PEDIATRIC EMERGENCY DEPARTMENT CLINICAL GUIDELINE:
CHILD PHYSICAL ABUSE – SIPA

Statistics
- Physical abuse accounts for approximately 20% of all reported child maltreatment. Manifestations include bruising, marks, burns, fractures, head injury, internal/visceral injury.

Presentation
- Injury to a child where the mechanism is concerning for physical abuse – presenting with caretakers for concern of physical abuse, sent in by investigative agencies for evaluation, or injury found during ER evaluation that is discordant with history provided and therefore concerning for physical abuse.

How do I contact PED social work?
- PAGER 8887
- On-site 80 hours per week
- After hours, SW is available by phone only for questions regarding evaluation

History:
- Detailed history is crucial to a physical abuse evaluation.
  - Please obtain a detailed history of the events surrounding the injury, for example, ask about feedings, naps or sleep, and transitions from one caretaker to another.
  - The absence of any explanation or history is very important to document.
  - Document all possible caretakers in the time period surrounding the injury.
  - Start building a timeline, especially if there is no explanation for the injury.
- If SW is on-site, please page them as they are an integral part of child maltreatment evaluations.
- If SW is off-site, please do the following:
  - Determine if the child has already been reported to DCFS or not, eg by first responders or OSH if transferred.
  - Determine who is present with the child and document their names and relationships to the child – i.e. parent, caretaker, family member, neighbor, sibling, etc.
  - If possible (child verbal AND willing to separate from accompanying adult) interview the child separately in order to obtain any history of the injuries directly from the child.

Physical Examination
- Perform a thorough physical exam - undress the patient completely to view his or her entire body
- Key points of physical exam:
  - Gen appearance – Age appropriate weight and height? Cachectic? Poor hygiene?
  - Skin:
    - Document location, size, pattern, color of all cutaneous injuries on EPIC body charts
    - Include non-traumatic lesions (i.e. slate gray macules, nevi, café-au-lait spots)
  - Abdomen – document any bruising, pain, or masses
  - Extremities - document any bruising, swelling, deformity, or pain to palpation
  - Neurologic – document mental status and neurologic deficits
- **RED FLAGS on physical examination**
  - TEN-4 BCDR (Bruising Clinical Decision Rule)
    - Bruises / marks anywhere on a child under 4 months old OR
    - Bruises / marks in TEN region (thorax, ears, neck) of a child < 4 years old AND
**Photographs:**
- If SW present, they take photos using the PED SW camera.
- If SW not present, use the digital camera located in the drawer behind the attending seat.
  - Photograph the patient’s label; photograph all lesions on the body; then photograph the patient label again so the photographs are easily identifiable, sandwiched between the two patient labels. Please include a head shot of the patient.
  - SW will download and store the photos in our files.
- Police may also have an evidence technician come to the ED to take photographs.

**Work-Up**
- Imaging for non-occult injury – guided by history and physical exam
- Imaging for occult injury (see table below)
- Screen for medical conditions mimicking abuse if warranted by history, family history, or physical exam – coagulopathy, rickets, congenital conditions

**Work-up for Occult Injury**

<table>
<thead>
<tr>
<th></th>
<th>Head CT</th>
<th>Skeletal Survey</th>
<th>Trauma labs</th>
<th>Abdominal CT</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–6 months</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes – if abdominal bruising, marks, or pain on exam (clinical signs of intra-abdominal injury)</td>
</tr>
<tr>
<td>6–12 months</td>
<td>No unless symptomatic</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes – asymptomatic but screening labs concerning for intra–abdominal injury • LFT’s &gt; 80 • Elevated pancreatic enzymes • Urinalysis with RBC • Unexplained anemia</td>
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<tr>
<td>12–24 months</td>
<td>No unless symptomatic</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>2–6 years</td>
<td>No unless symptomatic</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>6–18 years</td>
<td>No unless symptomatic</td>
<td>No</td>
<td>No</td>
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</tbody>
</table>

**Reporting:**
- After reviewing the injuries and reported mechanism of injury with the attending, if there is reasonable concern or suspicion for inflicted injury, make a report to DCFS (see below). If SW is present, she will make the report. If after hours, residents are responsible for reporting to DCFS.
- If the patient has already been reported to DCFS, review with the treating team safe disposition for the child.

**TRAUMA LABS = CBC, LFTs, Amylase, Lipase, Urinalysis (non-catheterized sample), Coagulation studies**
Making a report:
- Contact Illinois DCFS by calling 1-800-25-ABUSE
- What information does the hotline need?
  - Name, DOB, and address of the patient/victim
  - Name, DOB/age, and address of parents or caretakers
  - Name, DOB/age, and address of the alleged perpetrator (if available and different from above)
  - Name, DOB, and address of any siblings
  - Allegation, including any disclosure
  - Child’s condition, including any injuries
  - Involvement of police or other agencies
  - RD# if the police are involved

Disposition:
- Admit patients with the following:
  - Serious head injury in a child under 2 years old (skull fracture or ICH)
  - Burns in any child under 3 years old
  - Fractures suspicious for abuse in a child under 3 years old
  - Concerns of safety if discharged from ED
  - Disagreement with disposition plan per DCFS
- If patient is cleared for discharge, discuss disposition with DCFS. A mandate worker will come to the ER and determine safe disposition. Often the child is placed in a safety plan pending full investigation. This means they are placed with a family member who is protective and not an alleged perpetrator and the alleged perpetrator is not allowed to visit the child unsupervised.
- If there is no appropriate or available safety plan, DCFS must take protective custody and place the patient in a shelter. An alternative is to consider admission to the hospital if reasonable.

Confidentiality:
The confidentiality of every patient’s case shall be upheld and maintained. Therefore,
- Information shall not be released or disclosed to any investigative agency without verification of their identity and their involvement in the case.
- Information shall not be discussed with other family members unless permission has been given by the legal guardian or caretaker.
- Investigative agencies requesting the medical records should be referred to our social workers at pager 8887.

DISCLAIMER:
This clinical guideline has been developed for the purpose of unifying the general emergency care of patients with suspected child physical abuse. It is intended to aid, rather than substitute for, professional judgment. It is not intended to serve as a rigid protocol or a written proxy for the standard of care. Failure to comply with this guideline does not represent a breach of the standard of care.

References: