A&E PROTOCOL FOR GBV, CHILD PHYSICAL & SEXUAL ABUSE, PARTNER VIOLENCE

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Clinical Protocol for Child Abuse and Neglect Assessment and Management

1. Introduction: Child maltreatment is a prevalent issue, with over 650,000 children experiencing abuse or neglect annually in the United States. Emergency physicians play a crucial role in identifying nonaccidental injuries and preventing further harm. Child maltreatment

includes neglect (68%), physical abuse (16%), sexual abuse (8%), emotional abuse, and medical child abuse (8%).

2. Neglect Evaluation and Management:

- Neglect is the most common form of maltreatment, contributing to up to 50% of child maltreatment fatalities.
- Neglect occurs when a caregiver fails to provide basic needs, resulting in serious impairment of the child's health or development.
- Multiple risk factors associated with neglect, such as poverty, parental substance abuse, and mental health issues, should be assessed.
- In the emergency department (ED), recognize when neglect may be a concern, document presenting issues, and trigger a multidisciplinary team approach for investigation and management.

3. Clinical Features and Assessment:

- Children may present with failure to thrive, malnutrition, infections, repeated injuries, behavioural problems, or mental health concerns.
- Review the hospital record before obtaining parental medical history.
- Evaluate the parents' ability to provide a clear history and knowledge about their child's health.
- Note growth parameters, immunization status, medications, and chronic health problems.
- Observe parent-child interaction and document clothing, hygiene, and unusual behaviours.
- Focus on skin, hair, teeth, and respiratory system during the physical examination.
- Consider skeletal survey for severe neglect to identify abuse or skeletal abnormalities.

4. Laboratory Testing and Imaging:

- Perform investigations based on illness severity.

- Comprehensive nutritional and metabolic profile for failure to thrive cases.
- Consider a skeletal survey for serious neglect cases to assess abuse or nutritional deficiencies.

5. Treatment and Disposition:

- Stabilize acute medical issues and injuries.
- Manage severe malnourishment and fluid/electrolyte imbalance.
- Educate parents sensitively on urgent problems, further investigation, and treatment.
- Consult paediatric specialists or child abuse experts for concerns of neglect.
- Regular re-evaluation is necessary for comprehensive neglect management.

6. Physical Abuse Evaluation and Management:

- Physical abuse accounts for 16% of child abuse cases.
- Injuries can occur on the skin, skeleton, head, and abdomen.
- Prioritize medical evaluation and treatment over legal investigation.
- Gather a detailed history from all involved parties, focusing on the onset and progression of symptoms.
- Evaluate the child's alertness, work of breathing, perfusion, and movement.
- Examine the scalp, mouth, skin, and extremities for signs of injury.
- Document the precise location, size, and shape of any injuries.

7. Additional Considerations:

- Collaborate with multidisciplinary teams for thorough assessment and management.
- Maintain a respectful and culturally sensitive approach to parents and caregivers.
- Document findings, interventions, consultations, and recommended follow-up care.

- Comply with legal reporting requirements for suspected child abuse and neglect.

8. Conclusion: Child abuse and neglect assessments require comprehensive evaluations, interdisciplinary collaboration, and sensitive communication. Early recognition and appropriate management by emergency physicians are essential to ensuring the safety and well-being of vulnerable children.

Common Findings Associated with Child Abuse:

Child abuse can manifest with various physical and behavioural signs. In the emergency department (ED), certain markers can be used to assess the possibility of child abuse. Here are common findings associated with abuse and specific ED markers to consider:

1. Physical Signs:

- **Bruises:** Unusual or patterned bruises, especially on the face, torso, buttocks, or thighs.
    - **ED Marker:** Multiple or varying stages of bruises inconsistent with the history provided.
- **Burns:** Burns with distinct shapes or immersion patterns, cigarette burns, or rope burns.
    - **ED Marker:** Injuries inconsistent with accidental explanations, such as accidental scalding.
- **Fractures:** Multiple fractures at different stages of healing, spiral or rib fractures in infants.
    - **ED Marker:** Unexplained fractures, fractures in non-ambulatory children.

- **Head Trauma:** Subdural hematomas, retinal haemorrhages.
    - **ED Marker:** Head injuries inconsistent with the reported mechanism.

2. Behavioural and Emotional Signs:

- **Withdrawal:** Sudden behavioural changes, withdrawal from usual activities.
    - **ED Marker:** Child appears anxious, fearful, or avoids interaction with caregivers.
- **Aggression:** Aggressive behaviour or extreme anger.
    - **ED Marker:** Child displays anger or fear disproportionate to the situation.
- **Regression:** Reverting to younger behaviours, such as bedwetting or thumb-sucking.
    - **ED Marker:** Inappropriate behaviours for the child's developmental stage.

3. Neglect Indicators:

- **Malnutrition:** Visible signs of malnutrition, such as emaciation or chronic health problems due to neglect.
    - **ED Marker:** Documented failure to thrive, malnutrition, or poor growth.
- **Poor Hygiene:** Obvious lack of cleanliness, frequent infections, or untreated medical conditions.
    - **ED Marker:** Visible signs of poor hygiene or untreated infections.

4. Caregiver Interaction:

- **Unresponsiveness:** Caregiver fails to provide appropriate medical history or appears indifferent to the child's condition.
    - **ED Marker:** Inconsistent or vague history, lack of concern about the child's well-being.

- **Delay in Seeking Care:** Delayed presentation of the child for medical evaluation after an injury.
    - **ED Marker:** Injuries that appear older than reported.

5. ED Markers for Assessing Child Abuse:

- **Inconsistent History:** Discrepancies between the injury and the provided explanation.
- **Delay in Presentation:** Injuries that appear to have occurred days or weeks before presentation.
- **Patterned Injuries:** Bruises, burns, or marks that resemble objects or implements.
- **Multiple Injuries:** Presence of multiple injuries in different stages of healing.
- **Unexplained Injuries:** Injuries with explanations inconsistent with the injury pattern.
- **Behavioural Changes:** Child displaying fear, withdrawal, or aggression disproportionate to the situation.
- **Caregiver Indifference:** Caregivers who do not seek medical care for serious injuries.

It's important to note that these markers are not definitive proof of child abuse but should raise suspicion and prompt further investigation. When child abuse is suspected, healthcare professionals should follow established protocols for reporting, documentation, and involving child protective services as necessary. Collaboration with social workers, child abuse experts, and law enforcement is crucial for ensuring the safety and well-being of the child.

Atypical findings that could be associated with child abuse, along with specific markers that emergency department (ED) healthcare professionals should be aware of:

1. Atypical Fractures:

- **Rib Fractures:** Fractures in infants, especially multiple rib fractures, can be concerning.
    - **ED Marker:** Unexplained rib fractures, particularly in non-ambulatory infants.
- **Sternal Fractures:** Rare in accidental trauma, sternal fractures can be seen in abusive situations.
    - **ED Marker:** Sternal fractures without a plausible accident explanation.

2. Dislocated Joints:

- **Posterior Shoulder Dislocation:** Uncommon in accidental falls, it can result from violent yanking.
    - **ED Marker:** Posterior shoulder dislocation without a clear accident mechanism.

3. Internal Injuries:

- **Visceral Injuries:** Abdominal injuries, such as liver or spleen lacerations, can be caused by direct blows.
    - **ED Marker:** Abdominal injuries inconsistent with the provided history.

4. Genital Injuries:

- **Genital Trauma:** Bruises, abrasions, or bleeding in the genital area can raise suspicions of abuse.
    - **ED Marker:** Genital injuries without a plausible explanation or consistent with non-accidental trauma.

5. Psychological and Behavioural Indicators:

- **Fear of Caregiver:** Child displays fear or avoids a specific caregiver.
    - **ED Marker:** Child's reaction to a caregiver triggers suspicion.
- **Age-Inappropriate Sexual Knowledge or Behavior:** Displays knowledge or behaviour beyond their developmental stage.
    - **ED Marker:** Disclosure of inappropriate sexual experiences or behaviours.

6. Neglect-Associated Findings:

- **Social Isolation:** Children consistently lack interaction with peers or appear socially isolated.
    - **ED Marker:** Child's limited social interaction or isolation is noticeable.

7. Atypical Presentations of Common Complaints:

- **Unexplained Seizures:** Seizures without an underlying medical cause or known seizure disorder.
    - **ED Marker:** Seizures in an otherwise healthy child without an apparent reason.
- **Unexplained Altered Mental Status:** Sudden behavioural changes or altered consciousness.
    - **ED Marker:** Altered mental status without a clear medical explanation.

8. Non-Physical Neglect Indicators:

- **Educational Neglect:** Chronic truancy, lack of school attendance, or inability to read/write.
    - **ED Marker:** Child's educational neglect evident from school attendance records.

9. Parental Reactions:

- **Overattentive or Overprotective Parenting:** Caregiver appears overly concerned about the child's health, possibly as a cover-up.

- **ED Marker:** Caregiver behaviour that seems exaggerated or contrived.

10. Delayed Developmental Milestones:

- **Speech Delays:** Significant delays in speech development.
    - **ED Marker:** Parental lack of concern for speech delays or failure to seek intervention.

It's important to remember that atypical findings do not guarantee abuse, and they may occasionally have alternative explanations. However, they should serve as additional reasons to consider the possibility of non-accidental trauma and prompt a comprehensive evaluation. When healthcare professionals suspect child abuse, they should follow established guidelines for reporting, documentation, and collaboration with child protective services and law enforcement.

The steps to be taken by a medical officer in the emergency department (ED) in cases of suspected or confirmed neglect/abuse, based on South African law, include:

1. Ensure Immediate Medical Care:

- If the child is in immediate danger, provide necessary medical treatment and stabilization as required.
- Prioritize the child's safety and well-being.

2. Document Physical Findings:

- Thoroughly document all physical findings, including injuries, bruises, fractures, and any other indicators of abuse or neglect.
- Use detailed descriptions, photographs, and diagrams to accurately capture the extent and location of injuries.

3. Maintain Confidentiality:

- Protect the child's privacy and confidentiality during the examination and throughout the reporting process.
- Limit the dissemination of information to authorized parties only.

4. Consult Colleagues:

- Seek consultation and collaboration with other medical professionals, including specialists, as needed to assess and document the child's injuries.

5. Obtain a Detailed History:

- Collect a comprehensive medical history from caregivers, parents, and guardians.
- Document the child's medical history, developmental milestones, and any pertinent information related to the injuries.

6. Assess the Caregiver's Explanation:

- Evaluate the caregiver's explanation for the injuries and ensure consistency with the child's injuries and medical findings.
- Be vigilant for inconsistencies or explanations that do not align with the nature of the injuries.

7. Suspected Child Abuse Reporting:

- If there is reasonable suspicion or confirmation of child abuse or neglect, healthcare professionals are legally obligated to report it to the appropriate authorities.
- In South Africa, reporting is done to the South African Police Service (SAPS) or the designated child protection agency.

8. Inform Child Protection Services:

- Notify the relevant child protection services agency, such as the Department of Social Development, about the suspected or confirmed abuse/neglect.
- Provide accurate and detailed information regarding the child's injuries, medical findings, and circumstances.

9. Collaborate with Law Enforcement:

- If there is an immediate risk to the child's safety, involve law enforcement, who will work in conjunction with child protection services to ensure the child's protection.

10. Coordinate Multidisciplinary Team Assessment:

- Participate in or facilitate a multidisciplinary team assessment involving healthcare professionals, social workers, law enforcement, and other relevant experts.
- Collaboratively determine the appropriate course of action for the child's safety and well-being.

11. Provide Medical Records and Testify:

- Provide accurate and complete medical records to authorized agencies as required for legal proceedings.
- If necessary, be prepared to testify in court regarding the child's injuries and your findings as a medical professional.

12. Support Services for the Child:

- If the child is removed from the home, ensure they receive appropriate medical care, counselling, and support.
- Collaborate with child protection services to provide the child with the necessary resources.

13. Follow-Up Care:

- Provide follow-up medical care and monitoring for the child's injuries, as well as any necessary ongoing medical attention.

14. Continued Cooperation:

- Continue to cooperate with child protection services and law enforcement throughout the investigation and legal proceedings.

It's important to note that South African law places a legal and ethical obligation on healthcare professionals to report suspected or confirmed child abuse and neglect. These steps are meant to ensure the child's safety, provide necessary medical care, and contribute to the protection of

vulnerable children. Healthcare professionals should also familiarize themselves with specific reporting and documentation requirements in their region and institution.

Guide for medical officers in the emergency department (ED) in cases of suspected or confirmed sexual abuse of children, based on South African law. This guide covers the ED markers, atypical features, and the steps to follow:

Suspected or Confirmed Sexual Abuse of Children: A Medical Officer's Guide

Emergency Department Markers:

- Children presenting with genital, anal, or oral trauma or injuries.
- Presence of sexually transmitted infections (STIs) or other genital/anal infections in prepubescent children.
- Disclosure of sexual abuse by the child.
- Behavioural changes, anxiety, depression, or other psychological distress in the child.
- Delay in seeking medical care for genital/anal injuries.
- Presence of adult genital secretions on the child's clothing or body.
- Inappropriate sexual behaviour, language, or knowledge beyond the child's age and development.

Atypical Features:

- Inconsistencies between the caregiver's explanation and the child's injuries.

- Child's fear or avoidance of a specific individual.
- Regressive behaviours, bedwetting, nightmares, or loss of developmental milestones.
- Use of coercion, threats, or manipulation to prevent disclosure.
- Reluctance to change clothing or undergo medical examination.
- Child's denial or minimization of the abuse due to fear or grooming.

Steps to Follow:

1. **Immediate Medical Care:** Prioritize the child's physical and emotional well-being. If the child is in acute distress or requires medical attention, provide necessary care promptly.
2. **Document Physical Findings:** Carefully document all physical findings, including injuries, genital/anal trauma, and any signs of abuse. Use accurate descriptions and photographs when appropriate.
3. **Protect Privacy and Confidentiality:** Ensure the child's privacy and confidentiality throughout the examination and reporting process.
4. **Interviewing:** Interview the child sensitively, using age-appropriate language, and in a child-friendly environment. Use non-leading questions and avoid repeated interviews that could re-traumatize the child.
5. **Medical Examination:** Conduct a thorough medical examination, focusing on any genital, anal, or oral injuries. Collect forensic evidence if applicable.
6. **Medical and Psychological Support:** Provide immediate medical treatment, including prophylaxis against STIs and pregnancy if necessary. Consider involving a child psychologist or social worker for emotional support.
7. **Suspected Child Sexual Abuse Reporting:** If you suspect or confirm sexual abuse, you are legally required to report it to the relevant authorities. In South Africa, this reporting is done to the

South African Police Service (SAPS) or the designated child protection agency.

8. **Notify Child Protection Services:** Inform the appropriate child protection services agency, such as the Department of Social Development, about the suspected or confirmed abuse. Provide accurate and detailed information about the child's injuries and circumstances.
9. **Law Enforcement Involvement:** If there's an immediate risk to the child, involve law enforcement. Collaborate with them and child protection services to ensure the child's safety.
10. **Multidisciplinary Team Assessment:** Participate in or facilitate a multidisciplinary team assessment involving healthcare professionals, social workers, law enforcement, child advocates, and psychologists.
11. **Preserve Evidence:** Collect and preserve any physical evidence following established protocols. Work closely with law enforcement and forensic experts as needed.
12. **Provide Medical Records and Testify:** If necessary, provide accurate and complete medical records for legal proceedings. Be prepared to testify in court regarding your findings.
13. **Child Support Services:** If the child is removed from the home, ensure they receive appropriate medical, psychological, and emotional support.
14. **Follow-Up Care:** Provide ongoing medical care, counselling, and support as needed. Collaborate with child protection services to ensure the child's well-being.
15. **Continued Cooperation:** Cooperate with law enforcement, child protection services, and other relevant agencies throughout the investigation and legal process.

It's important to remember that South African law mandates the reporting of suspected or confirmed child sexual abuse. Healthcare professionals are vital in protecting children from further harm and ensuring their safety and well-being. Additionally, healthcare professionals should stay informed about any updates or changes in the law and reporting procedures in their region.

Guide For Medical Officers in The Emergency Department (ED) In Cases of Suspected Or Confirmed Spousal/Partner Physical Abuse,

based on South African law. This guide covers the ED markers, atypical features, and the steps to follow:

Suspected or Confirmed Spousal/Partner Physical Abuse

Emergency Department Markers:

- Patients presenting with unexplained injuries, such as bruises, cuts, fractures, or burns.
- Injuries inconsistent with the patient's explanation or mechanism of injury.
- Repeated visits to the ED for injuries with varying explanations.
- Signs of emotional distress, fear, or anxiety in the patient.
- History of previous injuries or abuse documented in medical records.
- Disclosure of abuse by the patient.
- Reluctance to speak openly due to fear or intimidation from the partner/spouse.
- Presence of a controlling or overbearing partner/spouse during the visit.

Atypical Features:

- Inconsistencies between the patient's explanation and the injuries.
- Delay in seeking medical care for injuries.
- Reluctance to answer questions openly due to fear of retaliation.
- Patient's fear of leaving the partner/spouse or seeking help.
- Attempts by the partner/spouse to control the medical examination or treatment.

Steps to Follow:

1. **Ensure Patient Safety:** If the patient is in immediate danger, ensure their safety by involving security personnel, law enforcement, or protective services.
2. **Document Injuries:** Carefully document all physical injuries, including their location, size, shape, and colour. Use accurate descriptions and photographs when appropriate.
3. **Private Environment:** Create a safe and private environment for the patient to speak openly, away from the partner/spouse.
4. **Interview Sensitively:** Interview the patient sensitively, using open-ended and non-judgmental questions. Listen carefully to their account of the incident and their concerns.
5. **Medical Examination:** Conduct a thorough medical examination, focusing on any injuries. Collect forensic evidence if applicable and ensure proper documentation.
6. **Safety Assessment:** Assess the patient's immediate safety and discuss options for safety planning. This may involve shelter services, restraining orders, or other protective measures.
7. **Medical Treatment:** Provide necessary medical treatment for injuries and any immediate health concerns.
8. **Psychological Support:** Offer emotional support to the patient and consider involving a social worker or counsellor.

9. **Reporting:** In cases of suspected or confirmed spousal/partner physical abuse, it is essential to provide support and offer resources. However, the decision to report the abuse to law enforcement or relevant authorities should be based on the patient's consent and best interests. In South Africa, there is no legal obligation for healthcare professionals to report adult domestic violence to the police without the patient's consent.
10. **Provide Resources:** Provide the patient with information about local support services, shelters, counselling, legal aid, and helplines for victims of domestic violence.
11. **Counselling:** Encourage the patient to seek counselling or support groups for victims of domestic violence to address the emotional and psychological impact of abuse.
12. **Medical Records:** Document all findings, injuries, conversations, and assessments accurately and thoroughly in the patient's medical record.
13. **Preserve Evidence:** If the patient chooses to report the abuse to law enforcement, work closely with them to collect and preserve any necessary evidence.
14. **Follow-Up Care:** Arrange for follow-up care and support and provide the patient with a safety plan.
15. **Legal Support:** If the patient decides to pursue legal action, offer information about legal options and resources.
16. **Empower Patient Choice:** Respect the patient's decisions regarding reporting and legal action. Empower them to make choices that prioritize their safety and well-being.

Remember that your primary responsibility is the well-being of the patient. If there is an immediate threat to the patient's safety, prioritize their safety and involve appropriate authorities. Always approach cases of

spousal/partner physical abuse with empathy, sensitivity, and a commitment to providing support and resources.

Suspected or Confirmed Gender-Based Violence and Sexual Assault:

Note: Ideally, patients should be assessed and managed at the hospital's specialized Rape Crisis Centre. However, if there are severe or life-threatening injuries or evidence of the patient being drugged, immediate care in the Emergency Department (ED) is crucial.

Emergency Department Markers:

- Patients presenting with physical injuries, including bruises, cuts, abrasions, or strangulation marks.
- Patients who appear distressed, anxious, or traumatized.
- Disclosure of sexual assault by the patient.
- Signs of recent struggle, torn clothing, or dishevelled appearance.
- Presence of genital or anal injuries.
- Evidence of forced sexual contact, such as semen or other bodily fluids on clothing or body.
- Inconsistent or vague explanations for injuries.
- Delay in seeking medical care after the assault.

Atypical Features:

- Denial or minimization of the assault due to shame, fear, or stigma.
- Inconsistent history or reluctance to share details due to trauma.
- Absence of physical injuries despite allegations of sexual assault.
- Reluctance to undergo a forensic medical examination.
- Patient expressing fear of retaliation from the perpetrator.

Steps to Follow:

1. **Ensure Patient Safety:** Ensure the patient's safety and well-being. If they are in immediate danger or experiencing medical distress, provide necessary medical attention and consider involving law enforcement or protective services.
2. **Private Environment:** Create a safe and private environment for the patient to speak openly about their experience.
3. **Trauma-Informed Care:** Approach the patient with sensitivity and empathy, recognizing the potential trauma they have experienced. Use open-ended and non-judgmental questions.
4. **Medical Examination:** Conduct a thorough medical examination, documenting all physical injuries and forensic evidence. Preserve any clothing or items the patient provides as evidence.
5. **Forensic Evidence Collection:** If the assault occurred within the past 72 hours, discuss the option of collecting forensic evidence, such as swabs and samples. Ensure the patient understands the process and their rights.
6. **Psychological Support:** Offer immediate psychological support to the patient. Consider involving a social worker or counselor experienced in trauma support.
7. **Medical Treatment:** Provide necessary medical treatment for injuries and any immediate health concerns. Offer prophylactic treatment for sexually transmitted infections (STIs) and pregnancy prevention if applicable.
8. **Reporting:** In cases of sexual assault, explain the option of reporting to law enforcement. If the patient consents to reporting, assist in contacting the police or providing a rape kit examination.
9. **Legal Support:** Inform the patient about legal options, including reporting to law enforcement, obtaining a protection order, and pursuing legal action against the perpetrator.

10. **Support Services:** Provide information about local support services, such as counseling, shelters, and helplines for survivors of sexual assault and gender-based violence.
11. **Follow-Up Care:** Arrange for follow-up care, including medical and psychological follow-up appointments.
12. **Documentation:** Thoroughly document all findings, injuries, conversations, and assessments in the patient's medical record.
13. **Empower Choice:** Respect the patient's autonomy and decisions regarding reporting and legal action. Empower them to make choices that prioritize their well-being.
14. **Preserve Evidence:** If the patient decides to report the assault, work closely with law enforcement to collect and preserve necessary evidence.
15. **Patient Education:** Educate the patient about the importance of preserving evidence and maintaining their own well-being.
16. **Cultural Sensitivity:** Be culturally sensitive and aware of the patient's background and potential barriers to seeking help.

Remember, survivors of gender-based violence and sexual assault may be experiencing extreme emotional distress. Your role is to provide compassionate care, support their choices, and offer resources to help them on their path to healing and justice.