When to Refer Children for Medical Evaluations

GUIDELINES FOR WEST VIRGINIA'S CHILD ADVOCACY CENTERS

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Acknowledgements

The guidelines and best practices contained herein were developed to assist West Virginia's Child Advocacy Centers and their multidisciplinary investigative teams in determining when to refer children of alleged sexual and physical abuse and neglect for medical evaluations. This document has been adapted from Children's Advocacy Centers™ of Texas, Inc. with their permission. Child abuse medical providers and CAC staff contributed greatly to the revision of this document to fit the needs of WV communities.

This final product is a significant step toward ensuring consistent, comprehensive treatment for all children of suspected abuse.

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When to Refer Children for Medical Evaluations: Guidelines for West Virginia's Child Advocacy Centers

OVERVIEW

Medical evaluations are a critical piece of both the therapeutic and criminal justice responses to the suspected sexual and physical abuse of children, as well as in cases of neglect. A medical evaluation assesses the child's emotional and physical health, while also providing crucial forensic findings that will aid in the investigation of concerns of abuse.

These guidelines have been developed for use by children's advocacy centers (CACs) and their multidisciplinary investigative teams (MDITs) for determining which children of suspected sexual or physical abuse or neglect would benefit most from a medical evaluation. While the primary focus of the guidelines is to ensure that the emotional, psychological and medical needs of the child are met, there are also important secondary considerations for the investigative and prosecutorial processes, for the following reasons:

- The information provided by a child to a doctor or nurse during a medical evaluation may be an exception to the evidentiary hearsay rule (A child sometimes discloses additional information to a medical examiner that he or she did not reveal during the forensic interview).
- When a child has disclosed an act that could have resulted in injury or infection, but is not subsequently referred for a medical evaluation, the child's disclosure may be made to appear less credible. The implication is that the non-medical MDT members did not consider the disclosure concerning enough to complete the evaluation for potential residual problems.

RESPONSE LEVELS

Note that these guidelines are divided into three different response levels to be used in determining the need for a medical evaluation. They include:

- Criteria A: When a child is first encountered by a non-medical MDIT member and has not yet had a medical evaluation after an injury or an outcry of abuse.

- Criteria B: When a child has been evaluated/treated for suspected abusive injuries by a medical provider, including a first responder (EMS), who is not part of the MDIT. Review of the case by the MDIT's medical consultant is recommended.

- Criteria C: Other specific situations that should be reviewed with the MDIT medical consultant to determine the need for medical evaluation.

SEXUAL ABUSE

Criteria A: For a child first encountered by a non-medical MDIT member and who *has not yet had a medical evaluation* after an outcry of sexual abuse:

Criteria A – Sexual Abuse:	Referral for Complete Evaluation:
Contact of abuser's mouth with child's genitals or anus at any time	Indicated if reported by child or witnessed by another individual
Contact of abuser's genitals with child's genitals or anus or mouth at any time	Indicated if reported by child or witnessed by another individual
Contact of abuser's hands or fingers with child's genitals or anus	Indicated if child reports pain or bleeding with event OR if concern child made incomplete disclosure
Any of the above types of contact, having occurred **within the past 72 hours and thus likely requiring forensic evidence collection**	**Urgent referral to MDIT's nearest medical provider/program available to conduct acute child sexual abuse medical evaluations.**
Risk for partial or incomplete disclosure or recantation, regardless of type of contact reported by child. Disclosure is a process—a child may say more eventually.[1]	Examples of risk factors: ▸ Caregiver does not believe child ▸ Child is protecting the alleged abuser ▸ Child is reluctant to talk (based on forensic interview) ▸ Child may disclose some abuse "perpetrator fondled breast," but CAC/MDIT have reason to suspect more than that happened
Preteen sibling of a preteen child confirmed to have STD	Examination and testing indicated

Criteria B: For a child who has *already been evaluated/treated by a medical provider*, who is not part of the MDIT. It is recommended that the MDIT medical consultant review case and medical information and determine the need for follow up. Some children will need an examination by a clinician with expertise in child abuse, some will need a record review by a clinician with child abuse expertise, and some will need no further medical assessment.

Criteria B-Sexual Abuse	Additional Considerations
Child examined and report initiated by a non-MDIT provider for genital and/or anal pain or discharge; lesions/bumps/ulcers; bleeding; or painful urination, regardless of type of contact reported by child	Prompt review by MDIT medical expert recommended to assess likelihood of sexual abuse and possible need for further examination, testing, or treatment.
Child or adolescent diagnosed by a non-MDIT medical provider with an abnormal examination or an STD	Prompt review by MDIT medical expert recommended to assess likelihood of sexual abuse and possible need for further examination, testing, or treatment.

[1] See "Important Note on Recantation", Page 6

PHYSICAL ABUSE/NEGLECT

Criteria A: For a child first encountered by non-medical MDIT members and who ***has not yet had a medical evaluation*** for his/her injury or outcry of physical abuse or neglect

Criteria A – Physical Abuse/Neglect:	Referral for Complete Evaluation:
Child is 0-6 months of age	Indicated for **any** injury
Patterned bruises, lacerations or burns (Examples: belt loop, cigarette burn, curling iron, etc.)	▪ Indicated if child has limited verbal skills (age 5 or under or speech-delayed) ▪ Indicated if injuries are widespread or causing pain
Child states he/she has been hit in the face, hit with an object, whipped, punched, slapped, kicked or beaten.	▪ Indicated if child has limited verbal skills (age 5 or under or speech-delayed) ▪ Indicated at any age if injuries are visibly widespread or causing pain ▪ Indicated if witnessed by someone else
Child appears malnourished or starved and/or demonstrates deprivational behaviors.	Examples: ▪ Child begs for food or eats out of the trash. ▪ Infants who chew excessively on objects or hands.
Siblings or housemates of children with injuries or conditions that are being evaluated for serious abuse or neglect	▪ Highest priority: infants under 2 years ▪ Next highest: preschool children (age 5 or under)
Severe or extensive injuries at any age, including but not limited to: head trauma, burns, fractures chest or abdominal injuries.	**Emergency situation: EMS transfer to nearest hospital**
Child appears to be intoxicated, drugged, or otherwise non-responsive or abnormally responsive.	**Emergency situation: EMS transfer to nearest hospital**

Criteria B: For a child who has ***already been evaluated/treated by a medical provider***, including a first responder (EMS), who is not part of the MDIT. It is recommended that the MDIT medical consultant review case and medical information and determine the need for follow up. Some children will need an examination by a clinician with expertise in child abuse, some will need a record review by a clinician with child abuse expertise, and some will need no further medical assessment.

Criteria B-Physical Abuse/Neglect	Additional Considerations
Severe injury or condition that required medical attention or hospitalization and that initiated a report to CPS or law enforcement	Includes but not limited to: head trauma; burns; fractures; chest or abdominal injuries

SEXUAL ABUSE, PHYSICAL ABUSE, *OR* NEGLECT:

Criteria C: Other specific situations that should be reviewed on a ***case-by-case basis*** with the MDIT medical consultant to determine need for medical evaluation or additional medical testing.

Criteria C – Cases to be Reviewed by MDIT Medical Consultant	Additional Considerations
Child displays abnormal sexualized behaviors.	
Child has been exposed to pornography.	
Child was in the care of intoxicated caregivers (abuse of drugs or alcohol in the home).	
Domestic or other violence has occurred in the home.	Examples of other violence: gang involvement, home invasion.
Child expresses fear or appears fearful of the parent or caregiver.	
Child was left unsupervised in environments that are potentially dangerous or lethal.	
Child was not being protected and/or basic needs were not being met.	Examples: soft drink in baby bottle; child found alone in street.
Persistent failure to comply with prescribed medical treatment; or suspected harmful overuse of medical services/treatment.	
Caregiver or investigator expressed a request for examination or a serious concern not included in other criteria.	
Drug-endangered children.	Concerns for heavy parental drug use and/or drug manufacturing or distributing in the home.
Child exposed to an alleged or reported perpetrator of other children.	▪ May occur with a victim's siblings or step-siblings. ▪ Children of an alleged or reported perpetrator may have been sexually abused and have their own reasons for denial.[2]

[2] See "Important Note on Recantation," page 6

IMPORTANT NOTE ON RECANTATION:

A child's denial of sexual abuse when circumstances suggest it may have occurred is much more likely when the child:

- Is a relative or close associate of the suspected perpetrator – someone the child (or family) may wish to protect.
- Bonds with the alleged perpetrator (e.g., child may have low self-esteem/self-confidence, be overly trusting or naïve, or be affection- or approval-seeking).
- Has cause for fear and anxiety due to a history of physical abuse, spousal violence, or significant family dysfunction.
- Has a parent who is non-believing or not supportive of the child's disclosure or other evidence that abuse has occurred (STDs, genital injury). In these cases, the child may give a partial disclosure or recant.

WHO CAN PERFORM A MEDICAL EVALUATION FOR ABUSE OR NEGLECT?

A medical evaluation should be performed by a professional with experience in child sexual and/or physical abuse. The National Children's Alliance outlines minimum training standards for medical professionals at multiple levels of practice:

- Child Abuse Pediatrics Sub-board eligibility or certification
- Physicians without board certification or board eligibility in the field of Child Abuse Pediatrics, Advanced Practice Nurses, and Physician Assistants should have a minimum of 16 hours of formal didactic training in the medical evaluation of child sexual abuse
- SANEs without advanced practitioner training should have a minimum of 40 hours of coursework specific to the medical evaluation of child sexual abuse followed by a competency based clinical preceptorship. This means a preceptorship with an experienced provider in a clinical setting where the SANE can demonstrate competency in performing exams.

In addition to gathering evidence for forensic purposes, the medical evaluation should also include a head-to-toe assessment and treatment of such health problems as injuries, sexually transmitted diseases, pregnancy, and mental health needs of the child and family.

SPECIAL NOTE: Each CAC community and child abuse medical provider must define the types of cases that the provider can do based on his/her level of medical training. For example, a provider without additional training in the evaluation of physical abuse and neglect may only be able to accept sexual abuse cases.

RESOURCES FOR TRAINING, SPECIALIZED EXAMINATION, OR CASE REVIEW

WV CACs can look for upcoming educational opportunities on wvchamp.org under the Events/Calendar sections. Information on developing and strengthening child abuse medical services in your community can be found on the password-protected "Local Center Resources" section of the WVCAN website.

REFERENCES/RESOURCES

The following resources were used in developing the criteria in this document:

- When to Refer Children for Medical Evaluations: Guidelines for Texas Children's Advocacy Center, March 2014

- Reference Card for hospital emergency room personnel developed by James Lukefahr MD, Nancy Kellogg MD and Kathleen Buckley CPNP; UT Health Science Center-San Antonio.

- ChildSafe (San Antonio Children's Advocacy Center) MDT Protocol, developed by Nancy Kellogg, MD.

- 'The 5 "Ps"', developed by Jerry Jones MD and Karen Farst MD, UAMS Center for Children at Risk.

- "The Physical Examination for Child Sexual Abuse: What Does It Prove? Is It Important? Does It Hurt?" PowerPoint presentation developed by James Lukefahr MD, UTHSC-SA.