Abuse and Maltreatment

Aliases

Maltreatment of vulnerable populations

Definitions

- **Abuse and Maltreatment:** Abuse and Maltreatment is any act or series of acts of commission or omission by a caregiver or person in a position of power over the patient that results in harm, potential for harm, or threat of harm to a patient
- **Child Maltreatment and Abuse:** Child maltreatment includes any act or series of acts of commission or omission by a parent or other caregiver that results in harm, potential for harm, or threat of harm to a child. An act of commission (child abuse) is the physical, sexual or emotional maltreatment or neglect of a child or children. An act of omission (child neglect) includes, but is not limited to, failure to provide for the child's needs (e.g. physical, emotional, medical/dental, and educational neglect) and failure to supervise (e.g. inadequate supervision or safety precautions, lack of appropriate car seat use, and exposure to violent or dangerous environments).
- **Human Trafficking:** Human trafficking is when people are abducted or coerced into service and often transported across international borders. Signs may include, but are not limited to: patient with branding/tattoos and environmental clues such as padlocks and/or doorknobs removed on interior doors, and intact windows that are boarded up

Patient Care Goals

1. Recognize any act or series of acts of commission or omission by a caregiver or person in a position of power over the patient that results in harm, potential for harm, or threat of harm to a patient.
2. Take appropriate steps to protect the safety of the responders as well as bystanders.
3. Get the patient out of immediate danger.
4. Assess any patient injuries that may be the result of acute or chronic events.
5. Attempt to preserve evidence whenever possible; however, the overriding concern should be providing appropriate emergency care to the patient.

Patient Presentation

1. Clues to abuse or maltreatment can vary with age group of the patient and type of abuse.
2. Not all abuse or maltreatment is physical.
3. EMS role is to:
    a. Document concerns.
    b. Assess potentially serious injuries.
    c. Disclose concerns to appropriate authorities.
    d. Initiate help to get the patient into a safe situation.
    e. Not investigate or intervene beyond the steps above.
    f. Leave further intervention to law enforcement personnel.

Inclusion/Exclusion Criteria

Absolute inclusion/exclusion criteria are not possible in this area. Rather, clues consistent with different types of abuse/maltreatment should be sought:

- Potential clues to abuse/maltreatment from caregivers or general environment:
    - Apathy by caregiver about patient's current situation
    - Overreaction by caregiver to questions about situation
    - Inconsistencies from caregivers or bystanders regarding history of what happened
    - Inconsistencies between injury patterns and information provided by caregivers or patient
    - Injuries not appropriate for patient's age or physical abilities (e.g. infants with injuries usually associated with ambulatory children, elders who have limited mobility with injury

mechanisms inconsistent with their capabilities)
    - Controlling behavior by caregiver (e.g., not allowing adult patient to speak for themselves—pay special attention to patients who cannot communicate due to young age or language and/or cultural barriers)
    - Inadequate safety precautions or facilities where the patient lives and/or evidence of security measures that appear to confine the patient inappropriately
- Potential clues to abuse or maltreatment that can be obtained from the patient:
    - Bruising in non-typical locations or multiple bruises in various stages of healing (See TEN-4-FACESp reference)
    - Age-inappropriate behavior (e.g. adults who are submissive or fearful, children who act in a sexually inappropriate way)
    - Pattern burns, bruises, or scars suggestive of specific weaponry used
    - Evidence of medical neglect for injuries or infections
    - Unexplained trauma to genitourinary systems or frequent infections to this system
    - Evidence of malnourishment and/or serious dental problems
- Have a high index of suspicion for abuse in children presenting with a Brief Resolved Unexplained Event (BRUE) [see BRUE guideline]

Patient Management

Assessment

1. Start with a primary survey and identify any potentially life-threatening issues.
2. Document thorough secondary survey to identify clues suggesting potential abuse/maltreatment:
    a. Inability to communicate due to developmental age, language and/or cultural barrier
    b. Multiple bruises in various stages of healing
    c. Age-inappropriate behavior (e.g. adults who are submissive or fearful, children who act in a sexually inappropriate way)
    d. Pattern burns, bruises, or scars suggestive of specific weaponry used
    e. Evidence of medical neglect for injuries or infections
    f. Unexplained trauma to genitourinary systems or frequent infections to this system
    g. Evidence of malnourishment and/or serious dental problems
3. Assess physical issues and avoid extensive investigation of the specifics of abuse or maltreatment, but document any statements made spontaneously by patient.
    a. Avoid asking directed questions of a child.

TEN-4-FACESp

Bruising Clinical Decision Rule for Children < 4 Years of Age

REGIONS

TEN

Torso | Ears | Neck

FACES

Frenulum
Angle of Jaw
Cheeks *(fleshy part)*
Eyelids
Subconjunctivae

INFANTS

4 months and younger

Any bruise, anywhere

PATTERNS

Patterned bruising

Bruises in specific patterns like slap, grab or loop marks

When is bruising concerning for abuse in children < 4 years of age?

If bruising in any of the three components (Regions, Infants, Patterns) is present without a reasonable explanation, strongly consider evaluating for child abuse and/or consulting with an expert in child abuse.

TEN-4-FACESp is not to diagnose abuse but to function as a screening tool to improve the recognition of potentially abused children with bruising who require further evaluation.

Ann & Robert H. Lurie
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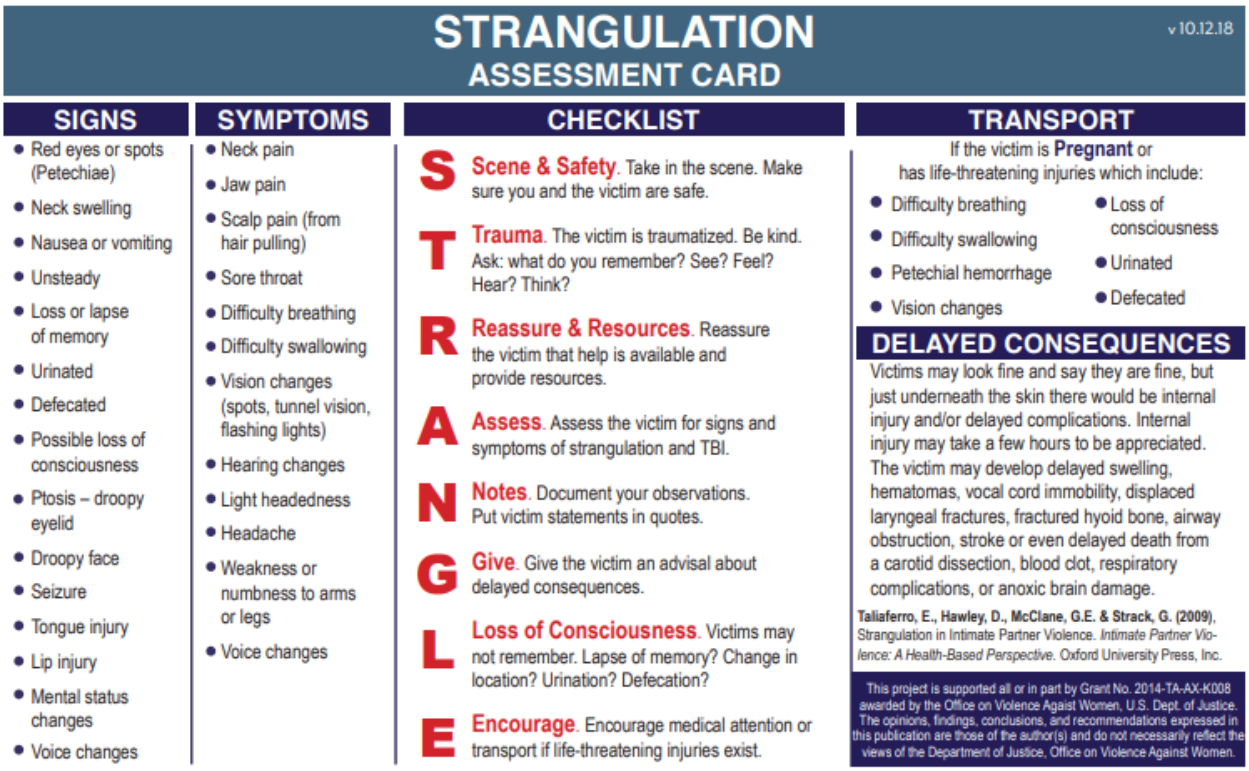
b. Assess for additional clues to possible airway edema secondary to strangulation



STRANGULATION
ASSESSMENT CARD

v 10.12.18

SIGNS

- Red eyes or spots (Petechiae)
- Neck swelling
- Nausea or vomiting
- Unsteady
- Loss or lapse of memory
- Urinated
- Defecated
- Possible loss of consciousness
- Ptosis – droopy eyelid
- Droopy face
- Seizure
- Tongue injury
- Lip injury
- Mental status changes
- Voice changes

SYMPTOMS

- Neck pain
- Jaw pain
- Scalp pain (from hair pulling)
- Sore throat
- Difficulty breathing
- Difficulty swallowing
- Vision changes (spots, tunnel vision, flashing lights)
- Hearing changes
- Light headedness
- Headache
- Weakness or numbness to arms or legs
- Voice changes

CHECKLIST

S **Scene & Safety**. Take in the scene. Make sure you and the victim are safe.

T **Trauma**. The victim is traumatized. Be kind. Ask: what do you remember? See? Feel? Hear? Think?

R **Reassure & Resources**. Reassure the victim that help is available and provide resources.

A **Assess**. Assess the victim for signs and symptoms of strangulation and TBI.

N **Notes**. Document your observations. Put victim statements in quotes.

G **Give**. Give the victim an advisal about delayed consequences.

L **Loss of Consciousness**. Victims may not remember. Lapse of memory? Change in location? Urination? Defecation?

E **Encourage**. Encourage medical attention or transport if life-threatening injuries exist.

TRANSPORT

If the victim is **Pregnant** or has life-threatening injuries which include:

- Difficulty breathing
- Difficulty swallowing
- Petechial hemorrhage
- Vision changes
- Loss of consciousness
- Urinated
- Defecated

DELAYED CONSEQUENCES

Victims may look fine and say they are fine, but just underneath the skin there would be internal injury and/or delayed complications. Internal injury may take a few hours to be appreciated. The victim may develop delayed swelling, hematomas, vocal cord immobility, displaced laryngeal fractures, fractured hyoid bone, airway obstruction, stroke or even delayed death from a carotid dissection, blood clot, respiratory complications, or anoxic brain damage.

Taliaferro, E., Hawley, D., McClane, G.E. & Strack, G. (2009), Strangulation in Intimate Partner Violence. *Intimate Partner Violence: A Health-Based Perspective*. Oxford University Press, Inc.

This project is supported all or in part by Grant No. 2014-TA-AX-K008 awarded by the Office on Violence Against Women, U.S. Dept. of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

ADVISAL TO PATIENT

- After a strangulation assault, you can experience internal injuries with a delayed onset of symptoms. These internal injuries can be serious or fatal.
- Stay with someone you trust for the first 24 hours and have them monitor your signs and symptoms.
- Seek medical attention or call 911 if you have any of the following symptoms: difficulty breathing, trouble swallowing, swelling to your neck, pain to your throat, hoarseness or voice changes, blurred vision, continuous or severe headaches, seizures, vomiting or persistent cough.
- The cost of your medical care may be covered by your state's victim compensation fund. An advocate can give you more information about this resource.
- The National Domestic Violence Hotline number is **1-800-799-SAFE.**

NOTICE TO MEDICAL PROVIDER

- The Medical Advisory Board of the Training Institute on Strangulation Prevention has developed recommendations for the radiologic evaluation of the adult strangulation victim. In patients with a history of a loss of consciousness, loss of bladder or bowel control, vision changes or petechial hemorrhage, medical providers should evaluate the carotid and vertebral arteries, bony/cartilaginous and soft tissue neck structures and the brain for injuries. A list of medical references is available at www.strangulationtraininginstitute.com
- Life-threatening injuries include evidence of petechial hemorrhage, loss of consciousness, urination, defecation and/or visual changes. If your patient exhibits any of the above symptoms, medical/radiographic evaluation is strongly recommended. Radiographic testing should include: a CT angiography of carotid/vertebral arteries (most sensitive and preferred study for vessel evaluation) or CT neck with contrast, or MRA/MRI of neck and brain. Strangled patients with arterial injuries can present with strokes months or years post-strangulation.
- ED/Hospital observation should be based on severity of symptoms and reliable home monitoring.
- Consult Neurology, Neurosurgery and/or Trauma Surgery for admission.
- Consider an ENT consult for laryngeal trauma with dysphonia, odynophagia, dyspnea.
- Discharge home with detailed instructions to return to ED if neurological signs/symptoms, dyspnea, dysphonia or odynophagia develops or worsens.

TRAINING INSTITUTE on STRANGULATION PREVENTION

StrangulationTrainingInstitute.com

Treatment and Interventions

1. Address life-threatening issues.
2. Remove the patient to a safe place even if no medical indication for transport.
    a. Report concerns about potential abuse and/or maltreatment to law enforcement immediately, in accordance with state law, if caregivers are impeding your ability to assess and/or transport patient, or refuse care for the patient.

3. For patients transported, report concerns to hospital and/or law enforcement personnel per mandatory reporting laws.

Patient Safety Considerations

- If no medical emergency exists, the next priority is safe patient disposition/removal from the potentially abusive situation.
- Do not confront suspected perpetrators of abuse and/or maltreatment. This can create an unsafe situation for EMS and for the patient.

Notes and Educational Pearls Key Considerations

- All states have specific mandatory reporting laws that dictate which specific crimes such as suspected abuse or maltreatment must be reported and to whom they must be reported. It is important to be familiar with the specific laws in your state including specifically who must make disclosures, what the thresholds are for disclosures, and to whom the disclosures must be made.
- Clues to abuse or maltreatment can vary depending on the age group of the patient and on the nature of the abuse. Remember that not all abuse or maltreatment involves physical harm. It is important to realize that the job of EMS is to document their concerns, assess the patient for potentially serious injuries, make sure that their concerns are disclosed to the appropriate legal authorities, and work towards getting the patient into a safe situation. EMS personnel should not take it upon themselves to investigate, interview, or intervene above and beyond those concepts and should leave further intervention to the appropriate law enforcement personnel.
- It is very important to have a high index of suspicion for abuse in children presenting with a Brief Resolved Unexplained Event (BRUE). Of the very serious causes of BRUE, child abuse has been found in as many as 11% of cases. One retrospective review noted that a call to 911 for BRUE was associated with an almost 5 times greater odds of abusive head trauma being diagnosed as the cause of the BRUE, clearly emphasizing the high index of suspicion EMS providers must have when responding to these calls.
- Abuse and maltreatment can happen to patients of all ages.
- Patients may be unwilling or unable to disclose abuse or maltreatment so the responsibility falls on EMS personnel to assess the situation, document appropriately, and take appropriate action to secure a safe place for the patient.
- Document findings by describing what you see and not ascribing possible causes (e.g. "0.5- inch round burn to back" as opposed to "burn consistent with cigarette burn").
- Providers should be knowledgeable about mandatory reporting statutes in their area, especially regarding adults (domestic violence, elder abuse).

Pertinent Assessment Findings

As noted above

Quality Improvement

Associated NEMSIS Protocol(s) (eProtocol.01)

9914187—General-Neglect or Abuse Suspected

Key Documentation Elements

Meticulous documentation of any statements by the patient and any physical findings on the patient or the surroundings are critical in abuse or maltreatment cases

Performance Measures

No recommendations

References

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5, 2016. Accessed August 21, 2017.
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3. TEN-4-FACESp | Stanley Manne Children's Research Institute at Lurie Children's: https://research.luriechildrens.org/en/community-population-health-and-outcomes/smith-child-health-outcomes-research-and-evaluation-center/tricam/ten-4-facesp/