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Abuse and Neglect (Adult/Child) Screening and Reporting of Suspected Cases

PURPOSE

Apply key principles of victim-related healthcare to improve outcomes for the child, adult, elder or care-dependent/disabled or incapacitated adult patient known or suspected to be a victim of abuse, neglect, or another form of maltreatment; of Domestic Violence (DV) or Intimate Partner Violence (IPV); or of human trafficking (sex and/or labor). Involve the on-call Forensic Nurse Examiner (serving VH) whenever a pediatric patient is suspected or identified as experiencing physical abuse, sexual abuse, neglect, or another form of child maltreatment. Consult the on-call Forensic Nurse Examiner or the Forensic Nurse Examiner Program for guidance in healthcare and legal steps related to a patient suspected or identified as a victim of Domestic/Intimate Partner Violence (DV/IPV), Human Trafficking (HT; sex or labor), or maltreatment of a disabled/care-dependent incapacitated adult, or an older/elder adult.

Terms

A. **Adult** refers to the patient (18 years of age or older) suspected or known to have experienced DV/IPV or maltreatment.

B. **Adult Protective Services (APS)** investigate cases involving known or suspected maltreatment of a vulnerable adult (**care-dependent, 18-59 years of age**), **or 60 years of age or older**. These

may be dual investigations by APS and Law Enforcement, depending upon the complaint, finding(s), or allegation(s).

C. **Alleged** is a legal term. Similar terms include allegedly, alleging, alleges, and allegation. These terms may be used for the purposes of this policy, however they should not used in the medical record or as the presenting complaint as these convey a lack of trust or belief on the part of the healthcare provider.

D. **Caregiver** refers to a family member or guardian who provides the patient with care and supervision, or a person in a position of authority (such as a teacher, babysitter, religious leader, counselor, or another trusted individual).

E. **Child Protective Services** investigates cases of reported maltreatment involving children between the ages of 0-17 (years of age)when the concern involves a caregiver. These are often dual investigations by CPS and Law Enforcement.

F. **Disclosure** is a term that refers to a patient making statements pertaining to their maltreatment, Human Trafficking, or DV/IPV experience, or when there are details provided relative to a positive screening for DV/IPV. There are many reasons why a patient experiencing maltreatment, DV/IPV, or Human Trafficking (HT) does not disclose or want to involve law enforcement (despite cases in which the healthcare provider reports due to mandatory reporting laws). Many victims have been threatened or have been made to fear what will happen to their children or family members. Some victims do not recognize the abuse or neglect. Trauma-bonding may prevent some patients from disclosing. The patient may lack trust in the healthcare system, or be influenced by past experiences or personal preferences. Always remember that signs of maltreatment, HT, or DV/IPV may have resulted from something other than violence, as few physical findings are pathognomonic for inflicted trauma. The patient is always treated with dignity and respect, and the patient is never pressured to disclose or treated as if they are not being believed.

G. **Domestic Violence (DV)** and **Intimate Partner Violence (IPV)** refers to abuse within the context of a current or former partner, spouse, or girl/boyfriend. These behaviors are perpetrated against a dating or intimate partner, and abuse tends to be chronic in nature and escalates in severity over time. DV/IPV is seen across all socioeconomic groups regardless of education, profession, or privilege. Females are the most vulnerable, with the majority of perpetrators being male. IPV also occurs in same-sex relationships, and males may be victimized by female partners. IPV is a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social and familial isolation; financial abuse, reproductive coercion, stalking, deprivation, intimidation and threats. Perpetrator may use physical, psychological, sexual violence, or a combination of these in order to maintain power and control over their victim. Children may also be used as leverage against the victim. Pregnancy places victims of IPV at the highest risk of harm. The patient may not recognize that what they are experiencing is dangerous and harmful. Healthcare providers may suspect DV/IPV based on the presence of injuries that are unusual due to their size(s), location(s), type(s), or are not consistent with the history or explanation. IPV is not always recognized based on the patient's presenting complaint or examination findings, and is sometimes suspected based on behaviors or statements. Healthcare providers serve a vital role in screening, detection, and intervention. These measures are for the purpose of aiding the patient to access interventions geared toward autonomy, empowerment, safety, protection, and positive outcomes; and not for the purpose of getting a

patient to leave their abuser or report their abuse to law enforcement.

H. **Elder, elderly,** and **older adult** refer to the patient (60 years of age or older) known or suspected of maltreatment or DV/IPV.

I. **Forensic Nurse Examiner (FNE)** refers to the nurse who is on-call for VH, and is employed by Winchester Medical Center. The Forensic Nurse Examiner (FNE) has specialized knowledge and experience in caring for victims of violent crime and maltreatment. Forensic Nursing is the application of scientific and evidence-based healthcare knowledge to matters that pertain to law. FNEs work with living victims of violent crime and maltreatment, suspected victims who are undergoing resuscitative efforts, and deceased victims when it has been authorized by the medical examiner. The court system utilizes Forensic Nurse Examiners to provide expert witness testimony in cases of sexual assault (including drug-facillitated sexual assault), sexual abuse, human trafficking, infant and child physical abuse and/or neglect, domestic and intimate partner violence, strangulation, gunshot wounds, and stabbings.

J. **Forensic** is a term that means the application of scientific methods and techniques to the investigation of crime.

K. **Human Trafficking (HT)** is known as 'modern-day slavery' and is referred to as a crime that is 'hidden in plain sight', and it exists in various forms in all communities in the United States. The two major methods of human trafficking are labor and sex trafficking. Human Trafficking is not the same as Human Smuggling, although persons to enter the U.S. illegally are vulnerable to HT or may have entered into debt-bondage (to pay off their smuggler). Victims are enslaved and controlled for profit or gain force, fraud, and/or coercion. Victims who access healthcare often have injuries, illnesses, or diseases that prevent them from working, and present without any identification or documentation, and with a person who is reported to be a family member and is controlling over the patient's healthcare interactions. Sex Trafficking victims may be mistaken as prostitutes, and minor children are targeted. Perpetrators of sex trafficking may be a pimp, or the controller could be a classmate, trusted adult, or even parent(s).

    1. **Sex trafficking** is the fastest growing criminal industry in the United States. There are two major types of controllers, pimps and individual controllers. In commecial sex trafficking the victim is under the control of a pimp and sometimes others placed in a position of power by the pimp. A patient may be accompanied by a person the pimp has assigned to train and monitor their victims, and these individuals may be known by the patient as the Bottom, Wifey, Sister, Wifey-In-Law. Victims of commercial sex trafficking may be children, adolescents, or adults (male, female, or transgendered), children and minors are the most targeted group. Runaways are extremely vulnerable to being recruited and trafficked. The victim may be a U.S. citizen or a foreign national. A parent, parents, or other caregivers may act as individual controllers and sell their children or loan them out for sex acts, or to perform other services or work, in exchange for money or drugs. Intimate partners may also require their partner to provide sex or sexual acts to others in exchange for money or drugs. The victim may be mistaken by the legal system as a prostitute and be charged criminally, arrested, and prosecuted. Pimps require their victim(s) to make a daily cash-quota, and are not permitted to keep any of their earnings. Victims often do not have the freedom to make even basic decisions for themselves, such as when, what, where, or how they will eat, drink, sleep, or use the bathroom, access birth control or healthcare, or manage their menstrual flow. Sex

trafficking does not have to involve travel, and occurs our of homes, schools, and neighborhoods. Direct confrontation of suspicions should be considered dangerous (for the patient and the healthcare professional), and victims are often silenced through death threats (against self or family members), and severe punishment (beatings and rapes).

Labor Trafficking victims can be found in the hotel, restaurant, agriculture, construction, and other industries and businesses. Victims are forced to work long hours and in unsafe working conditions, and to turn over their wages (debt-bondage may also be present). Victims of labor trafficking that present in healthcare and are most often detected by healthcare providers due to having one or more injuries related to unsafe working conditions.

L. **Incapacitated adult** refers to a patient that does not have "(1) decisional capacity to give informed consent to the treatment at hand; (2) an advance directive that addresses the treatment at hand and have no capacity to do so; and (3) a legally authorized surrogate, and no family or friends to assist in the decision-making process (Karp, et. al, 2003)."

M. **Maltreatment** is an umbrella term encompassing physical abuse, sexual abuse, emotional/ psychological and verbal abuse, abandonment, exploitation (including labor trafficking and/or sex trafficking), or neglect**.** Maltreatment is generally chronic in nature, associated with complex post-traumatic stress disorder (PTSD) and when physical violence is involved it tends to escalate over time.

N. **Mandatory Reporting Laws** exist in every state and are for the safety and protection of children (age 0-17), and vulnerable care-dependent adults and older adults. Healthcare providers are **mandated reporters,** and as such are required by law to report suspected or known pediatric or vulnerable adult maltreatment by a caregiver. **Reports** are most easily made to Adult or Child Protective Services (APS/CPS) by calling the state's Centralized Intake Hotline. Reports to law enforcement are made to the jurisdiction where the crime is suspected to have occurred.

O. **Multidisciplinary Team** refers to a diverse group of experts (healthcare, legal, advocacy, prosecutorial, therapy, and trained forensic interviewers) who are necessary to promoting the patient's health, safety, and legal outcomes. A multidisciplinary team approach should always be sought in order to improve patient outcomes and safety. Share information related to concerns or reported maltreatment or DV/IPV with other members of the healthcare team: healthcare providers directly involved in the care of the patient; the Forensic Nurse Examiner Program, case management, social work, and Crisis Care. Members outside of healthcare that may be essential to a multipronged approach include: Law Enforcement, Adult and Child Protective Services (APS/CPS), Victim Advocacy, Community-level shelter services, Child Advocacy Centers and Child Interviewers, and the Commonwealth Attorney or Prosecutor's Office.

P. **Neglect** is a type of maltreatment and refers to failure by a caregiver to provide for a child's or a care-dependent adult's basic needs, prescribed medications, treatment, or therapy; to access healthcare, to be medically evaluated in a timely manner following a traumatic or potentially serious injury or illness, or to provide appropriate supervision.

Q. **Patient** refers to the patient suspected of or known to have experienced violence, or to have been harmed or neglected by someone in the role of 'caregiver'. The individual should be viewed by all members on the healthcare team as a 'patient'. This policy does not cover all

violent crimes, but those that occur within the context of the relationship between the patient and the intimate partner, caregiver, or pimp/controller. See also 'sexual assualt' policy.

R. **Patient-Centered Care** refers to (see also, Trauma-Informed Care) the essential aspect of quality healthcare where the patient's individual values, preferences, and decisions are central to the healthcare provider's actions. The patient is informed in a manner that empowers them to make decisions that are best for them as an individual, options are explained, and their decisions are respected. When the patient refuses the healthcare provider will provide them with options and education on potential negative outcomes related to their refusal. The healthcare provider respects the patient-victim's decision. Healthcare providers follow mandatory reporting laws even when the patient does not want to report.

S. **Pediatric** refer to the patient who is under the age of 18. Among the pediatric population are infants (less than 12 months of age), toddlers (12-36 months of age), early childhood (36 months of age to 5 years of age), childhood (5 to 11 years of age), adolescent (12-15 years of age), and older adolescent (15-17 years of age).

T. **Perpetrator** refers to the intimate partner, pimp or controller, or the caregiver(s) of the patient who is reported as the abuser or maltreater. A perpetrator's actions against their victim are motivated by power and control, and these factors drive the dynamics of the relationship. Physical abuse of a child may be in the context of discipline. Physical violence may or may not be part of DV/IPV or maltreatment. Tactics of a perpetrator may include: physical; verbal, and psychological (including trauma-bonding and intimidation); sexual assault/abuse, sexual coercion, reproductive coercion, isolation, and financial abuse. Controlling behaviors on the part of the perpetrator in the healthcare setting are often observed by the healthcare provider, and the dynamics of the relationship between the perpetrator and the patient may lead to the patient's leaving or becoming confrontational. Escalating behavior may signal danger and violence. For example: the visitor tries to dominate the conversation and doesn't allow the patient to speak or answer for themselves, does not want the patient to be out of their sight or refuses to leave the patient alone, demands that the patient be discharged or signs out 'against medical advice' (AMA), appears hypervigilant, and the patient appears intimidated, afraid, or defers decisions to the visitor.

U. **Physical examination findings** are anything found during the patient's examination (body, blood, imaging, toxicology, and other data) that could be important to the investigation, as well as the medical care.

V. **Polyvictimization** is the term for when more than one form of maltreatment of a vulnerable individual (pediatric, disabled adult, elder/older adult) is suspected or known.

W. **Resiliency** refers to a healthcare provider(s) or staff member(s) ability to deliver quality healthcare to victims of violence and maltreatment while recognizing their own limitations and taking steps to mitigate trauma effects in themselves. A resiliency plan includes self-care acts and caring for ones relationships, spiritual needs, health needs, and having healthy coping mechanisms. Developing resiliency is always a work in progress, and even resilient individuals may suffer the effects of a trauma exposure. (see also, Vicarious Trauma).

X. **Risk** is related to the caregiver, pimp or controller, or the abusive intimate partner's risk of perpetrating these crimes. Factors such as a history of domestic violence, mental illness, substance abuse, poverty, unemployment, single or young parent, and caregiver burnout may contribute to the risk of perpetration. In the pediatric group, infants less than 12 months of age are at the highest risk for maltreatment and fatality.

Y. **Safety Planning** refers to two types interventions. A CPS worker may safety plan with a caregiver as a way to keep a child or children safe during an investigation. A trained person may safety plan with an adult patient in an abusive relationship to improve safety and empowerment. The safety plan may include personalized steps that an individual can take to protect themselves physically and emotionally.

Z. **Secondary trauma** refers to re-victimzation by the healthcare system. The risk of causing secondary trauma is reduced when healthcare is 'patient-centered' and 'trauma-informed'.

AA. **Screening** refers to the healthcare protocol in place to assess every female patient of child-bearing age for the presence of domestic/intimate partner violence. (The research does not support routine screening for child or elder maltreatment or human trafficking, however clinicians should use their knowledge of what is normal in these populations to identify and act on concerning findings or behaviors.)

AB. **Trauma Bonding** refers to a dynamic created by the perpetrator in the relationship with their victim. Often the victim is made to feel that what has happened is their fault, and that they cannot survive without the other person (the perpetrator). The patient may make decisions influenced out of wanting to protect, please, or enable their abuser. Trauma-bonding may interfere with a patient's ability to recognize their situation due to their trauma experience which includes deep sympathy for the abusive person, reinforced by cycles of abuse, and feelings associated with shame, low self-esteem, and remorse.

AC. **Trauma-Informed Care** refers to a patient-centered healthcare approach to reduce the victim-patient's vulnerablity to secondary or re-victimization by the healthcare experience. Communication with the patient and the provision of healthcare demonstrates awareness that the patient is vulnerable to re-experiencing trauma.

AD. **Vicarious Trauma** refers to a healthcare provider(s) or staff member(s) who experiences symptoms and difficulties similar to those experienced by victim's trauma, and can result from exposure to the trauma narrative, seeing injuries that resulted from vicitimzation, involvement with resuscitative efforts, due to empathic engagement, or taking steps to advocate for the patient.

AE. **Victim** is a legal term, and is used throughout this policy to describe the legal view of victimization. Victimization can occur anywhere across the lifespan. Healthcare providers should avoid using the term 'victim' when documenting their concerns in the medical record or when communicating with their patient. Patients who experience victimization often do not recognize their experience as the crime that it is, and do not understand exploitation. Not all patients with signs concerning for victimization are being abused. For the purposes of this policy the terms patient, patient-victim, and victim are used interchangably.

AF. **Victim Advocates** and counselors have expertise in working with victims. They help victims to safety plan when they are contemplating leaving or when the person has decided to leave their abuser or 'the life' in sex trafficking. Every community served by VH has a program to assist victims shelter services for the victim and their children, safety planning, obtaining an emergency protective order (EPO) or family protective order (FPO), and accessing therapy or counseling services. Advocates can be located within the Commonwealth Attorney or prosecutor's office, or by calling the Forensic Nurse Examiner's Office.

AG. **Vulnerable patient or population** refers to those who are vulnerable based on their relationship to the perpetrator. The perpetrator may be a caregiver or an intimate partner. Populations

include pediatric, disabled children, disabled and incapacitated adults, and older adults/elders, undocumented individuals needing work, and adolescent and minors recruited by sex traffickers.

AH. **Vulnerability** is related to patient's vulnerability to be victimized due to certain factors: age (pediatric or older adult/elder), inexperience or a past history of victimization, disability, inability, or developmental delay; having 'special needs', behavioral problems, illness, or chronic disease. In general, the greater the level of care-dependency the higher the vulnerability to maltreatment.

Policy

- Notify the **on-call nurse of the Forensic Nurse Examiner Program** (internal VH experts), for all suspected or known victim's of Human Trafficking (sex and/or labor), or maltreatment of a pediatric patient (infant, toddler, early childhood, adolescent, and older teen).
- **Screen** all female patients of childbearing age for Domestic and Intimate Partner Violence (DV/IPV) for the purpose of providing healthcare, education, community resources, and assessing safety needs. Screening for other populations is done when there are concerning signs or behaviors for DV/IPV.
- **Maintain safety** by recognizing the danger and staying alert to signs of escalating behavior that could result in violence when caring for patients experiencing abuse, assault, maltreatment, or human trafficking. Follow your organizations safety plan when you identify signs of danger.
- **Emergent or urgent healthcare needs** may exist in DV/IPV, Human Trafficking, or maltreatment. The patient's behavioral health or crisis care needs may be their most urgent healthcare need. Addiction, STI, pregnancy, complications following abortion, foreign body in the vagina or rectum, overdose, abdominal trauma, occult fractures, head injury, and strangulation injury are other well known and documented health issues in these patient populations.
- Involve the Forensic Nurse Examiner (FNE) Program as part of a quality multidisciplinary medico-legal team response.
- M**andatory reporting** should be done as soon as possible, and may have to be designated to another healthcare provider in order for timely reporting to occur.
- **Report** known or suspected child maltreatment to both Child Protective Services (CPS) and Law Enforcement. It is not the responsibility of the healthcare provider to prove maltreatment, but it is their responsibility to report any suspected maltreatment. The healthcare provider should not delay the report due to a lack of information or waiting on test results. Child and Adult Protective Service reports can be made using the state's hotline.
- It is **mandatory to report to Child Protective Services when a child has witnessed DV/IPV**.
- Reduce the risk of secondary trauma by providing **patient-centered and trauma-informed healthcare**. Know what victim resources exist in your and surrounding communities. Educate and provide victim-patient's with information, referrals, and contact information for healthcare, victim advocacy, counseling services, therapy services, shelter services, the victim-witness program, and any other community-level resources. Provide the patient with the phone number for the **Office of The Forensic Nurse Examiner Program of Winchester Medical Center**: **(540)**

536-4147.

- Strive to protect **biomedical, physical, trace, or DNA evidence.** Avoid actions that could result in cross-contamination, degradation, loss, or destruction of potential forensic evidence (DNA, trace, toxicological, physical evidence) that may exist on the patient's body, clothing, or belongings.
- **Document** in the medical record detailed information pertinent to your concern, observations, statements made, as well as your examination findings.
- Fully **cooperate** with law enforcement, criminal investigators, child or adult protective services (CPS/APS), and other members of the multidisciplinary team.
- Be aware of **Vicarious Trauma**, which healthcare providers and staff may experience due to exposure to trauma content and providing healthcare to victims of assault or maltreatment. The Forensic Nurse Examiner Program has nurses who are trained to assist you, and to provide strategies for resilience.

Procedure

A. **The Forensic Nurse Examiner Program** is available for consultation 24/7. Always contact the on-call FNE when you have a pediatric patient suspected of or known to have experienced maltreatment. Consult the on-call FNE for guidance on any case where there is suspected or known DV/IPV, maltreatment of an incapacitated adult, or older adult/elder abuse. The Forensic Nurse Examiner Program is available to assist healthcare providers on any matter related to the healthcare, mandatory reporting, or courtroom testimony involving a patient known or suspected of DV/IPV or maltreatment. To reach the on-call FNE, call Winchester Medical Center **540-536-8000** and ask to be connected with the on-call Forensic Nurse. The non-emergent number (Office of the FNE Program) is **540-536-4147**.

B. **All female patients of childbearing age are to be screened for DV/IPV.** Only screen the patient in a private setting, and when it is safe to do so. Never screen in the presence of their partner, caregiver, or even family members or friends that may not offer level of support that creates an opportunity to have an open dialogue. Disclosing puts the patient at an increased risk of injury or death, as does being found with literature on community resources, reporting to law enforcement, and leaving the abuser/perpetrator. A patient-victim may not want to disclose, and should never be pressured or made to feel like they are lying or doing something wrong. The goal of the screening protocol is to provide a patient who screens positive with an opportunity to share their concerns, and to receive compassionate care, community-level support, information about their options, and referral to community resources. Patients should never be pressured to report to the police or advised to leave their abuser. Free counseling, victim advocacy, and safety planning. Shelter services may also be available for patients and their children. Contact the Forensic Nurse Examiner Program for assistance.

C. Adult patients with capacity **have the right to not report** their complaint to law enforcement. The following exceptions exist: a weapon (knife or firearm/gun) was involved, posing imminent danger to the patient or others due to the perpetrators behavior, statements, or actions; the assault has resulted in life threatening injuries, or injuries that are expected to result in permanent disability or disfigurement. If any one of these exceptions exist, report the concern immediately to local law enforcement by calling 9-1-1. (Injuries caused by a weapon are also mandatory to report to law enforcement in the jurisdiction of the treating facility.)

D. Report to law enforcement suspected or known **sex or labor trafficking (Human Trafficking)**. Report also to CPS whenever sex trafficking of a child or minor involves a caregiver. Report any suspected sex trafficking of a child (under age 18) to the National **Human Trafficking Resource Center's hotline 1-888-373-8777**. Provide adult sex trafficking victims with the National Human Trafficking Resource Center's hotline and the **text messaging resource BEFREE (23373).**

E. Report known or suspected maltreatment of a care-dependent adult or older/elder adult to **Adult Protective Services (APS).** Make reports to the state's hotline in the state where the patient resides. Interview adult patients (who are able to provide their history) in a private setting. Document the patient's statements in the medical record.

F. **Strangulation** should be treated as a medical emergency. Victims experiencing strangulation are at risk for serious injury, permanent disability, and death. Manual strangulation can prevent airflow, blood flow to and from the brain, and result in swelling, bruising, and fracture. Hard signs of strangulation are identified from the patient's history, subjective complaints, and the assessment (see attached). The assessment includes respiratory and airway, neurologic, cardiac, and skin. Skin findings are not always visible, but when present should be photo-documented. Observe for bruising, abrasions, swelling, petechial hemorrhages, and patterned marks. Injuries may be present anywhere on the body, Inspect the neck, chest, face, ears, eyes and structures in the oropharyngeal cavity. Strangulation complications may be delayed for hours, days, or weeks, or longer.

G. **Patient-Centered Healthcare** includes educating the patient about their health, asking the patient what their health concerns are (which may be different from their presenting complaint), and providing them with information about the resources that exist in their community. All heathcare-related actions, decisions, and plans are to be patient-centered.

H. **Trauma-Informed Care** reflects an awareness on the part of the healthcare provider of the potential for healthcare interaction, communication, and delivery to add to or trigger a patient's trauma experience, resulting in secondary or re-victimization. This approach recognizes the neuro-biological and psychological effects from experiencing trauma, and especially chronic trauma. , Examples of triggers include: questioning a patient's decisions, making statements that may be perceived by the patient as blaming or shaming, rushing through care, not making eye contact, not listening to the patient, not informing the patient, not offering reassurance, not asking for permission (especially when the healthcare involves physical contact with the patient), not offering options, not respecting the patient's wishes or preferences, and/or not providing for privacy and confidentiality. Patients who have experienced violence or maltreatment may have psychological trauma that can influence their behavior, understanding of their situation, readiness to accept help, ability to make informed healthcare decisions, or their willingness to discuss their experience. Minimize how much and the number of times the patient has to talk about their trauma experience. Only ask questions that pertain to the patient's safety and healthcare outcomes. A child interview is part of the investigation, and should only be performed by a trained forensic interviewer.

I. **Safety** is paramount, and healthcare providers must stay alert to signs of violence. Violence may be directed toward the patient, the healthcare provider, staff members, or others in the healthcare setting. Consider safety issues before discharging or transferring the patient. Notify local law enforcement by calling 9-1-1 when there are concerns of danger or violence. Never and under no circumstances attempt to physically stop someone from leaving. If their leaving

presents a threat of danger to themselves, the patient, or the community notify local police immediately by calling 9-1-1.

J. **Safety Planning** may include helping an adult victim of human trafficking or DV/IPV to develop personalized steps they can take to protect themselves physically and emotionally, or a Safety Plan done by a CPS worker. In the case of an adult victim, safety planning can be done by a person trained to counsel victims of violence (in Human Trafficking or DV/IPV). The plan may include: safe places where the patient can go to protect themselves, children, or pets from violence; obtaining a phone, gathering names and contact information for people who provide support, information about local organizations and services, being informed or or providing a way to gather evidence of the abuse, such as photographs, developing a safe plan and taking steps to leave, considering factors such as money, a safe place to live, and work, child care and schooling, and a plan for staying safe after leaving. In the case of an infant, child, or adolescent patient a CPS worker is the person to decide who a child or children are safe to be with, or which caregiver(s) may or may not have access to the child or children. This includes in the healthcare setting, during transfer to a higher level of medical care, and following the patient's discharge from the hospital. CPS may decide to do a Safety Plan or to remove/take custody, due to imminent child endangerment. For these reasons it is essential that healthcare providers involve CPS as soon as possible, and that healthcare providers do not make safety decisions that they are not qualified or responsible. The on-call FNE is to be contacted whenever there is a concern of child maltreatment, or if CPS and/or law enforcement respond to or are needed to respond to the hospital for a pediatric patient.

K. **Mandatory Reports of known or suspected child maltreatment** is made by CPS by calling the hotline (Centralized Intake) in the state where the maltreatment is suspected or known to have occurred. Any pediatric patient with serious injuries or concerns require the presence of law enforcement and CPS. It is up to CPS to determine whether the child's caregiver(s) can continue to have access to the child. Note that CPS should be involved prior to the child's discharge or transfer to a higher level of medical care. Child Protective Services (CPS) must also be notified if a child witnessed domestic or intimate partner violence. In pediatric patients the interview ideally occurs at a conveniently scheduled time for the patient and family, and in a child-friendly Child Advocacy Centers (CAC).

L. **Mandatory Reports** often consist of social, demographic, and the complaint or concern history. Be prepared to provide the patient's name, date of birth, the address, phone number, the caregiver(s) name, the caregiver address(es) , and the caregiver's phone number, and a summary of the concern, statements made, or examination findings (including relevant laboratory studies or imaging results). You may be asked about things you do not have the answer to, such as whether there are guns in the home. You are not required to supply information that you would not normally have in the medical record. It is not unusual to have to wait on hold for 30 minutes when you make the call to the hotline (Centralized Intake).

M. **Documenting a Mandatory Report.** Document the date, time, agency, and name of the person receiving the report, and the name of the person who made the report in the patient's medical record. Any VH reporter who prefers not to disclose this information in the medical record should consult the on-call FNE (WMC). VH Form #309333 is a reporting and documentation tool (see attached). A completed form can be scanned into 'media' in the medical record, or retained by the FNE Office.

N. **In Addition to Mandatory Reporting:** Healthcare providers are to notify the **on-call FNE of the**

Forensic Nurse Examiner Program of Winchester Medical Center on every known or suspect case of child maltreatment, and this should occur prior to the patient's discharge or transfer. The on-call FNE is to be involved for the following:

1. A suspicious injury. Skin injuries with a high specificity for maltreatment (patterned bruises, ear bruises, bruises over the torso, genital injury (non-straddle), petechial hemorrhages, burns that do not fit the explanation;
2. Premobile infant or nonmobile child with a single bruise, injury, or suspicious injuries;
3. Infant under 12 months of age has a fracture, or whenever a child older than 12 months of age has a fracture, multiples fractures, or healing fractures;
4. Respiratory arrest, cardiac arrest, any child needing resuscitation (bagging), or death of an infant or child;
5. CT imaging of the brain where bleeding or injury is found;
6. A report of or healthcare event involving seizure activity, loss of consciousness, or altered mental status;
7. Vaginal, penile, or rectal bleeding or discharge; pregnancy or sexually transmitted infection;
8. Drug exposure or unintentional overdose;
9. Appears malnourished, or otherwise neglected;
10. Pregnancy (child or minor); STD (child or minor);
11. Caregiver delay in seeking medical care;
12. Caregiver in a motor vehicle accident and child was improperly restrained;
13. Caregiver appears to be under the influence of drugs or alcohol;
14. Caregiver signs child out against medical advice (AMA) or caregiver behavior that interferes with emergent medical attention of a child
15. Caregiver altercation where a child was a witness, injured, or in some way involved.
16. Any safety related concerns (endangerment)

O. When the patient who is known or suspected of experiencing abuse or assault is an **adolescent (under age 18)** law enforcement in the jurisdiction where the violence is suspected to have occurred is to be notified. When a caregiver has or is suspected to have abused or assaulted the adolescent it is to be reported to both Child Protective Services and law enforcement. The adolescent does not have to give permission for a report to be made to CPS or law enforcement. It is always appropriate to consult the on-call Forensic Nurse Examiner.

1. Report to law enforcement (adolescent patient):
    a. injury caused by violence
    b. a disclosure of sexual assault
    c. sexual relationship between an adolescent and and adult (over age 17)
    d. pregnancy (that began in a child under age under 18 years of age0.

P. **Documentation:** avoid using legal terms, such as 'victim', 'alleged', 'allegeing', 'alledgedly', and 'allegation'. Quote the patient or the caregiver, when taking the history or complaint. Only use quotes when the word for word is able to be documented accurately. Carefully note the name of each person's history. For example, 'James Doe, the patient's father, states "she was perfectly fine when she went to bed last night, and this is how I found her in her crib this morning." Mr. Doe states he's the one who put her to bed in her crib last night (date) "at 8pm" and states "I went in to get her this morning at 7:30am."
When documenting injury, use proper terminology and describe what is seen by documenting color, shape, and size (centimeters or millimeters). For example, 'there is a bluish-purple colored linear bruise (3cm.) on the left mid lateral thigh.

Q. **Evidence Collection**. The Forensic Nurse Examiner (FNE) Program will be consulted in cases where law enforcement is requesting the collection and packaging of biomedical or physical evidence. The FNE can instruct health care providers on proper evidence collection techniques and maintaining and documenting the chain of custody (see form attached). Adult non-care dependent patients are informed of their right to refuse evidence collection or a forensic examination and photography (informed consent/refusal is required).

R. **Photo-documentation (Forensic Photography)** Photograph all skin findings (using approved and secure methods) for medical purposes in the patient's medical record. Photographs provide a permanent record of the finding. Adolescent and adult patients (who do not require a caregiver) are asked permission (informed consent/refusal) before photographs are obtained. Adult patients must provide consent in order to photograph their injuries for forensic purposes. The on-call FNE should be consulted whenever there are physical findings that law enforcement requests be photo-documented. Principles of forensic photography include: an orientation shot, a midrange shot, and a close-up with and without a ruler.

S. **Evidence collection and/or photo-documentation** should not interfere with or delay the delivery of emergent or urgent healthcare. Details of injury to document include location(s), size/measurement, and a description of its appearance (color, shape, type of injury), the presence of bleeding, and the patient's complaint or pain scale. Document who provided the history for the injury. Put statements in quotes whenever possible.

Types of Abuse, defined (Maltreatment)

1. **Abandonment** is defined as an event where an infant, minor, elderly, or vulnerable/ incapacitated person is abandoned by a caregiver or left without appropriate communication/ arrangements for their supervision/care. Infant Safe Haven laws exist, however if an infant is abandoned it must be reported immediately to law enforcement and CPS. Safe Haven laws exist in order to protect infants from endangerment while allowing parents to relinquish the infant without fear of prosecution. Laws vary between states on the permissible age of the infant, who is legally able to relinquish and where, and whether and when the parent has forfeited their custodial rights.

2. **Abuse, Emotional and Psychological:** Examples of emotional abuse include, but are not limited to communicating a lack of concern about or disdain for, threatening, name calling or other personal insults; or deliberate withholding of affection, attention, communication, or other aspects of care that make a child feel loved and wanted. Document anything unusual or significant about the patient's general demeanor, affect, behavior, and statements made by patient and/or caregiver(s) in quotation marks. It is mandatory to report concerns of

physcholigcal/emotional abuse to Child Protective Services (CPS). Caregivers who lack knowledge, experience, ability, or resources may unintentionally neglect their child or other dependent(s).

3. **Abuse, Exploitation:** is an intentional act aimed at defrauding or obtaining something from another person that does not belong to the perpetrator. Exploitation is often accomplished through an abuse of power or trust to gain something from a vulnerable individual. The intent is to create a power differential where the perpetrator creates leverage or control in order to defraud or abuse. The perpetrator preys upon the victim by identifying something the victim or their caregiver needs, and makes unfulfilled promises or causes the victim (or caregiver) to become dependent upon them (financially, emotionally, or psychologically). The perpetrator may systematically blur or erase the victim's boundaries, or may normalize their behaviors or action. Perpetrators often exploit their victim(s) to obtain sexually explicit pictures or videos. Grooming a victim with the goal of gaining control over them (often sexual) is a form of exploitation. Force, fraud, or coercion are common elements in these types of crimes. Exploitation is a part of crimes such as labor trafficking (including child labor), sex trafficking, obtaining the property and/or funds belonging to another person, or taking over finances or property with the intent to benefit.
4. **Abuse, Financial**: Examples of financial abuse include, but are not limited to, when the care-dependent person is capable of but does not have control over their money, is not able to make decisions about their finances, or has no or limited access to their cash, incoming checks, or accounts; or where there is improper use of legal guardianship arrangements, power of attorney, or conservatorship.
5. **Abuse, Sexual:** sexual abuse of a vulnerable person (pediatric, disabled adult, elder/older adult) may include such things as fondling; voyeurism; oral, vaginal, and/or anal contact and/or penetration (digital, penile, object), masturbatory behavior/activity, indecent exposure, forced prostitution photographing/videoing, or allowing the care-dependent person to be used in any sexually explicit visual material. Sexual abuse is any sexually motivated behaviors, speech, and/or activities/contact perpetrated by an adolescent or adult against a child, disabled, or older adult/elderly. Frequently it involves coercion and results in unwanted, and/or forced sexual acts. Many victims lack sexual knowledge and do not understand that what is occurring is abuse. Often the perpetrator chronically abuses the victim, normalizes the abuse, or makes the victim feel responsible for and afraid to disclose the abuse ("a secret"). The victim may be threatened in order to control them and make them fearful to disclose. Physical injuries, such as signs of strangulation, petechial hemorrhages, bruises on the body, and bite marks may be a sign of sexual abuse.
   Often there are no physical signs of sexual abuse, and no physical or DNA evidence since most cases are not discovered within the evidence collection time frame (in general, 24 hours since the last sexual abuse event if it is a prepubescent child, and 120 hours for adolescent/adult penile-vaginal penetration), or the sexual abuse would not have resulted in the transfer of evidence (hair, fiber, or DNA), or when the transfer is explainable by other means (such as could have resulted normally during the course of providing care and hygeine).
6. **Abuse, Healthcare Fraud**: examples include, but are not limited to not providing or overcharging for healthcare, over/under medicating, or providing fraudulent remedies or healthcare.
7. **Abuse, Physical:** physical abuse refers to non-accidental injury (external and/or

internal). There may be more than one physical finding, and injuries may be skeletal, brain, or organ. It is possible for there to be no bruises in the presence of fractures.

i. Injuries in children are generally classified as accidental or non-accidental. Many non-accidental injuries occur in the context of 'discipline'. The caregiver history explaining how an injury occurred is one of the most important pieces to determining whether a finding is suspicious or provides a plausible explanation. Some of the red flags are if the history doesn't match the finding (inconsistent), a constellation of findings, the explanation does not fit the child's developmental abilities, the story changes, there was a serious injury that was 'unwitnessed', or there are signs that there may have been a delay in seeking medical attention.

ii. When there are signs of injury, the history for the injury should be carefully documented, and should include who provided the information. When the history for the injury does not match the finding(s) or the explanation is not plausible or reasonable.

a. Blunt force trauma (non-accidental/inflicted): slapping, kicking, biting, pinching, grabbing, squeezing; shaking, and throwing. Striking the body with an object (such as a cord, board, brush, kitchen utensil, belt, or hand). Blunt force injuries produced by an object leave linear or patterned mark, rather than diffuse and without a demarcated border). Suspicious locations for bruises (TEN4: Torso, ears, neck, under 4 months, under 4 years), but also: protected areas (under angle of the jaw, inner thighs, genitalia).

b. Sharp force trauma (non-accidental): incisions/cuts, penetrating cuts.

c. Burns (non-accidental): immersion, contact, chemical

d. Non-accidental asphxial injury: strangulation, covering the childs mouth/ nose, suffocation.

e. Inappropriate confining or restraining are another form of physical abuse.

f. Substance Exposure (prenatal, postnatal, pediatric) and intentional administration of a non-prescribed medication, other drug, or over-medicating to induce sedation or incapacitation. This includes clinical signs of the patient being under the influence or altered by a drug or non-prescribed medication (pediatric or care-dependent adult).

g. Hair Traction: pulling on or pulling out hair. Signs may include missing areas of hair, scalp bruising.

h. Forceful Shaking: The term 'shaken baby syndrome' is now referred to as 'abusive head trauma' (AHT). Signs are often neurological (unexplained seizure), unresposiveness, apnea, altered mental status, cervical spine injury, cerebral injury, subarachnoid or subdural hemorrahge, retinal hemorrhage, unexplained bruises (especially above the shoulders), classic metaphyseal lesions fractures (CML), rib fractures (especially lateral and posterior),

i. Visible evidence of tissue trauma may or may not be present.

j. Few physical findings are pathognomonic for abuse. Certain injuries are rarely accidental, such as bruises to the ear(s) and patterned bruises. A single bruise in a nonmobile infant is a red flag. The injury, injuries, condition, or other finding(s) are to be evaluated in the context of the history to explain the injury. Injuries considered to be red flags for maltreatment are bruising over posterior and/or padded locations (especially patterned marks), bruising in clusters, multiple bruises, bruises in various stages of healing, bruises to the abdomen, bruises on the torso, bruises on the ears, hands, or feet, intraoral injury, and petechial hemorrhages of the face, neck, and/or chest.The patient's age, history, growth and development, the number or injuries, and the location of the injuries should be factored in to the decision as to whether maltreatment is possible. Bruises and other findings may be a medical manifestation of illness, infection, disease, or even a normal variant related to the skin.

Resources

A. The Forensic Nurse Examiner Program 24/7 on-call: (540) 536-8000; request to be connected with the on-call FNE

B. The Forensic Nurse Examiner Program's non-emegency; 540-536-4147.

C. Mandatory Reporting for Suspected Child or Disabled Adult or Elder (>age of 59) Maltreatment

1. Virginia's Centralized Intake 24/7 Hotline: 1-800-552-7096
2. West Virginia's Centralized Intake 24/7 Hotline: 1-800-352-6513.
3. To find numbers for other states see the link in references to Child Welfare Information Gateway (2019)

D. National **Human Trafficking Resource Center's hotline 1-888-373-8777**. Provide adult sex trafficking victims with the National Human Trafficking Resource Center's hotline and the **text messaging resource BEFREE (23373)**

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Attachments

3816EDDWMC - CHAINofCUSTODY.doc

9334WMC -MandatoryReportingForm.doc

Approval Signatures

Step Description	Approver	Date

Sharon Rigney: SR DIRECTOR /ACNO, WMC	12/2021
Kammie Riggleman: Director Professional Practice	12/2021
Angela McCleaf: Director, Perioperative Services, Acute Care Hospi	12/2021
Jennifer Murray: Director, Critical Care	12/2021