- Evaluate any new symptoms
- Refer for ongoing medical care, if needed

Depending on risks and patient concerns

- Perform pregnancy testing.
- Follow-up evaluations for STIs are made on a case-by-case basis; they are typically recommended within 2 weeks (if not completed at time of initial concern), six weeks, and three months after the last suspected exposure.
- Administer hepatitis B vaccine. If series is initiated at acute examination, continue to complete the three-vaccine series.
- Any child with a positive STI should be referred Child Safe Program and be seen within two weeks.

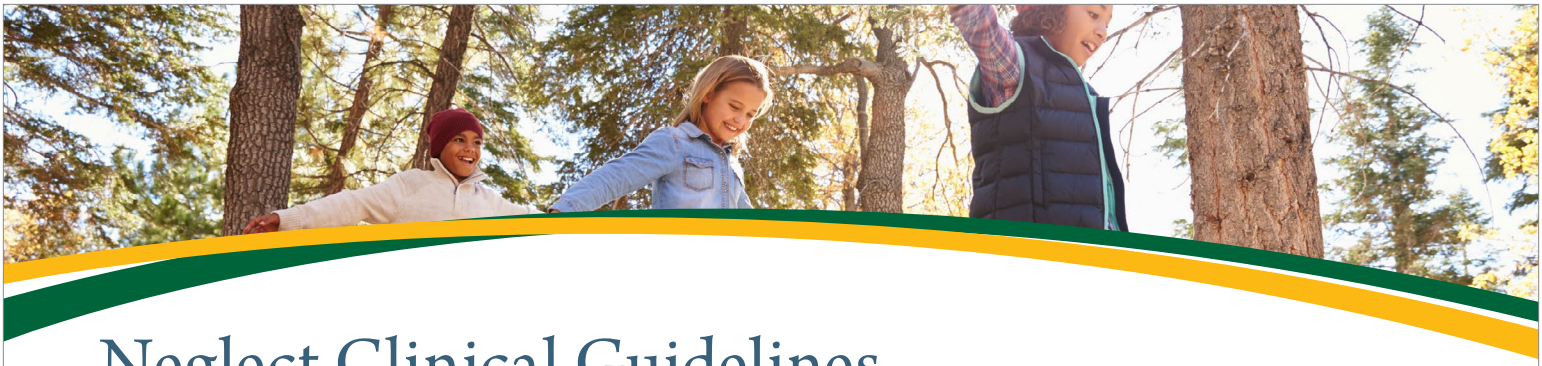
Assess social support (family, friends)

Refer for follow-up medical care, counseling and advocacy

Note: A mental health assessment and referral for treatment and support can be provided at any time after the assault.

Billing

By law, the Vermont Center for Crime Victim Services provides financial support to victims of sexual assault when the assault occurs in Vermont. The person is not required to make a police report and does not need a "positive finding" of sexual assault. Pediatric forensic nurse examiners complete the billing form and ensure privacy when there is a concern for safety.



Neglect Clinical Guidelines

Overview

Neglect is the most common form of child maltreatment. There are several types of neglect commonly identified in child maltreatment. These include physical/environmental, medical, dental, educational, emotional and supervisory. Neglect can have both short-term and long-term consequences for children.

Concerns about child neglect must be evaluated within the full context of the child's environment. Many factors must be considered when diagnosing neglect, including the parents' intellectual abilities, level of education, culture, parental substance abuse, resources available within the family and community, and parents' mental health needs.

Diagnosing neglect may be difficult. It is necessary to recognize how your own value systems and biases may influence the identification of neglect (the focus must remain on harm to the child). It is often helpful to involve other care providers when considering a diagnosis of neglect. If you are having trouble determining whether a case qualifies as neglect, the Child Safe Program is available for consultation.

POINTS TO CONSIDER WHEN THINKING ABOUT NEGLECT:

- **Severity:** Can you identify the current or potential level of harm to the child from the identified neglect?
- **Chronicity:** How long has this been going on? Is there a pattern of needs not being met over a period of time?
- **Frequency:** How many incidents have occurred? Does the family have prior child protection involvement for similar concerns?
- **Cultural context:** Parenting practices differ among cultures and religions. Health care professionals need to be aware of culturally diverse practices; however, be willing to intervene in those that are clearly harmful or pose a serious risk of harm.
- Whenever possible, it is important to be specific in describing the actual neglect and resulting harm or potential for harm. This provides relevant information about the danger to the child, as well as a clear direction for protective actions (e.g., lack of supervision, abandonment, chronic drug usage).
- Holding a care conference early in the process can be helpful in identifying specific concerns about neglect.
- Concerns about neglect can sometimes be mitigated by offering resources (e.g., assistance with transportation, interpreters, visual teaching tools).

Note: If the lack of medical compliance is placing the child in imminent danger of serious harm or death, contact the Department for Children and Families at 1-800-649-5285.

Child Neglect Clinical Guidelines: Medical Neglect

Overview

Diagnosing medical neglect requires looking at the medical, social, educational and financial context of the child and family. Often the reasons for medical neglect are multifactorial and may not be obvious without further exploration.

According to the AAP guidelines, the following factors are necessary for the diagnosis of medical neglect:

1. A child is harmed or is at risk of harm because of lack of health care.
2. The recommended health care offers significant net benefit to the child.
3. The anticipated benefit of the treatment is significantly greater than its morbidity, so that reasonable caregivers would choose treatment over non-treatment.
4. It can be demonstrated that access to health care is available and not used.
5. The caregiver understands the medical advice given[10]

Some examples of medical neglect are failure to provide required medication, significant delay in care that leads to further harm, and repeated failure to attend scheduled appointments for children who have medical diagnoses requiring routine monitoring.

Assessment

Some questions that may help in determining whether the situation rises to the level of medical neglect:

- What is the risk/harm associated with the caregiver's non-adherence to medical advice?
- How long has the non-adherence been going on?
- What actions have been taken by the medical team to address the concerns? Include actions and dates.
- What does the caregiver say are the reasons for his/her non-adherence? How and when have these issues been addressed by you or others?
- What are the barriers identified by the medical team?
- Have you explained to the caregivers, and documented, the risks and harm associated with non-adherence, including short-term and long-term consequences?
- What, if any, interventions have been implemented? Have they worked?
- Has the situation become worse over time?

Note: When evaluating for medical neglect, a care provider conference is strongly recommended to answer the above questions, determine level of concern and identify next steps.

Work-Up

If concern for medical neglect persists, a consult with the Child Safe Program is strongly recommended.

Special Considerations

The only religious exemption that Vermont statute allows is one regarding immunizations. Children can attend childcare and school without immunizations if the family holds religious beliefs opposed to immunization (18 V.S.A. § 1123).

Neglect Clinical Guidelines: Growth Faltering/Malnutrition

Overview

The AAP defines growth faltering as "an abnormal pattern of weight gain in children with weight consistently less than 80 percent of the median for age, weight on more than one occasion falling below the third percentile for age or weight that has fallen across two major percentiles on growth charts."[11]

Ninety percent of cases of growth faltering is due to inadequate caloric intake. Despite this, a full work-up and evaluation is often needed to rule out other underlying medical conditions that would impact weight gain. Chronic malnutrition can lead to both acute and chronic problems such as poor immune response, developmental delays, pressure ulcers and poor wound healing.

Assessment

- Document a comprehensive dietary history including reported feeding schedule, amounts and tolerance.
- Record and plot out body measurements (weight, length, head circumference up to 24 months); continue weekly.
- Assess child's oral motor skills (observing a feeding can be very helpful).
- Assess birth records for birth weight, in utero exposures and past medical history.
- Consider whether food insecurity is a factor and if the family has access to WIC or other financial supports.

Work-Up

Specific dietary recommendations for parent/caregiver should be discussed verbally, be provided in writing and include:

  - When feedings should occur (e.g., every 3 hours; 3 meals/3 snacks)
  - Where feedings should occur (e.g., being held; in high chair; at table with family)
  - How feedings should occur (e.g., bottle; spoon; cup)
  - Length of feeding (how much time should be spent)
  - Specific food/formula to be used (e.g., Enfamil 20 cal/oz; Pediasure 30 cal/oz; whole milk)
- Consider inpatient hospitalization to determine whether child is able to gain weight in a structured setting and whether there are underlying medical or social reasons for child's growth faltering.
- Social work evaluation is highly recommended.
- In severe cases of growth faltering/starvation, the following labs should be obtained:
  - UA to look at specific gravity (dehydration)
  - Nutrition labs (CBC, albumin, pre-albumin, Ca, Phos, Mag, AST, ALT)
- Keep in mind concerns for refeeding syndrome and potential need for refeeding labs.
- If you are considering making a report to child protective services for nutritional neglect, consultation with the Child Safe Program is recommended.

Special Considerations

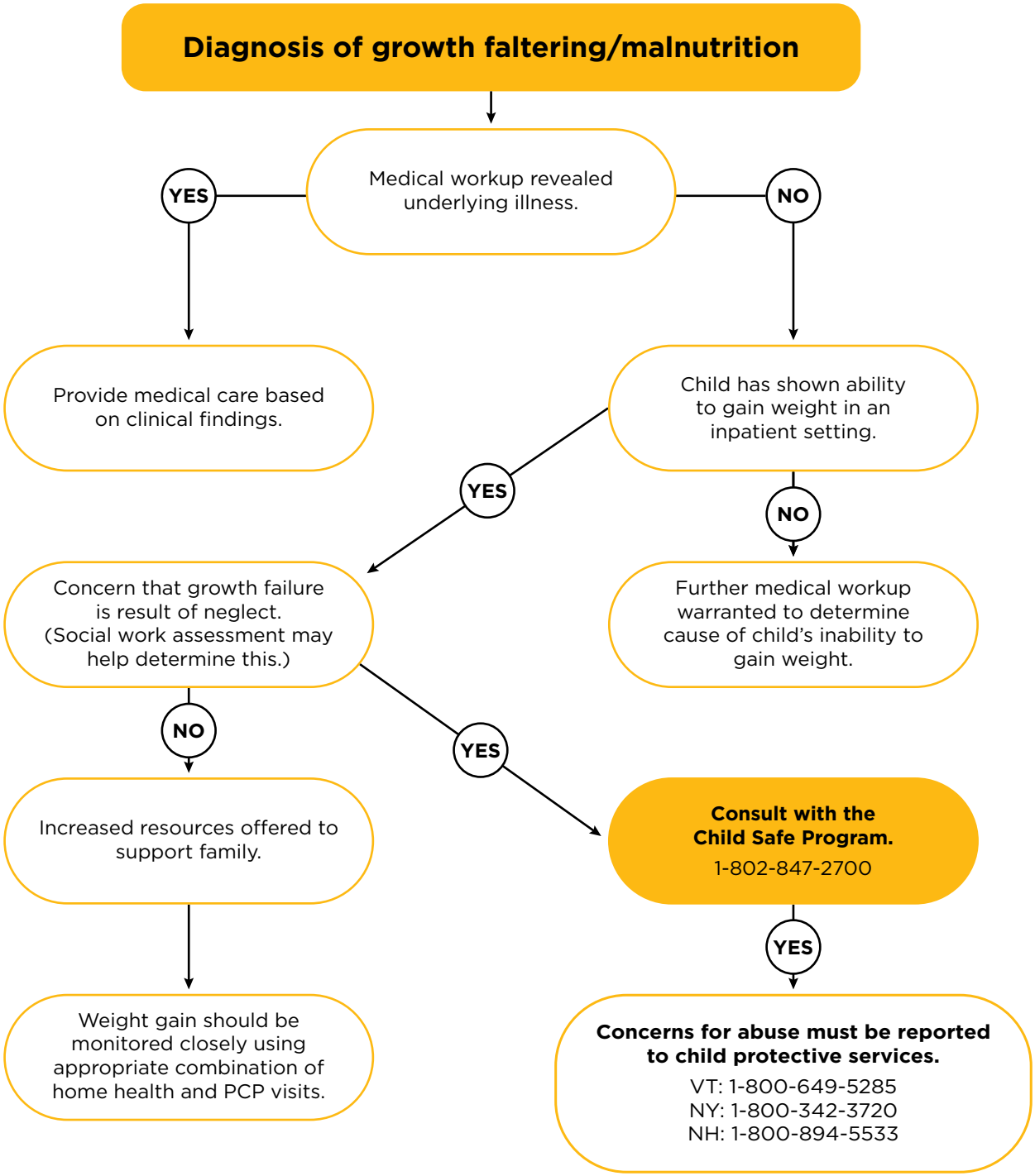
- Take into consideration the caregiver's level of understanding about feeding recommendations (e.g., parent's ability to make bottles with the correct ratios of formula and water).
- It is not necessary to determine caregiver motivation regarding inadequate calorie intake.
- Photo documentation may be helpful in cases of severe malnutrition/starvation to document severity of concerns and improvement with nutritional interventions.
- If/when making a report to child protective services, consider and be able to articulate both acute and chronic harm from malnutrition.

Follow-Up

Involvement of primary care provider and other community providers is recommended (home health, WIC, etc.).

Starvation is an extreme form of child abuse and requires expert evaluation from a Child Abuse Pediatrician and multidisciplinary team.

Decision Tree Growth Faltering/Malnutrition



Child Safe Program can be consulted at any point as a result of concerns identified.

Child Neglect Clinical Guidelines: Obesity

Overview

Childhood obesity should be looked at in the context of the overall health of the child and to what degree... not a question. To what degree is the child's obesity impacting physical and emotional well-being over both the short and the long term?

Although neglect is often more clear-cut in cases of nutritional deprivation, obesity too can be considered a form of neglect.[12] However, underlying medical conditions may be a factor in cases of obesity and must be taken into consideration.

When thinking about obesity as a child neglect concern, this checklist may be helpful in identifying the level of concern.

Weight Checklist

Child's Name:	Intake #	Date:		
Activities of Daily Living		**Yes**	**No**	**N/A**
1. Is the child's weight impairing his/her ability to walk comfortably?				
2. Does the child refuse to go to school because of his/her weight?				
3. Is the child unable to have an active lifestyle because of his/her weight?				
4. Is the child's ability to play with other children being affected by his/her weight?				
5. Is the child's cleanliness affected by his/her weight?				
6. Does the child have self-esteem issues because of his/her weight?				
7. Is the child being bullied because of his/her weight?				
8. Is there threat of a serious medical complication because of the child's weight?				
Known Medical Condition(s)				
1. Do you know what your child weighs currently?				
2. Does your child snore, or have a diagnosis of sleep apnea?				
3. Does your child have a medical diagnosis that has been directly caused by excess weight (e.g., high blood pressure, liver disease, diabetes)?				
4. Has the family sought medical care for the child's weight?				
5. Have medical interventions been implemented to manage his/her weight?				
6. Has the family failed to follow medical recommendations to manage the child's weight?				
7. Does the child have any medical diagnosis unrelated to weight?				
Family Dynamics				
1. Are other family members in the household overweight or obese?				
2. Does the family consider the child's weight a health problem?				
3. Is being "big" part of the family's identity?				
4. Has anyone in your family died at a younger age because of complications related to obesity (e.g., heart attack, stroke)?				
5. Does the family prefer to drink juice/soda instead of water, when thirsty?				
Home Environment				
1. Does the family have a bathroom scale to monitor the child's weight consistently?				
2. Does the family understand that the child should not spend more than two hours on screen time (TV, internet, video games) per day, maximum?				
3. Has the family tried to use any type of diet or physical activity regimen to address the child's excess weight?				
4. Do the pantry and refrigerator contain a good selection of healthy foods (e.g., fruits and vegetables)?				
5. Can the family give examples of what healthy food choices are?				
6. Can the family afford healthy food choices?				
7. Do the pantry and refrigerator contain a selection of unhealthy foods (e.g., cookies, chips, snack cakes and soda)?				
8. Does the family feel comfortable reading food labels?				
9. Can the adults in the home count calories?				
10. Does the child, or an older sibling, consistently prepare their meals?				
11. Does the family have access to a safe playground, or an affordable gym?				
12. Have adults in the family ever met with a nutrition specialist?				
13. Has the family ever bought over-the-counter products for weight management?				
14. Has the family ever had to worry about having enough to eat?				

Adapted from: Florida Department of Children and Families

Child Neglect Clinical Guidelines: Dental Neglect

Overview

Dental neglect is the failure to seek or obtain proper dental care. It can have serious health effects including pain, malnutrition and infection. Consider the following questions in diagnosing dental neglect:

- Is the child at harm or at risk for harm because of the lack of dental health care (e.g. consider pain as a form of harm)?
- Does the recommended dental care offer significant net benefit to the child?
- Is the anticipated benefit significantly greater than its morbidity, so the parents would choose treatment over non-treatment?
- Is dental care available? Is it accessible?
- Do the parents understand the dental advice offered?[13]

Psychological Maltreatment and Child Torture

Overview: Psychological Maltreatment

Psychological Maltreatment is a common form of child abuse. Unlike other types of maltreatment, psychological maltreatment can be much more insidious and less obvious. The impacts are just as harmful as other forms of child maltreatment and may have more significant long-term implications.

It may be difficult for medical providers to diagnose psychological maltreatment and determine when to report to child protection agencies.

The AAP defines psychological maltreatment as "a repeated pattern of parental behavior that is likely to be interpreted by a child [as indicating] that he or she is unloved, unwanted and serves only instrumental purposes, and/or severely undermine the child's development and socialization."[14]

There are several types of psychological maltreatment; including:

- Spurning (degrading, shaming, ridiculing)
- Terrorizing (making a child feel unsafe, threatening or perpetrating violence toward a child or loved ones)
- Isolating (confining, unreasonable limitations of freedom of movement)
- Exploiting/corrupting (modeling, permitting or encouraging antisocial or developmentally inappropriate behavior, restricting or interfering with cognitive development)
- Neglecting mental health/medical/educational needs (ignoring, preventing or failing to provide treatment for emotional, behavioral, physical or educational needs)
- Exposing to intimate partner violence

Overview: Child Torture

Child torture is an extreme form of child abuse that differs from other types of physical abuse as it is less episodic and more accurately described as prolonged or repeated psychological and physical maltreatment.[15]

Child torture can be defined as at least two physical assaults (or a single extended incident) and two or more elements of psychological maltreatment. Neglect is often present. Recognizing early signs of torture has the potential to reduce the significant morbidity and mortality associated with this type of maltreatment.

Common manifestations include:

- Physical assaults
- Isolation
- Intimidation
- Deprivation

Assessment

Signs and symptoms can include concerns around behavior, physical health and school performance. Some youth, especially younger children, can exhibit disorganization or aggressive/sexualized themes in play or interpersonal interactions. However, this is not inherently indicative of psychological maltreatment, exposure to trauma or child torture.

Work-Up

Obtain information and history from parents and child separately, if age appropriate. It is important to seek multiple perspectives and various insights into the concern. Additional information gathered as part of the multidisciplinary process can be critical. This includes information from caregivers outside the home (e.g, daycare workers, educational staff).

Special Considerations

Siblings are often involved and/or witness to the maltreatment or torture and should be independently assessed.

Psychological maltreatment of a child is often a “canary in the coal mine” for other concerns within the family system—unstable social determinants of health, substance misuse problems, skill deficits in parenting strategies or parental mental health.

Bullying: Children with differing abilities, either psychological or physical, may be the target of bullying and are at risk for psychological consequences. For example, research shows that children with orofacial or dental abnormalities are at high risk of experiencing bullying.

It is important to diagnosis child torture when identified. If considering this diagnosis, a consult with the Child Safe Program is recommended.

Follow-Up

Early intervention and treatment is essential, including individual psychotherapy (including but not limited to cognitive behavioral therapy) and psychotherapy focused on the family system (e.g., parent child interaction therapy [PCIT], child-parent psychotherapy [CPP]). Community partners such as the local designated mental health agency may have resources and support groups for parents or other caregivers who are struggling to manage both the child victim and also their own sense of guilt or responsibility.

Red Flags:

- excessive discipline (e.g. prolonged wall sits, military exercises)
- locks on outside of doors or refrigerators
- excessive surveillance cameras (e.g. in bedrooms)
- significant differential treatment of children in the home

Common Elements of Child Torture

Common Elements of Child Torture

Consider child torture when several of the following elements are identified within a case:

	Section One: Deprivation of Basic Necessities (at least 1 element)
☐	**Current or History of Allegations for Neglect** ☐ Withholding Food ☐ Withholding Water ☐ Withholding Clothing ☐ Subjecting to Extremes of Heat or Cold ☐ Limiting Access to Others ☐ Limiting Access to Routine Medical Care ☐ Forcing Child to Stay Outside for Extended Periods or Sleep Outside ☐ Limiting Access to Toilet ☐ Limiting Access to Personal Hygiene/Bathing ☐ Inability to Move Free of Confinement ☐ Withholding Access to Schooling/Withdrawing to Home School ☐ Sleep Deprivation ☐ Low Body Mass Index ☐ Other:
	Please explain (as needed):
	Section Two: Physical Abuse (at least 2 physical assaults or 1 severe assault)
☐	**Current or History of Allegations for Physical Abuse** ☐ Bruising Shaped like Hands, Fingers, or Objects, or Black Eyes ☐ Fractures that are Unexplained and Unusual ☐ Ligature, Binding, and Compression Marks due to Restraints ☐ Contact or Scald Burns to the Skin or Genitalia ☐ Flexion of a Limb or Part of Limb beyond its Normal Range ☐ Human Bite Marks ☐ Force-Feeding ☐ Asphyxiation ☐ Other:
	Please explain (as needed):
	Section Three: Psychological Maltreatment (2 or more elements, can be a single incident)
☐	**Current or History of Allegations for Psychological Maltreatment** ☐ Rejection by Caregiver ☐ Terrorizing ☐ Isolating ☐ Threats of Harm or Death to Child, Sibling(s) or Pets ☐ Exploiting/Corrupting ☐ Unresponsive to Child's Emotional Needs ☐ Shaming/Humiliation ☐ Other:
	Please explain (as needed):

Child Protection Accountability Commission, 900 King St., Ste, 210, Wilmington, DE, 19801
http://courts.delaware.gov/childadvocate/cpachistory.stm

Approved 1/19/16

Common Elements of Child Torture

	Section Four: Supplemental Items
☐	**Current or History of Allegations for Sexual Abuse** ☐ Penile, Digital or Object Penetration of the Anus ☐ Assault to the Genitals ☐ Forcing Sexual Intercourse ☐ Forcing to Remain Naked or Dance ☐ Forcing to Witness or Participate in Sexual Violence against another person ☐ Other:
☐	**Forcing Excessive Exercise for Punishment**
☐	**History of Prior Referrals and /or Investigations by the Division of Family Services (DFS)**
☐	**One Child is Targeted**
☐	**Sibling(s) Abused**
☐	**Siblings Join in Blaming Victim and Possibly Demonstrate Empathy Defects for Self Protection**
☐	**Family System is Blended and Both Caregivers Participate in the Alleged Abuse and/or Neglect**
☐	**One Caregiver Fails to Protect**
☐	**No Disclosure is Made by Targeted Child or Siblings**
☐	**Caregivers Provide Reasonable Explanations in Response to Allegations**
☐	**Caregivers Allege Mental Health Issues for Targeted Child (e.g. self injury) and Report Repeated Attempts to Seek Help**
	Please explain (as needed):

Sources: Holler, Jim. "Child Torture – the American Trend." 30th National Symposium on Child Abuse (2014). Knox, Barbara L., et al. "Child Torture as a Form of Child Abuse." *Journal of Child & Adolescent Trauma* 7.1 (2014): 37-49.

Medical Child Abuse

Overview

Medical child abuse (MCA)/caregiver-fabricated illness (previously termed Munchausen syndrome by proxy) is a form of child abuse defined as "a child receiving unnecessary and harmful or potentially harmful medical care at the instigation of a caretaker" (Roesler, T.A., Jenny, C. (2008). *Medical Child Abuse: Beyond Munchausen Syndrome by Proxy*). **The diagnosis of MCA focuses on the harm to the child and is not based on the motivation or mental health of the perpetrator.**

MCA can be difficult to diagnose and is best evaluated and treated using a multidisciplinary team approach. It is important to recognize that children experiencing MCA may be associated with underlying medical diagnosis. It is also known that children who are victims of MCA may take on the identity of a sick child over time. This may confound the diagnosis.

Assessment

- Medical child abuse should be considered in all cases in which the history and/or laboratory data are not consistent with the objective medical findings, particularly when there is a pattern over time.

Examples include:

  - Persistent constipation despite increasing doses of Miralax
  - Reported seizure activity with no corroborated medical findings
  - Requests from parent for invasive procedures that are not medically necessary
- Consult with a child abuse pediatrician is strongly suggested in all cases of suspected medical child abuse and should be obtained early in the work-up.
- As part of the evaluation, medical records should be obtained from all health care providers and carefully reviewed.

Indicators of MCA:

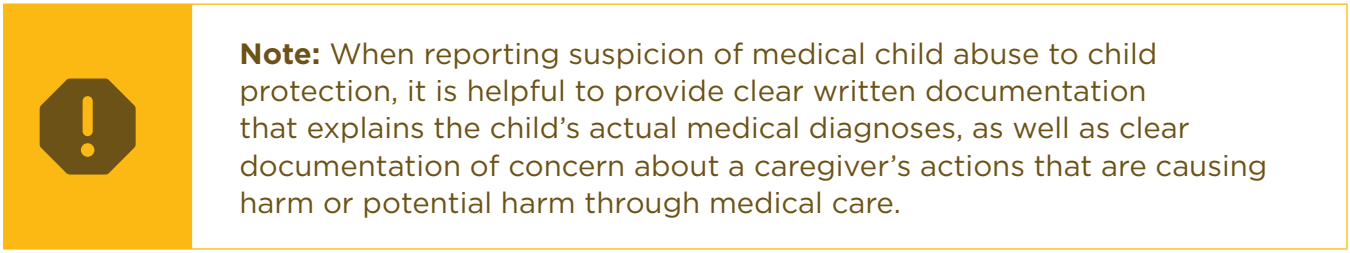
  - Symptoms exceed evidence of physiologic illness
  - Inconsistencies in the medical history; may contain clear contradictions
  - Symptom does not respond to usually effective therapy
  - Symptoms progress in highly unlikely ways
  - Pattern of illness does not make sense
  - Episodic symptoms occur only in the presence of one caregiver
  - One condition resolves only to be replaced by another
  - Parent encourages unnecessary diagnostic or therapeutic interventions
  - Parents not pleased or relieved by normal results of diagnostic tests
  - Siblings or other family members have a history of unusual or unexplained illness
  - Family frequently changes medical providers or involves numerous medical providers
  - Unclear rationale for invasive procedures and therapies (including central venous access, catheters, oxygen, tubes, etc.)

Work-Up

- Full record review (questions to answer: Are the history signs and symptoms of disease credible? Is the child receiving unnecessary and harmful or potentially harmful medical care? If so, who is instigating the evaluations and treatment?)
- Diagnostic testing (with a goal of better understanding underlying medical diagnoses)
- Video monitoring (in rare situations, covert video monitoring may be appropriate)
- Therapeutic separation of the child from the suspected perpetrator
- Inpatient hospitalization

Special Considerations

- In general, caregivers should not be told of the suspicion of medical child abuse, as this may escalate abuse or caregivers may abscond with the child.
- These cases require extensive collaboration of all medical providers. It may be very difficult for medical providers to recognize that they have been deceived by a family and it often takes time for all members of the medical team to acknowledge the concerns for MCA.
- Perpetrators of MCA often have extensive medical knowledge, which helps facilitate the splitting and deception of medical providers.
- Illnesses without diagnostic testing or that are based on child caregiver symptom report alone are concerning for medical child abuse.



Note: When reporting suspicion of medical child abuse to child protection, it is helpful to provide clear written documentation that explains the child's actual medical diagnoses, as well as clear documentation of concern about a caregiver's actions that are causing harm or potential harm through medical care.

In some instances, hospital admission can be helpful in affirming the diagnosis of medical child abuse. These types of admissions require a coordinated and well-planned treatment approach.

The purpose of a hospital admission is to:

- Better understand the medical condition of the child.
  - Clarify diagnoses that are still in question.
  - Obtain additional labs, imaging or other tests that will help in ruling in or out questionable medical conditions.
  - Observe the patient and family interactions, the child's response to standardized care, noting any disconnect between the family's percetion of the child's well-being and the medical team's objective findings.
  - Document/discuss any concern that the family is continuing to pursue medical opinions or testing that is not beneficial to the child.
  - Obtain specialty consults that are needed to help in understanding medical diagnosis.

Every effort should be made to identify necessary tests and consults prior to admission to reduce the length of stay needed.

Ingestion/Poisoning

Overview

Ingestions by children are common. Accidental ingestion of over-the-counter or prescribed medication where no other concerns for abuse or neglect have been noted may not warrant a child protection report. Each situation must be evaluated independently within the context of the specific ingestion.

Assessment

- What did the child ingest? Is the medication illicit? Is someone in the household prescribed the medication?
- What is the context around how the child got access (e.g., was it stored on the kitchen table in a non-childproof container versus one pill was dropped on the floor and parents weren't aware)?
- Is there any reason to believe the child was unsupervised for a length of time beyond what would be reasonable for the child's age/developmental level?
- What is the parent or caregiver saying about what happened?
- What was the parents' response to the ingestion? Was there a delay in accessing medical attention? Was there a reason for the delay?

Work-Up

Any time a patient presents obtunded or altered with a supporting history, these steps should occur:

- Consult with the Northern New England Poison Center: 1-800-222-1222.
- Consider expanded testing, confirmation requirements, and possible co-ingestions and drugs to consider that are not on typical rapid screens (e.g. fentanyl, buprenorphine, methadone, dextromethorphan, diphenhydramine, gabapentin, bupropion, methylphenidate, mitragynine)
- Obtain urine as early as possible- catheterize if necessary and hold specimen for future testing
- Verify urine specific gravity- helpful in interpreting urine drug concentration ratios
- At UVMMC, the panel is found under the EPIC order name Pediatric Ingestion/Exposure Panel, Urine ED and Peds Only (LAB 17771).
- Gather thorough medical history
- Complete head to toe medical exam
- Social work evaluation to help in determining circumstances surrounding ingestion and a safe discharge plan
- Assessment of child's developmental capabilities
- Consider consult with Child Safe Program

Note: Ingestion of a parent's prescribed medication-assisted treatment (e.g., methadone or buprenorphine) should be considered in the same light as ingestion of any other prescribed medication.

In light of the legalization of cannabis in Vermont, it is important to remember that cannabis consumption in any form can present serious health risks for children.

Any time lack of age-appropriate supervision is a factor in a child's ingestion, a child protection report is warranted.

Circumstances that warrant a report to child protective services include:

- You have knowledge that a child has ingested any illicit substance(s).
- There is information that leads you to believe the child was left without supervision for a length of time beyond what is reasonable for the child's age/developmental level and this was a contributing factor to the ingestion (e.g., parents were intoxicated or child was left home alone).
- Parents made a choice to delay care following the ingestion and the delay led to further harm to the child.
- Additional concerns, including signs of physical abuse, are noted.
- Explanation of ingestion is not consistent with the developmental ability of the child.

Anti-Trafficking and Child Sexual Exploitation

Overview

Trafficking, both sex and labor trafficking, is under-recognized. The signs of trafficking can be subtle; however, we know that sex trafficking of minors is occurring in Vermont and surrounding states. Identifying children and youth who have experienced sex or labor trafficking early can dramatically improve their outcomes. Consideration of trafficking should take place for all children entering the medical setting. The terms commercial *sexual exploitation of children and minor sex trafficking* are interchangeable and address the same concern.

According to Vermont Department for Children and Families policy, sex trafficking of minors is defined as a range of crimes committed against children and adolescents, including:

- Sexually exploiting a minor
- Recruiting, enticing, harboring, transporting, providing or obtaining minors by any means for the purpose of sexual exploitation
- Exploiting a minor through survival sex (exchanging sex or sexual acts for money or something of value, such as shelter, food or drugs)
- Using a minor in child pornography
- Exploiting a minor through sex tourism, mail order bride trade or early marriage
- Exploiting a minor by having them perform in sexual venues (e.g., peep shows or strip clubs)*

Note: Exploitation may begin as someone offering youth something non-sexually related (e.g., modeling work, recording studio time).

Note: Children being trafficked or exploited may present to the health care setting with a variety of medical concerns; some may be unrelated to their experience of being trafficked.

Risk Factors, Tips, and Red Flags

FIVE RISK FACTORS FOR LABOR OR SEX TRAFFICKING/EXPLOITATION

1. Runaway/homeless status
2. Substance use
3. History of child maltreatment and/or being in state custody care
4. Recent immigration
5. Identified as member of socially marginalized group

FIVE KEY TIPS FOR WORKING WITH PATIENTS WHO MAY HAVE EXPERIENCED LABOR OR SEX TRAFFICKING/EXPLOITATION

1. Establish trust prior to asking sensitive questions
2. Demonstrate compassion
3. Remain nonjudgmental; accept patient's perspective
4. Avoid the idea of "rescuing" a child from exploitation; the goal is to offer healthcare and resources
5. Make sure the patient knows you are available and that your health facility is a safe place to return

FIVE RED FLAGS FOR LABOR OR SEX TRAFFICKING/EXPLOITATION (EACH OF THESE IS NONSPECIFIC, AND MAY OR MAY NOT BE PRESENT)

1. Behavioral health concerns or mental health diagnoses (e.g., suicidal ideation, PTSD, externalizing behaviors)
2. Suggestion of ownership or commercial sex or gang affiliation (tattoos/branding; accompanying person who will not leave patient alone; third party listening through cell phone)
3. History of multiple sexually transmitted infections
4. Unexplained/poorly explained acute or remote injuries (suspicious for assault or related to preventable work-related injury)
5. Unexplained absence from school (not enrolled; poor attendance)

To decrease stigma/shame, it is important to ask questions in a way that normalizes the situation, facilitates a discussion and provides a safe space for disclosure. A lead-in statement can be: "I often ask these questions of my patients."

Questions to ask patient alone:

- Have you ever had to run away from home? Can you tell me about that?
- How are you getting money to buy food and other necessities? (Can lead to follow-up questions about how someone is being paid)
- Are you afraid of anyone?
- Has anyone touched you in a way you did not like? Or tried to get you to touch someone else in a way you did not want to?
- What does that tattoo mean to you?
- Has anyone told you they would hurt you if you didn't do something they wanted you to do?
- Has anyone told you they would hurt you if you didn't keep a secret?
- Has anyone told you they would hurt your family or pets?
- Has anyone taken photos or videos of you that made you feel uncomfortable?

One validated pediatric tool to screen for child sex trafficking is the Short Child Sex Trafficking Screen for the Healthcare Setting[16]

Medical Evaluation

- Mandatory social work evaluation to evaluate for immediate safety concerns
- Early involvement of a pediatric forensic nurse, if consent has been given
- Refer to Child Sexual Abuse Clinical Guidelines for clinical care details

Follow-Up

Follow-up care should include STI testing per CDC guidelines and comprehensive medical care in coordination with a medical home.

Local human trafficking resources:

- Hope Works (available 24/7 by calling 802-863-1236): hotline, advocates, therapy, support groups
- Vermont 211 (call 211 or text zip code to 898211) for assistance connecting with services
- Vermont Human Trafficking Hotline (available 24/7 by calling 1-888-984-8626)
- Vermont Sex Trafficking of Minors Information Sheet
- Give Way to Freedom

National Human Trafficking Resources:

- National Human Trafficking Resource Center Hotline (1-888-373-7888)
  - Sponsored by www.polarisproject.org (information in 170 languages, available 24/7)
- www.humantraffickingED.com
- Center for Missing and Exploited Children: www.missingkids.com
- AAP Toolkit: Child Trafficking and Exploitation: www.aap.org/en/patient-care/child-trafficking-and-exploitation

Note: Human trafficking of minors is a form of child sexual abuse and should be reported to the Vermont Department for Children and Families at 1-800-649-5285. Vermont DCF will coordinate with law enforcement regarding concerns of minors who have been trafficked.

Ray Helfer Society Committee on Human Trafficking

Quick Tips for Healthcare Professionals: Recognizing and Responding to Human Trafficking

Screening tools and Universal Education/Resources

- Short Screen for Child Sex Trafficking (sex trafficking of adolescents 11-17 years)
  - https://www.choa.org/-/media/Files/Childrens/medical-services/child-protection/cst-screen-with-explanation-and-criteria.docx?la=en&hash=A9D296796EB81643D5B0E1AACF5FFF0F630F932D
- Quick Youth Indicator of Trafficking (sex/labor trafficking youth 18-25 years)
  - https://www.sciencedirect.com/science/article/pii/S0190740918307540
- Universal Education/Resources (healthy relationships; sexual violence)
  - https://ipvhealth.org/health-professionals/educate-providers/

5 Risk Factors for Labor or Sex Trafficking/Exploitation

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5 Key Tips for Working with Patients Who May Have Experienced Labor or Sex Trafficking/Exploitation

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- History of multiple sexually transmitted infections
- Unexplained/poorly explained acute or remote injuries (suspicious for assault or related to preventable work-related injury)
- Unexplained absence from school (not enrolled; poor attendance)

What to do when you suspect exploitation/trafficking

- Offer local resources relevant to identified risk factors and patient needs (use warm hand-off when making referrals)
- Call National Human Trafficking Resource Center hotline
  - (1-888-3737-888)
  - Text Hotline:233733 (BE FREE)
  - Chat hotline: www.humantraffickinghotliine.org/chat
- Submit a tip online: https://humantraffickinghotline.org/report-trafficking
- Call local or state child abuse hotline and consider contacting law enforcement, as appropriate
- Safety planning (Will patient be safe after leaving healthcare facility? Discuss harm reduction strategies, resources, etc.)

Additional resources: AAP toolkit: "Child Trafficking and Exploitation"
https://www.aap.org/en/patient-care/child-trafficking-and-exploitation/

Health care professionals CAN make a difference

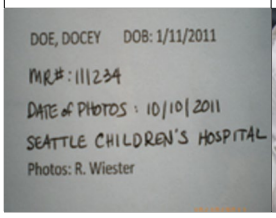
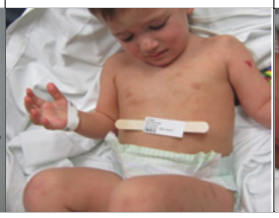
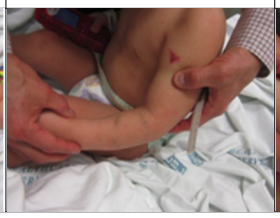
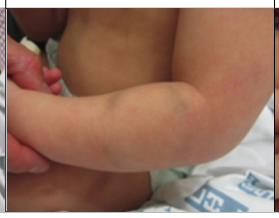
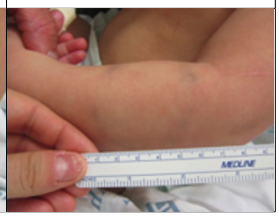
Photo Documentation Guidelines

Overview

Photos taken by health care professionals are for managing the health care of the child. Photos help in documenting injuries at first presentation to the hospital, as well as the progression and resolution of injuries. If visible injuries are present, photography is highly recommended for documentation. A standard protocol should be in place for taking photos, for storage and for transfer. Refer to your institution's photo documentation policy.

- **Consider taking photographs of the child prior to the collection of forensic specimens and medical interventions.**
- **Patient identification:**
  For legal purposes, patients' identification should be linked to photographic images according to facility policy.
- **Clear and accurate photographs:**
  Allow plenty of time to take the photos. Children can be challenging to photograph and it may take several tries to capture the photos. Look at the photos after each shot to make sure that they are clear and in focus. Children move and squirm, making blurry pictures common. If the photo is blurry or out of focus, retake the photo.
- **Measurement:** Use a standard measurement tool with centimeter markings. Make sure that the ruler is in the same orientation as the injury/lesion. This will help ensure that you can accurately measure the lesion.

Photos of patients are best accomplished in a standardized fashion. Each injury should include three photos following the guidelines below:

PHOTO 1	PHOTO 2	PHOTO 3	PHOTO 4	PHOTO 5
Identification	**Face/Body**	**Body Parts plus injury ~3′ away**	**close up of injury, 1′ away at 90°**	**Same as photo #4, with measuring stick**
				

Special Considerations

- Photographs do not replace detailed and accurate written documentation of injuries in the medical record.
- Photographs taken during examination are very personal in nature. They should be taken in a supportive and trauma-informed setting, such as a medical facility.
- For children who are patients with concerns for sexual abuse, only examiners with specific training on photography techniques and procedures should capture images.[17]
- These photos are important for helping to document the injuries to a child. They may be used by the medical providers for court testimony.
- Photos of suspected child abuse should be stored securely following your facilities policy.

Health care facility policy should allow release of photo documentation only in certain situations, to certain entities, in order to prevent misinterpretation and misuse.

Follow-Up

Follow-up photos may be necessary to document evolving injury or healing. They may also be necessary to clarify findings of stable normal variance and anatomy and non-specific findings such as birthmarks.

References

1 Sugar, N., et al. (1999). Bruises in infants and toddlers: Those who don't cruise rarely bruise. *Archives of Pediatric and Adolescent Medicine*, 153(4): 399-403. Retrieved from: https://jamanetwork.com/journals/jamapediatrics/article-abstract/346535

2 Pierce, M.C., et al. (2021). Validation of a clinical decision rule to predict abuse in young children based on bruising characteristics. *JAMA Network Open, 4*(4): e215832. Retrieved from: https://jamanetwork.com/journals/jamanetworkopen/article-abstract/2778559

3 Flaherty, E., et al. (2014). Evaluating Children with Fractures for Physical Abuse. *Pediatrics, 133(2)*:e477-e489. Retrieved from: https://publications.aap.org/pediatrics/article/133/2/e477/30888/Evaluating-Children-With-Fractures-for-Child?autologincheck=redirected

4 Kleinman, P.K., et al. (2009). Diagnostic imaging of child abuse. *Pediatrics, 123*(5):1430-1435.

5 Wootton-Gorges, S., et al. (2017). ACR Appropriateness Criteria® suspected physical abuse—child. *Journal of the American College of Radiology*, 14(5): S338-S349. Retrieved from: https://reader.elsevier.com/reader/sd/pii/S1546144017301436?token=DFC91E82398323BD72FDB6F8C925E28EBEC4F703867518E475A4128849B9495E800DE92079527B213FB1D949BA6CA4A2&originRegion=us-east-1&originCreation=20210604161737

6 Jenny, C., et al. (1999). Analysis of missed cases of abusive head trauma. JAMA, 281(7):621-626

7 Kellogg, N. (2010). Sexual behaviors in children: Evaluation and management. *American Family Physician, 82*(10):1233-8.

8 Kellogg, N. (2010). Sexual behaviors in children: Evaluation and management. *American Family Physician, 82*(10):1233-8.

9 Smith, T., et al. (2020). The medical evaluation of prepubertal children with suspected sexual abuse, *Paediatrics & Child Health, 25*(3): 180–186. Retrieved from: https://doi.org/10.1093/pch/pxaa019

10 Jenny, C., & Metz, J. B. (2020). Medical child abuse and medical neglect. Pediatrics in review, 41(2), 49-60.

11 Margot, N,. et al. (2021). Failure to Thrive or Growth Faltering: Medical, Developmental/Behavioral, Nutritional, and Social Dimensions. *Pediatrics in Review*, 42 (11): 590–603.

12 Varness, T., et al. (2009). Childhood Obesity and Medical Neglect. *Pediatrics, 123*(1):399-406.

13 Fisher-Owens, S.A., et al. (2017). Oral and Dental Aspects of Child Abuse and Neglect. *Pediatrics, 140* (2): e20171487.

14 Hibbard, R., et al. (2012). Psychological Maltreatment. *Pediatrics, 30* (2): 372–378.

15 Knox, B., et al. (2014). Child Torture as a Form of Child Abuse. *Journal of Child and Adolescent Trauma*. Retrieved from: https://www.tdcaa.com/wp-content/uploads/Knox-Torture-as-a-Form-of-Child-Abuse-article.pdf

16 Greenbaum, J., et al. (2018). A short screening tool to identify pediatric patients of child sex trafficking in the health care setting. *Pediatric Emergency Care, 34*(1): 33-37.

17 U.S. Department of Justice Office on Violence against Women, 2016

Additional References

APSAC Taskforce (2013).

Practice Guidelines: The Commercial Sexual Exploitation of Children: The Medical Provider's Role in Identification, Assessment, and Treatment. New York, NY: American Professional Society on the Abuse of Children. Retrieved from: https://2a566822-8004-431f-b136-8b004d74bfc2.filesusr.com/ugd/4700a8_57342ba449214e86a20aff48aaf4fc7f.pdf

APSAC Taskforce (2017).

Practice Guidelines: Munchausen by Proxy: Clinical and Case Management Guidance. New York, NY: American Professional Society on the Abuse of Children. Retrieved from: https://2a566822-8004-431f-b136-8b004d74bfc2.filesusr.com/ugd/4700a8_47be1e8b569a428dad3e41fd366e2f4f.pdf

Choudhary, A.K., et al. (2018).

Consensus statement on abusive head trauma in infants and young children. Pediatric Radiology, 48: 1048-1065. Retrieved from: https://doi.org/10.1007/s00247-018-4149-1

Christian, C. (2015).

The evaluation of suspected child physical abuse. Pediatrics, 135(5): e1388-e1352. Retrieved from: https://pediatrics.aappublications.org/content/pediatrics/135/5/e1337.full.pdf

Dubowitz, H. (2009).

Tackling Child Neglect: A Role for Pediatricians. Pediatric Clinics of North America, 56 (2): 363-378. Retrieved from: https://www.sciencedirect.com/science/article/abs/pii/S0031395509000042?via%3Dihub

Emergency Nurses Association, and International Association of Forensic Nurses.92023).

Joint position statement:Emergency department care for prepubescent patients who have been sexually abused. Retrieved from: https://evawintl.org/wp-content/uploads/Care_of_Pediatric_SAPatientsinEmergencyCare.pdf

Finkel, M., & Giardino, A. (2019).

Medical Evaluation of Child Sexual Abuse: A Practical Guide (4th Ed.). Itasca, IL: American Academy of Pediatrics.

Frank, Blenner, Wilbur, Black & Drotar, 2009.

Giardino, A., Lyn, M., & Giardino, E. (Eds.). (2019).

A Practical Guide to the Evaluation of Child Physical Abuse and Neglect. New York, NY: Springer.

Haney, S., et al. (2025).

Evaluating Young Children With Fractures for Child Abuse: Clinical Report. Retrieved from: https://publications.aap.org/pediatrics/article/155/2/e2024070074/200638/Evaluating-Young-Children-With-Fractures-for-Child

Hymel, K., & Deye, K.P. (2011).

Abusive head trauma. Child Abuse and Neglect (pp. 349-358). Philadelphia, PA: Elsevier Inc.

Jenny, C. (2011).

Child Abuse and Neglect: Diagnosis, Treatment, and Evidence. Philadelphia, PA: Elsevier Saunders.

Knox, B.L., & Starling, S.P. (2011).

Abusive burns. Child Abuse and Neglect (pp. 222-238). Philadelphia, PA: Elsevier Inc.

Laskey, A., & Sirotnak, A. (2020).

Child Abuse Medical Diagnosis and Management (4th ed.). Itasca, IL: American Academy of Pediatrics.

Maguire, S., et al. (2005).

Are there patterns of bruising in childhood which are diagnostic or suggestive of abuse? A systematic review. Archives of Diseases in Childhood, 90(2): 182-186. Retrieved from: https://adc.bmj.com/content/90/2/182.short

Narang, S., et al. (2020).

Abusive head trauma in infants and children. Pediatrics, 145(4): e20200203. Retrieved from: https://pediatrics.aappublications.org/content/pediatrics/145/4/e20200203.full.pdf

Narang, S., et al. (2025).

Abusive Head Trauma in Infants and Children: Technical Report https://publications.aap.org/pediatrics/article/155/3/e2024070457/201049/Abusive-Head-Trauma-in-Infants-and-Children

U.S. Department of Justice Office of Violence Against Women.(2016).

A national protocol for sexual abuse medical forensic examination:Pediatric. Retrieved from: https://www.ojp.gov/pdffiles1/ovw/249871.pdf

Child Abuse and Neglect Additional Resources

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN™

https://www.apsac.org/

APSAC is a nonprofit organization of professionals who work with maltreated children and their families. Members include professionals working in mental health, child welfare, law enforcement, health care and prevention.

HEALTH EQUITY GUIDING PRINCIPLES FOR INCLUSIVE COMMUNICATION

https://www.cdc.gov/healthcommunication/Health_Equity.html

PREVENT CHILD ABUSE VERMONT

802-229-5724 / 1-800-CHILDREN
www.pcavt.org

Promotes and supports healthy relationships within families, schools and communities to eliminate child abuse.

VERMONT 2-1-1

Call 211/ text your zip code to 898211
www.vermont211.org

Free, confidential call center that provides information about health and human services accessible across the state. Available 8 am-8 pm Monday-Friday.