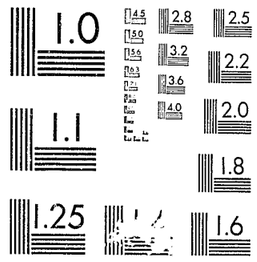

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THE USER MANUAL SERIES

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GUIDELINES FOR THE

HOSPITAL AND CLINIC

MANAGEMENT OF CHILD ABUSE AND NEGLECT

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THE USER MANUAL SERIES

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PREFACE

Hospitals and clinics serve as the front-line of protection for many children who are endangered by abuse and neglect. To assist medical staff in meeting their responsibilities to prevent, identify and treat child abuse and neglect, the Public Health Service and the National Center on Child Abuse and Neglect have jointly supported the publication of this manual, Guidelines for the Hospital and Clinic Management of Child Abuse and Neglect.

The Guidelines are the result of many years of experience in handling cases of suspected child abuse and neglect by the staff of the National Center for the Prevention and Treatment of Child Abuse and Neglect at the University of Colorado Medical Center in Denver. That experience has been supplemented by a field test in hospitals and clinics throughout the Rocky Mountain States and by the suggestions and reviews of medical and social work professionals from across the country.

The Public Health Service and the National Center hope that the clear definitions of child protective respnsibilities outlined in this manual will provide aid in nationwide efforts to protect endangered children. We are pleased to distribute the Guidelines and to encourage their adaptation and use in medical facilities.

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INTRODUCTION

The purpose of this manual is to help health care facilities manage child abuse and neglect (CA/N) cases by establishing standardized procedures. The manual is directed primarily at the roles of physicians, nurses, and hospital or clinic administrators. It also may be used by persons wanting to understand better the services that may be provided by a hospital or clinic.

Although health care facilities and personnel may be prepared to provide the services outlined in this manual, it should be noted that a hospital social worker or child protective services social worker must be available in most cases to accomplish the overall objectives for handling CA/N cases.

MANAGEMENT OBJECTIVES

Personnel in a health care facility have five main objectives in cases of CA/N.

1. Identify those children seen in the hospital setting who have been abused and neglected.

2. Provide adequate medical care for the injuries sustained. (This aspect of CA/N is not covered in this manual, but is left to textbooks of pediatrics and surgery.)

3. Carry out the legal obligations of reporting CA/N cases according to State law.

4. Collect data in a comprehensive manner so that if these data are needed later in court as evidence, they will be adequate to document the diagnosis of CA/N.

5. Remain therapeutic and helpful to the parents of the abused child so that parents will remain receptive to long-term treatment.

Larger hospitals will usually also need a hospital-based child protection team (CPT) to provide the expertise necessary to manage CA/N cases correctly and efficiently. The hospital is a logical focal

point for a CPT because most severe cases are seen initially in this setting. In addition, pediatricians or family physicians in practice, who cannot manage these cases themselves because of lack of time or inclination, can refer them to the hospital-based CPT. Also, physicians who are not inclined to report cases of CA/N are at least accessible for review by CPT members. In such instances, the team physician can carry out the duties incumbent upon the reporting physician as to written statements and court testimony.

TYPES OF HEALTH CARE FACILITIES

Hospitals and clinics are classified in this manual into three types to clarify what services should be available for CA/N cases in each setting.

1. A Type I health care facility is a clinic or emergency room that sees children but has no pediatric ward. Examples are a Neighborhood Health Center, multi-specialty group practice, or a private practitioner's office. These units obviously need a mechanism to transfer cases of child abuse to a hospital with inpatient services.

2. The Type II health care facility is a hospital that has a small-to-moderate pediatric ward and evaluates less than 30 cases of child abuse per year. Some of the cases for these units will require telephone consultation; a few will require transfer.

3. The Type III facility is a pediatric referral hospital that evaluates over 30 cases of child abuse per year. Examples of such a hospital would be a Children's Hospital, a University Teaching Hospital or a large City Hospital.

REQUIREMENTS

The requirements for a successful child abuse detection and evaluation system in each of the three facilities described above can be divided into three categories: personnel, laboratory facilities and policies/procedures. Exhibit I-1 presents a summary of the resources and policies needed for each type of facility.

EXHIBIT I-1

RESOURCES AND POLICIES NEEDED BY DIFFERENT HEALTH CARE FACILITIES

Resources and Policies	Types of Health Care Facilities: Type I. Clinic or ER with no Pediatric Ward	Type II. Small to Moderate Pediatric Ward	Type III. Pediatric Referral Hospital
Personnel			
1. Hospital-based CA/N contact person	X	X	X
2. Social worker (Child Welfare and/or hospital)	X	X	X
3. Primary pediatrician or family practitioner	X	X	X
4. Pediatrician who can provide consultation	X	X	
5. Pediatric consultant who can serve as expert witness			X
6. Gynecological consultant who can serve as expert witness			X
7. Child Protection Team (hospital based)			X
Laboratory and X-ray Facilities			
1. Radiological bone survey	X	X	X
2. Bleeding tests	X	X	X
Legal Policies and Procedures			
1. The legal definition of CA/N in the State of _____	X	X	X
2. Hospital policy on reporting and investigation of all cases of suspected CA/N	X	X	X
3. Reporting CA/N by phone and obtaining emergency Child Welfare services	X	X	X

CA/N = Child Abuse and/or Neglect
CPT = Child Protection Team
ER = Emergency Room

EXHIBIT I-1 (Cont.)

Resources and Policies	Types of Health Care Facilities: Type I. Clinic or ER with no Pediatric Ward	Type II. Small to Moderate Pediatric Ward	Type III. Pediatric Referral Hospital
Legal Policies and Procedures (Cont.)			
4. Reporting CA/N in writing	X	X	X
5. Police or Health Holds	X	X	X
6. Court-ordered treatment when parents refuse to consent	X	X	X
Emergency Room Protocols			
1. Nursing protocol for ER management of CA/N	X	X	X
2. Medical protocols for ER management of physical abuse	X	X	X
3. ER telephone consultation around CA/N diagnosis or management	X	X	
4. Transfer of CA/N case to hospital with additional services	X	X	
5. Incoming telephone calls about CA/N	X	X	X
Other Medical Protocols for CA/N			
1. Hospitalized cases of physical abuse		X	X
2. Sexual abuse	X	X	X
3. Failure to thrive secondary to nutritional deprivation		X	X
4. Newborn nursery -- identification of and intervention with high-risk families		X	X
Child Protection Team Protocols			
1. CPT members -- phone numbers for consultation			X
2. CPT meetings -- guidelines for mandatory team review			X
3. CPT intake data checklist			X

Personnel

Even if the hospital has no CPT, child abuse is a multidisciplinary problem that requires the input of several individuals. All hospitals need at least a hospital-based CA/N contact person, a social worker, and a primary physician. A Type III hospital should also have a CPT.

Hospital-Based CA/N Contact Person

To make a hospital/clinic child abuse system work, it is critical to designate a full-time hospital clinic employee as the contact or liaison person for CA/N cases in that setting. This person should receive all reports of suspected CA/N, collect any additional data needed to make these reports complete, refer these reports to the Child Protective Service (CPS) agency,[1] provide feedback to the reporting physician from that agency, and carry out any other legal obligations of the hospital in these CA/N cases. Without such a person, the hospital and clinic objectives in CA/N cases usually will be carried out in a very inconsistent manner.

In most hospitals, the professional designated to this role will be a hospital social worker. The missing data on most CA/N cases is social data. Therefore, it is appropriate that a social worker be involved at the hospital level. Also, this person needs to work closely with the social workers in the local CPS agency. It is fortunate that the Joint Commission on Accreditation of Hospitals requires that each hospital have at least one social worker on its staff.

If a social worker does not function in this capacity in a Type I clinic or emergency room, the head nurse can be designated that child abuse contact person. In a Type II hospital, the pediatric ward head nurse or nursing supervisor can be so designated. In a Type III hospital, the CPT social worker will fulfill this role, unless the volume of patients requires that the team have an additional person who is the CPT coordinator.

---

[1] The Child Protection Services (Child Welfare or Department of Social Services in some States) is the State agency mandated to receive reports of suspected CA/N, investigate these reports, and provide necessary intervention.

Social Worker

Every hospital needs access to intake social workers in the local CPS agency. (See Section II-B for a description of the responsibilities of the social worker in CA/N cases.) An evaluation of the family is essential to comprehensive case management and may be completed by the hospital social worker alone, CPS worker alone, or -- more likely -- both working collaboratively.

Primary Physician

In all hospitals a primary physician should be involved, be it a pediatrician, family practitioner, or house officer in training. In routine cases it is optimal that this person report the case himself/herself, or turn it over to the person legally designated to report for that institution. (See Section IV-B, V, VI and VII for a physician's responsibilities in CA/N cases.)

In Type I and II settings, a pediatrician should be available for consultation on problematic cases, if possible. This person can be the Chief of Pediatric Services, a designee, or regional or State pediatric consultant. The primary physician should be able to obtain first-level consultation from this person.

Child Protection Team

Type III hospitals need a hospital-based CPT with associated consultants in pediatrics, gynecology, and psychiatry/psychology, who can serve as expert witnesses in those special cases that require such expertise. (See Section IX-A, B and C protocols on special aspects of operating a CPT.)

Laboratory and X-ray Facilities

All facilities require the availability of x-ray examinations for occult fractures as well as a laboratory that can rule out a bleeding disorder. A radiographic bone survey consists of skull (AP and lateral), chest (AP), pelvis (AP, including lumbar spine), spine (lateral, centered at T-8 and including ribs), and long bones (AP, including hands and feet). A bleeding disorder screen usually consists of a bleeding time, partial thromboplastin time, thrombin time, prothrombin time, and platelet count.

Policies and Procedures

The remainder of this manual covers the projected policies and procedures necessary for each type of health care facility. The most important policies and procedures for all hospitals or clinics are described in Section III-A; the definitions of CA/N that require mandatory reporting in each State in III-B; the administrative policy for each hospital that requires all hospital personnel to report suspected cases of CA/N, even when they are in disagreement with other hospital professionals, in III-C; and the mechanism for telephone reporting of cases in that specific State in III-D.

It cannot be emphasized too strongly that these policies should be written and should be available prior to a time of crisis. For example, it is very difficult to work out the details of obtaining a police hold at the same moment the parents are attempting to remove their child from the hospital by force.

Modifications Required by State Statute

Variations in State law affect many of the policies and protocols in this manual. Before reviewing the sample protocols or attempting to write specific protocols for your State, it is important that you have the following information available to you:

1. Definitions of CA/N in your State
2. Persons mandated to report in your State
3. Specific law relating to the waiver of privileged communication in suspected child abuse and neglect cases
4. Mechanisms for obtaining protective custody, including a hospital hold, police hold or court hold
5. Reporting mechanism in your State, in terms of telephone reporting, written reporting, the official reporting form for your State, and where copies of such reports must be sent
6. Additional guidelines for special situations, such as care for children from a military base, Indian reservation, or an adjacent State.

Modifications Required by State and Local Resources

It is easier to simplify and streamline existing protocols than it is to expand abbreviated ones. Therefore, all the policies and protocols in this manual assume the availability of optimal resources. In the State of Colorado, for example, these resources include 24-hour, on-call CPS workers within each county, the availability of emergency receiving homes or foster homes, a 24-hour child abuse register, and an on-call, hospital-based CPT. The absence of any of these resources would require an alteration in the policies and protocols in this manual.

In addition, many of these protocols assume the presence in the hospital of a training program for residents. The description of how to include these residents in child abuse management leads to a more complex system, but it is necessary for training competent physicians.

WRITING AND IMPLEMENTING CA/N POLICIES AND PROCEDURES

The model policies and procedures in this manual should be looked upon as guidelines for development of policies and procedures; however, most cannot be placed into operation without some modification, because of differing State laws, State resources, and unique situations in each hospital and/or clinic.

It is anticipated that these policies and procedures optimally will be written by a committee which includes a physician, a nurse, an administrator, and a child protection agency or hospital-based social worker. In many cases, the sample policies and protocols can be reviewed, and additions and deletions can be penciled in. Then this draft can be typed for final approval by the committee.

Once these policies and protocols are approved, they should be posted at key locations in the hospital and clinic, sent to the heads of various services and revised yearly. Even more importantly, the hospital child abuse contact person or the CPS physician should provide inservice training around these materials. Care should be taken not to miss personnel who mainly provide nighttime coverage. Contacts should include staff physicians, emergency room physicians, nursing staff, and ward clerks.

SECTION II

RESPONSIBILITIES OF NON-MEDICAL CA/N PERSONNEL

A. Responsibilities of Hospital-Based CA/N Contact Person:

1. Referrals:

   a. Receives requests for evaluations of the suspected abuse or neglect case from hospital personnel (i.e. medical personnel, mental health personnel) and/or community agencies (i.e. CPS agency, police, schools).

   b. Initiates case referrals to appropriate personnel for consultation or evaluations (i.e. pediatric, social work).

   c. Maintains ongoing communication with all personnel (hospital and community) during evaluation process. Functions as liaison to promote unified approach among professionals involved.

2. Case management:

   a. Immediately reports all appropriate cases by telephone to CPS agency. Forwards official medical statement to local CPS agency.

   b. Obtains or arranges for:
      1) Previous medical record check
      2) Central Register record check
      3) Open or closed case records from local CPS agency
      4) Color photographs (as needed)
      5) Police holds (as needed).

   c. Obtains all evaluation summaries with treatment recommendations. Compiles Problem-Oriented Report on selected cases for conferencing.

   d. Schedules Dispositional Conference with all parties involved in diagnostic evaluation and ongoing treatment.

   e. Distributes all evaluation reports and recommendations to professionals involved.

3. Follow-up:

   a. Establishes and maintains case file with priorities for follow-up interval.

   b. Insures that CPT members are informed of subsequent court action, need for testimony and/or reports.

   c. Provides short- and long-term follow-up to ascertain if recommended treatment plan has been initiated, additional or changes of services are indicated, current status or progress of family is provided.

   d. Communicates case status to CPT. Initiates any recommended reconferencing.

B. Responsibilities of Social Worker:

1. Responsibilities common to role of hospital social worker and CPS social worker:

   a. Evaluates safety of the home by interviewing the parents, obtaining psycho-social information, compiling data and forming impressions of the situation:
      1) Completes the high-risk checklist on both parents.
      2) Arranges psychiatric consultation/evaluation on selected cases.

   b. Intervenes with and is supportive of the parents. (Honestly explains what is happening to them.)

   c. Participates in Dispositional CPT Conferences:
      1) Presents evaluation and tentative treatment recommendations.
      2) Assists in developing treatment plan and means of implementation.

   d. Initiates necessary legal action (e.g., helps initiate "police hold" or initiates juvenile court action).

   e. Dictates complete evaluation and distributes to appropriate agencies.

2. Responsibilities unique to hospital social worker:

   a. Acquaints parents with hospital procedures, encourages their participation in care of child.

   b. Writes brief evaluation in hospital chart.

   c. Helps hospital staff understand and be supportive of the parents.

3. Responsibilities unique to CPS social worker:

   a. Coordinates treatment plan.

   b. Provides ongoing therapy in selected cases.

   c. Organizes those cases which involve court action so pertinent data are presented to the court (i.e., submits reports, prepares testimony, enlists cooperation of and helps prepare other witnesses for testifying).

NOTE: Some of the non-evaluative responsibilities of the social worker coincide with responsibilities of the CPT Coordinator. Depending upon the staffing makeup of an agency or hospital, there can be interplay of responsibilities of the coordinator and social worker; in some cases, these two positions may be held by the same person.

SECTION III

LEGAL POLICIES AND PROCEDURES

A. The Legal Definition of Child Abuse and Neglect in the State of

_____.

The law in _____ defines CA/N for reporting
(State)
purposes to include:

1. Physical abuse, defined as:

_____

_____

_____

(Iowa example: Any nonaccidental physical injuries suffered by a child as a result of the acts or omissions of child's parent, guardian, or other person legally responsible for the child.)

(Oregon example: Nonaccidental physical injury, including any injury which appears to be at variance with explanation given; maltreatment which leads to physical harm; sexual molestation.)

(Colorado example: Nonaccidental physical injury [including failure to thrive] which seriously threatens the health or welfare of such child; specifically it includes: "Any case in which a child exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fractures of any bone, subdural hematoma, soft-tissue swelling, or death, and such condition or death is not justifiably explained, or where the history given concerning such condition or death is at variance with the degree or type of such condition or death, or circumstances indicate that such condition or death may not be the product of an accidental occurrence.")

2. Sexual abuse, defined as:

_____

_____

_____

(*Maryland example:* Any sexual abuse of a child, whether physical injuries are sustained or not.)

3. Neglect, defined as:

_____

_____

_____

(*Alabama example:* "Negligent treatment/maltreatment; failure to provide adequate food, medical treatment, clothing or shelter."

(*Michigan example:* Failure to provide adequate care or support.)

4. Emotional abuse or mental injury defined as:

_____

_____

_____

(*Montana example:* "Commission or omission of any act or acts which materially affect the normal . . . emotional development of a youth . . . .")

(*Wyoming example:* "'Mental injury' means an injury to the psychological capacity or emotional stability of a child as evidenced by an observable or substantial impairment in his ability to function with a normal range of performance and behavior with due regard to his culture.")

NOTE: The legal definition of child abuse and neglect may be different for purposes of reporting and for purposes of adjudication. Any case which on its facts is considered seriously harmful to the child and requiring intervention should be documented and pursued through legal service. Legal counsel may clarify that a case can be pursued best through public health laws, mental health statutes, or by some other means, rather than through abuse laws. Examples of situations which may require legal advice are inadequate sanitation, threats of harm, a heroin-addicted mother, medical neglect, etc.

B. Hospital Policy on Reporting and Investigating All Cases of Suspected CA/N[2]

Example: The State law of _____ makes it mandatory to report all *suspected* cases of nonaccidental injury, failure to thrive, sexual assualt, and severe physical neglect to the CPS agency. The law specifically mandates that all "hospital personnel engaged in admission, care, or treatment of patients" carry out such reporting. This would include all clerical staff, nursing staff, medical staff, social workers, etc. The professional does not have an option in the matter of reporting such cases for investigation. Reporting in good faith frees the professional from any liability if the report proves to be unfounded. On the other hand, willful failure to report opens the professional to criminal (Class 2 petty offense) or civil liability. (For example, see Landeros vs. Flood, 131 Calif. Reptr. 69 [1976].)

The State reporting laws are endorsed by this hospital and are fully in effect. At this hospital all *suspected* cases of child abuse and neglect must be reported to the hospital's CPT. This body will investigate these cases themselves or see that they are fully investigated by the appropriate community agency. They will also see to it that all reports are duly prepared and processed. If disagreement arises between hospital personnel as to whether or not a case of child abuse exists, the matter must be turned over to the CPT for evaluation and disposition. No private physician or attending physician shall refuse hospital compliance with this law.

In addition, the right to privileged communication and confidentiality between physician and patient is waived by state law in suspected child abuse cases. The physician can legally share this information with the CPT and professionals investigating such a case. However, the physician should refuse to share it with others (e.g., the press). In addition, the Medical Records Department should not release this information to parties other than the above without consulting the hospital administrator.

NOTE: In Type II hospitals, where there is no CPT, the reports of all suspicious cases should be sent to the child abuse liaison person or contact person for that hospital. This professional will usually be a social worker. In addition, any disagreements that arise with the medical staff should be directed to the chief of pediatric services or a designee. This physician will review the medical aspects of the case and attempt to provide clarification.

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[2]This policy usually will be signed by the hospital's executive administrator.

C. Reporting CA/N by Phone and Obtaining Emergency (Child Welfare) Services

1. The law in _____ (State) mandates that all cases of suspected CA/N be reported by phone (within a specified time limit, e.g., 24 hours) to the CPS agency of the county or location specified in the State's statute.

   CPS Day Phone Number: _____

   CPS Night Phone Number: _____

   State Hotline Phone Number: _____

2. On weekdays during normal working hours, this reporting can be done by the CPT coordinator. Most hospitalized cases can also wait until the next working day for reporting because the children are in a safe setting, as long as statutory time limits are satisfied.

3. In the Emergency Room on evenings and weekends, many hospitalizations of children with CA/N (who do not require hospitalization for medical reasons) can be prevented by contacting the on-call CPS worker. In some cases, the evaluation by the CPS worker may determine that the family setting is safe with ongoing treatment services. In other cases, the CPS worker may determine that the home is unsafe and that the child can be placed in an emergency receiving home. Sometimes, because of the unavailability of an emergency foster home, hospitalization will still be necessary.

D. Reporting CA/N in Writing

1. Policy:

   In many states, all telephone reports must be followed up by an official written report within 48 working hours. The report can be handwritten or dictated by the patient's physician. It should then be taken to _____ (Room _____) for rapid typing.

2. Content of Official Medical Statement:

   a. Pertinent history

   b. Pertinent physical findings

   c. Pertinent lab results, such as bone surveys or bleeding tests

   d. Concluding statement on why these findings represent child abuse or child neglect.

   (Samples of well-documented medical reports on physical abuse, nutritional deprivation and sexual abuse are found in Sections IV-B, V, VI and VII.)

3. Content of Official State Reporting Form:

   a. This form contains more identifying data and family information than is required in the medical statement.

   b. This form will be completed by the CPT coordinator or the CA/N contact person in the hospital and is not the concern of medical personnel.

4. Where to Send the Report:

   a. Make 3 copies of the medical statement and 3 copies of State reporting form.

   b. Attach a copy of the medical statement to each copy of the State reporting form.

   c. Distribution:
      1) Original to hospital chart
      2) Copy to CPS agency in county where child resides[3]
      3) Copies of State reporting form and National Clearinghouse Form to State Central Register[4]
      4) Duplicate copy of forms and medical statement into CPT file

   d. Transmit by mail.

   e. If the CPS agency needs the report immediately for a temporary custody hearing, arrangements should be made for a pickup.

E. Police or Health Hold Orders

1. Indications for a police hold are:

   a. The parents refuse to admit an abused child to the hospital.

   b. The parents threaten to take an abused child out of the hospital.

---

[3] A copy of the report to law enforcement personnel may be appropriate or required by State law. In Colorado, for example, the local Department of Social Services is required to forward a copy of the report to the local law enforcement agency.

[4] In most jurisdictions, these forms are available only through the Department of Social Services.

c. The parents make threats of physical violence against hospital staff.

2. Consultation with a member of the CPT should be made for assistance in obtaining the police hold, unless it is considered an emergency. Team members can be reached at the CPT office (Extension _____) or through the individual home telephone numbers listed on the consultation sheets in the clinics and wards. The physician can also ask the administrator on call (Extension _____) to obtain the police hold.

3. For obtaining a police hold on your own, directly contact the police or sheriff's department in the area where the child resides. Sometimes the police will give you a verbal police hold by phone and then come to the hospital to provide an official written police hold for the patient's hospital record.[5]

   Police Phone Number: _____

   Sheriff's Phone Number: _____

4. The hospital security guard (Extension _____) can be called if the parents actually try to remove their child by force. If the parents succeed in removing their child, the police in the child's area of residence should be called so that they can try to locate the child and return him/her to the hospital.

F. Court Order to Provide Medical Care When Parents Refuse to Consent

1. Indications:

   Indications for a court order to treat (administrative consent) are situations where the parent refuses to give consent for a specific diagnostic procedure or treatment in a life-threatening or permanent damage situation. Examples are:

[5] Procedures for police holds are different for different States. State statutes must be consulted to ascertain the correct procedures for a given State. For example, in Colorado, an order of temporary protective custody can be obtained over the phone from the courts by an agent of the Department of Social Services, law enforcement officer, hospital administrator, or a doctor (who has before him/her a child reasonably believed to have been abused or neglected, whether or not additional medical treatment is required.)

a. A spinal tap in suspected meningitis confirmed by two physicians.

b. A blood transfusion for severe bleeding.

c. An infectious disease that threatens the public safety if it goes untreated (e.g., diptheria).

2. Mechanism:

a. The physician may have to call the judge personally, if time and circumstances permit or require it. A written order should be requested simultaneously with the request for verbal approval. The physician should record the date, time, judge's name, and the judge's exact orders precisely in the patient's chart.

   Judge's Number: _____

b. Extremely busy physicians can turn this problem over to the administrator on call. (Extension _____).

NOTE: A court order to treat may or may not need to be obtained through a court in the child's county of residence. Most frequently, the court within the county where the hospital is located will have jurisdiction over a child in a hospital in that county.

SECTION IV

EMERGENCY ROOM PROTOCOLS

A. Nursing Protocol for Emergency Room (ER) Management of CA/N:

1. Expedite the Evaluations of CA/N Patients:

   Cases of suspected CA/N should be given high priority. Even when they are not medical emergencies, they are social emergencies and should be seen before any routine problems or children with minor illnesses. The only cases of higher priority should be suspected physical emergencies. The nurse can help to expedite these cases by detecting them in the waiting room and notifying the physician as soon as possible.

2. Help the Physician Arrive at the Correct Diagnosis:

   In some instances the nurse may consider the diagnosis of inflicted injury before the physician. If the physician is reluctant to consider this diagnosis, the nurse can provide the data that are believed to confirm this diagnosis. The nurse can also remind the physician that both of them are obligated by State law and hospital policy to report all suspected cases of CA/N. (See Section III-A and III-B.) Indeed, if the nurse continues to suspect abuse and the physician thinks otherwise, the nurse should report it alone. The nurse can also mention the mechanism for obtaining a medical telephone consultation around this diagnosis. (See Section IV-C.)

3. Direct the Physician to the Protocols on Complete Medical Evaluations of These Problems:

   For physical abuse cases, see Section IV-B; for sexual abuse cases, see Section VI; for failure to thrive cases, see Section VII.

4. Help the Physician Arrive at a Correct Disposition:

   The nurse can mention that the physician will not have to report the case personally if the case is referred to a local pediatrician who is interested in this problem or to the nearest referral hospital with a CPT. (See Section IV-D.) Another option is to call the CPS agency and request its intervention if the injuries do not require hospitalization. (See Section III-C.) After the interview, the CPS worker may decide, on the basis of the patient's cooperation and strengths, to keep the child in the natural

home with ongoing services. If the parents refuse hospitalization or consultation, the nurse can help the physician obtain a police hold. (See Section III-E.)

5. Maintain a Helping Approach Toward CA/N Parents:

   Feeling angry with CA/N parents is natural but expressing this anger is very damaging to parent cooperation. Keep in mind that most of these parents are lonely, frustrated, unloved, or otherwise needy people, who actually love their children but who have lashed out at them in anger. The nurse should attempt to keep the ER staff supportive and therapeutic in these cases and insure that the parents are kept informed of what is happening to their child at all times.

B. Medical Protocol for ER (or Clinic) Management of Physical Abuse:

1. See CA/N Patients Immediately:

   Patients who are brought in by other professionals (nurses, social workers, police, etc.) will be seen in the ER before other walk-in patients. Other patients on the log sheet should be skipped when CA/N patients are present. The reason for this policy is that a professional who is on duty should not have to spend long periods of time waiting to see another professional. The only cases of higher priority are suspected emergencies.

2. Maintain a Helping Approach Toward CA/N Parents:

   This is the hardest step. Feeling angry with CA/N parents is natural, but expressing this anger is very damaging to parent cooperation. Repeated interrogation, confrontation, and accusation must be avoided. Keep in mind that most of CA/N people are lonely, frustrated, unloved, or otherwise needy people who actually love their child but have lashed out in anger.

3. Hospitalize Selected Cases:

   When CPS workers or police officers bring a child to the Outpatient Department, they may only want a pediatric evaluation to document the medical evidence for physical abuse. Children who have been abandoned, left unsupervised, or live in other adverse environments may also be brought in for physical checkups. In some cases where the home is unsafe, the CPS agency will take the child to a foster home after the medical evaluation is completed.

By contrast, when a parent or guardian brings a child with suspected nonaccidental trauma to the ER, usually the child should be hospitalized so that the child will be in a protective environment until the diagnosis can be established or ruled out. The extent of the injuries is not relevant to this requirement. The reason given to the parents for hospitalization can be that "further studies are needed". In the ER or clinic, it is not helpful to mention the possibility of nonaccidental trauma. The outpatient physician should keep incriminating questions to a minimum. Once the child is safely admitted to the ward, the parents should be fully informed regarding the possible diagnosis of CA/N and the need for full evaluation. If it becomes difficult to persuade the parents of the need for admission, contact doctor (Extension _____) for assistance. If the parents refuse hospitalization, a police hold can be obtained. (See Section III-E.) The police hold is rarely needed and should not be a routine procedure.

A case can be safely evaluated without hospitalization in some instances such as where CPS is readily involved, or where the offender no longer has access readily to the child (i.e, a boyfriend who is in jail or a babysitter who is no longer employed). Serious homicidal threats (e.g., "If I have to spend another minute with that kid, something bad is going to happen") also require admission and psychiatric consultation.

4. Elicit a Detailed History of the Injury:

   A complete history should be obtained by one physician as to how the injury allegedly happened (the informant, date, exact time, place, sequence of events, people present, time lag before medical attention sought, etc.) (See Exhibit IV-1.) The parents can be pressed for exact details when necessary. No other professional should have to repeat this detailed, probing interview. If the parents are not present, the physician can request that the person who brought the child to the clinic (e.g., police officer or social worker) also bring the parents to the hospital for brief interview. It is important for the physician to talk with the parents directly so that this history is not looked upon as hearsay evidence (second-hand information) in court. If the child is old enough to give a complete history (usually over age 6), the parents may not need to be brought in.

5. Perform a Thorough Physical Exam:

   All bruises should be listed by site and recorded by their size, shape, and color. If they resemble strap marks, grab

EXHIBIT IV-1
SAMPLE

PHYSICAL ABUSE - MEDICAL REPORT

PATIENT'S NAME: S.D.
BD: 12/7/68
CGH #: 222333

History: On 7/12/76, at 3:20 p.m., this 7 1/2-year-old boy was brought to the Colorado General Hospital/Child Care Clinic by R. Smith of the Adams County Child Welfare Department for medical evaluation of suspected child abuse. The patient states that his mother struck him numerous times last evening (about 7:30 p.m.) with a strap. She also shook him. He claims the punishment was for refusing to take out the garbage. His older sister witnessed the beating. He reported the incident to his teacher today, who then notified Child Welfare. Prior to last evening, the patient states he has been struck with fan belts, bicycle tires, straps, and various wooden paddles. He states this has left bruises on at least two other occasions, but only on his buttocks.

During a brief phone conversation with the mother, she admits to hitting the patient with a belt, but claims he bruises easily.

Physical Exam: The patient was at the 60th percentile for hgt. and the 70th for wgt. The exam was normal except for the following:

1. Head: (R) ear - linear bruise 1" x 2", running across top portion and including adjacent scalp (resembles strap mark). Posterior scalp - tender swelling, 2" x 2", no bruise.
2. Arms: (R) upper arm - 3 oval shaped bruises, dime size (resemble grab marks).
3. Back: 2 linear bruises, on (R) side below shoulder blade, 1" x 3" and 1" x 4" (resemble strap marks).
4. Buttocks: at least 8 bruises; most are linear, a few circular, (R) more than (L); length 2" to 6" (resemble strap marks, tongue of belt visible at 2 sites).
5. Legs: (R) upper lateral thigh -- 1 linear bruise, 1" x 3".

NOTE: All the above bruises are purple-red and are recent.

Lab Tests:

Bleeding screen -- normal
Trauma x-rays -- not indicated

Conclusion: This 7 1/2-year-old boy has at least 12 strap-mark bruises inflicted by his mother with a belt. The one on the head points to serious loss of control. The history of past similar incidents increases the risk for this child.

_____ Date

_____ M.D.

marks, slap marks, bite marks, loop marks, tie marks, choke marks, cigarette burns, the outline of a blunt instrument, or any identifiable object, this should be recorded. Special attention should be paid to the retina, eardrums, oral cavity, and the genitals for signs of occult trauma. All bones should be palpated for tenderness and joints tested for full range of motion. The height and weight of the child should be plotted and, if the child appears malnourished, arrangements should be made for a return appointment for a weight check after two weeks, either in the foster home with ad lib meals, or in the natural home with specific feeding advice.

6. Order Bone Survey X-rays on Selected Cases:

   Every suspected CA/N case under 5 years of age should receive a radiologic bone survey (also termed "trauma survey"). Over age 5, X-rays should be obtained only if there is any bone tenderness or limited ROM on physical exam. If films of a tender site are initially negative, they should be repeated in two weeks to pick up calcification of any subperiosteal bleeding or nondisplaced epiphyseal separations that may have been present.

7. Order a Bleeding Disorder Screen on Selected Cases:

   If there are bruises and the parents deny inflicting them or claim the child has "easy bruising", a bleeding disorder screen (platelet count, bleeding time, partial thromboplastin time, thrombin time, and prothrombin time) should be ordered (Extension _____). During nights or weekends, such patients should be scheduled to return for these tests during the morning of the next working day.

8. Request a CPT Pediatric Consultation on Difficult Cases:

   Some cases are obvious; others are confusing. Try to observe the following guidelines:

   a. Weekdays -- call doctor (Extension _____) or the CPT office (Extension _____) on all CA/N cases for consultation. Usually wait until your evaluation is completed and any diagnostic studies are back.

   b. Evenings or weekends -- call the ER attending on all cases. If the ER attending feels that the diagnosis is definitely confirmed and an expert witness will not be needed in court, a CPT consultation is unnecessary. If the attending ER feels the diagnosis is uncertain or the case is complex and may require an expert witness in court, call the doctor at the home number posted on the CPT consultation list.

c. Always SAVE the chart for the CPT, so that a typed report can go in within 48 hours.

9. Request a CPT Social Worker Consultation on Selected Cases:

In general, the psycho-social evaluations in these cases will be done by the CPS worker. However, if you feel the need for another opinion, call the CPT social worker (Extension _____). An example might be where the police are going to return the child home but you feel that temporary foster care is necessary for the child's safety. On weekends and evenings if you need a social worker, phone the on-call CPS worker in the county of residence. (See Section IV-D.)

10. Complete an Official Written Report of the Physical Abuse Within 48 Hours:

The case should be reported to the CPS agency by phone immediately, and this will be done as soon as you notify the CPT Coordinator (Extension_____). The official medical report generally is required by law within 48 hours and should be written by the examining physician. As long as the medical record of the clinic visit contains the following data, the official typed medical report can be extracted from it. (See Exhibit IV-1.) After completing your chart notes, give the chart to the doctor or the CPT Coordinator immediately. On weekends or evenings, save the chart until the next working day because there is ordinarily no facility for typing these reports during these hours.

To prepare an adequate report, your chart notes must include:

a. History:
   1) Date and time the CA/N patient is brought into CCC
   2) Name(s) of professional(s) who accompany the patient
   3) Informant (parent, child, or both)
   4) Date, time, and place of the abuse incident
   5) How the abuse occurred
   6) Who allegedly abused the child
   7) Any history of past abuse.

b. Physical Exam (description of the injury or injuries):
   1) List the injuries by site (e.g., head, arms, legs, back, buttocks, chest, abdomen, genitalia).
   2) Describe each injury by size, shape, color, etc.
   3) If the injury identifies the object that caused it, always say so (e.g., strap mark, cigarette burn).

   4) Use nontechnical terms like "cheek" instead of "zygoma," "bruise" instead of "ecchymosis."
   5) Use inches instead of centimeters, where possible.

NOTE: A diagram of the body surface findings is helpful, but it is not as important as the verbal description of the same.

c. Lab tests -- x-rays, bleeding tests, etc.

d. Conclusion -- concluding statement on reasons why this represents nonaccidental trauma.

11. Provide Follow-Up Appointment:

A child with physical abuse who is not placed in a foster home needs close follow-up of his/her physical condition. The first appointment is usually made at a 1-2 week interval. If the child has a primary physician, the child should be reappointed to that physician. If the child has no prior health care resource return him/her to our clinic. The child may need immunizations or routine screening tests brought up to date. Some families will benefit from a public health nurse referral.

C. ER (or Clinic) Detection of High-Risk Families:

1. Identification:

Many families seen in the emergency room setting are noted to be at high-risk for CA/N or other symptoms of family dysfunctioning. Although the child manifests no evidence of physical abuse, the nursing and medical staff may become concerned because of the presence of severe marital discord, serious mental illness in one of the parents, drug addiction or alcoholism in either parent, violent behavior on the part of a parent, the absence of signs of attachment to the baby (no eye contact or holding of the baby), rough handling of the baby, hygiene neglect, or excessive spanking of young children.

2. Intervention:

The families mentioned above cannot be officially reported to child protective services as CA/N. However, they can be referred to CPS and other community agencies as families in need of extra services. Most CPS agencies are receptive to such referrals and are interested in providing supportive services as a preventive measure before more serious problems develop. Among the types of referrals to consider for these families are:

a. Continuity of medical care

b. Public health nurse referral (Telephone No. _____)

c. Mental health services (Telephone No._____)

D. ER Telephone Consultation Around CA/N Diagnosis or Management

1. Indications:

a. The diagnosis is uncertain (e.g., the physician needs medical help with deciding whether the injury is accidental or nonaccidental).

b. The diagnosis is certain, but the physician is unclear about what constitutes a comprehensive medical evaluation (e.g., whether or not bleeding tests are needed).

c. The diagnosis is certain, but the physician has legal questions or psycho-social questions.

2. How to Obtain Consultation:

a. For medical questions, call the pediatrician on the nearest child protection team (CPT):

Name: _____ Office No. _____ Home No. _____

b. For legal or psycho-social questions, call the social worker in the appropriate CPS agency. (See Section III-C.)

CPT Social Worker _____ Office No. _____ Home No. _____

If that person is unable to answer your questions, call the appropriate professional on the nearest CPT.

CPT Lawyer: _____ Office No. _____ Home No. _____

CPT Psychiatrist: _____ Office No. _____ Home No. _____

CPT Social Worker: _____ Office No. _____ Home No. _____

E. Transfer of CA/N Case to Hospital with Additional Services

1. Transfer from Type I, ER/Clinic to Type II Setting (Hospital With Pediatric Ward)

a. Indications for Transfer -- All cases of child abuse except:

1) Where the perpetrator (e.g., babysitter or boyfriend) is believed to be safely out of the house, e.g., in jail, out of State, or otherwise "definitely" out of the home.

2) Where the CPS worker is on call, comes to the clinic and evaluates the family, finds the home to be safe and the family receptive to ongoing services, or the home to be unsafe and can place the child in an emergency foster home (See Section III-C.)

3) Minor bruises on the buttocks or legs from spanking in older children (i.e., over age 5) where the physician feels the home is currently safe.

NOTE: These inflicted injuries in nonhospitalized children still require reporting. (See Section III-E.)

b. Techniques for Transfer:

1) In general, do not tell the parents your suspicions regarding the diagnosis of inflicted injury until there is a reasonable certainty of the diagnosis. Instead, tell them their child needs hospitalization for further observation and tests.

2) Most parents can drive their child to the admitting hospital. Give them the name of a physician or nurse at the receiving hospital who will know who they are.

3) If the parents are transients or raise any questions as to whether or not they will proceed to the other hospital, attempt to obtain police or CPS assistance. Otherwise, transport the child by ambulance.

4) The contact person at the other hospital should confirm the arrival of the patient by recontacting the ER physician.

5) With no arrival within one hour, the police should be notified.

2. Transfer to Referral Hospital (From Type I or Type II Setting to Type III Hospital):

a. Indications for Transfer:

1) Injury requiring special tertiary level medical care (e.g., major burns).

2) Documentation requires a pediatric trauma expert to see the patient since the diagnosis remains uncertain despite phone consultation (e.g., bruises that may or may not correspond to a handprint).

3) The case is predicted to require an expert witness in court (e.g., shaking-induced subdural hematomas, intentional poisoning, complex sexual abuse, an alleged accident with excessive body damage, cases with complicated histories, etc.).

4) If, for any reason, the physician is reluctant to report (e.g., the private physician feels he/she is too close a friend of the parents).

b. Techniques for Transfer:

1) Call the chief resident at the Referral Center to arrange admission. Phone number: _____.

2) Complete medical transfer form.

3) Transport by ambulance (not by parents). Phone number:_____.

c. Optional:

In a large city, the pediatric consultant may wish to leave the patient in the primary hospital and provide consultation by traveling there. This is less practical for rural hospitals.

F. Incoming Telephone Calls About CA/N

Calls can be triaged as follows:

1. The CPT office is staffed from 9:00 a.m.-5:00 p.m. on weekdays (_____). During these hours, they will attempt to handle all calls relating to CA/N.

2. On evenings or weekends, refer all calls to the head nurse or a physician in the Pediatric Emergency Room (_____).

3. The Pediatric Emergency Room nurse or physician has the following options:

a. Encourage the parents to bring their child directly to the emergency room and assure them there are people there who can help them. Provide any medical instructions that might be needed. Dispatch an ambulance if the injuries sound serious. Before hanging up, obtain the name, address, and phone number.

b. If the parent wants to talk to someone about abusive concerns or tendencies in themselves or someone else, suggest they call the psychiatric ER (_____) or the Child Abuse Helpline (_____).

c. The CPT staff is available for consultation with the pediatric and psychiatric house staff as the need arises. These home numbers are posted on each ward and clinic. (See Section IX-A.)

SECTION V

HOSPITALIZED CASES OF PHYSICAL ABUSE --

PHYSICIAN'S GUIDELINES TO MANAGEMENT

1. Treat the Child's Injuries:

   Once the child is in the hospital, medical and surgical problems should be cared for in the appropriate manner. Orthopedic consultation is commonly needed. Opthalmologists, neurologists, neuro-surgeons and plastic surgeons are occasionally consulted. The parents can be reassured that good medical care for their child is the first priority.

2. Elicit a Detailed History of the Injury:

   A complete history should be obtained by one physician as to how the injury allegedly happened (the informant, date, exact time, place, sequence of events, people present, time lag before medical attention sought, etc.). (See Exhibit V-1.) If possible, the parents should be interviewed separately. The parents can be pressed for exact details when necessary. No other professional should have to repeat this detailed, probing interview. This history should be obtained as soon after admission as possible, before the parents have had time to change the story. It is important for the physician to talk with the parents directly, so that this history is not looked upon as hearsay evidence (second-hand information) in court. Ordinarily, a child over age 3 should be interviewed regarding what happened to him.

3. Perform a Thorough Physical Exam:

   All bruises should be listed by site and have recorded their size, shape and color. If they resemble strap marks, grab marks, slap marks, bite marks, loop marks, tie marks, choke marks, cigarette burns, a blunt instrument, or any identifiable object, this should be recorded. Special attention should be paid to the retina, eardrums, oral cavity, and the genitals for signs of occult trauma. All bones should be palpated for tenderness and joints tested for full range of motion.

EXHIBIT V-1

SAMPLE

PHYSICAL ABUSE - MEDICAL REPORT ON HOSPITALIZED CASE

PATIENT'S NAME: D.F.

BD: 2/26/72

CGH#: 444555

History: The child and both parents were brought to (hospital) on 29 April 73 at 3:00 p.m. by the police. The child was admitted for intensive burn therapy. At 8:00 a.m. on this day, the father reports that he bathed this 14-month-old baby because she had "messy" pants. It is known that the parents are currently trying to toilet train this child. Despite her crying, he admits to holding her in the bathwater continually for 15 to 20 minutes. When he took her out, he noted the burn. Allegedly she usually cries during the bath, so this did not alarm him. Also, the father states that "he can't tell hot from cold water." He states that the bruise on her cheek is probably from a fall off the sofa yesterday. He sates he did not notice the bruise until we pointed it out. The parents deny easy bruisability in the child.

Physical Exam:

1. 70-80% body burn up to midchest and involving both forearms. Many blisters present ranging in size from 1" to 8". No open burns.

2. 2-3 cm., round, fading bruise on left cheek and scattered bruises of left earlobe, less than 0.5 cm. These are yellow-blue and at least 5 days old.

Trauma X-rays: normal

Conclusion: This burn is a classic dunking burn, probably inflicted as punishment for resistance around toilet training. The forearm burns are from struggling to get out of the tub. The child is old enough to climb out unless forcibly held. The bruise on the left cheek and ear is the type that usually results from being slapped, and is older than the father's description.

_____ (Date)

_____ M.D.

4. Order Bone Survey X-rays on Selected Cases:

   Every suspected case involving a child under 5 years of age should receive a radiologic bone survey (also termed "trauma survey"). Over age 5, X-rays should be obtained only if there is any bone tenderness or limited ROM on physical exam. If films of a tender site are initially negative, they should be repeated in two weeks to pick up calcification of any subperiosteal bleeding or non-displaced epiphyseal separations that may have been present. If there are visible physical findings, color photographs should be obtained before they fade. These may be needed in court in addition to the X-rays. (The CPT Coordinator at Extension _____ can arrange for photographs via medical photography or the CPS or police.)

5. Order a Bleeding Disorder Screen on Selected Cases:

   If there are bruises and the parents deny inflicting them or claim the child has "easy bruising," a bleeding disorder screen (platelet count, bleeding time, partial thromboplastin time, thrombin time, and prothrombin time) should be ordered (Extension _____). During nights or weekends, such patients should be scheduled for these tests during the morning of the next working day.

6. Request CPT-Pediatric Consultation to Help Confirm Your Diagnosis on All Cases Within 24 Hours of Admission:

   Some cases are obvious, others are confusing. The stakes are high; physical abuse is a life-threatening disease. Diagnosis of physical injuries is the pediatrician's job -- not the psychiatrist's or social worker's. It is based on medical judgment. If there is any doubt about the diagnosis, the CPT pediatrician should be called during the initial admission, since CA/N parents sometimes do not visit the child. In most cases, however, wait until you have completed your own evaluation and any needed diagnostic studies are back. For pediatric consultation call Dr. _____. Phone numbers are posted on the CPT consultation sheet on the bulletin boards of the clinics and wards.

   Indications for CPT-Pediatric Consultation Are:

   a. Physical abuse (i.e., unexplained or inadequately explained bruises, swellings, fractures or burns. This should also include any bruises or other injuries which are inflicted in the name of discipline).

b. Failure to thrive, secondary to under-feeding (as documented by having the infant gain at over 1.5 ozs. per day while in the hospital on a regular diet or suspected on admission because of the mother's behavior). (See Section VIII.) Also refer suspected deprivational dwarfism.

c. Sexual abuse -- molestation or incest. (See Section VI.)

d. Medical care neglect (i.e., not seeking medical care or not administering therapy when the omission is life-threatening).

e. Intentional drugging or poisoning (i.e., caretakers who give children dangerous drugs without a physician's orders).

If child abuse has not occurred, steps 7-18 need not be taken.

7. Tell Parents the Diagnosis and the Need to Report it:

Tell the parents the diagnosis and the need to report it. One can state: "Your explanation for the injury is insufficient. Even though it wasn't intentional, someone injured this child. I am obligated by (your State) law to report all suspicious injuries to children." The physician should do this, if the case is reported on the basis of the physician's medical findings or if he has a relationship with the parents. In fact, after all diagnostic studies are completed, the physician should review the interpretation of the actual cause of each specific injury in a way that is supportive to the family. This convinces the parents that we know what actually happened and permits them to turn their attention to therapy. The physician should be willing to discuss the general content of the medical report. The overall outlook should be positive and emphasize that this problem is treatable, that the CPS worker will be involved (preferably not the police, unless required by the law of the jurisdiction), that the matter will be shared only with professionals (will not appear in the newspapers), and that everyone's goal is to help them find better ways of dealing with their child (not to punish the parents). If the parents become argumentative, they can be advised to seek legal counsel.

8. Examine All Siblings Within 12 Hours:

It is possible that several children will be abused in the same family at the same time. For the safety of any siblings, they should be brought in for a full examination within 12

hours of reporting a case. Parents can be told this is "child protective service policy" or "hospital policy." If the parents say they cannot bring the other children in because of transportation problems, the protective service agency can accomplish this. If the parents refuse to have their other children seen, the CPS agency may obtain a court order and pick up the children with the help of the police.

9. Maintain a Helping Approach Toward These Parents:

This is the hardest step. Feeling angry with these parents is natural, but expressing this anger is very damaging to parent cooperation. Repeated interrogation, confrontation and accusation must be avoided. During visits, the ward staff must go out of their way to be courteous to these parents. The primary physician must see or phone them daily. They become suspicious quite easily if communication is not optimal. If the child is brought in with multiple life-threatening injuries, the parent requires an emergency psychiatric evaluation because he/she may be psychotic or suicidal.

10. Involve the Parents in the Child's Hospital Care:

The ultimate goal is to have the parents care for their child adequately. The parents should be encouraged to visit frequently and to take over the care of their child during these times. Since the appropriate disposition may depend on the parents' involvement with the child on the ward, an exact record should be kept of the number of visits, the duration of the visits, and what each parent does during the visits.

Even if the parents visit regularly, the hospital should attempt to provide the nurturing environment these children need. A "foster grandmother" and/or selected ward nurse can attempt to be parent surrogates for these children. In addition, a public health nurse or social worker should visit the parents and help them overcome any problems that keep them from visiting the hospital regularly.

11. Report to CPS Agency by Phone Immediately

The call goes to the agency charged with children's protective services in the patient's county of residence. The CPT Coordinator will place this call if the physician wishes him/her to do so.

12. Complete an Official Written Report of the Physical Abuse Incident Within 48 Hours:

A written medical report is often required by law. It should be written by a physician and contain the following brief but accurate data:

a. History:
   1) Date and time the patient is brought into CCC
   2) Name(s) of professional(s) who accompany the patient
   3) Informant (parent, child, or both)
   4) Date, time, and place of the abuse incident
   5) How the abuse occurred
   6) Who allegedly abused the child
   7) Any history of past abuse.

b. Physical exam (description of the injury or injuries):
   1) List the injuries by site (e.g., head, arms, legs, back, buttocks, chest, abdomen, genitalia)
   2) Describe each injury by size, shape, color, etc.
   3) If the injury identifies the object that caused it always say so (e.g., strap mark, cigarette burn)
   4) Use nontechnical terms like "cheek" instead of "zygoma," "bruise" instead of "ecchymosis"
   5) Use inches instead of centimeters, where possible.

   NOTE: A diagram of the body surface findings is helpful, but is not as important as the verbal description of the same.

c. Lab tests -- x-rays, bleeding tests, etc.

d. Conclusion -- concluding statement on reasons why this represents non-accidental trauma.

This report should be hand-written on ordinary paper by the pediatric intern in charge of the case. It should be taken to the CPT Coordinator, Room ____, for typing on official forms. The CPT Coordinator will also have it critiqued and co-signed by the CPT pediatrician.

13. Request CPT Social Worker Consultation Within 48 Hours

This referral can be explained to parents as "hospital policy." The CPT Coordinator will schedule these appointments. The social worker does the in-depth psycho-social interview to

determine overall family problems, environmental problems, the safety of the home, the state of the marriage, how disturbed the parents are, and how likely they are to accept therapy. In severe or complex cases, or when the initial social history information is inconclusive, the CPT social worker may request a psychiatric evaluation. (This helps to uncover the 10% of parents that are very dangerous because they are sociopathic or psychotic.) On hospitalized cases, the CPS social worker will carry out a concurrent evaluation, the extent of which may vary from case to case.

14. Refer Parents Who Need Crisis Psychotherapy:

After diagnosis, some of these parents will experience anger and other stong emotions that require ventilation. Also, some of them have strong dependency needs. Pediatric interns or residents may desire to help these parents personally. Usually, however, they will not have the time. Those parents who obviously need a long talk with someone about subjects other than their child's medical status can be referred to the CPT Coordinator or social worker. If a psychiatric crisis develops on nights or weekends and the CPT social worker cannot be reached, contact the child psychiatry fellow on call. (See Section IX-A.) If the parents threaten to take the child out of the hospital against medical advice, a temporary hold should be obtained. (See Section III-E.) Any member of the CPT or the hospital administration can help with this.

15. Attend CPT Dispositional Conference:

The social worker, pediatric consultant, house staff, CPS worker, police representative, psychiatrist, CPT Coordinator and any other community agencies involved with this family should meet within one week of admission. All evaluations should have been completed. All possible suspects (including babysitters, neighbors, siblings, boyfriends) should have been interviewed. When decisions are urgent, the physician, CPT social worker, and CPS worker involved on the case will meet on a nonscheduled basis and make the necessary decisions. Their actions will later be reviewed by the full CPT.

The regular CPT dispositional meetings with consultants present take place on _____(day) at _____ o'clock. An attempt is made to list all the family's problems in the case being reviewed. Then a joint decision is reached

regarding the best immediate and long-range plans for each problem. Based on the assessed safety of the home, a decision must be made on whether to have the child followed voluntarily or to go to court for temporary foster-home placement or court-enforced supervision. In severe cases, the CPT may decide to urge the court to terminate parental rights and place the child for adoption. The CPT Coordinator will convey these recommendations immediately by phoning the CPS agency if someone has not been able to attend the meeting. The composite recommendations of this meeting are typed and copies distributed to all involved individuals or agencies.

16. Provide Medical Testimony for Cases Which Go to Court:

Usually these cases are heard in juvenile court or family court rather than criminal court. Petitions are sustained on the basis of a "preponderance of evidence." The physician's statement that it is highly unlikely, if not impossible, that the injury was due to an accident, puts the burden on the parents to prove that they did not cause the injury in question. If the physician keeps precise medical records, reviews them before the hearing, and confers with the protective service agency's lawyer about the points wished to be stressed, the likelihood of a successful court hearing is improved. As part of the full hospital record on the case, the physician should bring a copy of the typed medical report to court. An extra copy should be available to submit into evidence. Extra copies of particular graphic photographs should be brought to court and used as evidence. X-rays may or may not be needed in the courtroom.

When the house staff are subpoenaed for court, one of the CPT pediatricians will accompany them, if possible. Only after seeing a CPT physician testify should they be requested to assume this role. The CPT pediatrician and/or lawyer should review with the house staff members, in advance, the questions they will probably be asked during cross-examination.

17. Provide Follow-Up Appointment to Monitor the Child's Physical Status:

Children who have been abused or neglected need more frequent well-child care visits than the average child. They should be seen weekly for a while. They need follow-up to detect any recurrence of physical abuse. If they have sustained

head injuries, they need follow-up for long term effects, such as mental retardation, spasticity, and subdural hematomas. These return visits can be provided by the pediatric resident who initially was involved on the ward, or a pediatric group practice. If the parents come from a great distance, the pediatric follow-up should be assigned to a physician in that community. The follow-up physician should receive telephone notification prior to discharge. In many cases, the physician will need the assistance of a public health nurse.

18. Child Protective Services Will Provide Psycho-Social Follow-Up and Treatment:

The pediatrician should not feel responsible for the restoration of these families to emotional health. The CPS agency is primarily responsible for coordination of the family's therapy. This therapy should begin while the child is still in the hospital. Some innovative types of therapy that have been successful when designed for individual cases are: Lay Therapists or Mothering Aides, Homemakers, Parents Anonymous groups, telephone hotlines, day care centers, environmental crisis therapy, marital counseling, vocational rehabilitation, etc. CPS also makes home visits and attempts to locate any families who become lost for follow-up contacts. A pediatrician can contribute to the therapeutic process by giving the parent his/her telephone number to call if things get rough. It is best if the parent has several people available as lifelines. After the parent calls, the CPS worker should be notified if the parent is in a crisis and needs non-medical help.

SECTION VI

INCEST AND OTHER FAMILY-RELATED SEXUAL ABUSE CASES: PHYSICIAN'S GUIDELINES TO MANAGEMENT

Sexual abuse of children by parents or caretakers includes incest (sexual intercourse), sodomy (anal intercourse), oral-genital contact, and molestation (fondling, masturbation, digital manipulation, etc.). The sexually-abused child is female in over 90% of cases, and this protocol mainly addresses the evaluation and treatment of the female victim.

Sexual abuse incidents usually occur without force. By contrast, rape can be defined as a) sexual intercourse, b) usually forced upon a victim using violence or threats of harm, and c) usually inflicted by a non-family member or stranger. All cases of incest and other forms of family-related molestation should be evaluated by the pediatric house staff. Rape cases (except in emancipated minors) should also receive a brief consultation. These cases should be seen promptly, since the family usually looks upon the situation as an emergency. Exhibit VI-1 outlines the guidelines for triaging sexual complaints.

The following guidelines are recommended for the pediatrician:

1. Protect the Patient from Additional Emotional Trauma:

   Victims of rape or other sexual assault are usually in serious emotional distress upon arrival in the emergency room. (By contrast, victims of chronic incest or molestation may not be upset.) Before any examination takes place, they should be allowed to ventilate about what has happened to them. If possible, a woman resident should be assigned to cases that involve female victims. If the physician does not have time to deal with these aspects of the problem, crisis counseling should be provided by a CPS worker, clinic social workers or psychiatrist on call. The patient should not disrobe until after she is feeling better. The pelvic exam should obviously be preceded by careful explanation and humane preparation by the clinic nurse, especially if it is the first exam for the child.

EXHIBIT VI-1

GUIDELINES FOR TRIAGING SEXUAL COMPLIANTS IN CHILDREN AND ADOLESCENTS

The following five situations are likely to occur in the Pediatric Clinic or the Emergency Room. The appropriate role and responsibilities of pediatric and ob-gyn house staff are outlined below. In those cases which do not fit the situations listed below, the physician should use his/her clinical judgment to decide what is best for the patient.

Type of Alleged Sexual Assault	Complete Evaluation and Rx. by GYN resident in ER(4)	Eval. and Rx. by PED in Adol. Clinic or ER(5)	GYN consult for forensic pevic exam(6)	Report to CPS (7)	Stat Psycho-social Evaluation	Psycho-social Follow-up Appointment	Call Rape Counseling Service
1. Rape -- over 18 years/ plus under 18 if married or emancipated minor (1)	X		All	None	Most ER psychiatrist	As needed Adult Psych.	Most (11)
2. Rape -- 17 and under, unless married or emancipated minor (1)		X	All	None	Most Adolescent Clinic SW(8)	Most Adolescent Clinic SW(10)	Most (11)
3. Concern by parents regarding recent alleged sexual relations in their teenager (but no rape or desire to prosecute).		X	None	None	Some, Adolescent Clinic SW(8)	As needed Adolescent Clinic SW(10)	None
4. Incest (2) (family-related)		X	All with intercourse within 48 hours	All	All CPT-SW(9)	Child Welfare SW	None
5. Child molestation (3) (both family-related and non-family related)		X	None	All	All CPT-SW(9)	Child Welfare SW	None

NOTE: Items (1)-(11) are explained on the following page.
For additional information call Dr._____.

EXHIBIT VI-1 (Continued)

KEY FOR TRIAGING SEXUAL COMPLAINTS CHART

1. Emancipated minor -- by Colorado law, for example, any person 16 years of age or older who lives separate from parents and makes his/her own financial decisions.

2. Incest -- sexual intercourse between family-related adult and child. (Anal intercurse and oral intercourse should also be evaluated according to these guidelines.)

3. Child molestation -- sexual contact other than sexual intercourse (e.g., fondling, masturbation, exposure).

4. See Gynecologist's Protocol: "The Management of Patients Who Have Been Sexually Assaulted."

5. See Pediatrician's Protocol: "Incest and Other Family-Related Sexual Abuse Cases: Physician's Guidelines to Management."

6. Page the Gynecology-resident (_____) to come to the Pediatric Clinic.

7. Weekdays: The CPT Coordinator will do this. (Extension_____). Evenings or Weekends: Call the CPS social worker on-call in county of residence -- posted on bulletin board. SAVE chart for CPT Coordinator.

8. Days: Adolescent Clinic social worker for all.
   Nights and Weekends: If distraught, child psychiatrist on-call. If stable, reappoint to Adolescent Clinic.

9. Days: CPT soical worker for all. (Exception: CPS social worker accompanies the patient.)
   Nights and Weekends: Call the CPS social worker in county of residence or get a consult from someone on CPT.

10. Leave name and phone number for Adolescent Clinic social worker. (Room_____.) He/She will set up an appointment.

11. Rape Counselors:

    a. ER Rape Counselors. Call the charge nurse in the ER for the name and phone number for the on-call person. He/She will come in and provide crisis counseling. OR

    b. Rape Crisis Center. Call _____. Free crisis counseling is available 24 hours a day, 7 days per week. This agency will also help with transportation, a safe place to stay and legal problems.

2. Elicit a Detailed History of the Incident:

Documentation of sexual abuse is usually totally dependent upon the history. Therefore, the interview needs to be long, relaxed and tactful. The patient should be encouraged to reveal all details concerning the incident(s). No other professional should have to repeat this interview, if possible. In incest or rape cases, an additional interview by the police is probably inevitable and the patient should be adequately prepared for it.

If the patient describes symptoms that could be related to sexual abuse, the story must sometimes be drawn out by a question such as, "I have a feeling that maybe somebody has done something to your body that has frightened you. Why don't you tell me about it?" The child's special names for body parts will often be helpful. In addition, to facts regarding date, time, place and person, the physician must document sites of sexual abuse (e.g., mouth, breasts, genitals, anus). Also information on menstrual history, whether or not penetration occurred, and whether or not ejaculation took place should be sought and recorded.

3. Perform a General Physical Examination:

The patient needs a general physical exam to look for any signs of body injury or infection. The mouth, anus and external genitals should receive special scrutiny for signs of trauma (i.e., redness, abrasions, purpura, petecchiae, tears). The hymenal ring should be inspected for size, fresh tears or old scars.

4. Lab Studies on Cases Not Referred to Gynecology:

The pediatric resident should check molestation cases for the presence of sperm even in the absence of a history of ejaculation. A moistened cotton-tipped applicator can be inserted into the vagina and then spread on a slide. The finding of vaginal discharge or an inflamed through should lead to a culture for gonorrhea. Any history of anal manipulation should lead to a sperm test and gonorrhea culture of this site.

5. Refer Selected Cases to Gynecology for a Forensic Vagina Exam:

The gynecology resident on call to the ER has the expertise to perform a forensic vaginal exam that can stand up in criminal court. All rape cases (post-pubertal or pre-pubertal) should be referred to gynecology. Incest cases should be referred if intercourse has taken place in the last 72 hours; otherwise, the exam described in Guideline 4 above can be performed by the pediatric house staff. (Evidence for sperm rarely persists beyond this time period.) Obviously, molestation cases do not need a gynecological referral.

The gynecology resident will usually collect the following evidence: (1) all underwear, (2) any stained clothing, (3) wet smear for sperm (examined in the ER), (4) dry smear for sperm, (5) vaginal swab for acid phosphatase, (6) gonorrhea culture, (7) blood type of victim, (8) VDRL on victim, (9) pubic hair specimens, etc. All specimens must be carefully identified with the patient's name and then placed in a sealed envelope. The sealed envelopes must be given to the investigating police officer for delivery to the police lab.

Cases at-risk for pregnancy should receive prophylactic stilbesterol, 25 mg. b.i.d. for 5 days, assuming the history suggests that the patient is not pregnant. Cases at-risk for veneral disease should receive 1.0 gm of probenicid plus 4.8 million units of procaine penicillin IM or 3.5 gm. ampicillin p.o. The gynecology resident usually will attend to these matters.

6. Hospitalize Selected Cases:

The immediate objective in sexual abuse cases is to prevent continued sexual exploitation of the child. This usually requires placing the child in a foster home and getting the parents into therapy. In cases where a CPS workers accompanies the family, the above actions usually can be arranged quickly. In cases where the parents or girl present themselves to the hospital, without any prior CPS agency involvement, the best course of action usually is to hospitalize the girl until CPS can become involved.

7. Request a CPT Pediatric Consultation on Difficult Cases:

   Many of these cases are difficult. To avoid repeating the history or exam, call in the CPT consultant or ER attending before beginning your history.

   a. Weekdays--Call Dr. _____ (Extension _____) or the CPT office (Extension _____) on all cases for consultation.

   b. Evenings and weekends--Call the ER attending on all cases. If the ER attending feels that the diagnosis is definitely confirmed and will not need an expert witness in court, CPT consultation us unnecessary. If the ER attending feels the diagnosis is uncertain or the case is complex and may require an expert witness in court, call Dr. _____ at the home number posted on the CPT consultation list.

   c. Always SAVE the chart for the CPT, so that a typed report can go in within 48 hours.

8. Request a CPT Social Worker Consultation on Selected Cases:

   In general, the psycho-social evaluations in these cases will be done by CPS workers. However, if they do not accompany the patient, call our CPT social worker (Extension _____). Another reason for consultation might be where the police and CPS worker are going to return the child home, but you feel that temporary foster care is necessary for the child's safety. On weekends and evenings, if you need a social worker, phone the on-call CPS worker in the county of residence. (See Section IX-A).

9. Complete an Official Written Report of the Sexual Abuse Incident:

   The case should be reported to CPS by phone immediately, and this will be done as soon as you notify the CPT Coordinator (_____). The official medical report should be written by the examining physician. This medical report is required by law in some states, sometimes within a specified time period (for example, within 48 hours). (See Exhibit VI-2). As long as the medical record of the clinic visit contains the following data, the official typed medical report can be extracted from it. After completing your chart notes, give the chart to Dr. _____ or the CPT Coordinator immediately. On the weekends or evenings, SAVE the chart until the next working day. We have no facility for typing these reports during the evening hours. The report should include:

   a. History -- the alleged sexual abuse incident (with dates, times, places, sites involved, people involved, etc.)

   b. Physical exam -- description of any positive findings or pertinent negative findings. (Use non-technical terms as much as possible.)

   c. Vaginal exam by gynecology consultant -- if done, list the consultant's name here.

   d. Lab -- results or pendings studies.

   e. Conclusion -- concluding statement on reasons why this incident represents sexual abuse.

10. Provide Follow-Up Appointments:

    The hospital CPT will become involved as soon as notified and will arrange to have all female siblings interviewed to rule out the possibility of any similar incidents with them. (Male siblings should also be interviewed if there is any suspicion that they have been mistreated.) If supportive counseling has not been provided by a mental health professional in the emergency room, the girl will be referred to such a person for evaluation as soon as possible after the incident. If the patient is post-pubertal and runs any risk of becoming pregnant, she should have a one-month follow-up appointment in the Adolescent Clinic to see a physician.

EXHIBIT VI-2

SAMPLE

SEXUAL ABUSE MEDICAL REPORT

PATIENT'S NAME: T.L.
BD: 6/12/67
CGH#: 222333

History: This 7-year-old chidl was brought to Colorado General Hospital 8/20/74 by her mother because of concern about sexual molestation of the girl by her husband (girl's stepfather). The mother is worried this has been going on for 6 months and quite frequently. The following history is directly from the mother. In the past two weeks since the mother quit work, the little girl, Tracy, has been coming to her to say such things as "Daddy tickles my bottom with his tongue, then he potties on me." (Interpretation -- oral-genital contact and ejaculation.) The mother states that she has found the stepfather and daughter lying together on their bed and both have jumped when she walks in. The mother came in today because last night Tracy told her that her father "tickled my bottom with his finger" while the mother was at the laundromat. She says she wants her husband and/or daughter to get help and she has confronted her husband with this. He denies molesting Tracy, but says he will go to get help for himself. The girl is unwilling to talk to the examiner. However, she says "Yes" when questioned about her mother's story. She denies that her father has ever put his penis in her bottom.

Physical Exam:

No signs of physical abuse. No signs of genital trauma or discharge. Hymenal opening intact and virginal.

Lab: Wet prep from vagina negative for sperm.

Conclusion: This 7-year-old girl has been repeatedly sexually abused by her stepfather. This includes oral-genital contact and other forms of molestation. Urgent intervention is needed.

_____ (Date)

_____ M.D.

SECTION VII

FAILURE TO THRIVE SECONDARY TO NUTRITIONAL DEPRIVATION: PHYSICIAN'S GUIDELINES TO MANAGEMENT

Failure to thrive can be defined as an underweight and malnourished condition. Failure-to-thrive children are usually below the 3rd percentile for weight and above the 3rd percentile for height and head circumference. Although there are numerous causes of failure to thrive, these guidelines pertain to the child who is failing to thrive because of underfeeding or nutritional deprivation. This diagnosis is confirmed when the failure-to-thrive-child, who has not been able to gain weight at home, easily gains weight in the hospital setting. The following steps will help in management of these children.

1. Hospitalize These Babies:

   Any baby with failure to thrive who does not respond to a one-month trial of increased calories and Public Health Nurse visits in the home should be hospitalized. Any case where maternal deprivation is suspected should be hospitalized immediately as these children are hard to follow as outpatients.

2. Flicit a Detailed Diet History and Feeding History:

   In most cases the mother will claim that the child is receiving more than adequate calories. In a few cases, the baby will be reported to be on a very bizarre diet, and this will help to uncover a psychotic parent. In some cases, the mother will report that the child has significant vomiting and diarrhea. The child's subsequent course in the hospital will prove most of these diet and feeding histories to be false. However, it is important to initially document these misleading histories in the medical record so that they can later be contrasted with the child's actual behavior in the hospital setting.

   The previous attempts by the parents to seek medical care for the child's failure to thrive should be noted (sometimes no physician has been consulted). A history of any preceding acute medical illness such as severe diarrhea or pneumonia that is well documented by a previous physician should also be recorded. The parents obviously should not be held accountable for a transient debilitating illness that caused weight loss and that is followed by a rapid weight gain in the hospital.

3. Perform a Thorough Physical Exam:

The physical examination of children with failure to thrive due to nutritional deprivation should reveal a healthy but underweight child. The only abnormal physical findings should relate to malnutrition. The physician should obtain all available past heights and weights on the patient and carefully plot them. The growth chart in this disorder should reveal a falloff or plateauing of weight that greatly exceeds the plateauing of height. Head circumference plateauing only occurs with severe malnutrition. Signs of associated hygiene neglect or inflicted injuries should also be looked for.

4. Order Limited Laboratory Tests:

A child showing failure to thrive in an otherwise normal physical examination requires very few baseline laboratory tests unless an attempt at caloric rehabilitation fails. A complete blood count, erythrocyte sedimentation rate, urine analysis, urine culture, stool pH, stool Clinitest, stool hematest, stool culture, serum electrolytes, BUN, and tuberculin test are adequate. Elaborate endocrine tests, malabsorption tests, and gastrointestinal X-rays could be deferred unless the baby fails to gain weight during a one-week period of adequate feeding. Diagnostic tests for alleged vomiting or diarrhea should not be ordered unless these symptoms are verified in the hospital setting.

5. Order Bone Survey X-rays in Selected Patients:

A radiologic bone survey is indicated in any child once the nutritional deprivation is documented. In 5 to 10% of these children fractures will be detected and confirm that they also are suffering from physical abuse. Obviously, these X-rays should be ordered initially in any children who have associated limited range of motion or other bone or joint findings. A before-and-after photograph of the child with failure to thrive can vividly demonstrate the malnutrition and may be helpful in court.

6. Evaluate the Infant's Psycho-Social Development on the Day of Admission:

Over 90% of the children who have failure to thrive on a maternal-deprivation basis will also manifest delays in development as well as deprivational behavior. A DDST should be obtained on the day of admission so that it can be compared to a later DDST after the child has received adequate

stimulation. Any bizarre behavior that the child has on admission should also be carefully recorded in the physician's and nursing notes.

7. Refer to CPT for Consultation as Soon as Nutritional Deprivation Becomes a Likely Diagnosis for the Failure to Thrive:

Certain cases of failure to thrive should be referred to the CPT on the day of admission so that a social evaluation can be obtained. The indications for this early referral depend on the presence of specific psycho-social findings. These findings usually will be elicited by the ward nurse or physician.

a. The child who is referred in by CPS or the police should have immediate CPT involvement.

b. Certain findings in the baby point to the need for early referral, such as:

   1) A severe degree of malnutrition (e.g., minimal weight gain in the previous two months)
   2) A baby who has not received any medical attention despite failure to thrive
   3) The child whose parents are not at all concerned about a weight problem
   4) Associated non-accidental trauma
   5) Gross hygiene neglect
   6) Lack of supervision
   7) Inadequate past medical care
   8) Previously documented physical abuse or failure to thrive in a sibling.

c. Early referral is indicated when the mother on admission is depressed, suicidal, overwhelmed with crises, retarded, psychotic or bizarre.

d. Early referral is indicated when the mother/child interaction on the ward reveals a lack of interest by the mother or open hostility toward the child.

e. Also, a history of the child being unwanted/rejected requires the same course of action.

In the above cases, the CPT social worker will evaluate the mother before she leaves the hospital on the day of admission. This is important because she may need immediate services, such as pyschiatric hospitalization in a suicidal mother. In

addition, the early interview tends to elicit a history that is more valid and prevents the problem of having difficulty with getting the mother in for the history at a later date. The children with failure to thrive who are not referred to the CPT on the day of admission should be referred after they demonstrate a rapid weight gain for two or three days in the hospital.

8. Involve the Parent in the Child's Hospital Care:

   The ultimate goal is to have the parent care for the baby adequately. Parents should be encouraged to visit frequently and to take over the care of the baby during these times. Since failure-to-thrive evaluations may require one-to-two weeks of hospitalization, the mother should be encouraged to room-in with her baby. At a minimum, this rooming-in will be required during the last two or three days of hospitalization. During this time the ward medical and nursing staff should offer help, remain supportive, compliment the parents on their efforts, and generally build confidence in them as parents. Criticism should be avoided and, if advice must be given, it should focus on the aspect that "He's a somewhat difficult child to feed."

   Since the appropriate disposition may depend on the parent's involvement with the child on the ward, an exact record should be kept of the number of visits, the duration of the visits, and what the parent does during these visits. If the parent does not visit or visits rarely, the hospital should try to provide the nurturing environment these children need. A foster grandmother and/or selected nurse can attempt to be parent surrogates for these children. These babies also need extra cuddling and verbal stimulation during their hospitalization from all the ward doctors, nurses, and clerks. A public health nurse or social worker should seek out the mother and help her overcome the problems that keep her from visiting in the hospital regularly.

9. Treat the Baby's Failure to Thrive with Unlimited Feedings of Regular Diet for Age:

   This step is essential to reach a definitive diagnosis. The formula should be identical to the one reportedly provided at home. Rapid weight gain on a special formula free of cow's milk protein or lactose would not prove that the child was underfed in the home setting. The daily intake should approach 150-200 calories per kilogram per day (ideal weight). The baby should be fed at regular intervals plus on-demand at other times. The

child should also be provided with supplemental vitamins. A nutritionist should be consulted to document the daily hospital intake and calories per kilo per day attained. This diagnostic trial of feeding should be carried out for a minimum of one week and in some cases extended to two weeks.

10. Confirm the Diagnosis of Nutritional Deprivation by Documentation of a Rapid Weight Gain:

    While in the hospital, the baby should be weighed on a daily basis on the same scale. Babies with failure to thrive on a nutritional deprivation basis will gain rapidly and easily in the hospital and also will demonstrate a ravenous appetite in most cases. A rapid weight gain can be defined as a gain of over 2 oz. per day sustained for a one-week period, a gain of greater than 1.5 oz. per day sustained for 2 weeks, or a gain that is strikingly greater than seen during a similar interval at home. Average weight gains for normal children vary according to age: 0.9 oz. per day in the first three months of life, 0.8 oz. per day from 3 to 6 months, 0.6 oz. per day from 6 to 9 months, and 0.4 oz. per day from 9 to 12 months of age.

11. Report All Confirmed Cases to CPS Agency by Phone and in Writing:

    By law in most states, cases of failure to thrive due to underfeeding should be reported to the CPS agency in the patient's county of residence. (See Exhibit VII-1.) The only exception is where the underfeeding was due to ignorance on the parent's part or economic conditions and was easily remedied by office advice or referral for financial assistance. The CPT Coordinator will be glad to place this call if the physician requests it. Within 48 hours the phone reporting should be followed by an official medical report written by the pediatric intern in charge of the case. It can be handwritten on ordinary paper and taken to the CPT Coordinator, Room _____, for typing on the official form. The CPT Coordinator will also have the report critiqued and co-signed by the CPT pediatrician. (A sample of a well-documented report is included at the end of this protocol.)

12. Initiate an Organic Workup for the Babies Who Fail to Gain Adequately in the Hospital Setting:

    The babies with organic failure to thrive will fail to gain rapidly with unlimited feedings. Some of them will gain 1 oz. per day with great effort on the part of the nursing staff but will then level off after the initial week (e.g., those with dysphagia or cardiochalasia). Most of them will not gain anything sub-

EXHIBIT VII-1
SAMPLE

NUTRITIONAL DEPRIVATION - MEDICAL REPORT

PATIENT'S NAME: D.L.
BD: 1/22/73
CGH#: 333444
COUNTY: Fairfax

History: This 7 1/2-month-old girl was admitted on August 2, 1973 for the second time for severe failure to thrive. The mother states that the child has frequent vomiting and is a picky eater.

Physical exam: Scrawny child with little fat tissue. No other findings.

Hospital course: The child had a revenous appetite. There was no vomiting. On a regular diet the fo owing weights were recorded:

1. Birth: 6 lb. 13 oz. to adm. #1 (gained <1 oz./wk)

2. Admission #1: (May 29) 7 lb., 14 oz.
   Discharge: (June 11), 9 lb., 3 oz. (gained > 2 oz./day)

3. Two months at home: no weight gain

4. Admission #2: (August 2), 9 lb., 3 oz.
   Discharge: (August 9), 10 lb., 2 oz. (gained >2 oz./day)

Trauma X-rays: normal

Conclusion: This child has been seriously underfed at home as documented by rapid weight gain in the hospital on two occasions. Treatment in the home has failed.

_____ (date)

_____ M.D.

stantial. These babies have an organic basis fo" their failure to thrive and, in general, fall into four groups. The first group has associated vomiting and will be recognized early in their hospital course (e.g., hiatal hernia). The second group will have inadequate caloric intake due to anorexia but without vomiting. The poor feeders seem disinterested in food and in some cases have a poor sucking reflex. The underlying cause is often a central nervous system defect as evidenced by associated microcephaly, developmental delays, floppiness, or seizures. A third group will have an adequate caloric intake in the hospital but will not have an adequate weight gain. Most of these babies have associated diarrhea and the underlying cause will be determined by a full malabsorption workup (e.g., celiac disease). A fourth group of babies will have an adequate caloric intake without any adequate weight gain but will have no diarrhea (e.g., diencephalic syndrome or hyperthyroidism). Usually there will be adequate diagnostic clues to suggest a selective laboratory approach to these patients who fail to gain weight in the hospital. Consultation is often in order at this point.

13. Provide Follow-Up Appointments:

Full nutritional catch-up to ideal weight may require four to six weeks. During this time, the child should be seen weekly for weight checks. In addition, the natural mother or foster mother may need dietary counseling from the physician. The physician's recommendations should not be misinterpreted as forced feedings which could lead to secondary food refusal. If the child has a feeding problem, the ward nurse and nutritionist should be involved in this discharge counseling. The physician will need the assistance of a public health nurse on many of these cases.

SECTION VIII

NEWBORN NURSERY: IDENTIFICATION OF AND INTERVENTION WITH HIGH-RISK FAMILIES

1. Identification:

   There are many behaviors that suggest to the Newborn Nursery or Maternity Ward staff that a mother may be unable to properly care for her baby. These include drug addiction; history of serious mental illness; an abusive upbringing of one of the parents; lack of maternal attachment, as indicated by poor cuddling or lack of eye-contact with the baby; disparaging remarks about the baby; postpartum depression; inadequate visiting, if the mother is discharged earlier than the baby; and so forth.

2. Hospital Social Service Referral:

   If, for any reason, there is concern that the family of a newborn baby is high-risk or potentially abusive, they should be referred as early in the hospital stay as possible to the social worker covering the Maternity Ward. (Call Extension _____.) The social worker will determine which community resources are needed by the family as well as the presence of any indications for a CPS referral.

3. Follow-up:

   The minimum follow-up post-discharge on all the babies should include a visit two days after discharge by a Public Health Nurse and a visit two weeks after discharge to a primary physician. Both of these professionals should be identified well before discharge and the parents so informed. The parents obviously will be involved in the choice of a specific primary physician. Medical visits during the first year of life should continue at intervals more frequent than provided for routine well-child care, and the Public Health Nurse should visit as frequently as is necessary.

4. CPT Referral:

   The CPT will not become directly involved with most high-risk families. However, some families are so clearly unsafe for the newborn that they should receive a complete CPT evaluation

before discharge. (Call Extension _____.) Examples are serious abuse or death of a sibling, spanking or dropping the baby, threatening to hurt the baby, a mother who is alcoholic or drug-addicted to the point of not being able to care for herself, etc. The evaluation of the family's current functioning may indicate that the baby must go directly from the hospital to a foster home. The CPT remains available for telephone consultation around any case.

SECTION IX

CHILD PROTECTION TEAM PROTOCOLS

A. CPT MEMBERS--PHONE NUMBER FOR CONSULTATION OF CHILD ABUSE OR NEGLECT CASES

1. Weekdays:

On weekdays from 9:00 a.m. - 5:00 p.m. call the CPT office (Extension _____). Consultations will be initiated by the CPT Coordinator (_____). If no answer, try general page (_____).

2. Weekends or Evenings:

If the CPT office is closed, specific consultations can be obtained as follows: (A pediatrician on the CPT usually is the best person to contact first--especially if the diagnosis is uncertain.)

a. Pediatric Consultants:

	Office Phone	Home Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

b. Coordinators (for help with routine reporting, emergency foster placement, police holds, etc.)

_____	_____	_____
_____	_____	_____

c. Social Work Consultants:

_____	_____	_____
_____	_____	_____

d. Psychiatric Consultants:

_____ _____ _____

_____ _____ _____

e. Legal Assistance:

_____ _____ _____

_____ _____ _____

B. CPT MEETINGS -- GUIDELINES FOR MANDATORY TEAM REVIEW

The following types of cases should be routinely reviewed by the hospital-based multidisciplinary team.[6] A specific weekly meeting time should be scheduled for this purpose.

1. Severe physical or sexual abuse (e.g., life-threatening abuse, multiple injuries, large burns, sadistic injuries, incest, severe malnutrition, deliberate poisoning, etc.).

2. Re-abuse cases (all failures). (Exception: few bruises in child over age 5 on one or two occasions.

3. Severe emotional abuse -- child severely emotionally disturbed and totally rejected/unwanted by parents.

4. Child less than one year old with any physical abuse.

5. Parent suspected of being dangerous (e.g., psychotic, sociopathic, suicidal, alcoholic, drug abuser, etc.)

6. Considering foster care placement or foster placement has been accomplished.

7. Considering termination of parental rights.

8. Specific questions exist regarding diagnosis or treatment.

9. The recommendations of different professionals or agencies are in conflict.

10. An unusual number of professionals and agencies are involved in a multi-problem family situation.

[6] Cases which are managed as outpatients and are reviewed by a community-based CPT usually do not need additional review by the hospital-based CPT.

C. CPT INTAKE DATA CHECKLIST

NAME: _____ CGH#: _____

BIRTHDATE: _____ COUNTY: _____

PLEASE RECORD THE DATE COMPLETED OR "NOT APPLICABLE" (N.A.) IN THE FIRST SPACE. ALSO RECORD THE RESULTS WHERE THEY ARE REQUESTED.

a. Checklist for Medical Data (CPT Pediatrician)

1. Child Abuse and Neglect, Diagnostic Category

a) _____ _____

b) _____ _____

2. History of Injury

a) Detailed injury history from mother _____

b) Detailed injury history from father _____

c) Brief injury history from child _____ Results _____

d) Other _____

3. Physical Exam of Patient _____ Results _____

4. Trauma X-Ray Survey _____ Results _____

5. Bleeding Disorder Screen _____ Results _____

6. Sub-specialty consults that may be needed in court

a) _____ _____

b) _____ _____

7. Color Photographs _____

8. Physical exam of siblings (within 12 hours)

   a) _____ _____ Results _____

   b) _____ _____

   c) _____ _____

9. Behavioral Assessment of Patient _____ Results _____

10. Developmental Assessment of Patient _____ Results _____

11. Submit an official, typed medical report to Child Welfare (within 48 hours). (Medical problem list to be taken from this.) _____

12. Inform parents that injury will be reported _____

b. Checklist for Psycho-Social Data (CPT Social Worker)

1. Interview mother _____ Impressions _____

   Interview father _____ Impressions _____

   Interview boyfriend _____

   Interview babysitter _____

   Interview other _____

2. Observe mother-child interaction (by CPT or Ward RN) _____ Results _____

3. Take parent on brief tour of the hospital _____

4. Write brief evaluation in CGH chart _____

5. Complete High-risk check list (prior to mini-conference)

   Mother _____ Score _____

   Father _____ Score _____

6. Arrange psychiatric consult

   Mother _____ Diagnosis _____

   Father _____ Diagnosis _____

7. Arrange for home evaluations (CPT or CPS) _____ Results _____

8. Prepare psycho-social problem list including recommendations (1st draft, prior to mini-conference) _____

9. Arrange interpretive hour with both parents after Dispositional Conference _____

10. Dictate complete evaluation _____

C. Checklist for CPT Coordinator's Task

1. Prepare

   a) file _____

   b) face sheet _____

   c) CGH registry cards _____

   d) statistical sheet _____

2. Check previous medical resource

   a) _____ _____ Results _____

   b) _____ _____ Results _____

3. Check State Central Register _____ Results _____

   Check County Child Protective Services _____ Results _____

4. Report to Child Protective Services by phone (within 24 hours) _____ Results _____

5. Obtain, type and mail State Reporting Forms _____

6. Keep ward physician and ward nurse informed of any change in status (e.g., police hold, projected date for foster placement, etc.). Make chart notes accordingly. _____

7. Schedule other consultations or special tests.

   a) _____ _____

   b) _____ _____

   c) _____ _____

8. Schedule Dispositional Conference and contact all participants. _____

   a) house staff _____

   b) ward nurse _____

   c) _____ _____

   d) _____ _____

   e) _____ _____

9. Type tentative Team Report (POR) before Dispositional Conference, preferably following mini-conference _____

10. Retype revised Team Report after Dispositional Conference _____

11. Distribute final Team Report with recommendations to:

   a) CGH and CPT charts _____

   b) Child Protective Services _____

   c) Primary physician _____

   d) PHN _____

   e) County attorney _____

   f) Guardian ad litem _____

   g) Parent's attorney only if attended CPT conference _____

   h) Coordinator of County CPT _____

12. Distribute additional copies of official medical statement to:

   a) Primary physician or medical care facility _____

   b) PHN _____

   c) Guardian ad litem _____

   d) Parent's attorney, even if did not attend CPT conference _____

13. Distribute typed social work evaluation to:

   a) CGH and CPT charts _____

   b) Child Protective Services _____

   c) Primary physician _____

   d) PHN _____

   e) Guardian ad litem _____

   f) Psychiatrist, if one is involved _____

14. Distribute typed psychiatric evaluation report to:

    a) Psychiatrist who submits _____

    b) CGH and CPT charts _____

    c) Child Welfare _____

    d) Guardian ad litem _____

15. Notify billing department if child becomes temporary ward of State _____

16. Arrange discharge with county worker if foster placement planned _____

17. Initiate team follow-up as follows:

	To be done	Completed
Education review	_____	_____
Consultation review	_____	_____
Indefinite reviews	_____	_____

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APPENDIX

PHYSICAL AND BEHAVIORAL INDICATORS OF CHILD ABUSE AND NEGLECT

TYPE OF CA/N	PHYSICAL INDICATORS	BEHAVIORAL INDICATORS
PHYSICAL ABUSE	Unexplained Bruises and Welts: - on face, lips, mouth - on torso, back, buttocks, thighs - in various stages of healing - clustered, forming regular patterns - reflecting shape of article used to inflict (electric cord, belt buckle) - on several different surface areas - regularly appear after absence, weekend or vacation Unexplained Burns: - cigar, cigarette burns, especially on soles, palms, back or buttocks - immersion burns (sock-like, glove-like doughnut shaped on buttocks or genitalia) - patterned like electric burner, iron, etc. - rope burns on arms, legs, neck or torse Unexplained Fractures: - to skull, nose, facial structure - in various stages of healing - multiple or spiral fractures Unexplained Lacerations or Abrasions: - to mouth, lips, gums, eyes - to external genitalia	Wary of Adult Contacts Apprehensive When Other Children Cry Behavioral Extremes: - agressiveness, or - withdrawal Frightened of Parents Afraid to go Home Reports Injury by Parents
PHYSICAL NEGLECT	Consistent Hunger, Poor Hygiene, Inappropriate Dress Consistent Lack of Supervision, Especially In Dangerous Activities or Long Periods Constant Fatigue or Listlessness Unattended Physical Problems or Medical Needs Abandonment	Begging, Stealing Food Extended Stays at School (early arrival and late departure) Constantly Falling Asleep in Class Alcohol or Drug Abuse Delinquency (e.g. thefts) States There is No Caretaker
SEXUAL ABUSE	Difficulty in Walking or Sitting Torn, Stained or Bloody Underclothing Pain or Itching in Genital Area Bruises or Bleeding in External Genitalia, Vaginal or Anal Areas Venereal Disease, Especially in Pre-teens Pregnancy	Unwilling to Change for Gym or Participate in PE Withdrawal, Fantasy or Infantile Behavior Bizarre, Sophisticated, or Unusual Sexual Behavior or Knowledge Poor Peer Relationships Delinquent or Run Away Reports Sexual Assualt by Caretaker
EMOTIONAL MALTREATMENT	Habit Disorders (sucking, biting, rocking, etc.) Conduct Disorders (antisocial, destructive, etc.) Neurotic Traits (sleep disorders, speech disorders, inhibition of play) Psychoneurotic Reactions (hysteria, obsession, compulsion, phobias, hypochondria)	Behavior Extremes: - compliant, passive or - aggressive, demanding Overly Adaptive Behavior: - inappropriately adult - inappropriately infant Developmental Lags (physical, mental, emotional) Attempted Suicide

END