Suspected Child Abuse and Neglect (SCAN) Medical Protocol

Summary This guideline provides a new standard template for medical staff to record a forensically oriented medical assessment of a child or young person, to enable an informed opinion about the probability that injuries have been caused intentionally.

Document type Guideline

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Author branch Healthy Families and Communities

Branch contact 02 9391 9000

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Policy manual Patient Matters

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Previous reference N/A

Status Active

Functional group Clinical/Patient Services - Baby and Child, Critical Care

Applies to Local Health Districts, Specialty Network Governed Statutory Health Corporations, Public Hospitals

Distributed to Public Health System, Ministry of Health

Audience Paediatric Staff;Social Workers;Child Protection and Wellbeing Staff;Emergency Department NUM

NSW GOVERNMENT Health

GUIDELINE SUMMARY

SUSPECTED CHILD ABUSE AND NEGLECT (SCAN) MEDICAL PROTOCOL

PURPOSE

This protocol provides medical staff with a standard template and clinical guidance to record a forensically orientated medical assessment of a child or young person. A forensically oriented medical assessment is conducted to enable an opinion to be formed as to the probability that injuries have been caused intentionally or that neglect is present.

KEY PRINCIPLES

Medical staff are required under the *Children and Young Persons (Care and Protection) Act 1998* to provide medical examinations of children and young people in need of care and protection when requested by Community Services or the NSW Police Force, s173; or upon order of the Children's Court, s53. The SCAN Medical Protocol should be used to document these examinations. As a minimum this protocol should be used to document findings in all s173 examinations. An examining doctor is required to provide a written report to the Director General Community Services following completion of a s173 medical examination. The NSW Police Force, the Joint Investigation Response Team (JIRT) and Community Services are required to serve the hospital with a notice requesting s173 medical assessment.

USE OF THE GUIDELINE

The Protocol should be used in conjunction with NSW Health Policy Directive *PD2013_007 Child Wellbeing and Child Protection Policies and Procedures for NSW Health* which provides information to assist health workers to recognise and respond to child wellbeing and child protection concerns by setting out the legislation; the interagency and NSW Health policies that empower health workers; child abuse and neglect risk indicators; the mandatory reporting requirements and the tools and response mechanisms to children and young people suspected at risk of significant harm.

The NSW Health State Forms Management Committee has endorsed the SCAN Medical Protocol as a form for State-wide use. The Protocol can be accessed as a downloadable self-print document from the NSW Health print portal https://eprintondemand.salmat.com.au

REVISION HISTORY

Version	Approved by	Amendment notes
GL2014_012	Deputy Secretary, Population and Public Health	New guideline

ATTACHMENTS

1. Suspected Child Abuse and Neglect (SCAN) Medical Protocol

NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SCAN MEDICAL PROTOCOL

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Introduction

The Suspected Child Abuse and Neglect (SCAN) Medical Protocol has been developed for use by Paediatric Service medical staff involved in assessing children or young people who have been or are suspected of being physically abused or neglected. This includes children or young people who present with injuries that need a careful forensically oriented assessment, possibly including a site visit by police, to enable an opinion to be formed as to the probability that these injuries have been caused intentionally. It also includes children and young people who present with indications of neglect such as significant issues related to nutrition, hygiene and clothing and/or significant lack of parental/carer supervision, and lacking a safe living environment.

Use this Protocol in conjunction with NSW Health PD2013_007 Child Wellbeing and Child Protection Policies and Procedures for NSW Health. If there are concerns about possible child sexual abuse, the child should be referred to an appropriate sexual assault service.

This Protocol should only be made available as a pdf. document and printed when used so that there will always be a paper record.

Consultation

The medical officer completing the protocol should discuss the assessment with their local on-call paediatrician. Consideration should also be given to consultation with a tertiary child protection service. The medical officer completing the Protocol should ask for the paediatrician or medical consultant on call for child protection at one of the following hospitals:

- The Sydney Children's Hospitals Network Westmead Campus Ph: 9845 0000
- The Sydney Children's Hospitals Network Randwick Campus Ph: 9382 1111
- John Hunter Children's Hospital Ph: 4921 3000

Assessment

Optimally, assessment is to be conducted by the medical officer with a social worker or other health professional colleague e.g. a nurse present to facilitate a holistic assessment.

Photography

Medical photography of injuries is recommended and should be arranged as soon as is practicable. A consent form is required to be signed prior to photography. The hospital consent form for photography should be used. A NSW Kids and Families Photography Policy is in development. Visual images will need to be stored in accordance with the Policy.

Consent

A medical examination is performed, generally, to assess a patient's potential injuries. Where a child is brought in by a parent or guardian, consent is implicit for a general examination. Consent to a medical examination, including the taking and analysis of samples and the use of any machine or device that enables or assists in the examination, is taken to have been given when Community Services or a police officer requires the child to be medically examined under Section 173 of the Children and Young Person's (Care and Protection) Act 1998.

Anatomical Illustrations

The body and head illustrations have been reproduced with the permission of Dr. Terrance G Donald PSM MBBS Dip Paed Psych FRACP, Senior Consultant and Paediatric Forensic Physician Child Protection Services Women's and Children's Hospital Adelaide South Australia.

The feet and genitalia illustrations have been reproduced, and the hands have been adapted, with permission, from resources at The Royal Children's Hospital, Melbourne, Australia http://www.rch.org.au/clinicalguide/.

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Place (Hospital) Seen _____

Date and Time Seen _____

Name of Doctor completing protocol _____

Doctor's position (specify e.g. Paediatric Registrar, CPU Registrar) _____

Name and position of other health worker present _____

Referral Details: (include relevant contact numbers)

Referred By _____

Name of accompanying CS/ JIRT/ Police Officer _____

_____

_____

Name of accompanying Person _____

Relationship to Child/ Adolescent _____

If the family identifies as Aboriginal, make an offer for an Aboriginal health worker, health liaison officer or Aboriginal worker from Community Services or JIRT to be present, if possible, during the interview.

Aboriginal worker present: Yes, No, N/A

If English is not the first language of the child or family, arrange for an interpreter to be present, if possible, during the assessment. Please contact the NSW Health Care Interpreter Service in your Local Health District.

Interpreter present: Yes, No, N/A **Interpreter in attendance by telephone:** Yes, No, N/A

Reason for referral:

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Household/ Family Members:
Please identify the name, relationship to the child or young person, age and gender.

Genogram

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History of injury or situation of concern

(As obtained from carer or accompanying adult)

Where an injury or injuries have occurred, obtain a detailed history of the incident/s.
Record the history verbatim of what happened or the situation currently causing concern.
Avoid suggesting alternate scenarios.

Pages 6, 7 and 8 provide space to record histories.

Note: the following questions and/or observations should be recorded

- When was the child or young person last well? E.g. when did the child last eat, play
- What was the child or young person doing just before the injury? Explore whether the child or young person was running or pushed. E.g. if the child or young person fell, how far and onto what surface, and whether with added velocity.
- When did the incident occur (date, time) or when did the carer first notice the injury/mark/condition?
- What did the carer first notice?
- What did the carer report as the cause of the injury and where did it happen? Provide a detailed account of what happened.
- Who witnessed the incident? Was anybody else present at the time?
- What happened then? What was the time course of subsequent symptoms?
- When and where did the child or young person and carer/s present for help in relation to the injury?
- Who brought the child or young person to hospital?
- Was there a delay in presentation and if so what was the reason given?
- What action was followed?

NOTE: History from the child or young person is recorded separately if appropriate (see pages 9 and 10)

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Presenting History (1):

Note: History may be provided by one or more referrers / carers. Avoid questions that suggest that a particular individual is responsible for the injuries. Consider involvement of a second health professional (social worker, nurse, doctor) at time of obtaining this history. The names of persons giving information should be clearly documented. Please record the information provided by different informants separately.

Name of person giving information _____

Relationship to child or young person _____

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Presenting History (2) - continued:

Name of person giving information _____

Relationship to child or young person _____

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Presenting History (3) - continued:

Name of person giving information _____

Relationship to child or young person _____

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History from Child or Young Person when relevant

It may not always be safe or possible to ask the child or young person for an account of the injuries.

Remember that investigative interviewing is the responsibility of the NSW Police Force or the Department of Family and Community Services.

- Direct questions and prompting should be strictly avoided to prevent any possibility of 'leading' the child or young person.
- The child or young person should not be questioned in the presence of a possible perpetrator.
- Preferably the parent/carer should not be present; and
- A second health professional (social worker, nurse, doctor) should be present at the time of obtaining this history

Record the child's or young person's actual words

- Whenever possible the child or young person should tell the story in their own words.
- Use the child's or young person's expressions.
- If the doctor is the first person the child or young person tells then the history as given by the child or young person should be **recorded verbatim.**
- Ask open ended questions E.g. can you tell me what happened?
- Avoid questions that suggest that a particular individual is responsible for the injuries
- Include any relevant statements made by the child during the medical examination

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Presenting History from Child or Young Person when relevant:

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Medical History:

Perinatal History:
Record the history of pregnancy, labour, delivery and neonatal period. If the child is an infant record if vitamin K was given at birth.

Feeding/ weight gain:

Developmental History:
Comment on milestones, parental/ other concerns regarding development or behaviour.
(E.g. baby able to roll, child pulls to stand, walks with steady gait).

Behavioural History:
How do the parents describe the child's or young person's temperament and behaviour? Are there difficulties with discipline, sleeping, feeding etc? Ask for examples. How do the parents/carers describe their relationships with the child or young person?

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School/ preschool/ childcare: _____

_____

_____

Name of (pre)school attended: _____

Year (school): _____

Academic Progress: _____

_____

_____

Other significant issues E.g. Friends/ Bullying etc.

Current and recent medications: _____

Allergies: _____

Immunisations: _____

Blue Book sighted: YES ☐ NO ☐

Past medical history

Include previous injuries (e.g. fractures / burns) / hospital / clinic attendances and admissions

a) History from parents / carer:

_____

_____

_____

_____

b) Information from health service records:

_____

_____

_____

_____

Detailed history about bruising and bleeding (in the child or young person and family members): Consider prolonged bleeding from the umbilicus as neonate, from circumcision (in boys), from venipuncture sites, after surgery, after dental extractions, after accidental falls with cuts (to the face/mouth), following immunisations, nosebleeds that needed cautery, bleeding into joints, menorrhagia (adolescent girls).

Family history: e.g. bone disease.

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Psychosocial history:

Document social history - current stressors and social supports, include custody and access details, household members, parental drug and alcohol history or mental illness, prior child protection reports, other care givers E.g. babysitters, day-care etc. Comment on whether the child is living in a safe living environment (if known).

Is there a history of domestic violence? You should consider exploring this with the following questions from the Routine Screening for Domestic Violence Protocol:

1. Within the last year have you been hit, slapped or hurt in other ways by your partner or expartner?
2. Are you frightened of your partner or ex-partner?

If the woman answers YES to either or both of the above questions continue to question 3.

3. Are you safe to go home when you leave here?
4. Would you like some assistance with this?

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SMR060.550

NH606680 270314

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Observations by the health workers of the carer's presentation:

Record specific observations about the behaviour of the carer/s.

- Quality of the interaction with the child or young person

- Intoxicated or unusual affect? List descriptive behaviours

- Manner towards staff members?

- Ability to understand relevant information?

- Cooperation with recommended assessment?

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Examination:

Careful consideration should be given as to who is present during the examination. Best practice would be that children or young people are not examined in the presence of a possible perpetrator.

1. Document findings clearly: written description and use diagrams
2. Describe the child's or young person's presenting behaviours (E.g. anxious, clingy, destructive, aggressive…)
3. Comment on child's or young person's interactions with carer and other adults (E.g. avoidant, aggressive, indiscriminate affection…)
4. Perform a complete medical examination
5. Comment on general health nutrition and signs of neglect (e.g. muscle bulk and subcutaneous fat), hygiene, clothing.
6. For each cutaneous finding document:
   (a) nature of injury – bruise, abrasion, laceration, burn, scar etc
   (b) site – include distance from anatomical landmark
   – note if injuries are in multiple body planes
   (c) size (measurements)
   (d) pattern/ shape
   (e) colour
   (f) tenderness/ swelling
   (g) evidence of old injuries
   (h) explanation given by child or young person or carer for each lesion

Terminology:

Abrasion – a superficial injury of the skin – includes scratches

Bruise – an area of haemorrhage beneath or within the skin

Laceration – a ragged or irregular tear or split in the skin, subcutaneous tissue or organ resulting from blunt trauma. Lacerations tend to have irregular margins with bruised or abraded surrounds and are often contaminated e.g. with dirt

Incised wound – an injury whose length is greater than its depth and is produced by sharp edged objects. Incised wounds generally have sharply defined edges and minimal damage to surrounding tissue

Stab wound – an injury whose depth is greater than its length on the skin surface

Growth:

Weight (kg)	Percentile
Height (cm)	Percentile
Head circumference (cm)	Percentile

General Appearance/ behaviour:

_____

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Head/Scalp:

ENT: _____

Ears: _____

Mouth / Frenulum: _____

Nose: _____

Throat: _____

Neck/nodes: _____

Eyes: _____

(Fundi?)

Cardiovascular: _____

Respiratory: _____

Abdominal: _____

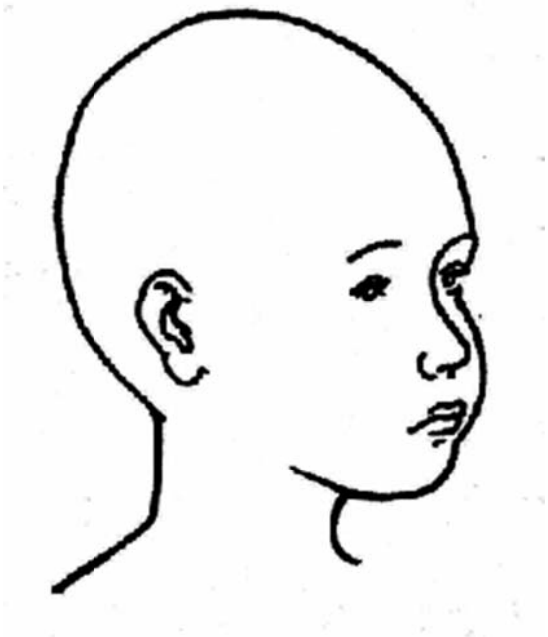
External Genitalia
Perineum and Buttocks: _____

Neurological: _____

Musculoskeletal: _____

Cutaneous Findings:

Check head, face, chest, abdomen, back, buttock, anogenital region, and all four limbs.
Number each finding on the diagrams to indicate location and write a detailed description. If appropriate, ask for child or young person's and /or carer's explanation for each finding.



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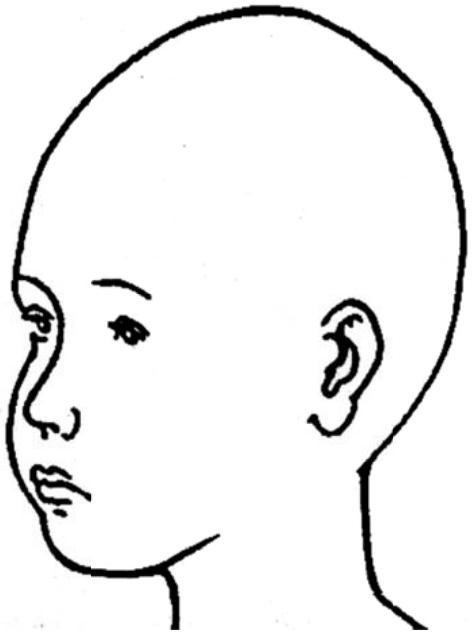

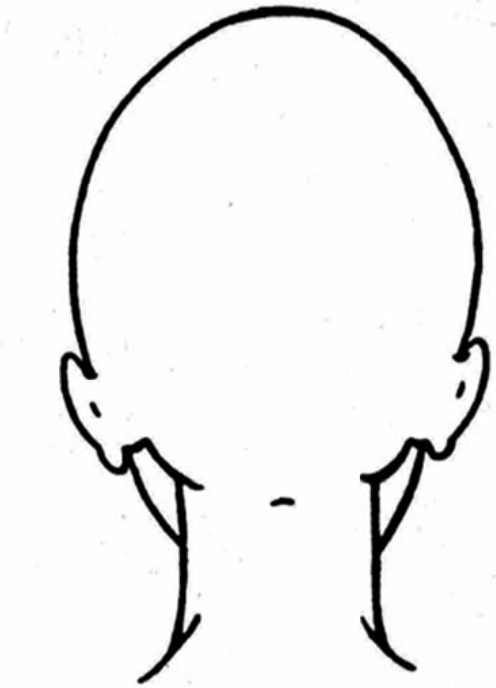

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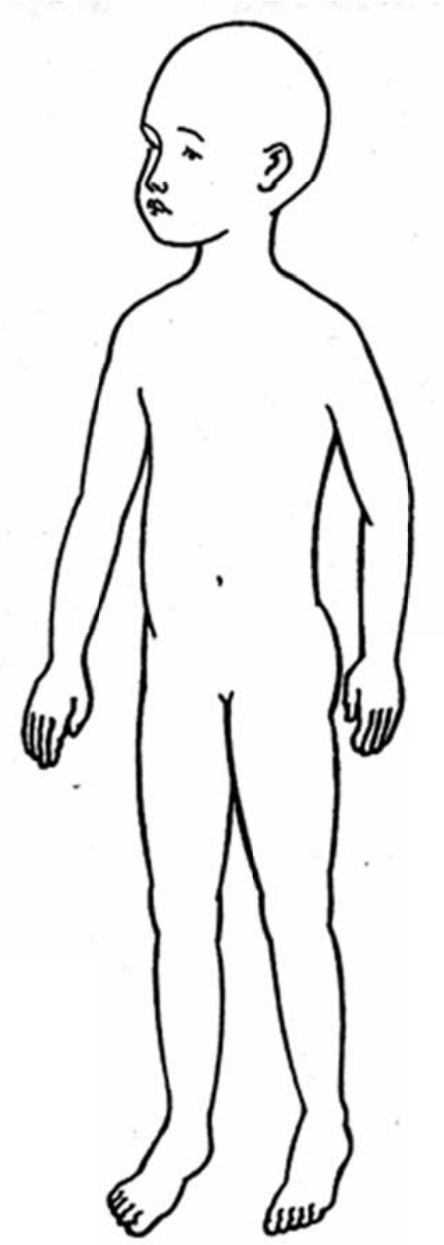

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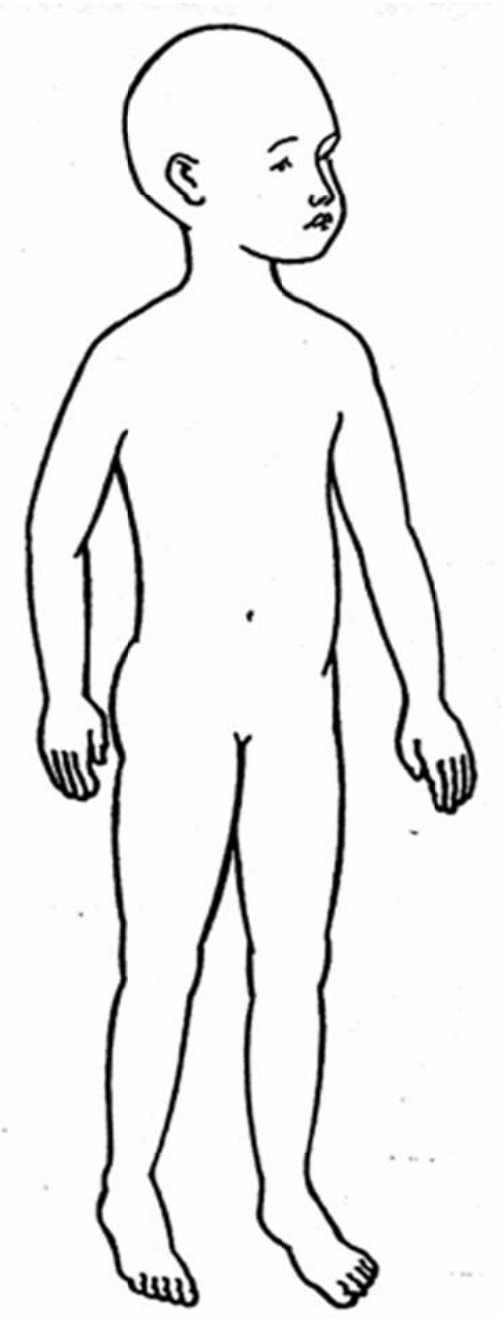

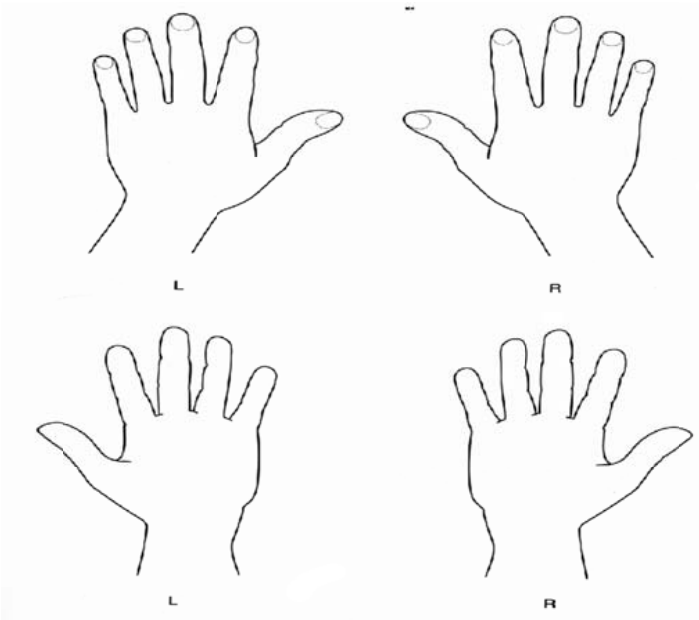

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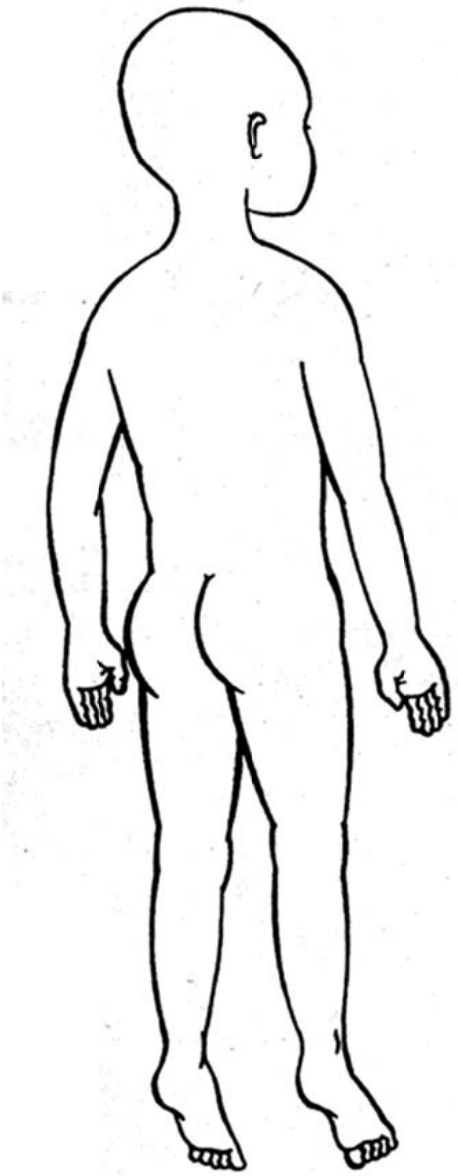

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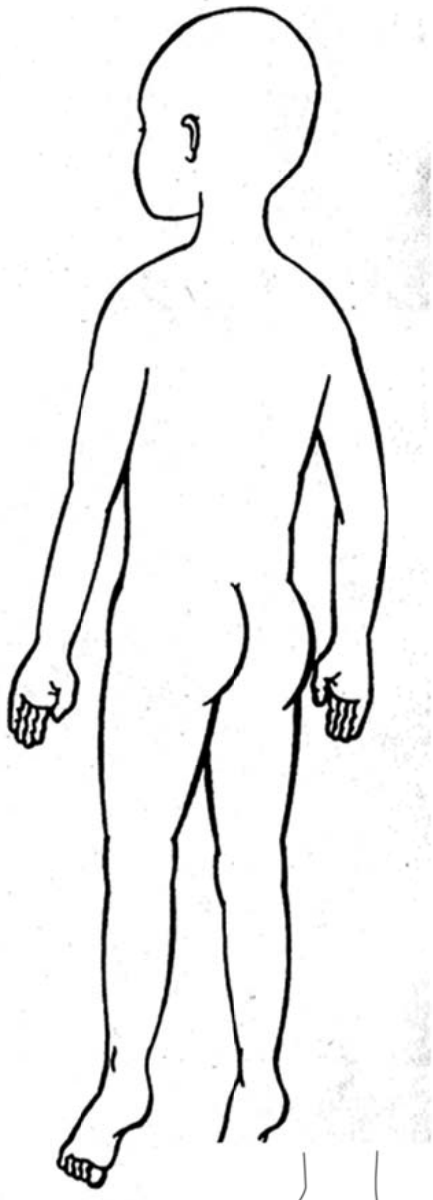

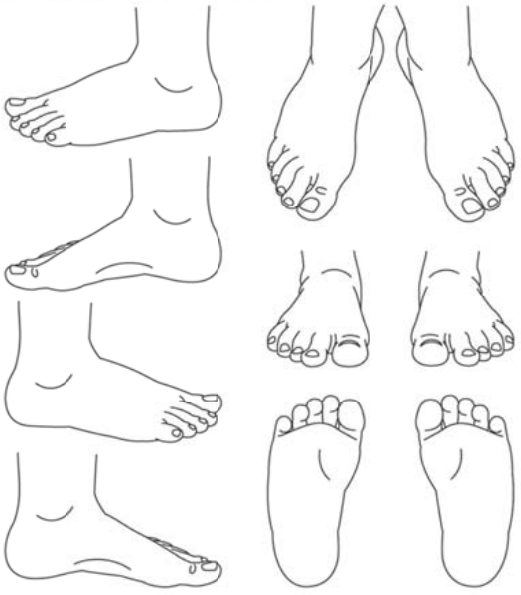

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NH606680 270314

SCAN MEDICAL PROTOCOL

SMR060.550

NSW GOVERNMENT Health

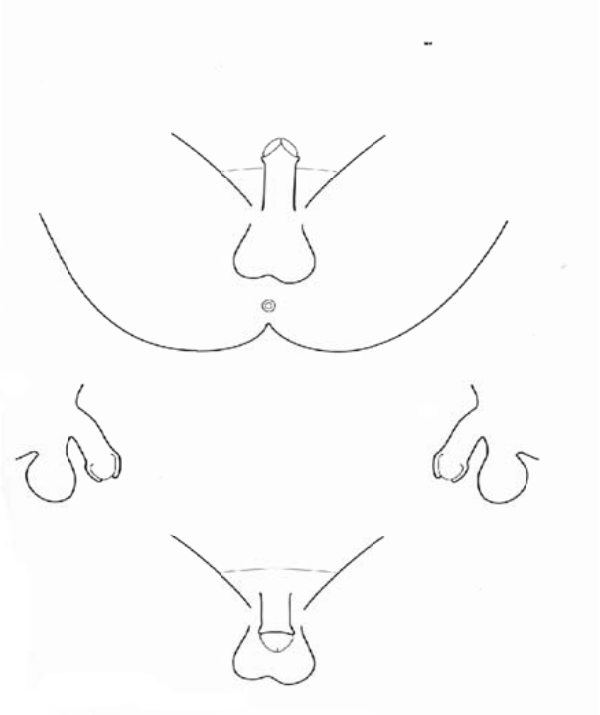
Facility:

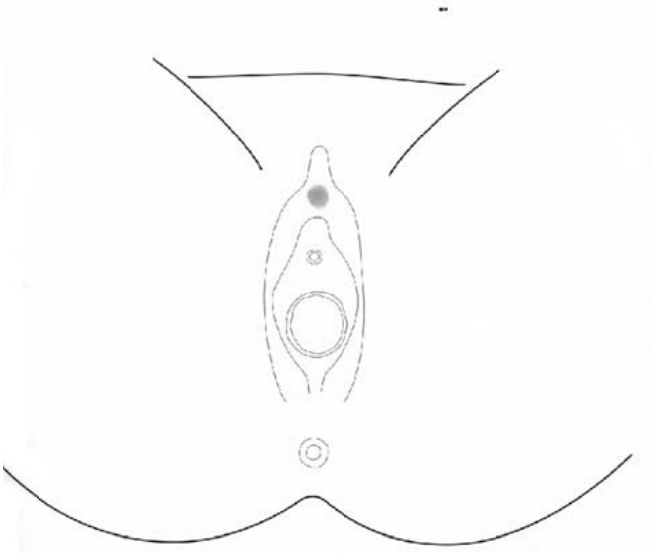
FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SCAN MEDICAL PROTOCOL

The Child Sexual Assault Protocol should be used for sexual assault cases and the child or young person should be referred to the appropriate sexual assault service.





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SCAN MEDICAL PROTOCOL

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Investigations Ordered (only if indicated):

Please discuss with the on-call consultant. Consult with a tertiary child protection unit if needed. See page 2 for contact details.

Laboratory

☐ FBC, film

☐ Coagulation screen INR, APPT

☐ Full coagulation testing
This testing should be discussed with a tertiary child protection specialist and a paediatric haematologist prior to ordering

☐ EUC

☐ Liver function tests

☐ Amylase/ lipase

☐ Ca Mg P

☐ Vitamin D, Parathyroid hormone (PTH)

☐ Bone disease screen
This testing should be discussed with a tertiary child protection specialist prior to ordering

☐ Urinalysis

☐ Urine metabolic screen

☐ Urine drug screen (for laboratory testing)
Need to specifically request testing for marijuana and methadone if this is a concern

☐ Other (specify)

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SCAN MEDICAL PROTOCOL

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Imaging

☐ X-rays (specify) _____

There are guidelines titled "Standards for Radiological Investigations of Suspected Non-Accidental Injury" available at http://www.rcpch.ac.uk/Policy/Child-Protection/Child-Protection-Publications. Consider discussion with a child protection specialist and review of images with a paediatric radiologist.

☐ Skeletal survey

☐ Bone scan

☐ CT head

☐ MRI head

☐ CT abdomen

☐ Other

Photography

☐ Clinical photography

Medical photography of injuries is recommended and should be arranged as soon as is practicable. A consent form is required to be signed prior to photography.

Consultations

☐ Child Protection

Children or young people who require medical treatment at a tertiary children's hospital (e.g. for significant suspected abusive head, abdominal or other major trauma) should be transferred as medically indicated. Consultation with a tertiary child protection service may also be required if the necessary investigations are not available at the peripheral hospital, particularly where there is a question of bone fragility or easy bruising.

☐ Ophthalmology

☐ Other (specify)

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SCAN MEDICAL PROTOCOL

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Summary of Findings and Opinion:

This must be discussed and signed off by a senior doctor. A final opinion may need to be deferred until the results of further investigations are available and there has been an opportunity for discussion with colleagues.

Factors to consider:

- Possible mechanism for injury
  - Is the pattern of injury consistent with any object having been used?
    - E.g. teeth marks, cigarette burn, finger marks, linear object (stick, flex)?
- History provided
  - Is the history from the child or young person and/or the carer consistent with the injury?
  - Is the injury consistent with the child's or young person's reported stage of development?
  - Is it consistent with the child's or young person's clinically observed developmental skills?
  - Has the history changed in any way since first account given by the carer?
- Colour of bruises is not an accurate indicator of the age of injury
- Opinion regarding the findings
  - Accidental, Suspicious for Inflicted injury, Neglectful, Unexplained …

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SCAN MEDICAL PROTOCOL

Management plan

1. **Is a report to Community Services required?**
   If Community Services (CS) is not already involved and you are concerned that the child or young person may be at risk of significant harm complete the Mandatory Reporter Guide (MRG) http://sdm.community.nsw.gov.au/mrg/ and **report** if indicated to the **Child Protection Helpline 13 3267.**

   A report made to the Child Protection Helpline must be documented in accordance with Ministry of Health policy PD2013_007. Documentation may be written within the clinical notes of the child's or young person's Medical Record OR by completing a "Risk of Significant Harm Record of Report" fax form if this form used to make your report to the Helpline. Documentation should include: the date and time contact was made with the Helpline; the name of the Helpline officer spoken to; the nature of concerns reported and details of information provided; and the MRG outcome.

2. **Documentation in medical record**
   File the SCAN Medical Protocol as part of the child's or young person's main medical record. Include documentation of the discussion with parents / carers about any concerns, what was done and why, if a report to the Child Protection Helpline is made and about consent for further medical investigation.

3. **Admission, discharge, follow up**
   The child or young person should be **admitted to hospital** if he or she is considered at risk of significant harm and CS cannot provide a place of safety immediately. This may require CS to assume care of the child or young person. Section 173 gives parental responsibility to Community Services for up to 72 hours for the purpose of conducting the assessment and may include hospital admission.

   Discharged: Into care of –

   Date and Time –

   Follow-up: Appointment(s):

Medical Officer responsible for reviewing investigation results:

Name (please print) _____

Designation _____

Contact details _____

Signed: _____ Date: _____

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NO WRITING

Provision of written reports to other agencies

1. Requests for reports

- S 173
  If the child or young person has been assessed following a S173 request for medical examination made by Community Services or a Police officer, the examining Medical Officer is required, under the *Children and Young Persons (Care and Protection) Act 1998,* to provide a written report concerning the examination of the child. This report is forwarded to the caseworker at the FaCS office named on the S173 request. A photocopy of the completed S173 form (request for examination) should be obtained and placed in the child's or young person's medical record prior to the release of medical documentation.

- Other requests
  The necessary documentation required under the *Children and Young Persons (Care and Protection) Act 1998* e.g. a court subpoena, Chapter 16A or Section 248 written request is to be provided before medical information is released to Community Services or the Court.

2. Types of reports that may be required

Medical reports of an assessment may be required by a Community Services Centre, JIRT or the Children's Court. The Medical Consultant should determine the type of report to be provided to all requests. The type of reports that may be required are:

- SCAN Medical Protocol
  A photocopy of the completed SCAN Medical Protocol. Medical consultants should be aware that where a photocopy of the SCAN Medical Protocol is requested by appropriate persons with a non-medical background an accompanying assessment report should be provided.

- Assessment report
  A separate written report on the findings from the assessment. This report should be signed by a medical consultant. An assessment report will be required for Section 173 assessments (see above).

- Expert certificate
  The Medical Officer, ideally the medical consultant, may be required to complete an expert certificate for Court proceedings. This does not need to be completed immediately after the assessment. Consultant Staff in tertiary child protection services (contact details see page 2) are available to assist in writing the expert certificate.

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