VFPMS Guide to Forensic Evaluation of Child Abuse

These clinical practice guidelines provide advice to assist decision-making in clinical situations when child abuse and neglect are considered. They do not serve to replace health services’ procedural guidelines or restrict discretion and good judgement in complex situations.

Clinical Practice Guidelines for child abuse and neglect, vulnerable children and “at risk children” are considered within 4 categories, recognising that differing forms of child abuse often co-exist.

1) Physical harm / Non-accidental injury  
2) Sexual harm / Sexual abuse  
3) Neglect  
4) Vulnerable child / at risk of abuse

Medical practitioners are encouraged to seek advice from the Victorian Forensic Paediatric Medical Service (VFPMS), senior medical staff and to always operate within jurisdictional legislative requirements.

Physical harm / Non-accidental injury (NAI)

Children who attend with an injury that might have been inflicted need a full assessment of their physical condition and psychosocial situation.

The priorities in dealing with child physical abuse are to:

1. suspect physical harm / non-accidental injury  
2. diagnose, treat and document the child’s injuries,  
3. interpret a pattern of injury or findings leading to the suspicion of abuse,  
4. notify and involve the Victorian Forensic Paediatric Medical Service (VFPMS),  
5. assess the child’s psychosocial situation,  
6. provide, when consent is given or legislation requires information sharing in the absence of guardian’s consent, a verbal and/or written report to Child Protection and the Police. VFPMS may be responsible for this task.  
7. plan for the child’s safe discharge and ongoing medical /psychological care.

Contact

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<th>Victorin Forensic Paediatric Medical Service (24 hours 7 days a week)</th>
<th>1300 66 11 42</th>
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Assessment of a child’s psychosocial situation may be conducted as a multidisciplinary assessment by professionals within the health service, including social workers and mental health professionals, working in partnership with Child Protection, police and community-based professionals.

**Management of suspected NAI**

**Admission or Discharge?**

Admission to hospital should be arranged when it is medically necessary (head injury, fractures, failure to thrive etc) or when it is necessary for the child’s safety.

A low threshold for admission is appropriate when dealing with an injured child.
Consider NAI in any infant who presents with an unexplained encephalopathy. Any infant with a cerebral injury, from shaking or direct trauma, should be admitted to ICU for monitoring overnight. Delayed deterioration may occur. (At RCH - ICU admission should only be declined following assessment by the ICU consultant).

The safe discharge of the child is the responsibility both of the hospital and Child Protection.

SCAN ("Suspected Child Abuse and Neglect") multi-disciplinary professionals' meetings

All admitted patients should be the subject of a SCAN meeting held within 24 hours of admission.

The SCAN protocol is designed to help coordinate early discussions with Paediatric medical staff, Victorian Forensic Paediatric Medical Service, Child Protection and police.

See SCAN Meeting Resources

Medical Investigation of Suspicious Injury

Forensic Investigation of suspicious bruising

First line investigation of bruising
- FBE
- APPT
- PT
- Fibrinogen
- Calcium
- LFT (proteins)
- U&E, Creatinine

Extended clotting profile
- Factor VIII, IX, XI, XIII
- Von Willebrand’s screen (and blood group)
- Platelet function tests
- +/- Lupus anticoagulant (+/-additional tests for lupus)
- +/- Inflammatory markers (if vasculitis suspected)
Forensic investigation of suspected intra-abdominal trauma

- Amylase and lipase
- LFT
- FBE
- Fibrinogen
- Dipstick urine (blood)
- Ultrasound
- CT abdomen if significant concerns about paralytic ileus, intra-abdominal haemorrhage and elevated amylase (> 3 hours post trauma)

Forensic investigation of suspected Abusive Head Trauma

Consider radiological imaging (MRI and/or CT brain scan) of the brains of infants and young children who might have been shaken.

Consider MRI cervical spine

Investigate as for fracture

Consult with an ophthalmologist (and arrange for examination by the ophthalmologist)

Investigate as for bruising when intracranial haemorrhage exists

Urine Metabolic screen

Admission to ICU should be considered whenever altered conscious state has occurred after suspected shaking because of the high risk of further neurological deterioration caused by progressive brain swelling

Forensic Investigation of suspicious Fractures

Radiograph (x-ray) sites of clinically suspected fracture(s).

Bone scan and skeletal survey (both together) are recommended in children <3 years of age, to search for occult fractures.

Note: a bone scan is not a sensitive tool for the detection of skull fractures; if suspected, obtain a skull radiograph or CT scan in addition. Note that the dose of irradiation must be weighed against the need to determine whether a skull fracture exists.

In children > 3 years, bone scans are used only if occult or healing fractures are suspected. Note that bone scan is unlikely to detect an occult fracture that occurred more than 12 months previously.

Blood tests to investigate suspicious fracture

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<td>Calcium</td>
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<td>Phosphate</td>
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<td>LFT</td>
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<td>U&amp;E Creatinine</td>
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<td>Vit D</td>
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<td>FBE</td>
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<th>Second line tests</th>
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<td>Magnesium</td>
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<td>Copper</td>
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<td>Parathyroid hormone</td>
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<td>Syphilis serology</td>
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<tr>
<td>Urine Metabolic Screen</td>
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<tr>
<td>Inflammatory markers</td>
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<td>Also consider genetic tests for OI</td>
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**Forensic investigation of suspicious burns and scalds**
If suspicions exist about intentional thermal injury such as scalds and contact burns in children aged < 3 years, then skeletal survey, bone scan and additional investigations for other forms of child abuse should be considered.

**Toxicological tests**
Toxicology tests might be considered when ingestion or poisoning is possible as a result of care-giver neglect or intentional exposure/ingestion. Also consider toxicology tests in children with unexplained altered conscious state, head injury, thermal injury and sexual assault.

- Consult with forensic experts before collecting samples.
- Ensure chain of evidence procedures if sending samples to forensic laboratory
- Collect blood and urine if ingestion or poisoning was within prior 24 hours
- Collect urine if ingestion or poisoning was more than 24 hours previously
- Consult with VFPMS if considering sampling hair for toxicological analysis.

Forensic toxicology laboratories and hospital biochemistry laboratories differ significantly in the analytical techniques used for drug detection and in the way that results are reported. Send samples to the laboratory that can perform the required tests.

**Sexual harm / Sexual abuse**

All children about whom there are suspicions of sexual abuse should be discussed with the VFPMS in the first instance. This will facilitate exclusion of the diagnosis of sexual assault in children who have not been sexually assaulted but who have conditions such as genital symptoms that are sometimes confused with sexual assault. This will reduce angst and suffering in children and their caregivers when there is an unreasonable suspicion of sexual assault.

In general, genital examinations for forensic purposes will only be performed by appropriately trained and experienced consultants.

The priorities in dealing with child sexual abuse are to:

1. suspect sexual harm
2. consult with the Victorian Forensic Paediatric Medical Service (VFPMS) to determine the best person, place and time for forensic evaluation.
3. when a child has made an allegation of sexual assault, notify and involve local Centre Against Sexual Assault (CASA) counsellor
4. diagnose, treat and document the child’s injuries
5. assess the child’s psychosocial situation,
6. provide, when consent is given or legislation requires information sharing in the absence of guardian’s consent, a verbal and/or written report to Child Protection and the Police. VFPMS is usually responsible for this.
7. plan for the child’s safe discharge and ongoing medical / psychological care.

After consultation with the VFPMS, when an urgent forensic examination by VFPMS is deemed to be unnecessary, limited inspection for a specific purpose such as determination of the amount of bleeding or the extent of a rash or discharge may be performed with the cooperation of the child.

After a recent sexual assault (< 72 hours) rapid evaluation is required. Contact the VFPMS, and speak to the consultant on-call. Collection of forensic evidence is an important consideration. You may be advised to assess and treat any urgent medical problems (e.g., bleeding), being careful to collect any clothing that is removed in the process. Ensure the child is as comfortable as possible and has appropriate emotional support. Await the on-call VFPMS consultant who will perform the forensic examination as a joint response with the CASA counsellor.

STI prophylaxis: Azithromycin 1 g stat

Pregnancy prophylaxis: Postinor (post coital contraception) within 72 h of sexual contact. Arrange for a follow-up pregnancy test

HIV prophylaxis: NPEP (according to ASHM post exposure prophylaxis guidelines)
Post sexual assault Sexually Transmissible Infection Screen

1. At time of examination (optional)
   First pass urine
   Gonorrhea and Chlamydia PCR

2. Baseline tests (2 weeks post assault)
   First pass urine (unless test performed when child examined & results negative)
   Gonorrhoea and Chlamydia PCR
   Blood serology for
   Hep B
   Hep C
   HIV
   syphilis

3. At 3 months blood serology
   Hep C
   HIV

4. At 6 months blood serology
   HIV
Neglect

The evaluation of child neglect is a complex process that should involve assessment of the child’s physical health, growth, development, behaviour, safety, emotional /psychological wellbeing and relationships.

Evaluation of child neglect should be mindful of the cumulative harms that occur when a child has been neglected over significant periods of time, particularly when neglect may have occurred at critical periods of the child’s development.

Evaluation of child neglect should assess the scope and extent of child neglect, the child’s current needs and the caregivers’ capacity to meet their child’s needs.

The priorities in dealing with child neglect are to:

1. suspect and diagnose child neglect
2. document neglectful events, situations and circumstances that constitute evidence of neglect.
3. document findings (examination findings and results of investigations) that constitute evidence of harm that occurred as a result of neglect.
4. assess the child’s psychosocial situation, particularly the child’s support systems
5. intervene to moderate neglectful situations and remediate the negative impact of neglect.
6. consult with the Victorian Forensic Paediatric Medical Service (VFPMS) in situations of serious harm to children or when seeking advice regarding case-management or preparation of medico-legal reports.
   a. VFPMS will provide the medico-legal report for a child seen at VFPMS Clinic.
   b. VFPMS proforma can guide assessment and opinion formation.
7. provide, when consent is given or legislation requires information sharing in the absence of guardian’s consent, a verbal and/or written report to Child Protection and the Police. VFPMS can help you write the report for a child you assess.
8. plan for the child’s safe discharge and ongoing medical / psychological care.

In situations of suspected neglect a multidisciplinary assessment should be performed using information gathered from a number of sources that include community-based health and welfare professionals, Child Protection and police. Social workers and/or mental health professionals should contribute to the assessment of children’s psychosocial situations, safety and parental capacity to meet children’s needs.
A report to Child Protection should occur when the child has suffered or is likely to suffer significant harm and the parents have failed to protect or are unlikely to protect the child from such harm.

A referral to Child FIRST should occur when there are significant concerns about a child’s wellbeing.

**Vulnerable Child / At Risk**

The priorities in dealing with a vulnerable child are to:

1. suspect and identify vulnerability
2. assess the child’s psychosocial situation,
3. conduct a multi-disciplinary assessment of vulnerabilities and protective factors using an ecological framework that focusses on the child, their caregivers, family, community, support systems and agencies that might better support children and their caregivers
4. refer to services to modify risk and promote resilience / protection.
5. Plan ongoing monitoring of the child’s safety, wellbeing and vulnerability to harm

After a multi-disciplinary assessment, when significant concerns exist about a child’s wellbeing, referral to Child FIRST should occur.

**Notes**

All medical staff working in the Emergency Department & Wards must be aware of the possibility of child abuse, and be able and prepared to act appropriately if it is suspected.

Medical and Nursing staff are mandated reporters who must notify Child Protection after forming a belief, on reasonable grounds, that a child has been, or is likely to be, physically or sexually abused and the parents have not protected, or are unlikely to protect, the child from such harm. There is an obligation upon all hospital staff to notify Child Protection if they have formed a belief that a child is in need of protection. See *Children, Youth and Families Act 2005 - SECT 162*
For Victorian Health Professionals:

The Victorian Forensic Paediatric Medical Service is available 24/7 for forensic medical advice and consultation.

As well as regular clinics each Monday to Friday, the VFPMS provides a 24 hour service for evaluation of possible causes of injury and advice for professionals regarding evaluation of suspected child abuse. They can also advise on good medical report writing, provide peer review of medico-legal reports and can liaise with the external agencies.

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In Melbourne

The Victorian Forensic Paediatric Medical Service is situated at RCH and MMC

- At RCH - at Clinic C on the 1st floor of the East building at RCH (9345 4299)
- At MMC - opposite radiology on the ground floor at MMC, Clayton (9594 2155).

Refer to Department of Social Work for psychosocial assessment when there are concerns about risk of harm to a child.

- At Royal Children’s Hospital contact Social Work Department 9345 6111 and after hours via RCH switchboard 93455522
- At Monash Children’s Hospital contact Social Work Department 95942290 and after hours via MMC switchboard 95946666

Refer children and their family members for counselling to a Centre Against Sexual Assault when an allegation of sexual abuse has been made.

- At Royal Children’s Hospital contact Gatehouse 93456391 and after hours via RCH switchboard 93455522
- At Monash Children’s Hospital contact SECASA 03 9594 2289 and after hours via MMC switchboard 95946666 or Sexual Assault Crisis Line (SACL) 1800 806 292 (Freecall Victoria).
Resources

- Victorian Forensic Paediatric Medical Service Web Site
- Proforma for suspected Child Abuse Consultation
- Proforma for “child at risk” and neglect consultation
- Diagrams for recording injuries
- Advice on writing a good medical report
- WCPSRG -reviews of child protection literature

SCAN Meeting Resources

(Suspected Child Abuse or Neglect)

- SCAN Meeting Procedures
- Medical Information summary for SCAN patients
- Agenda for SCAN meetings

Recording of decisions made at SCAN meetings.

- The social worker is responsible for distribution of the agenda.
- At the start of the SCAN meeting a person should be appointed to record the minutes.
- Minutes of the SCAN meeting should be distributed to all attendees within 24 hours of the SCAN meeting.
- Amendments to the minutes (if necessary) should be made without delay and the agreed final version of the SCAN meeting minutes filed in the patient’s medical record.