CHILD MALTREATMENT

MEDICO-LEGAL TERMINOLOGY AND INTERPRETATION OF MEDICAL FINDINGS

A CONSENSUS OF MEDICAL AND LEGAL CHILD PROTECTION PRACTITIONERS IN THE PHILIPPINES

4th Edition
Manila, Philippines
2015
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INTRODUCTION TO THE FOURTH EDITION

The fourth edition of the Consensus is a substantially expanded and updated version of the last edition released almost 10 years ago.

Those familiar with the Consensus will immediately notice a new lay-out. While the third edition focused on how to do a medico-legal certificate, the present edition is designed to guide the physician in filling up the medical modules of the Women and Child Protection Management Information System (WCPMIS). Developed in 2000 to facilitate case management and research, the WCPMIS is capable of generating a medico-legal certificate from encoded data. This manual will guide the physician through a complete medical evaluation and give instructions on filling up the WCPMIS accordingly. Used as a supplement to the WCPMIS manual, it describes what information should be gathered during history-taking and physical examination and provides additional information to guide the physician’s assessment of the child. The corresponding portions of the medico-legal certificate are also shown for the benefit of those who will not be generating a report through the WCPMIS.

The latest evidence-based research can be found together with recent Supreme Court decisions on the interpretation of medical findings in child abuse. These highlight the importance of a child’s disclosure and emphasize the significance of normal findings. “Sexual abuse by history” and “it’s normal to be normal” are key messages stressed throughout this publication. This edition also features new illustrations, photographs, and recommendations on diagnostic tests and interventions for the physician to use as a quick reference bedside and when testifying in court.

In this edition, the Consensus has evolved into a comprehensive guide that brings together the collective knowledge and experience of medical and legal child protection practitioners in the Philippines from the past ten years.
The Consensus was first published in 2000 when a technical working group comprised of physicians, lawyers, and judges who work with abused children was convened by the Child Protection Network Foundation, Inc. (formerly the Child Protection Unit Network). Together with the National Bureau of Investigation’s (NBI) Medico-Legal Division and Violence Against Women and Children Division (VAWCD), the Philippine National Police (PNP) Crime Laboratory and Women’s Crisis and Child Protection Center (WCCPC), members of the Child Protection Network Foundation, Inc. (CPN) and the Department of Health (DOH) – medical and legal professionals met to examine the vocabulary used by child protection physicians throughout the world. At that time there was a dramatic increase in diagnosis of sexual abuse of children in the Philippines. This was coupled with an alarming lack of agreement between professionals and lack of clarity over the identification and interpretation of physical findings.

This technical working group finalized a comprehensive and up-to-date child protection vocabulary and agreed upon definitions for ambiguous terms. The working group then devised a common medical certificate that is being utilized by physicians of child protection units (CPUs), the DOH, the NBI, the PNP, or other public and private medical institutions, and that is recognized by judges and legal professionals across the country. To cope with the demand, a second edition with minor additions followed closely two years later in 2002. New research and updates were incorporated in the third edition which came out in 2005.

Research done on the legal outcomes of sexually abused cases seen at the Child Protection Unit of the Philippine General Hospital from 1997-2000 found that factors associated with a case reaching court included: referral source ($p < 0.0001$), acute evaluation ($p < 0.001$), disclosure involving penetration ($p = 0.005$), and abnormal anogenital findings ($p = 0.00003$). The odds of a case reaching court were increased 4.8 times for self-referred patients, 4 times for patients examined acutely, and 2 times more for patients with anogenital injuries. From the first edition in 2000 till today, the medical certificate remains as the most valuable evidence in the investigation of child abuse cases and in cases reaching court.

It has been almost 10 years since the last edition was published. Nationwide trainings for physicians, social workers, law enforcement officers, judges and court personnel have been conducted e.g. Philippine Judicial Academy’s (PHILJA) Competency Enhancement Training for Judges and Court Personnel Handling Cases Involving Children, PNP’s Specialized Course for Women and Child Protection Desks Officers and the Committee for the Special Protection of Children’s Protocol for the Case Management of Child Victims of Abuse, Neglect & Exploitation. The DOH issued Administrative Order (A.O.) No. 2013-0011: “Revised Policy on the Establishment of Women and Child Protection Units in all Government Hospitals.” The A.O. recognizes the training needs of Women and Child Protection Unit (WCPU) personnel and identifies the Women and Child Protection Specialist Training of the CPN as the required training of WCUPUs. As of December 2014, there are 72 WCUPUs across the country. The goal is that any abused woman or child will have access to trained personnel within 2 hours anywhere in the country.

OUR GOALS

The objective of the authors is that, after reading this publication, users will benefit from:

- **Improved technical understanding:** By becoming more familiar with the child protection medical terminology and examination, members of the medical and legal community will have a stronger grasp of the information contained within the medico-legal certificate, reducing the possibility of misinterpretation.

- **Ability to “speak the same language”:** Child abuse occurs globally; hence, physicians must share a single vocabulary so as to better communicate ideas and best practices worldwide.

- **Standardized procedures:** The standardization of terminology and the certificate itself may lead to standardized procedures. If one comprehensive examination can be created and agreed upon by all members of the medico-legal community, there will be decreased cause for multiple exams and, thus, decreased possibility of re-traumatizing patients.

Ultimately, it is our intention that this publication will serve as both an educational tool for child protection professionals unfamiliar with the medico-legal examination, and as a guideline for those in the medical community actually performing the examination. Please note that this manual is not intended to be a substitute for actual child protection specialist training.

HOW TO USE THIS GUIDE

This guidebook takes the physician through a comprehensive medical evaluation of an abused child. It begins with obtaining the child’s general and demographic information, followed by the interview and physical examination, and ends with interventions addressing medical concerns and the child’s safety. This publication serves as a supplement to the Women and Child Protection Management Information System (WCPMIS) manual, thus, it is divided into chapters that correspond with relevant modules of the WCPMIS. Each chapter of this book features a screenshot of the related WCPMIS module followed by detailed instructions on how to complete the module. The physician will also see the corresponding portion of the standard medico-legal certificate so that the guide can still be used even without the WCPMIS.

When examining a patient, the physician may refer to the chapter on extragenital and anogenital examination where the types of injuries are described together with the corresponding medico-legal terminology and interpretation. Additional information to guide the physician’s assessments may be found in the appendices.

Ana Maria R. Cruz is not a real person. Her fictional character and other details were created to serve the educational purpose of this Concensus. Confidentiality is an over-arching consideration in cases of child abuse.

For facility, the child will be referred to as “she” or “her” throughout this publication.
MEDICO-LEGAL CERTIFICATE

DEMOGRAPHIC DATA

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Cruz, Ana Maria R.</th>
<th>Age</th>
<th>14</th>
<th>DOB</th>
<th>08/22/2000</th>
<th>Sex</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Address</td>
<td>307 De los Santos St., Bgy. 44, Malate, Manila</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Civil Status</td>
<td>Single</td>
<td>Occupation</td>
<td>Grade 3 student</td>
<td>Nationality</td>
<td>Filipino</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requesting Party</td>
<td>Maria Leonora R. Cruz</td>
<td>Place, Time &amp; Date of Exam</td>
<td>September 12, 2014</td>
<td>4:20 PM</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☑ Acute Evidentiary Examination (within 72 hours of incident) ☐ Non-Acute Examination

Date & Time of Most Recent Incident: September 10, 2014 11:00 PM
Place of Incident: Malate, Manila

FINDINGS

GENERAL PHYSICAL FINDINGS

<table>
<thead>
<tr>
<th>Height</th>
<th>150 cm</th>
<th>Weight</th>
<th>60 kg</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Survey</td>
<td>Ambulatory, not in respiratory distress</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Status</td>
<td>Conscious, coherent, oriented to time, place and person</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Irritable, cooperative</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The child has delayed schooling and may have learning disability.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pertinent Physical Findings/Physical Injuries</td>
<td>NECK: Anterior triangle: Right - Multiple purplish, circular and ovoid discolorations with an area of 6.0 x 5.0 cm. Individual lesions range in size from 1.0 x 0.5 cm to 2.5 x 1.0 cm.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Breasts Tanner Stage: 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ABDOMEN: Umbilical - Enlarged with fundic height of 20 cm. Fetal movements appreciated; fetal heart tones 140/minute on right lower quadrant.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>LMP: April 25, 2014 G1P0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ANOGENITAL EXAM

| External Genitalia | Tanner Stage: 4 |
|                   | No evident injury at the time of examination. |
| Uretha and Periurethal Area | No evident injury at the time of examination. |
| Perithymenal Area and Fossa Navicularis | No evident injury at the time of examination. |
| Hymen            | Stage: 4 Estrogenized. Redundant. |
| Perineum         | No evident injury at the time of examination |
| Discharge        | Minimal, yellowish, foul-smelling |
| Internal and Speculum Exams | No evident injury at the time of examination. |
| Anal Examination | No evident injury at the time of examination. |

DIAGNOSTICS AND EVIDENCE GATHERING

| Forensic Evidence and Laboratory Results | Buccal swab, Body surface (neck) swab, External genitalia swab, Vaginal swab and Anal swab |
|                                         | Pregnancy Test (12-Sep-14, positive). Smear for Sperm (12-Sep-14, negative). |
|                                         | Gram Stain, Gonorrhoea Culture of Vaginal Swab, VDR, Hepatitis B Serology, HIV Test (12-Sep-14, laboratory examination results pending). |

IMPRESSIONS

Findings on the neck are consistent with suction marks. Anogenital examination show no evident injury at the time of examination. Pregnancy, 20 weeks age of gestation by last menstrual period. Medical evaluation is diagnostic of sexual abuse.

SARA VILLANO, MD
Name and Signature of Examining Physician
The Medical Evaluation of Child Abuse

Just like any medical evaluation, physicians must focus not only on the interpretation of physical findings but also recognize the clinical manifestations of victimization and understand the sequence of events from the first abusive incident to the first disclosure. A comprehensive medical history and physical examination can be therapeutic for the child and family as the physician can address any worries or concerns that they might have.

The Comprehensive Medical Evaluation of Child Abuse

- The child’s account of what was experienced, whenever possible; complete medical history; review of systems; social history
- Documentation of historical details
- Extragential and anogenital examination to diagnose and treat acute and chronic injuries and sexually transmitted infections
- Collection of forensic evidence (when applicable)
- Collection of specimen for laboratory examinations
- Photographic or video documentation
- Differential diagnosis of physical injuries or behavioral and physical complaints that may mimic abuse
- Reassure the parent/guardian and child that the child is “OK” and that any physical injuries found will heal
- Assess the child’s mental and emotional state and make appropriate referrals for counseling and medical management
- Address the child’s safety

Source: Adapted from references (1, 2)
A consent form (Appendix A) must be signed by the child and/or accompanying parent, legal guardian or relative, authorizing the WCPU physician to perform the medical examination. In the absence of a parent, legal guardian or relative, the required consent form shall be signed by a licensed Local Social Welfare and Development Office (LSWDO) social worker. In the absence of a licensed LSWDO social worker, the consent form shall be signed by the Department of Social Welfare and Development (DSWD), through its Social Welfare and Development (SWAD) team member or Social Worker Officer (SWO II) in the province (Appendix B, No. 3).

The profile contains demographic information including the child’s name, age, date of birth, sex and current address. The same information is used to fill up the Demographic Data portion of the Medico-Legal Certificate.
The child must not be re-traumatized by repeating details of her experience. While retelling may also be therapeutic, a child who is not ready to talk should not be pushed (Appendix R). The interview may be deferred to another time when the child is prepared to talk, when she is emotionally ready. The interview of the child may be omitted if she is developmentally unable to disclose (usually below 4 years old, but there may be exceptions).

**Developmental Assessment.** Examining physicians who are not developmental specialists may still include general observations concerning a child’s developmental status. In cases of suspected developmental delay or intellectual disability, physicians should indicate that their observations serve as estimations only and that the child will be referred to a psychiatrist, psychologist, or developmental pediatrician for assessment.
## RED FLAGS FOR DEVELOPMENTAL DELAY

The following red flags in each area of development can serve as a guide to the physician’s observations in assessing a child’s developmental status:

<table>
<thead>
<tr>
<th>MOTOR DELAY</th>
<th>LANGUAGE DELAY</th>
<th>PSYCHOSOCIAL DELAY</th>
<th>COGNITIVE DELAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor head control by 3 months</td>
<td>No social smile by 3 months</td>
<td>Not alert to mother at 2 months</td>
<td></td>
</tr>
<tr>
<td>Hands still fisted by 4 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unable to hold objects by 7 months</td>
<td>Does not turn to sound by 6 months</td>
<td>Not laughing in playful situations by 6 months</td>
<td>Not searching for dropped objects at 6 months</td>
</tr>
<tr>
<td>Does not sit independently by 10 months</td>
<td>Does not babble or use gestures by 1 year</td>
<td>Hard to console, stiffens to approach by 1 year</td>
<td>No object permanence at 1 year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INFANCY</th>
<th>1 to 3 years</th>
<th>3 to 5 years</th>
<th>SCHOOL-AGED CHILDREN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to 1 year</td>
<td>No single word utterance by 16 months</td>
<td>In constant motion, resists discipline</td>
<td>• Slow to remember facts</td>
</tr>
<tr>
<td></td>
<td>No two-word phrases by 2 years</td>
<td></td>
<td>• Slow to learn new skills, relies heavily on memorization</td>
</tr>
<tr>
<td></td>
<td>No three-word phrases by 3 years</td>
<td></td>
<td>• Poor coordination, unaware of physical surroundings and prone to accidents</td>
</tr>
<tr>
<td></td>
<td>Cannot stand on one leg by 3 years</td>
<td></td>
<td>• May be awkward and clumsy, has trouble with fine motor skills</td>
</tr>
<tr>
<td></td>
<td>No simple sentences at 3 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Speech not understandable to an unfamiliar adult less than half of the time at 3 ½ years</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not able to tell or retell a familiar story at 4 ½ years</td>
<td></td>
<td>Does not know letters or colors at 5 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Does not know own birthday or address at 5 ½ years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Speech not fully understandable to an unfamiliar adult at 5 years</td>
</tr>
</tbody>
</table>

If developmental delay is suspected, the child should be referred to a child developmental specialist for evaluation.

Source: reference (3)
THE MEDICAL HISTORY

A good medical history comprises 90% of the diagnosis.

- The time-honored practice of obtaining a medical history before conducting a physical examination applies to the medical evaluation of child abuse as it would to any other medical condition (1)*.

“Sexual abuse by history is the most common medical diagnosis from such evaluations (4).”

- The medical history follows the sequence of events as they happened. It is obtained in a developmentally-appropriate, non-leading and non-suggestive manner. Physicians should be knowledgeable about child development, sexual abuse victimization, biomechanics of injuries, and effects of abuse to be able to conduct a good history and convey professional understanding of what the child has experienced.

- In child sexual abuse, physical findings are rare and the only available evidence is what the child says about his or her experience (5).

The medical history is NOT a forensic interview.

- The purpose of the medical history is two-fold. One is to formulate a diagnosis as to the physical and mental health of the child and the second is to look for possible evidence of abuse. It is important to address the patient’s well-being and to treat injuries, sexually transmitted disease, or significant psychological sequelae.

The medical history is confidential and part of the medical records. When asked, the physician submits in court a report that summarizes pertinent information obtained from interviews with the informant and child.

*The bracketed numbers indicate the source. Please refer to the References section of this book.
INFORMANT’S INTERVIEW

The informant may be a parent, guardian, social worker or anyone who has personal knowledge of the abuse. The historical details provided by others provide a framework for understanding what the child has experienced but, whenever possible, the diagnosis should be based primarily on information directly obtained from the child.

The complete medical evaluation begins with the informant’s interview and should focus on the following:

1. Child’s past medical history
2. Review of systems with emphasis on the gastrointestinal and genitourinary systems
3. Social history
4. The history of the presenting illness or concern which takes into account how the informant learned of the incident and their response plus all intervening details up until the examination.
5. Any observations, worries and concerns

The medical record must clearly separate the statements made by the child and the information obtained from the caretaker.

The questions asked and the child’s responses must be documented verbatim.
PATIENT’S INTERVIEW

The child is separated from the accompanying parent / guardian whenever possible. If the child is not willing to be separated, the child may be interviewed with the guardian sitting behind the child so that the child cannot see the guardian’s facial expression. If possible, the guardian should not hold the child so there can be no accusation that the guardian is prompting the child’s replies. Before proceeding, the physician must ensure that the guardian will be able to listen to the child without getting upset and that the guardian will remain neutral throughout the interview. The guardian should be briefed that she cannot speak or react during the child’s interview and that her presence is merely to lend moral support. Children are less likely to disclose or describe details of their experience if they are afraid of the parent/guardian’s response or if they do not want to cause them grief.

The history obtained from the child provides the greatest insight into what she experienced. It allows her to describe in her own words and developmental perspective what happened and gives the child the opportunity to express worries or concerns.

The most important determinant of children’s memory is age. As children develop, they remember more for longer periods of time. A child younger than 10 years needs to be assessed in terms of her knowledge of time, dates, word comprehension and developmental skills like counting, sequencing, etc. The success of the interview is dependent on the skill of the interviewer and not the child (6). Appendix C provides details on the language development of children and its implications on interviewing them.

The interview proceeds as with any medical history-taking: chief complaint, history of present illness, review of systems, past medical history, and family and social history. The review of systems should focus on gastrointestinal and genitourinary complaints that mimic signs and symptoms associated with sexual abuse. Genital hygiene practices should also be elicited.

All physicians performing the medico-legal examination need to take the medical history. The physician should ask the child how her body felt before and after the abusive incident. The symptoms can then be correlated to the acts described (7).
**CHIEF COMPLAINT:** The child’s interview begins with asking if she knows the purpose of the examination (Appendix D).

**DISCLOSURE:** A child’s disclosure may be categorized as voluntary or elicited. A purposeful disclosure allows a planned intervention while an accidental or elicited disclosure more likely leads to a crisis response. How the parent responded to the disclosure is important. Castigating or physically abusing the child may result in the child not fully disclosing during the interview and/or may give rise to new injuries.
Research studies show that child sexual abuse victims often delay disclosure or do not disclose at all, particularly if they were abused by a person they know and/or are close to. Sexually abused children are also more likely to recant if they were abused by a family member living in the child’s household and if they lack family support. Thus, inconsistencies and recantations may be due to reluctance rather than a false allegation (8).

INCIDENT: When filling in this data, write down the date and time of the most recent incident that was disclosed by the child or the informant. If there is no information available, write “unknown.” It is important to indicate the first and last incident, but additional records can be created for each separate incident.

Among Filipino sexually abused children aged 4 – 17 years who underwent medico-legal evaluation, initial disclosures were more commonly elicited (47.1%) than voluntary (34.9%) and disclosures within 72 hours of the first/only incident were less frequent (37.2%). Similar patterns of disclosure were seen: the odds of delayed disclosure were increased 4 times with an intrafamilial perpetrator (p=0.001, CI 1.69-9.00). Delayed disclosures were also 3 times more likely with an intrafamilial confidant (p=0.046, CI 2.46-17.72), and 6.6 times more likely for children who were threatened verbally (p<0.001, CI 1.02-8.93) (9).

SUPREME COURT DECISION

PEOPLE V AUDINE, G.R. NO. 168649, DECEMBER 6, 2006

“Particularly in incestuous rape, this Court has consistently held that delay in reporting the offense is not indicative of a fabricating charge.

In this case, private complainant, who was 14 years old when she was ravished, satisfactorily explained why she did not immediately report the matter to anybody. She revealed that she is afraid of her father and that the latter threatened to kill her and her siblings if she would divulge the sexual attack on her. Accused-appellant, being her father, exercises moral ascendancy and influence over her. Thus, her reluctance that caused the delay should not be taken against her. Neither can it be used to diminish her credibility nor undermine the charge of rape.”
ALLEGED PERPETRATOR: In child abuse cases, the perpetrator is usually someone who is known to the child. The top sexual abuse perpetrators seen in the WCPUs are the neighbor, boyfriend, acquaintance, and family members. The current location of the alleged perpetrator is important in assessing the child’s safety.

ACTS DESCRIBED: While all sexual contact with a child is inappropriate, the type of sexual contact described can indicate the likelihood of finding residual physical injuries. Many children do not have a clear concept of what “penetration” actually means. This is especially true for the prepubertal child who does not “see” the extent of the penetration and has no experience to differentiate between full vaginal penetration and attempted or partial penetration.

SUPREME COURT DECISIONS

PEOPLE V MANALILI, G.R. NO. 191253, AUGUST 28, 2013

“...The mere introduction of the male organ into the labia majora of the complainant’s vagina, consummates the crime.

...The absence of laceration and semen does not preclude the fact that rape has been committed. In the crime of rape, complete or full penetration of the complainant’s private part is not at all necessary. Neither is the rupture of the hymen essential.”

PEOPLE V TEODORO, G.R. NO. 175876, FEBRUARY 20, 2013

“Full penile penetration of the female’s genitalia is not likewise required.”
ACTS DESCRIBED

VERBAL THREATS AND OTHER STATEMENTS: Anything said to the child regarding secrecy and the consequences perceived by the child will help explain why disclosure is delayed.

PAST AND COMORBID ABUSE

The child is asked if she has experienced similar or other forms of abuse in the past. Ongoing abuse by other perpetrators is also elicited. Research has shown that it is more common for a child to experience multiple forms rather than a single type of abuse (10).
THE PHYSICAL EXAMINATION

The purpose of the medical examination is to assess the patient for acute or chronic injuries and to treat and prevent sexually transmitted infections. A head-to-toe physical examination is performed to ensure that all injuries related to abuse are documented (Appendix E). A complete physical examination will also address co-occurring healthcare needs.

It is important to have another person present during the examination, such as a nurse or a relative. The physician must tell the child what she is about to do at every step of the examination. Children should not be forced to undergo an examination. Because sexually abused children were not given choices about sexual interaction, giving them the opportunity to make choices at this point is empowering for the child.

TIMING OF THE PHYSICAL EXAMINATION

The urgency of the physical examination is primarily decided by the time interval since the last incident of abuse.

Factors to Consider in Performing an Immediate Examination:

HISTORY OF ABUSIVE INCIDENT WITHIN 72 HOURS
  • Genital trauma heals rapidly and may heal completely thus there are less chances of identifying injuries among children examined 72 hours after the incident (11).

HISTORY OF ACUTE GENITAL, ANAL OR EXTRAGENITAL TRAUMA PARTICULARLY BLEEDING OR INJURY
  • History of bleeding or pain, such as dysuria, increases the chances of identifying injuries when the child is examined.

PREGNANCY EVALUATION AND PREVENTION
  • Emergency contraception may be given to female adolescents who are seen within 72 to 120 hours of the most recent sexual contact.

DIAGNOSIS AND MANAGEMENT AND/OR PREVENTION OF SEXUALLY TRANSMITTED INFECTIONS (STIs)
  • The decision to screen for STIs among sexually abused children is influenced by several factors. When a child is seen acutely after an assault, the incubation period, which ranges from days to months for various STIs, must be considered in relation to the timing of examination.

SAFETY ISSUES
  • Alternative placement must be done if it is dangerous for the child to go home because of the perpetrator’s access to the child.

SUICIDE RISK
  • If the child is suicidal, the child must not be sent home without being seen by a psychiatrist.

Source: adapted from reference (2)
REQUESTING PARTY/COMPANION

When filling in the requesting party, insert the agency or individual referring the patient. The person accompanying the child who is of legal age may also be the requesting party. There is no need for a formal referral letter.

For example:
- The organization listed in the letter of request accompanying the patient
- If no referring agency, the individual who signed the consent for the patient (and his or her relationship to the patient)

PREVIOUS EXAMINATION

It is in the best interest of the child that she undergo only one examination conducted by a physician trained in the evaluation of child abuse. Nevertheless, a previous examination by another health care professional does not contraindicate the medical evaluation by a trained physician so that all of the child’s needs will be addressed. The physician who previously examined the child and the date of examination should be indicated.

DEFERRED EXAMINATION

The physical examination may be deferred to a more appropriate time under the following circumstances:

1. Adolescent refuses to be examined and there is no urgent indication for the examination.
2. Child/adolescent has other medical problems that need urgent medical or surgical management.
**GENERAL SURVEY**

The general survey describes the patient’s general appearance, vital signs, height, weight and level of consciousness.

**Medico-legal Certificate**

**FINDINGS**

**GENERAL PHYSICAL FINDINGS**

<table>
<thead>
<tr>
<th>Height</th>
<th>150 cm</th>
<th>Weight</th>
<th>60 kg</th>
</tr>
</thead>
</table>

**General Survey**

Ambulatory, not in respiratory distress

Note for possible signs of physical neglect, including dirty and unkempt appearance, stunting and wasting, or failure to thrive.
MENTAL STATUS

**Update Medical Exam:** CRUZ, ANA MARIA REYES 2000-08-22

<table>
<thead>
<tr>
<th>Info</th>
<th>General Survey</th>
<th>Symptoms</th>
<th>Extravagential Exam</th>
<th>Axonagential Exam</th>
<th>Laboratory Record</th>
<th>Child's Behavior</th>
<th>Findings</th>
<th>Impressions</th>
<th>Pictures</th>
</tr>
</thead>
</table>

- **Temperature:** 97.00 °F
- **Height:** 150 cm
- **Weight:** 80 kg
- **Heart rate:** 80 bpm

**Current medication:**

<table>
<thead>
<tr>
<th>SF Monarch?</th>
<th>Yes, start age:</th>
<th>Date of last period:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>11.00</td>
<td>April 25, 2014</td>
</tr>
</tbody>
</table>

**General Survey:**
- **Ambulant:**
- **Non-Ambulant:**
- **Not in Respiratory Distress:**
- **Others:**
- **Respiratory Distress:**

**General Survey Remarks:**

**Describe past hospitalization:**

- **Pertinent medical history:**
- **Urinary tract infection - June 2014, treated with unrecalled antibiotics**

**Mental status:**
- Conscious, coherent, oriented to time, place and person
- Irritable, cooperative
- The child has delayed schooling and may have learning disability.

**General Survey Findings:**

**Summary of non-abuse findings:**

---

**ORIENTATION TO TIME, PLACE AND PERSON:** Some children are obviously too young to be “oriented”; in these situations, simply describe the child’s level of awareness (e.g., awake, asleep but easily awakened, alert, etc.).

**CONSCIOUSNESS, DEMEANOR:** Describe what the child is doing while under observation (e.g., playing, crying but easily consoled by mother, sitting quietly, etc.). For older children and adolescents, note indicators of demeanor, including blank staring or a depressed appearance.

**DEVELOPMENTAL ASSESSMENT:**

- If the child has delayed or neglected schooling: “Child has delayed schooling and may have learning disability.”
- If child has obvious, moderate to severe intellectual disability: you can immediately state “[T]he child presents with intellectual disability” even without a psychometric exam performed by a psychologist.
- If the child is delayed in specific domains of development, for example language development, you can cite “[T]he child has a hard time understanding simple questions and has significant language impairment so that she cannot fully express her thoughts in words.” If the child is delayed in at least 2 domains of development, you can state that the child has Global Developmental Delay.

**MENTAL HEALTH ASSESSMENT:** Indicate if the child has suicidal thoughts/attempts, self-mutilation, intrusive thoughts (e.g. “Pictures of what happened keep popping into my head”), avoidance (e.g. “I try not to think of what happened”) or is very emotional (e.g. often feels irritable for no reason at all, feels anxious all the time).
The child’s emotional state is considered throughout the physical examination. The examining physician should ensure that the medical evaluation does not cause further trauma or stress to the child. Some children who are initially resistant to being examined will be able to complete the examination with proper guidance and reassurance.

The patient’s consciousness, orientation, demeanor, behavior and any observations made on developmental and mental health assessment may be documented under Mental Status in the Medico-legal Certificate.
Sexual abuse may present with various physical or behavioral signs and symptoms (Appendix F). While the presence of one or more of these findings are worrying, they should be interpreted with caution in the absence of a disclosure or diagnostic physical/laboratory finding.

Sexual behaviors in children vary from normal and age-appropriate to those that are developmentally-inappropriate, intrusive, coercive and abusive (Appendix G). Sexual behaviors are common manifestations but not pathognomonic of sexual abuse. Further assessment by a mental health professional may be necessary (12).
EXTRAGENITAL EXAMINATION

PHYSICAL INJURIES

Note any pertinent physical injury in this section.

Physical injuries should be properly documented in diagrams and, even better, with photographs (Appendix H). Each injury should be described as follows:

- **Number**: Note how many of the same classification of injuries are found.
- **Site**: Record the anatomical position of the wound(s).
- **Size**: The dimensions of the wound(s) should be measured in centimeters.
- **Shape**: Describe the shape of the wound(s) (e.g. linear, curved, irregular).
- **Surrounds**: Note the condition of the surrounding or the nearby tissues (e.g. bruised, swollen).
- **Color**: Note the color of the wound(s).
- **Contents**: Note the presence of any foreign material in the wound (e.g. dirt, glass).
- **Borders**: The characteristics of the edges of the wound(s) may provide a clue as to the weapon used, if any.
- **Depth**: Give an indication of the estimated depth of the wound(s).

Thus, in filling up the extragenital examination section, describe the findings but do not make any conclusion on what category these injuries might be. For instance, the following common physical injuries may be described as follows:

- **Suction mark**: reddish, ovoid discoloration measuring ___ cm. by ___ cm.
- **Bite mark**: arch like contusion, reddish area measuring ______ cm. or curvilinear array of regular abrasions measuring ______ cm.
- **Bruise**: mass of reddish or bluish or flesh-colored area measuring ___ cm by ___ cm.
## Medi-co-Legal Certificate

### Findings

#### General Physical Findings

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td>150 cm</td>
</tr>
<tr>
<td>Weight</td>
<td>60 kg</td>
</tr>
</tbody>
</table>

**General Survey**
- Ambulatory, not in respiratory distress

**Mental Status**
- Conscious, coherent, oriented to time, place and person
- Irritable, cooperative
- The child has delayed schooling and may have learning disability

**Pertinent Physical Findings/Physical Injuries**
- **NECK:** Anterior triangle: Right - Multiple purplish, circular and ovoid discolorations with an area of 6.0 x 5.0 cm. Individual lesions range in size from 1.0 x 0.5 cm to 2.5 x 1.0 cm.

### Categories and Definitions of Common Wounds or Injuries Are Given Below:

**Abrasions:** Superficial injuries to the skin caused by the application of blunt force and are produced by a combination of contact pressure and movement applied simultaneously to the skin. Careful examination of an abrasion may allow identification of the causative implement and the direction of the force applied. There are a number of different types of abrasions; these are subdivided as follows:

- Scratches (e.g. produced by fingernails or thorns); the pattern of the weapon may leave a characteristic abrasion on the skin. Certain abrasions may be in a pattern that identifies the causative object, e.g., 4 parallel scratches may indicate a human hand or an animal’s paw depending on the size and distance between the parallel marks.
- Scrapes (e.g. grazes from contact with carpet or concrete)

**Bruises:** An area of hemorrhage beneath the skin due to blunt force. Bruises are also called contusions. Bruising follows blunt trauma; the discoloration is caused by blood leaking from ruptured blood vessels. Bruises may also occur within a body cavity or within an organ. When commenting on bruises, caution must be exercised for the following reasons:

- It must be re-emphasized that the current evidence states that the age of a bruise cannot be determined with any degree of accuracy. However, this was previously thought possible and is widely taught in older textbooks.
- The apparent color of the bruise may be affected by skin pigmentation (e.g. bruising may not be readily visible on darker skin) and by different types of lighting. Furthermore, describing color inevitably involves a subjective element and more than one color may be present in the same bruise.
- The site of bruising is not necessarily the site of trauma; for instance: bruising may extend beyond the site of the impact; bruising may appear at a site distant from the impact; visible bruising may be absent despite considerable force being used.
- Patterned contusion may indicate the weapon used.

**Color is Not Reliable in Aging Bruises**

Contrary to commonly held beliefs, the exact time a bruise was inflicted cannot be determined accurately based on appearance. A systematic review of studies on aging of bruises in children by Maguire et al. in Archives of Disease in Childhood 2005 showed there are only very few studies that have been done which have limited subjects. The review also concluded that the age of bruises in children cannot be accurately determined based on color in vivo or by photographs. Different colors may appear at any time from within one hour of injury to resolution of the bruise, and so this cannot be used to accurately date the age of bruises. Further, bruises of identical age and cause on the same patient may vary in appearance and change colors at different rates. More scientific research is recommended at this time because there are no adequate studies that could give sound scientific conclusions on aging of bruises in children.
Nevertheless, some bruises bear features that may well assist in their interpretation:

**Bite Marks:** oval or circular bruises with a pale central area; there may also be some abrasion. In some instances, there may be a discernable dentition pattern that may differentiate between a bite by a child or adult. Adult bite marks have a maxillary intercanine distance of more than 2-3 cm. Human bite marks are usually superficial while animal bites cause deep punctures or lacerations.

**Fingertip Bruises.** These are caused by the forceful application of fingertips. They usually appear with as 1-2 cm oval or round shaped clusters of three to four bruises. There may also be a linear or curved abrasion from the fingernail pressing into the skin.

**Papchial Bruises.** These are pinpoint areas of hemorrhage and are caused by the rupture of very small blood vessels. This type of bruising is usually seen in the face or bulbar and palpebral conjunctiva (i.e. white part of the eye (sclera) and inner eyelids) after neck compression. They may occur in children after forceful or prolonged crying, coughing or vomiting, so inquiries must be made about these symptoms in the course of the evaluation.

**Tramline Bruises.** These are parallel linear bruises with a pale central area produced by forceful contact with a linear object (e.g. a stick or a baton). Three or four parallel marks of a size compatible with finger lengths suggest a blow with an open hand (slap). A greater number of parallel marks may suggest multiple slaps.

**Patterned (Imprint) Bruises.** These occur when a bruise takes on the specific characteristics of the weapon used (e.g. hanger). A clothing imprint may also occur when the force is delivered through the clothing and onto the skin.
SUCTION MARKS. Purplish, circular and ovoid discolorations usually found on the neck or chest.

In the Impressions box, the following statement may be used:

<table>
<thead>
<tr>
<th>IMPRESSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Findings noted on (site on the body) are consistent with (suction marks, fingertip bruises, bite marks, etc.)”</td>
</tr>
</tbody>
</table>

Patterns of bruising that are suggestive of physical child abuse include:

- Bruising in babies and young children who are not independently mobile
- Bruises that are seen away from bony prominences
- Bruises to the face, back, abdomen, arms, buttocks, ears and hands
- Multiple bruises in clusters
- Multiple bruises of uniform shape
- Bruises that carry the imprint of implement used
- Bruises indicating a ligature (wrists, ankles)

If any of these injuries are present, the following statement may be used in the Impressions box:

<table>
<thead>
<tr>
<th>IMPRESSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical evaluation is consistent with physical injuries that are inflicted by non-accidental means. Please correlate with the child’s disclosure, witness’ account and/or relevant investigation findings.</td>
</tr>
</tbody>
</table>

If patterned bruises are present, the following statement may be used in the Impressions box:

<table>
<thead>
<tr>
<th>IMPRESSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injuries sustained on the (part of the body) are consistent with the imprint of a (implement).</td>
</tr>
</tbody>
</table>
It is also important to note that if abuse is suspected, physical injuries particularly bruising must be assessed in the context of medical and social history, the child’s developmental stage, the explanation given, full clinical examination (which may include laboratory examination such as blood coagulation or bleeding parameter studies), and other relevant investigations.

Accidental bruising in children tends to occur in specific locations, particularly the front of the body and over bony prominences (Figure 7). On the other hand, abusive bruising is commonly found in the head and neck which are rare sites of accidental bruising (Figure 8). The arms and legs may also show ‘defensive bruises’ where the child tried to protect his or her body.

**Figure 7. Accidental bruising pattern**

**Figure 8. Abusive bruising pattern**

*Source: adapted from reference (13)*

**BURNS:** injuries to tissues that may be caused by heat, electricity, chemicals or radiation. The severity of injuries are influenced by the thickness of skin and blood supply to affected tissues as well as the length of contact and temperature of the source. Burns are characterized according to severity of tissue damage:

- First degree – pain, redness and swelling in the epidermis (outermost layer of skin)
- Second degree – pain, redness, swelling and blistering extending to the dermis (deeper layer of skin). Also called partial thickness burn.
- Third degree – whitened or blackened skin, may be numb, causes significant scarring. Also known as full thickness burn involving all layers of the skin and may extend to underlying fat, muscle or bone.

Among abused children, burns most commonly result from immersion in boiling water, branding or dry contact heat and cigarettes. As with bruises, the pattern of burn injuries may suggest the instrument used or the mechanism used to inflict the injuries. Children < 2 years of age who present with burns are also at risk to have fractures. It is recommended that a skeletal survey is performed among these children (38).
Patterns of burns that are suggestive of physical child abuse include:

- Scalding immersion burns: no splash marks, clear tide levels, and well-demarcated outline of the contacted surface; stocking- or glove-pattern burn

- Doughnut pattern: burns localized to the perineum buttocks with central sparing of buttocks
- Skinfold sparing
- Symmetrical distribution
- Burns consistent with the mechanism of injury, including:

Brandishing/dry contact burns showing the imprint of hot objects
**LACERATIONS:** ragged or irregular tears or splits in the skin, subcutaneous tissues or organs resulting from blunt trauma (e.g. beating with a stick), or an open wound caused by a jagged object (e.g., rock)

The main characteristics of a lacerated wound are:
- ragged, irregular or bruised margins, which may be inverted
- intact nerves, tendons and bands of tissue within the wound
- presence of foreign materials or hair in the wound

The shape of the laceration may reflect the shape of the causative implement.

**INCISED WOUNDS:** injuries produced by sharp-edged objects whose length is greater than their depth. A knife, razorblade, scalpel, sword or glass fragment may produce incised wounds. It is important to distinguish between lacerations and incised wounds (also referred to as incisions or cuts) as this may assist in identifying the type of causative weapon. Lacerations and incised wounds are compared in Table 1.

Table 1. Comparison of Incised Wounds and Lacerations

<table>
<thead>
<tr>
<th>FEATURES</th>
<th>INCISED WOUNDS</th>
<th>LACERATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borders</td>
<td>Sharply defined edges</td>
<td>Ragged irregular margins</td>
</tr>
<tr>
<td>Surrounds</td>
<td>Minimal damage</td>
<td>Bruised or abraded</td>
</tr>
<tr>
<td>Blood loss</td>
<td>Variable, often profuse</td>
<td>Variable, often relatively small amounts (except in the scalp)</td>
</tr>
<tr>
<td>Contents</td>
<td>Rarely contaminated</td>
<td>Frequently contaminated; tissue bridges often visible</td>
</tr>
</tbody>
</table>

Source: reference (14)

**STAB WOUNDS:** incised wounds whose depth is greater than their length on the skin surface. The depth of such wounds and, in particular, the degree of trauma to deeper structures, will determine the seriousness of the injury, (i.e., whether the outcome is fatal or not).

Important points to note with respect to stab wounds include:
- The dimensions of the wound may not be the dimensions of the blade.
- The depth of stab wounds are affected by a number of factors, such as:
  - the amount of force delivered
  - the robustness of protective clothing
  - the sharpness of the tip of the blade
  - tissue resistance and any movement of the victim
- The dynamics of a stabbing (unless the victim is otherwise immobilized) demand great caution when interpreting the relative positions and movements of assailant and victim.
- There may be no relationship between the external dimensions of the wound and the resultant trauma to internal structures.

When the injuries are non-specific (no obvious pattern or mechanism of injury) but may be consistent with a child’s disclosure, the following statement may be used in the Impressions box:

**IMPRESSIONS**

Findings noted on *(site on the body)* may be consistent with the child’s disclosure.

If there are no injuries found, the following statement may be used in the Impressions box:

**IMPRESSIONS**

No evident injury at the time of examination.
PREGNANCY-RELATED FINDINGS

Pregnancy is evaluated according to the following criteria:

- Date of last menstruation (LMP)
- Gravidity & Parity
- Enlarged abdomen (measure fundic height)
- Presence of fetal movement
- Presence of fetal heart tone (FHT) (record rate and location)

The age of gestation is estimated based on the following:

- Date of last menstruation (LMP)
- Fundic height
- Onset of fetal movement
- Ultrasound results

Pregnancy-related findings are documented under Pertinent Physical Findings in the Medico-Legal Certificate. Pregnancy test and other results should be recorded under the section on Laboratory Examinations.

MEDICO-LEGAL CERTIFICATE

<table>
<thead>
<tr>
<th>Pertinent Physical Findings/Physical Injuries</th>
<th>NECK: Anterior triangle: Right - Multiple purplish, circular and ovoid discolorations with an area of 6.0 x 5.0 cm. Individual lesions range in size from 1.0 x 0.5 cm to 2.5 x 1.0 cm.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ABDOMEN: Umbilical - Enlarged with fundic height of 20 cm. Fetal movements appreciated; fetal heart tones 140/minute on right lower quadrant. LMP: April 25, 2014 G1P0</td>
</tr>
</tbody>
</table>
**ANOGENITAL EXAMINATION**

### Demographic Data

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Cruz, Ana Maria R.</th>
<th>Age</th>
<th>14</th>
<th>DOB</th>
<th>08/22/2000</th>
<th>Sex</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Address</td>
<td>307 De los Santos St., Bgy. 44, Malate, Manila</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Civil Status</td>
<td>Single</td>
<td>Occupation</td>
<td>Grade 3 student</td>
<td>Nationality</td>
<td>Filipino</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requesting Party</td>
<td>Maria Leonora R. Cruz (mother)</td>
<td>Place, Time &amp; Date of Exam</td>
<td>September 12, 2014 4:20 PM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Acute Evidentiary Examination (within 72 hours of incident)**

- Date & Time of Most Recent Incident: September 10, 2014 11:00 PM
- Place of Incident: Malate, Manila

### Anogenital Exam

- **External Genitalia:** Tanner Stage: 4
  - No evident injury at the time of examination.
- **Urethra and Periurethral Area:** No evident injury at the time of examination.
- **Perihymenal Area and Fossa Navicularis:** No evident injury at the time of examination.
- **Hymen:**
  - Stage: 4
  - Estrogenized. Redundant.
  - No evident injury at the time of examination.
- **Perineum:** No evident injury at the time of examination.
- **Discharge:** Minimal, yellowish, foul-smelling
- **Internal and Speculum Exams:** No evident injury at the time of examination.
- **Anal Examination:** No evident injury at the time of examination.

### Diagnostics and Evidence Gathering

- **Forensic Evidence and Laboratory Results:**
  - Buccal swab, Body surface (neck) swab, External genitalia swab, Vaginal swab and Anal swab
  - Pregnancy Test (12-Sep-14, positive). Smear for Sperm (12-Sep-14, negative).
  - Gram Stain, Gonorrhea Culture of Vaginal Swab, VDR, Hepatitis B Serology, HIV Test (12-Sep-14, laboratory examination results pending).
FORENSIC EVIDENCE COLLECTION

Forensic evidence collection is incorporated in the medical examination and the collection of specimen proceeds based on details obtained during history-taking. Research shows that forensic evidence is found less often among sexually abused children (less than 25%) compared to adult rape victims (50%) (11). Forensic evidence collection in children is indicated less often than in adult cases for the following reasons: the child usually knows the perpetrator so there is no need to identify the perpetrator through forensic evidence, disclosures are often delayed thus there is no opportunity to collect forensic evidence while it is present, and the type of contact involved in some cases of child sexual abuse (e.g., fondling, kissing) does not involve significant exchange of biological material. Most current guidelines and protocols recommend forensic evidence collection if the sexual abuse occurred within 72 hours (1, 11, 15, 16). This follows the recommendations for the evaluation of adult rape victims and is based on the length of time that sperm can be identified in the vaginal canal after sexual contact, though Christian et al. found that swabbing a prepubertal child’s body is unnecessary after 24 hours (17).

Forensic evidence collection is indicated in all children with history of sexual abuse within the past 72 hours:

---

CHAIN OF CUSTODY

Evidence collected during examination should be stored and turned over to the evidence custodian following recommended protocol (Appendix B, No. 7).
Figure 12. Male Genital Anatomy

Figure 13. Female Genital Anatomy
THE TANNER DEVELOPMENT STAGES

Figure 14. Sexual Maturity Rating (Tanner Staging)
Source: reference (18)
TABLE 2. The Huffman Stages of Estrogen Effect on Female Genitalia

<table>
<thead>
<tr>
<th>Stage</th>
<th>Stage 1: Post Neonatal Regression</th>
<th>Stage 2: Early Childhood</th>
<th>Stage 3: Late Childhood</th>
<th>Stage 3: Premenarche</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>0-2 months</td>
<td>2 months - 7 years</td>
<td>7-11 years</td>
<td></td>
</tr>
<tr>
<td>Estrogen Effect</td>
<td>Estrogenic effect due to maternal hormones</td>
<td>Little endogenous estrogen</td>
<td>Estrogen production increases</td>
<td></td>
</tr>
<tr>
<td>Hymen</td>
<td>Thick, pink, lubricated hymenal membrane</td>
<td>Less prominent vascular pattern due to slightly thickened hymen and vestibule tissue</td>
<td>Thick hymen, superficial vessels not seen, small labia minora, clear vaginal discharge</td>
<td>Redundant hymen with thick projections, adipose tissue below skin of textured vestibule, pigmented labia minora</td>
</tr>
</tbody>
</table>

Source: adapted from reference (1)

SUPREME COURT DECISION

PEOPLE V DELIGERO, G.R. NO. 189280, APRIL 17, 2003

“Dr. Savella…adequately explained that the absence of laceration was not due to the absence of force during the intercourse, but because of the type of hymen of the subject.”

“…That there was no laceration of the hymen…does not prove that the sexual intercourse between accused-appellant and AAA was consensual.”

“It is possible for the victim’s hymen to remain intact despite repeated sexual intercourse…likewise, whether the accused’s penis fully or only partially penetrated the victim’s genitalia, it is still possible that her hymen would remain intact because it was thick and distensible or elastic.”
# Anogenital Examination

## External Genitalia

Update Medical Exam: CRUZ, ANA MARIA REYES 2000-08-22

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pubic Hair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labia Minora</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labia Majora</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monro Pubis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posterior Fourchette</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ostium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vestibule</td>
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</tr>
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</table>

## Urethral and Perihymenal Area

Update Medical Exam: CRUZ, ANA MARIA REYES 2000-08-22

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urethral Meatus</td>
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<td></td>
</tr>
<tr>
<td>Paraprostatal Area</td>
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<td></td>
</tr>
<tr>
<td>Perihymenal Area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fossa Navicularis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
EXTERNAL GENITALIA INJURIES

Acute trauma to the external genital tissues:

1. Acute lacerations or extensive bruising of labia, perihymenal tissues, penis or scrotum (if it is certain that there is no unwitnessed accidental trauma).

2. Fresh laceration of the posterior fourchette, not involving the hymen (must be differentiated from dehisced labial adhesion or failure of midline fusion, or may be caused by accidental injury).

These findings are diagnostic of trauma and are highly suggestive even in the absence of a disclosure (7).

The following statement is used in the impressions box:

<table>
<thead>
<tr>
<th>IMPRESSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anogenital findings are indicative of acute trauma to the (specify site) and is highly suggestive of sexual contact or sexual abuse (if a disclosure of one is given).</td>
</tr>
</tbody>
</table>

Note: Healed (residual) injuries, such as scar of posterior fourchette (discrete, pale, off the midline) are rare and difficult to assess unless acute injury at the same location was documented.

In the Medico-Legal Certificate, injuries to the labia majora, labia minora, mons pubis, posterior fourchette, clitoris and vestibule are documented under External Genitalia, as are injuries to the penis and scrotum. Injuries to the urethra, periurethral area, perihymenal area and fossa navicularis are documented in the corresponding portion of the Medico-legal Certificate.

MEDICO-LEGAL CERTIFICATE

DEMOGRAPHIC DATA

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Cruz, Ana Maria R.</th>
<th>Age</th>
<th>14</th>
<th>DOB</th>
<th>08/22/2000</th>
<th>Sex</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Address</td>
<td>307 De los Santos St., Bgy. 44, Malate, Manila</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Occupation</td>
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</tr>
<tr>
<td>Requesting Party</td>
<td>Maria Leonora R. Cruz (mother)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Place, Time &amp; Date of Exam</td>
<td>September 12, 2014 4:20 PM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Acute Evidentiary Examination (within 72 hours of incident)
- Non-Acute Examination

Date & Time of Most Recent Incident: September 10, 2014 11:00 PM
Place of Incident: Malate, Manila

FINDINGS

GENERAL PHYSICAL FINDINGS

<table>
<thead>
<tr>
<th>Height</th>
<th>150 cm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>60 kg</td>
</tr>
</tbody>
</table>

General Survey: Ambulatory, not in respiratory distress
Mental Status: Conscious, coherent, oriented to time, place and person
Irritable, cooperative
The child has delayed schooling and may have learning disability

Pertinent Physical Findings/Physical Injuries

Breasts Tanner Stage: 4
NECK: Anterior triangle: Right - Multiple purplish, circular and ovoid discolorations with an area of 6.0 x 5.0 cm. Individual lesions range in size from 1.0 x 0.5 cm to 2.5 x 1.0 cm.
ABDOMEN: Umbilical - Enlarged with fundic height of 20 cm.
Fetal movements appreciated; fetal heart tones 140/minute on right lower quadrant.
LMP: April 25, 2014 G1P0

ANOGENITAL EXAM

External Genitalia: Tanner Stage: 4
No evident injury at the time of examination.

Urethra and Periurethral Area: No evident injury at the time of examination.

Perihymenal Area and Fossa Navicularis: No evident injury at the time of examination.
HYMEN SHAPE AND APPEARANCE

Describe the shape of the hymen using the characteristics below. Also, describe the thickness and the degree of estrogenization of the hymen.

Shape:
- Annular / Crescentic / Cribriform / Imperforate / Septate

Thickness and Estrogenization:
- Thin / Beginning estrogenization / Estrogenized

Normal Variants, including:
- Hymenal cyst / Mound / Rolled edges / Septal remnant

No measurement of hymenal opening will be performed during the medico-legal examination. Studies have demonstrated that hymenal opening measurements in the evaluation of child sexual abuse are not useful; measurements vary with the child’s position or state of relaxation, and the techniques used to obtain measurements (19).

SUPREME COURT DECISION

PEOPLE V BARING, JR., G.R. NO. 137933, JANUARY 28, 2002

This now unacceptable method of examination was emphasized in People v. Baring, Jr. (374 SCRA 696), a case of statutory rape against a seven-year-old girl. The medico-legal report showed that the “External vaginal orifice admits tip of the examiner’s smallest finger.” The Supreme Court of the Philippines declared that, “The insertion of a finger or any foreign matter inside the hymenal opening under the pretext of determining abuse is unnecessary and inappropriate.” The Court further stressed that “the value of collecting evidence should always be weighed against the emotional cost of the procedure and examination of the child.”
Locating Hymen Injuries

Describe the injury (type, size, color & shape), as well as the location of injury, at the time of examination. When describing the location of injury on the hymen, use the “clock position reference,” a method by which the location of a structure or finding may be designated using the numerals on the face of a clock. The 12 o’clock position is always near the urethra.

Figure 15. Congenital Variants in Hymen Appearance

Figure 16: Clock position reference for location hymen injuries
FINDINGS IN THE HYMEN INDICATIVE OF TRAUMA

If a child was examined and the genital finding is any of the following listed below, the findings indicate blunt force or penetrating trauma (7). The history is critical to the final determination of abuse or accidental injury. These findings support a disclosure of sexual abuse, if one is given, and are highly suggestive of abuse even in the absence of a disclosure, unless a clear, timely, plausible description of accidental injury is provided by the child and/or caretaker. It is recommended that good quality photo images of the examination findings be obtained for review with an experienced medical provider before reaching a conclusion regarding the nature of the trauma or its significance.

1. **Laceration (tear, partial or complete) of the hymen, acute.**

   Healing time is affected by a variety of factors, including age, nutrition, individual healing capacity and the extent of the wound. Descriptions, such as those listed below, serve as guidelines only; they are not intended to be definitive measurements.

   - Fresh (presence of fresh blood, edema): injury occurred within past 24 hours or so
   - Healing (presence of granulation, no blood): injury recent, already healing; cannot be dated accurately
   - Healed: injury cannot be dated accurately

2. **Contusion (bruising) on the hymen:** Hemorrhagic area on the hymen due to extravasation of blood into a mucous membrane

3. **Hymenal transection (healed):** An area where the hymen has been torn through, to or nearly to the base, so there appears to be virtually no hymenal tissue remaining at that location, confirmed using additional examination techniques such as swab, prone knee-chest position, Foley catheter or water to float the edge of the hymen. This finding has been referred to as a “complete cleft” in sexually active adolescents and young adult women.

   Posterior transections or “complete clefts” among prepubertal girls are considered clear evidence of trauma. Among adolescent girls, hymenal transections strongly suggest previous genital penetration but its absence is not inconsistent with a history of sexual activity. Its location (posterior or lateral) is not significant in diagnosing abuse (21).

4. **Missing segment of hymenal tissue:** Area in the posterior (inferior) half of the hymen, wider than a transection, with an absence of hymenal tissue, extending to the base of the hymen, which is confirmed using additional positions/methods. The hymen is present in all newborns; an absent hymen is not a congenital finding. In the crescentic hymen, it is normally absent between the 11 and 1 o’clock positions. In the posterior rim, it is clear evidence of trauma.

With these findings, the following statement is used in the Impressions box:

**IMPRESSIONS**

Anogenital findings are indicative of blunt force or penetrating trauma.
OTHER POSSIBLE HYMEN INJURY CATEGORIES INCLUDE:

- **Abrasions** – Area of body surface denuded of skin or mucous membrane by some unusual or abnormal mechanical process

- **Petechiae** – Pinpoint, non-raised, perfectly round, purplish red spot. It can be a marker for acute injury (20)

- **Hematoma** – Mass of unclotted or clotted blood that forms in a tissue, organ, or body space as a result of a broken blood vessel

- **Cleft/Notch** – Angular or “V”-shaped indentation on the edge of the hymenal membrane and may extend to the muscular attachment of the hymen. Notches or clefts are characterized by depth (superficial or deep depending on whether it reaches downward to more than 50% of the hymen) and location (anterior, lateral, or posterior). Superficial notches are considered nonspecific findings. Deep notches (extend through more than 50% of the width of the hymen) may support a child’s clear disclosure of sexual abuse, if one is given, but should be interpreted with caution if the child gives no disclosure. These findings are seen in both abused and non-abused children and there is no expert consensus on interpretation with respect to sexual contact or trauma. It is still recommended that children with these findings be reported to authorities for further investigation (7,21,39).

THE NEED TO BE SPECIFIC AND DESCRIPTIVE ACCORDING TO ACCEPTED INTERNATIONAL STANDARDS

Whenever the hymen and hymenal tissues are described, physicians are urged to be as specific as possible concerning the character and appearance of the hymen. Physicians must avoid inaccurate and non-descriptive terms, such as “virgin”, “virgin-state”, and “intact hymen” (22). Terms used must be scientifically supported, in accordance with presently accepted international standards such as those endorsed by the American Professional Society on the Abuse of Children (APSAC) and the International Society for the Prevention of Child Abuse and Neglect (ISPCAN).
Thus, if a child has been referred for sexual abuse evaluation and has a notch or cleft in the hymen rim, at or below the 3 o’clock or 9 o’clock location and may extend nearly to the base of the hymen, use this phrase in the Impressions box:

**IMPRESSIONS**

Anogenital findings may suggest previous trauma to the hymen.

When the examination does not reveal any injury, one cannot automatically conclude that no abuse has happened. Possible explanations for not finding any injury include:

1. No abuse happened
2. Type of abuse does not usually cause injury (e.g., fondling with clothes on, oral sex)
3. Abuse with penetration happened but did not cause injury
4. Abuse happened and caused injuries but those injuries have since healed completely.

Thus, if a child discloses sexual abuse and no injury is found, or examination reveals normal variants or findings caused by other medical conditions, the following statement is used in the Impressions box:

**IMPRESSIONS**

No evident injury at the time of examination but medical evaluation cannot exclude sexual abuse.

Supreme Court Decision

**PEOPLE v FELIX ORTOA, G. R. NO. 174484, FEB. 23, 2009**

“Research in medicine even points out that negative findings are of no significance, since the hymen may not be torn despite repeated coitus.”

**PEOPLE v BONAAGUA G. R. NO. 188897, JUNE 6, 2011**

“…If the tongue, in an act of cunnilingus, touches the outer lip of the vagina, the act should also be considered as already consummating the crime of rape through sexual assault, not the crime of acts of lasciviousness.”

Certain types of molestation do not result in visible injuries (e.g., fondling, oral sex, intracranial intercourse). In cases where the child gives a spontaneous, clear, consistent, and detailed description of such abuse, use this phrase:

**IMPRESSIONS**

No evident injury at the time of examination but medical evaluation cannot exclude sexual abuse. The absence of anogenital findings are to be expected in a child who describes this type of molestation.
IT'S NORMAL TO BE NORMAL

Normal or non-specific findings in a patient do not necessarily imply that no abuse occurred. In 1994, Adams et al., conducted a study entitled “Examination findings in legally confirmed child sexual abuse: it’s normal to be normal” to determine the frequency of abnormal findings in a population of children with legal confirmation of sexual abuse (23). In their review of 213 cases with perpetrator conviction for sexual abuse, 77 percent of these girls had normal or non-specific genital examination findings. As Adams notes:

“Abnormal findings are not common in sexually abused girls... More emphasis should be placed on documenting the child’s description of the molestation, and educating prosecutors that, for children alleging abuse, “it’s normal to be normal”.

FREQUENCY OF ABNORMAL FINDINGS IN CHILD SEXUAL ABUSE

Since then, various research studies have shown that majority of sexually abused girls have normal genital examinations. Among prepubertal children examined within 72 hours, Christian, et al., in their study entitled “Forensic evidence findings in prepubertal victims of sexual assault” published in Pediatrics in 2000 found only 23% had evidence of anogenital injury and only 16% of these injuries were hymenal (17). In Heger et al.’s five-year prospective study entitled “Children referred for possible sexual abuse: Medical findings in 2384 children” published in Child Abuse and Neglect in 2002, only 4% of the children had abnormal examinations at the time of evaluation. Among those who disclosed vaginal or anal penetration, the rate of abnormal medical findings was only 5.5%. The authors concluded that history from the child is the most important diagnostic feature in coming to the conclusion that a child has been sexually abused (24).

In study by Heppenstall-Heger et al. in 2003 published in Pediatrics entitled, “Healing Patterns in Anogenital Injuries: A Longitudinal Study of Injuries Associated With Sexual Abuse, Accidental Injuries, or Genital Surgery in the Preadolescent Child” it was demonstrated that even in cases of child sexual abuse with a clinical history of pain and bleeding and in which acute injuries have been documented, only 14.6% of these injuries healed with significant anatomic changes. Thus, if a child were examined later on, majority (85.4%, if based on Heger’s study) would have normal findings on examination (25).

Moreover, the poor correlation of sexual contact or abuse and absence of genital findings on examination was proven in a 2004 study by Kellogg et al. published in Pediatrics and aptly titled Genital Anatomy in Pregnant Adolescents: “Normal” Does Not Mean “Nothing Happened.” Among pregnant adolescents examined in Kellogg et al’s study, only 2 of 36 had evidence of penetration or hymenal injury (26).

In the Philippines, a review of 153 cases of sexually abused pregnant adolescents seen in a child protection unit of a tertiary hospital from 2005-2010 showed that hymen was normal in half (52.3%) of cases of pregnant adolescents (27).

It is frequently assumed that children who are involved in long-standing sexual abuse involving increasing number of genital penetrations would have evidence of trauma. However, Anderst et al. in their study published in Pediatrics in 2009 entitled “Reports of Repetitive Penile-Genital Penetration Often Have No Definitive Evidence of Penetration” found no association between the number of reported penile-genital penetrative episodes (non-acute) and definitive genital findings of healed trauma (28).
The findings of a sexually abused child’s medical examination depends on:

1. Invasiveness of the sexual contact as determined by a combination of the following factors:
   - Amount of force
   - Stage of estrogenization of the hymen
   - Size of the penetrating object
   - Size of the child

2. Elapsed time between the last sexual contact and the examination

3. Expertise of the physician performing the examination (training, experience, knowledge of normal genitalia)

4. Equipment used by the physician (e.g., a colposcope to magnify and photograph the genitalia)

On the basis of the medical examination, the physician cannot say what object caused an anogenital injury; it can be a finger, a penis, or a foreign object. The physician also cannot say when exactly it occurred (once injury has healed), how many times it happened and who did it (unless there is DNA evidence).

An adolescent may give a partial or incomplete disclosure if she was doing something she was not supposed to be doing when she was abused (e.g., cutting class or drinking alcohol). She may also not disclose information that her parents do not approve of (e.g., having a boyfriend and being sexually active). Physicians may find healed lacerations from undisclosed previous sexual contact among adolescents being evaluated for a more recent sexual contact/abuse.

---

### MEDICO-LEGAL CERTIFICATE

**DEMOGRAPHIC DATA**

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Cruz, Ana Maria R.</th>
<th>Age</th>
<th>14</th>
<th>DOB</th>
<th>08/22/2000</th>
<th>Sex</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Address</td>
<td>307 De los Santos St., Bgy. 44, Malate, Manila</td>
<td></td>
<td></td>
<td></td>
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<td>Civil Status</td>
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<td>Grade 3 student</td>
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<td>Requesting Party</td>
<td>Maria Leonora R. Cruz (mother)</td>
<td>Place, Time &amp; Date of Exam</td>
<td>September 12, 2014</td>
<td>4:20 PM</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- ☑ Acute Evidentiary Examination (within 72 hours of incident)
- ☐ Non-Acute Examination

**Date & Time of Most Recent Incident:** September 10, 2014 11:00 PM

**Place of Incident:** Malate, Manila

### ANOGENITAL EXAM

<table>
<thead>
<tr>
<th>External Genitalia</th>
<th>Tanner Stage: 4</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Urethra and Periurethral Area</th>
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<tbody>
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<td>No evident injury at the time of examination.</td>
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<table>
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<tr>
<th>Perihymenal Area and Fossa Navicularis</th>
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</thead>
<tbody>
<tr>
<td>No evident injury at the time of examination.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Hymen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage: 4</td>
</tr>
<tr>
<td>Estrogenized. Redundant.</td>
</tr>
<tr>
<td>No evident injury at the time of examination.</td>
</tr>
</tbody>
</table>

---

**SUPREME COURT DECISION**

**PEOPLE V LORENA, G.R. 191362, OCTOBER 9, 2013**

Dr. Imperial could not be expected to establish the cause of such lacerations with particularity because he has no personal knowledge of how these hymenal lacerations were inflicted on “AAA.”

**SUPREME COURT DECISION**

**PEOPLE V DE JESUS, G.R. NO. 190622, OCTOBER 7, 2013**

…the fact that the examining doctor found healed lacerations “DOES NOT NEGATIVELY AFFECT AAA’S CREDIBILITY NOR DISPROVE HER RAPE.” The absence of fresh lacerations in Remilyn’s hymen does not prove that appellant did not rape her.
INJURIES OF THE PERINEUM

- Acute lacerations or extensive bruising of the perineum

As with acute trauma to the external genitalia, these findings are diagnostic of trauma and are highly suggestive of abuse even in the absence of a disclosure (7).

This statement may be used in the Impressions box:

**IMPRESSIONS**

Anogenital findings are indicative of acute trauma to the perineum and is highly suggestive of sexual contact or sexual abuse (if a disclosure of one is given).
VAGINAL DISCHARGE

Any discharge found should be described according to the following categories:

Amount: Minimal / Moderate / Profuse / Oozing
Odor: Odorless / Fishy / Clorox / Foul smelling
Color: Clear / Whitish / Yellowish / Greenish
Consistency: Watery / Mucoid / Pasty
Other: No blood present / Blood tinged / Bloody

Vaginal discharge has both infectious and non-infectious causes. Cultures must be done to establish the presence of a sexually transmitted infection.
If the patient is not yet an adolescent, internal and speculum examinations are not required unless the indications listed below are noted; in these instances, the internal examination should be performed under sedation or general anesthesia.

1. Increased or profuse vaginal discharge which suggests a foreign body in the vaginal canal
   • Foreign body may be removed with saline rinses in prepubertal children if the child is cooperative
2. Increased or profuse vaginal bleeding which suggests internal injury
3. External injury requiring repair

A full pelvic examination is indicated for adolescent girls who have reached puberty (16).
An anal examination is routinely performed in the medical examination of an abused child and involves external visualization with traction. Digital rectal examination is done only when indicated to avoid re-traumatizing the child. Each injury must be described, including its location.
ANAL INJURIES:

1. Perianal lacerations extending deep to the external anal sphincter (not to be confused with partial failure of midline fusion).

This finding indicates blunt force or penetrating trauma and are highly suggestive of abuse even in the absence of a disclosure (7).

The following statement is used in the Impressions box:

<table>
<thead>
<tr>
<th>IMPRESSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anogenital findings are indicative of blunt force or penetrating trauma to the anus.</td>
</tr>
</tbody>
</table>

Note: Healed (residual) injuries such as perianal scar (discrete, pale, off the midline) are rare and difficult to assess unless acute injury at the same location was previously documented (7). Perianal scar may also be due to other medical conditions such as Crohn’s Disease or from previous medical procedures).

2. Complete anal dilation with relaxation of both internal and external sphincters, in the absence of predisposing factors such as chronic constipation, anesthesia, or neuromuscular conditions.

This finding is suspicious for anal penetration (29,39).

The following statement is used in the Impressions box:

<table>
<thead>
<tr>
<th>IMPRESSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anogenital findings may suggest previous anal penetration.</td>
</tr>
</tbody>
</table>
CONGENITAL VARIANTS AND FINDINGS CAUSED BY OTHER MEDICAL CONDITIONS

EXTERNAL GENITALIA

Findings that are seen in newborns and non-abused children: Hyperpigmentation of the skin of the labia minora or perianal tissues, periurethral bands, dilatation of the urethral opening with labial traction.

Findings caused by other medical conditions: Labial adhesion, friability of the posterior fourchette or commissure.

Conditions commonly mistaken for sexual abuse: Lichen sclerosus et atrophicus, urethral prolapse, failure of midline fusion, vulvar ulcers caused by viral infections other than Herpes, vulvovaginitis caused by Group A beta hemolytic streptococci.

HYMEN

Normal Variants: Intravaginal ridges or columns, hymenal bumps or mounds, hymenal tags or septal remnants, Linea vestibularis (midline avascular area), hymenal notch/cleft in the anterior (superior) half of the hymenal rim in prepubertal girls, shallow/superficial notch or cleft in the posterior rim of hymen, external hymenal ridge, “thickened hymen” due to estrogen effect, folding, swelling from infection.

Findings caused by other medical conditions: Erythema (redness) due to irritants, infection, or dermatitis; increased vascularity (“dilatation of existing blood vessels”) of vestibule and hymen due to local irritants or normal pattern in the nonestrogenized state.

PERINEUM

Conditions commonly mistaken for sexual abuse: Failure of midline fusion, also called perineal groove.

ANUS

Normal Variants: Diastasis ani (smooth area), perianal skin tag.

Findings caused by other medical conditions: Anal fissures usually due to constipation or perianal irritation, venous congestion or venous pooling in the perianal area usually due to positioning of child or constipation.

Conditions commonly mistaken for abuse: Rectal prolapse; complete dilation of the internal and external anal sphincters, <2cm in AP diameter, revealing the pectinate line; partial dilation of the external anal sphincter, with the internal sphincter closed, causing the appearance of deep folds in the perianal skin, Group A beta hemolytic streptococci of the perianal tissues.

Source: reference (7)

With these findings, the following statement is used in the Impressions box:

**IMPRESSIONS**

No evident injury at the time of examination.

However, if the child makes a clear disclosure of sexual abuse, the following impression can be made:

**IMPRESSIONS**

No evident injury at the time of examination but medical evaluation cannot exclude sexual abuse.

In these cases, the physician can attach a summary of the medical history.
LABORATORY EXAMINATIONS

SMEAR FOR SPERM

Identification of spermatozoa by microscopy is diagnostic of sexual contact. While motile sperm is the best indicator of recent ejaculation, sperm motility decreases rapidly (Table 3).

Table 3. Length of time spermatozoa is available after ejaculation by sample location

<table>
<thead>
<tr>
<th>SPECIMEN</th>
<th>VAGINA</th>
<th>CERVIX</th>
<th>RECTUM</th>
<th>MOUTH</th>
<th>SKIN</th>
<th>DRIED SKIN CLOTHING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motile Sperm</td>
<td>3-24 h</td>
<td>2-7 d</td>
<td>Several Hours</td>
<td>(n.a.)?</td>
<td>(n.a.)?</td>
<td>(n.a.)?</td>
</tr>
<tr>
<td>Non-motile Sperm (max 72+ h)</td>
<td>12-24 h</td>
<td>1+ weeks</td>
<td>2-3 days</td>
<td>? h</td>
<td>24+ h</td>
<td>12+ mo. if dry</td>
</tr>
<tr>
<td>Acid Phosphatase (max 72 h)</td>
<td>18-36 h</td>
<td>?</td>
<td>?</td>
<td>?</td>
<td>24+ h</td>
<td>Years</td>
</tr>
<tr>
<td>P-30 Antigen</td>
<td>&lt; 48</td>
<td>?</td>
<td>?</td>
<td>?</td>
<td>28+ h</td>
<td>?</td>
</tr>
</tbody>
</table>

Source: reference (1)
Cervical mucus may extend motility for a number of days. Among prepubertal girls, the lack of cervical mucus decreases sperm survival. Motile sperm is less likely to be found in the rectum. It survives shorter times in the mouth because of the action of salivary enzymes and on the skin because of drying. Non-motile sperm may last up to 72 hours in the vagina and up to one week in the cervical mucus. It is stable in dried secretions and can be detected in clothing stains or on bedding for many months. Acid phosphatase is an enzyme secreted by the prostate gland and found in seminal products. It is less sensitive and specific than sperm but persists longer after sexual assault. P-30 antigen is found in greatest concentration in seminal fluid.

The following findings are diagnostic of sexual contact:
1. Finding sperm or seminal fluid in or on a child’s body
2. Pregnancy

With these findings, the following statement is used in the Impressions box:

<table>
<thead>
<tr>
<th>IMPRESSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical evaluation is diagnostic of sexual contact or sexual abuse.</td>
</tr>
</tbody>
</table>

Note that the presence of spermatozoa is not required to prove that sexual abuse occurred:

**SUPREME COURT DECISION**

**PEOPLE V MANALILI, G.R. NO. 191253, AUGUST 28, 2013**

“...The absence of spermatozoa in the vagina could be due to a number of factors, such as the vertical drainage of the semen from the vagina, the acidity of the vagina or the washing of the vagina immediately after sexual intercourse”.

“The presence or absence of spermatozoa is immaterial because the presence of spermatozoa is not an element of rape”.

**SEXUALLY TRANSMITTED INFECTIONS (STIs)**

The collection of vaginal specimen for testing can be painful and traumatic for the prepubertal child. Testing for STIs is strongly indicated in the following situations (30):

1. The child has or has had symptoms or signs of an STD or of an infection that can be sexually transmitted, even in the absence of suspicion of sexual abuse. Among the signs that are associated with a confirmed STD diagnosis are vaginal discharge or pain, genital itching or odor, urinary symptoms, and genital ulcers or lesions.
2. A suspected assailant is known to have an STD or to be at high risk for STDs (e.g., has multiple sex partners or a history of STDs).
3. A sibling or another child or adult in the household or child’s immediate environment has an STD.
4. The patient or parent requests testing.
5. Evidence of genital, oral, or anal penetration or ejaculation is present.

Only tests with the highest specificities should be used because of the legal and psychosocial consequences of false-positive results. The timing of examination for an STI depends on the history of abuse. If the initial exposure is recent, there may not be sufficient concentrations of organisms present to produce positive test results. A follow-up examination two weeks after the most recent episode of sexual abuse may be done for collection of additional specimen. Another follow-up examination 12 weeks after the most recent episode of sexual exposure allows adequate time for antibodies to develop so that sera may be collected. A single examination is sufficient if a substantial amount of time has elapsed between the last exposure and medical evaluation. Table 4 presents the recommended timing of examinations for STIs.
Table 4. Recommended Timing of Examinations for Sexually Transmitted Infections

<table>
<thead>
<tr>
<th>INITIAL AND TWO-WEEK FOLLOW-UP EXAMINATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Visual inspection of the genital, perianal, and oral areas for genital discharge, bleeding, odor, irritation, warts and ulcerative lesions.</strong></td>
</tr>
<tr>
<td><strong>Specimen collection for N. gonorrhoeae</strong></td>
</tr>
<tr>
<td>Data on the use of Nucleic Acid Amplification Tests (NAATs) for detection of N. gonorrhoeae in children are limited. Consultation with an expert is necessary before use of NAATs for this indication in children to minimize the possibility of positive reactions with nongonococcal Neisseria species and other commensals. NAATs can be used as alternative to culture with vaginal specimens or urine specimens from girls. Culture remains the preferred method for urethral specimens from boys and extragenital specimens (pharynx and rectum) in boys and girls.</td>
</tr>
<tr>
<td>Gram stains are inadequate to evaluate prepubertal children for gonorrhea and should not be used to diagnose or rule out gonorrhea.</td>
</tr>
<tr>
<td>Specimen collection for culture for N. gonorrhoeae includes the pharynx and rectum in boys and girls, the vagina in girls, and the urethra in boys. Cervical specimens are not recommended for prepubertal girls. For boys with a urethral discharge, a meatal specimen discharge is an adequate substitute for an intra-urethral swab specimen.</td>
</tr>
<tr>
<td><strong>Specimen collection for C. trachomatis</strong></td>
</tr>
<tr>
<td>Cultures for C. trachomatis can be collected from the rectum in both boys and girls and from the vagina in girls.</td>
</tr>
<tr>
<td>NAATs can be used for detection of C. trachomatis in vaginal specimens or urine from girls. No data exist on the use of NAATs in boys and extragenital specimens (rectum) in boys and girls. Culture remains the preferred method for extragenital sites in these circumstances.</td>
</tr>
<tr>
<td><strong>Specimen collection for T. vaginalis infection</strong></td>
</tr>
<tr>
<td>Culture and wet mount of a vaginal swab specimen.</td>
</tr>
<tr>
<td><strong>Testing for antibodies to T. pallidum, HIV and HBV</strong></td>
</tr>
<tr>
<td>Collection of serum sample for immediate evaluation and to be used as a baseline for comparison with follow-up serologic tests.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FOLLOW-UP EXAMINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If there is concern for transmission of syphilis, HIV or Hepatitis B but baselines tests were negative</strong></td>
</tr>
<tr>
<td>Follow-up examination six weeks, three months and six months after the last sexual exposure should be done.</td>
</tr>
</tbody>
</table>

Adapted from references (30, 31)

When a child has been diagnosed with an STI, testing for other STIs should be done.

The presence of the following infections confirms mucosal contact with infected and infective bodily secretions and it can be concluded that the contact was most likely sexual in nature (7):

1. Positive confirmed culture for gonorrhea, from genital area, anus, or throat, in a child outside the neonatal period
2. Confirmed diagnosis of syphilis, if perinatal transmission is ruled out
3. *Trichomonas vaginalis* infection in a child older than 1 year of age, with organisms identified by culture or, in vaginal secretions, by wet mount examination
4. Positive culture from genital or anal tissues for chlamydia, if child is older than 3 years at time of diagnosis and if specimen was tested using cell culture or comparable method approved by the Centers for Disease Control
5. Positive serology for HIV if perinatal transmission, transmission from blood products, and needle contamination have been ruled out.

With these findings, the following statement is used in the Impressions box:
Not all sexually transmitted infections present beyond the natal period confirm sexual abuse. Some sexually transmissible infections may also be acquired through household exposure or caretaking activities (e.g. washing, bathing). The presence of the following infections support a child’s clear disclosure of sexual abuse, if one is given (7,39). Further investigation must be done if the child gives no disclosure:

1. Genital or anal Condyloma accuminata in child, in the absence of other indicators of abuse. Lesions appearing for the first time in a child older than 5 years may be more suspicious for sexual transmission.

2. Herpes Type 1 or 2 in the genital or anal area in a child with no other indicators of sexual abuse. Isolated genital lesions caused by HSV-2 in a child older than 4–5 years may be more suspicious for sexual transmission.

With these findings, the following statement is used in the Impressions box:

<table>
<thead>
<tr>
<th>IMPRESSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>The presence of (cite infection) confirms mucosal contact with infected and infective bodily secretions, most likely due to sexual contact or sexual abuse.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IMPRESSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anogenital findings may suggest sexual contact or sexual abuse.</td>
</tr>
</tbody>
</table>
When physical abuse is suspected, laboratory tests and imaging procedures may be conducted to screen for other injuries or underlying medical causes of injuries (32). The appropriate imaging procedure is based on the age of the child, the presence of neurologic, thoracic or abdominopelvic injuries and whether there is a discrepancy between a child’s injuries and the history provided (Appendix J).

A radiographic skeletal survey (SS) is always indicated in children younger than 2 years old with fractures suspicious for child abuse. A single whole body radiograph or baby gram is not acceptable. The standard skeletal survey imaging protocol is presented in Table 5.

### Table 5. The Complete Skeletal Survey

<table>
<thead>
<tr>
<th>Appendixular skeleton</th>
<th>Humeri (AP); Forearms (AP); Hands (PA); Femurs (AP); Lower legs (AP); Feet (AP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axial skeleton</td>
<td>Thorax (AP, lateral, right and left obliques), to include ribs, thoracic and upper lumbar spine; Pelvis (AP), to include the mid lumbar spine; Lumbosacral spine (lateral); Cervical spine (lateral); Skull (frontal and lateral)</td>
</tr>
</tbody>
</table>

Source: reference (33)

Explicit consensus guidelines for performing the skeletal survey among children less 2 years old who do not have clear and verifiable mechanism of accidental trauma or history of accidental injury have also been developed (34).

In children 2-5 years of age, a skeletal survey is recommended if a child has unexplained head or abdominal injuries that are suspicious for abuse. In older children, it is appropriate to tailor the radiograph to the area(s) of injury. A repeat skeletal survey performed after 2 weeks can provide additional information on the presence and age of fractures. All images are included in the follow-up study except for skull radiographs since new findings would not be expected in the images. A bone scan is indicated when the skeletal survey is negative yet clinical suspicion remains high.

CT scan of the head without intravenous contrast should immediately be performed in children with a history of head trauma, those with skull fractures or clinical signs and symptoms of an intracranial injury and those who are at “high risk” (e.g., with rib fractures, multiple fractures, facial injury or less than 6 months of age) (35). Bone window setting images can reveal skull and facial fractures. The medical work-up of abusive head trauma also includes coagulation studies and screening for blunt abdominal trauma (Appendix K). CT scan of the chest, abdomen and pelvis with contrast are indicated if there are signs and symptoms of abuse or if abnormal findings are seen on conventional radiography or laboratory procedures. Tests for hematologic disorders are indicated when bleeding disorder is a concern because of clinical presentation or family history. Screening for Disseminated Intravascular Coagulation is recommended when there is an intracranial injury as this leads to an altered coagulation state.
TOXICOLOGY SCREEN

Toxicology tests are done to determine the possible use, deliberately or unknowingly, of drugs to alter the child’s consciousness (Appendix L).

OTHER PROCEDURES

AUTOPSY

An autopsy is indicated in cases of suspicious and/or abuse related deaths (Appendix B, No. 6). The Department of Justice (DOJ) released Circular No. 55 on September 11, 2002 which authorizes regional state, provincial, and city prosecutors and their assistants to order the conduct of autopsy of a child who may have died under suspicious or abuse-related circumstances. Circular No. 87 approved the “Order of Autopsy” to implement DOJ Circular No. 55 (Appendix M, M-1, M-2).

SUSPICIOUS CHILD INJURIES AND DEATH INVESTIGATION

Suspected non-accidental injuries and deaths due to abuse or neglect require a multidisciplinary response and investigation (Appendix N).
Use the Impressions Box of the WCPMIS and the Medico-Legal Certificate to present an overall conclusion of findings, as well as your assessment of the compatibility of your findings with the allegations of abuse. When formulating an impression, consider all available information:

1. Medical history
2. Behavior changes
3. Physical findings
4. Pregnancy
5. STDs
6. Forensic evidence (e.g., presence of sperm, results of DNA studies)

All of this information may not be available at the time of examination. In fact in many situations, it is only the medical history that that indicates the abuse.

It is quite common for a medical certificate to be issued immediately after the patient is examined, since a provisional medical certificate is often required for inquest purposes even before the results of the diagnostic and forensic tests are available. As it is also a recommended practice to submit the colposcopic pictures for peer review (Appendix O), the following statement may be used in the medical certificate after the examining physician records the impression:

“This initial report is issued exclusively for inquest of said case pending the release of the Official Medico-Legal Report on the physical examination conducted”.

Further, there may be situations in which the initial examining physician has little knowledge or experience in the evaluation of cases of suspected child abuse. In such circumstances, the following text or a similar variation may be used:

“The interpretation of the evaluation and physical findings is deferred for later review with expert consultation.”
IMMEDIATE INTERVENTION AND PLANS

MEDICAL INTERVENTION

ADVICE ON WORRIES AND CONCERNS

The child may have worries about pregnancy while parents may be concerned about “virginity” or damage to their child. Asking about any fears or anxieties and addressing these helps make the experience of the medical evaluation therapeutic for the parent and child.

ANTIBIOTICS

Presumptive treatment for sexually abused children is not routinely recommended since the incidence of STIs in children who were abused is low and because prepubertal girls are at lower risk for ascending infections compared to adolescents and adult women. Presumptive treatment might be considered when the parent/guardian is concerned about the possibility of infection and if follow-up of the child cannot be ensured. Antibiotics are given after all the necessary specimens have been collected.

Sexual abuse is the most common cause of gonococcal infection among pre-adolescent girls with vaginitis as the most common presentation. Anorectal and pharyngeal gonococcal infections are also common among sexually abused children but are frequently asymptomatic.

Table 6 presents the recommended treatment regimen for children who have uncomplicated gonococcal infections of the cervix, urethra, and rectum.
### Table 6. Recommended treatment regimen for children who have uncomplicated gonococcal infections of the cervix, urethra, and rectum

| Recommended regimen for children ≤45 kg who have uncomplicated Gonococcal Vulvovaginitis, Cervicitis, Urethritis, Pharyngitis, or Proctitis | Ceftriaxone 125 mg IM in a single dose *Follow-up cultures are unnecessary if ceftriaxone is used. Only parenteral cephalosporins (i.e., ceftriaxone) are recommended for use in children. No data are available regarding the use of oral cefixime to treat gonococcal infections in children. | Azithromycin 1g orally in a single dose or doxycycline 100 mg orally twice daily for 7 days *Patients treated for gonococcal infection are also treated routinely with a regimen that is effective against uncomplicated genital Chlamydia trachomatis infection because of frequent co-infection. |
| Recommended treatment regimen for children >45 kg who have uncomplicated Gonococcal infections of the cervix, urethra, and rectum | Ceftriaxone 250 mg IM in a single dose | Source: adapted from reference (29) |

### EMERGENCY CONTRACEPTION

Emergency contraception is recommended for female child sexual abuse victims who have reached menarche and who are seen within 72 to 120 hours of the incident. Emergency contraception should be started as early as possible within 72 hours up to 120 hours after the incident regardless of menstrual history. Baseline urine pregnancy test should be performed because the patient could be pregnant from previous sexual activity but it is not a prerequisite to the use of emergency contraception. Table 7 presents hormonal emergency contraception regimens.

### Table 7. Hormonal Emergency Contraception Regimens

<table>
<thead>
<tr>
<th>Recommended regimen</th>
<th>Levonorgestrel-only regimen</th>
<th>Alternative regimen</th>
<th>Combination Oral Contraceptive (OC) regimen or “Yuzpe method”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommended regimen</td>
<td>One dose of levonorgestrel 1.5 mg taken within 120 hours. Levonorgestrel can also be taken in two doses (0.75 mg each; 12 hours apart).</td>
<td>Alternative regimen</td>
<td>Two doses taken 12 hours apart. Each dose to contain at least 100ug of ethinyl estradiol and a minimum of 0.50mg of levonorgestrel (pills containing norgestrel require doubling the dose of progestin).</td>
</tr>
</tbody>
</table>

Source: reference (2)

### REFERRAL FOR MENTAL HEALTH EVALUATION

The most common childhood mental health outcomes associated with abuse are attachment disorders, behavior disorders (e.g., externalizing behaviors, anger and aggressive behavior, and antisocial behavior), post-traumatic stress, and mood disorders (e.g., depression, anxiety, withdrawn behavior). The reported incidence rates of PTSD in children who experienced sexual abuse have been found to be as high as 90% and as high as 50% for children with a history of physical abuse. These symptoms continue to be evident in many children for a significant time after the victimization experience indicating that the effects of abuse on childhood mental health may be long-lasting (36).
SOCIAL WORK INTERVENTION

POSSIBILITY OF RECANTING

The child is asked how she feels and what she wants to happen now after having disclosed. The child may express fears and anxieties about the consequences of disclosing that may indicate the possibility of withdrawing her statement. The physician and social worker should assess whether the child has Child Sexual Abuse Accommodation Syndrome (Appendix P).

IMMEDIATE SAFETY ASSESSMENT

Safety assessment refers to the application of a method to identify the presence of threats to a child’s safety within the family or home (37). It determines whether safety and protective interventions are required in any given situation. The goal of safety assessment is to arrive at a conclusion on whether a child is safe or not safe in the home and to come up with a safety plan to protect the child if she is not safe.

A child is considered safe when there is no threat of danger to a child within the family/home or when the protective capacities within the home can manage threats of danger (Appendix Q).
I hereby request a medical examination of ________________________, ________ years old, for evidence of sexual and/or physical abuse and treatment for injuries. I understand that collection of evidence may include photographing injuries and these photographs may include the genital area. All such photographs are part of the patient’s confidential medical record. I further understand that hospitals and physicians are required by law to notify child protective agencies (e.g., DSWD) about the incident.

Hinihiling kong masiyasat at mabigyan ng karampatang lunas si ________________________, ________ gulang, ng isang doktor upang matugunan ang anumang hinala hinggil sa anumang anyo ng abuso. Batid ko na maaaring sa pangangalap ng katibayan ay may pangangailangang kunan ng mga larawan ang ilang bahagi ng katawan tulad ng “genitalia” o maseselang bahagi. Ang lahat ng larawan ay mananatiling bahagi ng mga dokumentong itinuturing na kompidensyal (confidential). Batid ko rin na tungkulin ng mga pagamutan/ospital at/o dalubhasa/doktor na ipagbigay-alam sa mga ahensya para sa pangangalaga ng mga bata, tulad ng DSWD, ang pangyayari.

Child’s name (pangalan ng bata)

_____________________________________________________

Printed name of guardian (pangalan ng tagapag-alaga)

_____________________________________________________

Signature of guardian (lagda ng tagapag-alaga)

_____________________________________________________

Relation to child (kaugnayan sa bata)

_____________________________________________________

Others accompanying child to CPU (iba pang kasama)

_____________________________________________________

Date (petsa) ______ / ____ / ____ Time (oras) __________

Source: Philippine General Hospital-Child Protection Unit Consent Form (PGH Form No. Q-660001)
APPENDIX B

MEDICAL EVALUATION/MEDICO-LEGAL EXAMINATION (CSPC PROTOCOL)

In all cases, the child shall be immediately referred to a WCPU or hospital for medical evaluation and/or medico-legal examination. The following guidelines shall be observed:

1. The examination must be conducted by a WCPU trained child protection specialist. In the absence of a WCPU in the area, the medico-legal officer or the city or municipal health officer shall conduct the examination.

2. Before the conduct of the examination, a consent form must be signed by the child and/or the accompanying parent, legal guardian, or relative. Attached is sample consent form.

3. In the absence of a parent, legal guardian, or relative, the required consent form shall be signed by a licensed LSWDO social worker. In the absence of a licensed LSWDO social worker, the consent form shall be signed by DSWD, thru its SWAD team member or SWO II in the province.

4. Properly and accurately document the child’s age, physical condition including any disability, injuries and other conditions, signs of abuse, and other medical impressions.

5. Immediately release the medico-legal examination to the investigating Law Enforcement Agency (LEA). If several work-ups are necessary and the medico-legal report cannot be issued right away, the examining doctor shall issue a written certification to the effect that the child is still undergoing several laboratory tests and the medico-legal report will be released as soon as it is available.

6. In case of a child’s suspicious and/or abuse-related death, immediately inform the LEA and the LSWDO. Mandatory autopsy must be conducted upon the verbal request of the child’s parents, written request by the LEA, or order of a competent court, mayor, or provincial/city prosecutor.

7. The concerned LEA shall designate an evidence custodian who shall properly store evidence taken during the examination, including colposcopic pictures and a rape kit. The rape kit and medical evidence shall be sealed, dated, and signed by the examining physician before the turn over to LEA. The transfer of evidence shall be properly logged and documented by the evidence custodian to show chain of custody; facilitate tracking; and protect the integrity and admissibility of evidence.

8. If the child needs other specialized medical care and management, the examining physician shall refer the child to other specialists (e.g., surgery, orthopedics, psychiatry).

APPENDIX C

LANGUAGE DEVELOPMENT: IMPLICATIONS IN INTERVIEWING CHILDREN

Preschoolers (2-5 years)
- Unable to give accurate information as to time, date, frequency or duration of events, distance, size, height, weight
- Statements tied to behavioral routines (i.e., bedtime, bathing)
- Concept of “before” or “after” are inconsistent
- Verbal and cognitive abilities may not be consistent
- Verbal account may be brief because of short attention span rather than an inability to recall events
- Can freely recall one or two facts without prompting
- Cannot compare the characteristic of one person with another (i.e., taller, thinner)
- Do not assume they understood a question; often they think they understand the question
- May appear inconsistent because describes different details of the same incident when asked at different times
- Dependent on adults to ask the right questions
- Literal interpretation of verbal communication
- Story may contain what appear to be imagined elements because of lack of words or experience to describe the abuse
- Cannot reliably identify people from photos if they do not know these people well
- They assume adults already know everything about them
- Clues come from behavior
- Unlikely to have learned adult sexual behavior except from direct experience
- Child’s report only one part of the puzzle

School-age (6-10 years)
- Begin to develop sense of time but still have difficulty using units of time correctly
- Describe time frame through the use of identifying markers (i.e., grade in school, house they lived in at that time).
- Can freely recall 6 facts without prompting
- Better able to describe location and the context of the abuse
- Feel responsible for external events
- Know which behavior is acceptable or unacceptable
- Describe the offender’s method (i.e., establishing and maintaining secrecy and control over the child)
- Still thinks in concrete terms
- Still dependent on the question to frame the narrative report
- Question about being touched will not elicit description of being forced to touch the offender
- Question about what happened to her will not lead to reports of other children present

Young teens (11-13 years)
- Can tell story sequentially
- Usually know the behavior is wrong
- Understands possible consequences to offender, family and self
- May tell friend then feel guilty about participation and previous silence
- May deny everything happened and acts as if everything is fine

Adolescence (13-17 years)
- Greater independence and high level of testing behavior
- Teen’s efforts to deal with the abuse can lead to truancy, drug abuse, increase in sexual behavior, lying

APPENDIX D

ALGORITHM OF THE DUTCH SCENARIO MODEL INTERVIEW

INTRODUCTION
- We are here at the Women and Children’s Desk of NBI/Police Station number _______.
- My name is _________, I am a ________, I won’t hurt you or put you in jail. I’m just here to ask questions and listen to you.
- I talk to a lot of children just like you.
- Don’t worry, I won’t get mad or get surprised by whatever you tell me.
- We are here just to talk about what really happened to you.

OFFER CHOICE OF COLORING OR PLAYING
Would you like to play, color or would you rather that we talk about why you are here?

DEVELOPMENTAL SCREENING & RAPPORT BUILDING
(Use Developmental Questions*)
- What is your name?
- Do your parents call you by another name?
- How old are you?
- Where do you live?

DEVELOPMENTAL SCREENING & RAPPORT BUILDING (CONTINUED)
- Colors
- Numbers/Counting
- Alphabet
- Writing name
- Concept of ‘put it in/take it out’
- Concept of inside/outside
- Truth vs Lie, importance of telling the truth
- Child’s memory of event

CHILD CHOOSES TO PLAY OR COLOR:
“Ok, we’ll chat/play/color for three minutes. After that time, we’ll start talking about why you are really here.”

CHILD CHOOSES TO TALK AT ONCE
OPENING QUESTIONS (CHOOSE ANY):
- Do you know why you are here?
- Why are you here?
- Why were you brought here?
- Earlier, you wanted to tell me something, what is it about?

CHILD DOES NOT KNOW OR NO RESPONSE
ADDITIONAL OPENING QUESTIONS
(Ask the following questions in order)
1. Who accompanied you here? What did he/she tell you about your visit here?
2. Do you really not know, are you just ashamed to talk about it, you’re not ready to talk, or is there another reason?
3. Is this about something nice or not so nice?
4. Is this about you or is it about another person?

STILL NO RESPONSE
STILL NO RESPONSE: USE ANATOMICAL DRAWINGS
STILL NO RESPONSE: GO TO Scenario C
STILL NO RESPONSE: Closure

CLOSING INTERVIEW
1. Do you want to ask me anything?
2. Did I forget to ask you anything else?
3. Thank you, (child’s name) for talking to me about you.
4. Would you like to play some more or help me clean up before we go?

STILL NO RESPONSE
STILL NO RESPONSE: USE ANATOMICAL DRAWINGS
STILL NO RESPONSE: GO TO Scenario C
STILL NO RESPONSE: Closure

Developmental Questions
If child is not yet in school if child is of school age
(Less than 7 y/o)* (7 y/o and above)*
- Colors
- Schooling
- Numbers/Counting
(what grade?)
- Alphabet
- What time in school?
- Writing name
- How long to get there?
- Concept of ‘put it in/take it out’
- Activities after school/hobbies?
- Concept of inside/outside
- What day is today?
- Truth vs Lie, importance of telling the truth
- Names? Ages?
- Child’s memory of event
- Address?

SCENARIO A: Child talks freely at once
SCENARIO B-1: Using environment or relationships as memory aids
SCENARIO B-2: Using anatomical drawings as memory aids
SCENARIO C: Bringing in information
Interview Scenario Techniques

SCENARIO A: CHILD TALKS FREELY AT ONCE

A child who is willing to talk about the abuse incident right away can be interviewed using Scenario A.

1. Free Recall

If a child starts talking right away, she is encouraged to tell the story in her own words. This is “free recall”, which is the most reliable and least influenced by the interviewer. The following techniques can be used in eliciting information to encourage the child to continue to disclose.

   a. Keeping quiet and not interrupting the child’s narrative
   b. Uh-huh, And then…?
   c. Repeating what the child/ witness just said
   d. Nodding your head

2. Continuation instructions prior to questioning

   a. “I need to ask some more questions because I wasn’t there when it happened. Please tell me what you remember. There is no right or wrong answer.”
   b. “You can tell me to repeat the question or tell me if you don’t understand the question.”
   c. “I may repeat certain questions because I didn’t understand the first time you answered. It doesn’t mean you gave the wrong answer.”

3. Questioning (Ask open-ended questions first before specific questions.)

   a. Open Q’s: Ask about ACTS before CIRCUMSTANCES
      • “What happened.”
      • “How did it happen”
      • “When did it happen?”
      • “Where did it happen? Where were you when this happened?”
      • “Who did this to you? Was anybody else there when it happened? Who else was there?
      • Threats (“Did he tell you anything about telling other people?”)
      • Other perpetrators (“Did anybody else do the same thing to you?)
      • Other victims (“Do you know if he did this to other children?)
      • Disclosure (“Who did you first tell about what happened to you?)
      • Witnesses (“Did anybody see him do this to you?)

   b. Specific Open Q’s (Follow up questions depending on the child’s answers to your open-ended questions.)
      • “What do you mean when you said you were raped?”
      • “Which room in your house did it exactly happen?”
      • “Which part of our body did he touch?”

   c. Multiple Choice Q’s (A technique that can be used in follow-up questions to children who need to be encouraged to talk.)
      • Minimum of 3 choices, followed by “something/ someone/ somewhere else?”
      • Right choice should NOT be the first or the last choice.
      • Example: “When did this happen: was it in the morning, evening, noon or was it another time”?
      • Example: “Where did it happen: in the kitchen, the bedroom, the living room or was it another room?”

   d. Closed Q’s any question answerable by “yes” or “no”
4. Checking questions (To further validate the child’s answers.)
   a. “How did you know?”
   b. “How did you see it?”
   c. “How did you know it was him?”

5. Showing (Technique to be used for young children who may not have the vocabulary to describe what happened)
   a. Ask permission to demonstrate and to use dolls
   b. “Can you show me how he __________?”

6. Important Points to Observe:
   a. Child’s emotional condition when describing what happened (e.g. crying, upset, calm, excited, traumatized)
   b. Spontaneity of description of abusive act

7. Give instructions before summarizing:
   a. “I’ll repeat what you told me.”
   b. “Tell me if this is correct.”
   c. “If what I say is wrong, please tell me, ok?”

8. Summarizing: 3-5 pieces of information at a time and following it with the question “Is that correct?”
   (At the end; give child/witness time to correct you.)

**SCENARIO B-1: USING ENVIRONMENT OR RELATIONSHIPS AS MEMORY AIDS**

If the child does not disclose the abusive incident right away, the interviewer may ask questions about the child’s environment. If the child mentions the suspect, the interviewer may then ask the child’s relationship with this person.

1. Ask about living environment (General information, neutral questions)
   - “Who lives with you in that house?”
   - “Who are your playmates?”
   - “Who is your neighbor?” Etc…

2. Ask about relationships (General information, neutral, rapport-building questions)
   - “What do you do when you’re with ________?”
   - “What do you like about ________?”
   - “What don’t you like about ________?”
   - “What don’t you want to do when you’re with ________?”
   - “Who do you love? Or Do you love _________? Why? Why not?”
SCENARIO B-2: USE OF ANATOMICAL DRAWINGS AS MEMORY AIDS

If the child does not disclose after using the techniques in Scenario B-1, the interviewer may use sketches of a naked boy and a naked girl. The drawings should be introduced to the child. The child may be asked “What are these?”. If the child answers “boy” or “girl”, the child is asked how she can tell the difference.

1. “What can you see here?”
2. “How do you know this is a girl/boy?”
3. Name parts (head to foot, front and back). (“What do you call this part?”)
4. Name 2 functions of each body part (“What is this body part for?”)

For emotionally charged body parts:

5. “Have you seen this (body part)?”
6. “Whose?”
7. “Did anything happen to you (body part)? What did you feel? Who did it?”

SCENARIO C: BRINGING IN INFORMATION

If SCENARIO A AND SCENARIO B did not elicit any information from the child, the interviewer then switches to SCENARIO C where information form the police blotter or prior disclosure to another person are brought up.

1. Excuse yourself from the room. (Please excuse me, I’ll just go to the next room.”)
2. Leave child with something to do. (“You may continue coloring or playing until I get back.”) Praise her when you come back.
3. “I forgot to ask you something. The people in the next room said you told ________ (mommy/teacher etc.) something? Is that correct? What did you tell ________ (mommy/teacher/etc.)?
4. (“Mommy/teacher/etc.) ____________, said, something happened at ___________ (place). Is that correct? What happened there?”
5. NEVER MENTION SUSPECT’S NAME AND ACT! This must come from the child.

The examination should proceed affording as much dignity and privacy as possible. Limit exposure of the body to the area that is being examined (e.g., when observing the breast, only expose that particular area, draping the rest of the body to allow the child privacy).

## APPENDIX E

### THE “TOP-TO-TOE” PHYSICAL EXAMINATION

<table>
<thead>
<tr>
<th>STEP</th>
<th>OBSERVATIONS</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Note the child’s general appearance, demeanor, and developmental stage.</td>
<td>Take vital signs, height, weight, and head circumference when appropriate.</td>
</tr>
<tr>
<td>Step 2</td>
<td>Inspect the head and scalp. Observe for areas of missing hair, and evidence of bruising/petechiae on the scalp.</td>
<td>Palpate the scalp for areas of tenderness. Gentle palpation of the scalp may reveal tenderness and swelling, suggestive of hematoma. Hair loss due to hair pulling during the assault may cause loose hair to be collected in the gloved hands of the examiner or petechiae at the surface of the scalp; gentle palpation of jaw margins and orbital margins may reveal tenderness indicating bruising not yet visible.</td>
</tr>
<tr>
<td>Step 3</td>
<td>Inspect the eyes; observe for areas of bruising around the eyes (this may be subtle), and look for the presence of conjunctival petechiae or hemorrhage. Inspect all surfaces of the neck for injury.</td>
<td>Palpate the neck for subcutaneous emphysema. Any of these signs may indicate a strangulation event has occurred.</td>
</tr>
<tr>
<td>Step 4</td>
<td>Inspect the external and internal ears, not forgetting the area behind the ears, for evidence of shadow bruising or Battle’s Sign (postauricular ecchymosis); this may be a sign that a skull fracture exists. Bleeding or leakage of cerebrospinal fluid (CSF) from the ear may also indicate skull fractures.</td>
<td></td>
</tr>
<tr>
<td>Step 5</td>
<td>Inspect the nose and mouth; Look in the nose for signs of bleeding or leakage of CSF, or areas of bruising on the outside of the nose. The mouth should be inspected carefully, include the lips, gums, and tongue, checking for injury of these structures and the buccal mucosa. Petechiae on the hard/soft palate may indicate oral penetration or strangulation. Check the area of the frenulum for tearing injuries and observe for broken teeth.</td>
<td>Collect oral swabs, as indicated.</td>
</tr>
<tr>
<td>STEP</td>
<td>OBSERVATIONS</td>
<td>OTHER</td>
</tr>
<tr>
<td>------</td>
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</tr>
<tr>
<td>Step 6</td>
<td>Injuries observed on the neck can indicate a possible strangulation event warranting further questions by the provider. Inspect all surfaces of the neck for injury.</td>
<td>Palpate the neck for subcutaneous emphysema and note any ligature marks. Any of these signs may indicate a strangulation event has occurred. Abrasions seen at the neck in cases of strangulation may be caused by the child as they try to protect themselves from strangulation. Petechiae or red bruising from bites or sucking should be noted and swabbed for saliva before being touched.</td>
</tr>
<tr>
<td>Step 7</td>
<td>Assess the child’s hands inspecting all sides for injury, and observe general appearance; observe the wrists for signs of ligature marks.</td>
<td>Collect trace evidence from fingernails as appropriate.</td>
</tr>
<tr>
<td>Step 8</td>
<td>Inspect the forearms for injuries, appropriate circulation, sensation, and motion; any injuries or intravenous puncture sites should be noted.</td>
<td>Palpate for tenderness.</td>
</tr>
<tr>
<td>Step 9</td>
<td>Inspect the inner surfaces of the upper arms and axilla for signs of injury appropriate circulation, sensation, and motion.</td>
<td>Children who have been restrained by hands may have “fingertip” bruising from the perpetrators hands on the arms.</td>
</tr>
<tr>
<td>Step 10</td>
<td>The breasts and trunk should be examined. Subtle obvious injury may be seen in a variety of places on the trunk. Breasts are frequently a target of assault in female patients, including sucking and bite marks.</td>
<td>Swab areas for saliva if indicated. Auscultate the lungs.</td>
</tr>
<tr>
<td>Step 11</td>
<td>Observe the back of the child, this can be accomplished at this time by rolling them over to complete the assessment, or by having them stand up at the exam completion to do a final observation of the back while standing up.</td>
<td>Observe for injury, bruising, and be sure to palpate for areas of tenderness.</td>
</tr>
<tr>
<td>Step 12</td>
<td>Complete the abdominal examination, including inspection, auscultation, and palpation to exclude any internal trauma.</td>
<td>If body fluid or saliva is suspected to be present, swab for evidence.</td>
</tr>
<tr>
<td>Step 13</td>
<td>Examine the anterior and posterior aspects of the legs paying special attention to the inner thighs for injury. Observe for injury, foreign materials, and assess for tenderness. Also assess the feet and ankles for similar injury, foreign materials, and tenderness including the soles of the feet.</td>
<td>Collect foreign materials if present, palpate for tenderness, limited range of motion.</td>
</tr>
<tr>
<td>Step 14</td>
<td>Inspection of the posterior aspects of the legs may be easier to achieve with the child standing or sitting on the parent’s lap. Alternatively, the child may be examined in a supine position and asked to lift each leg in turn and then rolled slightly to inspect each buttock.</td>
<td>Any biological evidence should be collected with moistened swabs (for semen, saliva, blood) or gloved hands (for hair, fibers, grass, soil).</td>
</tr>
<tr>
<td>Step 15</td>
<td>Obvious physical deformities should be noted.</td>
<td>Notation of tattoos is generally unnecessary unless the presence of the tattoo is somehow related to the crime itself (i.e., the perpetrator tattooed the victim at the time of the crime).</td>
</tr>
</tbody>
</table>

## APPENDIX F

### PHYSICAL AND BEHAVIOURAL INDICATORS OF CHILD SEXUAL ABUSE

<table>
<thead>
<tr>
<th>PHYSICAL INDICATORS</th>
<th>BEHAVIOURAL INDICATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unexplained genital injury</td>
<td>Regression in behavior, school performance or attaining developmental milestones</td>
</tr>
<tr>
<td>Recurrent vulvovaginitis</td>
<td>Acute traumatic response such as clingy behavior and irritability in young children</td>
</tr>
<tr>
<td>Vaginal or penile discharge</td>
<td>Sleep disturbances</td>
</tr>
<tr>
<td>Bedwetting and fecal soiling beyond the usual age</td>
<td>Eating disorders</td>
</tr>
<tr>
<td>Anal complaints (e.g., fissures, pain, bleeding)</td>
<td>Problems at school</td>
</tr>
<tr>
<td>Pain on urination</td>
<td>Social problems</td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>Depression</td>
</tr>
<tr>
<td>STI&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Poor self-esteem</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Inappropriate sexualized behaviours&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Presence of sperm</td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup> Considered diagnostic if perinatal and iatrogenic transmission can be ruled out.

<sup>b</sup> No one behavior can be considered as evidence of sexual abuse; however, a pattern of behaviors is of concern. Children can display a broad range of sexual behaviors even in the absence of any reason to believe they have been sexually abused.

# Appendix G

## Examples of Sexual Behaviors in Children 2 to 6 Years Old

<table>
<thead>
<tr>
<th>Normal, Common Behaviors</th>
<th>Less Common Normal Behaviors</th>
<th>Uncommon Behaviors in Normal Children</th>
<th>Rarely Normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Touching / masturbating genitals in public / private</td>
<td>• Rubbing body against others</td>
<td>• Asking peer / adult to engage in specific sexual act(s)</td>
<td>• Any sexual behaviors that involve children who are 4 or more years apart</td>
</tr>
<tr>
<td>• Viewing / touching peer or new sibling genitals</td>
<td>• Trying to insert tongue in mouth while kissing</td>
<td>• Inserting objects into genitals</td>
<td>• A variety of sexual behaviors displayed on a daily basis</td>
</tr>
<tr>
<td>• Showing genitals to peers</td>
<td>• Touching peer / adult genitals</td>
<td>• Explicitly imitating intercourse</td>
<td>• Sexual behavior that results in emotional distress or physical pain</td>
</tr>
<tr>
<td>• Standing / sitting too close</td>
<td>• Crude mimic of movements associated with sexual acts</td>
<td>• Touching animal genitals</td>
<td>• Sexual behaviors associated with other physically aggressive behavior</td>
</tr>
<tr>
<td>• Tries to view peer / adult nudity</td>
<td>• Sexual behaviors that are occasionally, but persistently, disruptive to others</td>
<td>• Sexual behaviors that are frequently disruptive to others</td>
<td>• Sexual behaviors that involve coercion</td>
</tr>
<tr>
<td>• Behaviors are transient, few, and distractible</td>
<td>• Behaviors are transient and moderately responsive to distraction</td>
<td>• Behaviors are persistent and resistant to parental distraction</td>
<td>• Behaviors are persistent and child becomes angry if distracted</td>
</tr>
</tbody>
</table>

---

*Assessment of situational factors (family nudity, child care, new sibling, etc) contributing to behavior is recommended.

*Assessment of situational factors and family characteristics (violence, abuse, neglect) is recommended.

*Assessment of all family and environmental factors and report to child protective services is recommended.


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### APPENDIX H
### DIAGRAMS TO DOCUMENT PHYSICAL INJURIES

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date &amp; Name of Exam:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age / Sex:</td>
<td>Examining Physician:</td>
</tr>
<tr>
<td>Case Number:</td>
<td>Photographs Taken:</td>
</tr>
<tr>
<td></td>
<td>□ YES □ NO</td>
</tr>
</tbody>
</table>

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![Diagram of physical injuries](image_url)
<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date &amp; Name of Exam:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age / Sex:</td>
<td>Examining Physician:</td>
</tr>
<tr>
<td>Case Number:</td>
<td>Photographs Taken:</td>
</tr>
<tr>
<td></td>
<td>□ YES □ NO</td>
</tr>
</tbody>
</table>

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[Diagram of a human body front and back]
<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date &amp; Name of Exam:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age / Sex:</td>
<td>Examining Physician:</td>
</tr>
<tr>
<td>Case Number:</td>
<td>Photographs Taken:</td>
</tr>
<tr>
<td></td>
<td>□ YES □ NO</td>
</tr>
<tr>
<td>Patient Name:</td>
<td>Date &amp; Name of Exam:</td>
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</tr>
<tr>
<td>Age / Sex:</td>
<td>Examining Physician:</td>
</tr>
<tr>
<td>Case Number:</td>
<td>Photographs Taken:</td>
</tr>
<tr>
<td></td>
<td>□ YES □ NO</td>
</tr>
</tbody>
</table>

![Diagram of body with right and left sides labeled](image-url)
<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date &amp; Name of Exam:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age / Sex:</td>
<td>Examining Physician:</td>
</tr>
<tr>
<td>Case Number:</td>
<td>Photographs Taken:</td>
</tr>
<tr>
<td></td>
<td>□ YES □ NO</td>
</tr>
</tbody>
</table>

![Diagram with labels for Right and Left]
Documentation of visual findings is an important component of child abuse evaluation. Apart from careful examination and written documentation, photographs are useful adjuncts to preserve visual findings. These photographs assist physicians in recalling or re-confirming findings, or in discovering previously undetected results. Should a second opinion be required, high quality photographs can be reviewed in lieu of re-examination, thus sparing the child unnecessary trauma. Further, physicians may use photographs to illustrate and further clarify their testimony when serving as expert witnesses in court. Finally, photographs facilitate technical peer review: by obtaining the opinions of their peers on difficult-to-evaluate cases, child protection specialists improve their skills, benefiting from the experience and expertise of others.

Anogenital injuries may be viewed using the naked eye, through the use of an otoscope or with the aid of a colposcope. A colposcope is a binocular instrument used to visualize ano-genital structures during sexual abuse evaluations. A colposcope offers a light source and varying magnification capability, and may also attach to a camera in order to photograph genital injuries. Although colposcopic photography is used primarily to document abnormal findings, it may also be prudent to photograph cases with normal findings, as these photographs may be of comparative value if the patient is later re-examined. The advantages of using a colposcope are usually offset by its cost and need for extensive training for ease of use.

Nowadays, digital photography may be a less expensive means of documenting injuries. Digital photography started in 1981 with the manufacture of the first digital camera. Many experts on child abuse evaluation are using digital cameras to document physical as well as genital injuries. There have been discussions on this technique ranging from storage of data to its admissibility in court.

A digital camera might look very much like a conventional camera, but the method by which the image is recorded is fundamentally different. A sensing apparatus within the camera corresponds to the pixel grid of the desired image, and calculates the numeric value assigned to each pixel. The digital information can then be recorded directly, with no need to create an analog or printed representation of the image.

Although digital photographs may ultimately be displayed in a printed form, it is not necessary to do so -- they can just as easily be displayed on a monitor screen.

Because digital data consists of only numbers, information may readily be added, removed, or replaced. Any such corruption of the original data is likely to occur in one of three contexts: it may be accidental, it may be intentional but innocent, or it may be fraudulent. Accidental alteration might result from a variety of causes -- for example, a magnetic disk on which data is stored might be placed too near a powerful magnetic field (such as that generated by some computer monitors).

Intentionally manipulated images, however, are another matter. There are a number of commercially available software packages, which allow the user to remove elements from an image, rearrange the elements of an image, or add elements to an image. Even subtle details such as color, contrast, light, and shadow may be adjusted.

Of course, the possibility of misrepresentation by visual image is not unique to digital photographs. From simple techniques such as choice of film, lighting, exposure interval, lens -- or more simply, posing or staging-- to sophisticated darkroom editing and collage procedures, photographers have had opportunities to manipulate images virtually since the camera was invented. Thus, misrepresentation is not an exclusive domain of digital photography.

The principal requirements to admit a photograph (digital or film-based) into evidence are relevance and authentication. With Republic Act No. 8792 or “Electronic Commerce Act of 2000” digital photographs or images
may be used in court as evidence as stated in section 12 “In any legal proceedings, nothing in the application of the rules on evidence shall deny the admissibility of an electronic data message or electronic document in evidence -

a. On the sole ground that it is in electronic form or
b. ... In assessing the evidential weight of an electronic data message or electronic document, the reliability of the manner in which it was generated, stored or communicated, the reliability of the manner in which its originator was identified, and other relevant factors shall be given due regard.’

The pressing issues would now be preserving the chain of evidence of the photograph and more importantly, the credibility of the photographer/examiner. WCPUs are encouraged to establish a protocol in handling photographic evidence. Each photograph should have a label to include the following:

1. Child’s identification whether by his or her initials and/or a record number
2. Date the photograph was taken
3. The photographer which may just be his or her initials

Storage and filing of these photograph evidence must then be ensured to safeguard both against unnecessary display and possible manipulation.

Figure 23. Colposcope
FORENSIC PHOTOGRAPHY

Tips for Photographing a Suspected Victim of Child Abuse

• Establish a protocol or checklist for photodocumentation
• Decide in advance who will photograph the suspected victim.
• Label all photographs appropriately.
• Prior to photographing the injuries, identify the suspected child abuse victim by taking a full-face picture of the child with the child’s name or initials, date of birth, date and time of photographs, case number, and the photographer’s name or initials. It is also prudent to have the above identification data in front of the victim’s injury for each picture.
• Place a measuring device such as a ruler with a metric scale directly above or below the injury to ensure accurate representation of the size and depth of the injury. It is ideal to use an ABFO (American Board of Forensic Odontology) scale, which is an L-shaped piece of plastic used in photography that is marked with circles, black and white bars, and 18-percent gray bars to assist in distortion compensation and provide exposure determination. For measurement, the plastic piece is marked in millimeters.

• A standardized color bar may be placed in the photographic plane for comparison with the color of the injury. This ensures that adequate color comparisons can still be made if color is distorted in the developing or printing process.
• Include two photographs of each wound or injury- one with the anatomic landmark and another that fills the frame or a close-up of the wound or injury.
• Photograph the injury with an anatomic landmark. The inclusion of an elbow, knee, belly button, or other body part identifies the location of the injury.
• Position the camera so that the plane is parallel to or directly facing the injury. If an ABFO scale is used, a direct camera angle would not result in the distortion of the three circles incorporated on the ABFO scale.
• Vary the perspective of the photograph by taking shots from various angles and distances.
• Have two copies made of each view and angle taken, one for the file and one for court.
• Review all photographs.
• Keep photographs protected.
Methods for Photographing Specific Injuries: Punctures, Slashes, Rope Burns or Pressure Injuries

Take photographs straight on and at a slight angle. The former provides an overall view of the surface while the latter provides depth and texture to a photograph.

**BITE MARKS**
These injuries should be photographed straight on and with various slanted angles. The direct or parallel views would depict the shape and size of the injury while slanted angles would highlight the texture of the bites including the depth of indentations. This is best photographed using the ABFO scale.

**BRUISES**
Bruises go through changes over time and may be more evident after several hours or days. Thus, additional photographs may be needed to document the injury. If a second or third series of photographs are required, the angles and positions used to photograph the first series should be reproduced. Both old and new bruises should be photographed. Areas of swelling sometimes appear as reflection caused by the flash bouncing off the swollen or rounded injury site, which may obscure the photograph. Take pictures from several different angles to minimize these reflections. Follow-up photographs may be needed to demonstrate when the swelling has gone down.

**BURNS**
Take photographs of burns include scalds from all angles before and after treatment. It is better to have initial photographs before any creams or oils have been applied.

**FACIAL INJURIES**
If an injury is inside the mouth, use a tongue depressor to keep the mouth open and the injury visible. If the injury is in or near the eye, use a flashlight or toy to distract the child's gaze in different directions to show the extent of the eye injury.

**AMPUTATION**
Take a picture of the dismembered part and then in relation to the body as a whole. Take a close-up of the skin's torn edges, which may help verify the method of amputation later on.

**NEGLECT**
The child's general appearance should be documented. Take a photograph of the child in his or her own clothing. Document other signs of neglect such as splinters in the soles of the feet, hair loss, extreme diaper rash, wrinkled or wasted buttocks, prominent rib cage, and/or swollen belly.

**SEXUAL ABUSE**
- Approach suspected victims of sexual abuse as follows:
- Photograph the child in the presence of a trusted relative or guardian
- Inform the child of what will be involved in taking photographs
- Consider the child’s level of development when speaking to him or her
- Make eye contact with the child to make him or her feel more comfortable
- Allow time for the child to become accustomed to the photographer before being photographed. Do not surprise the child. Do not make quick moves toward the child, as these may be frightening.
- Inform the child what parts of the body need to be photographed.
- Let the child undress or have the guardian or parent help.
- Photograph the sexual organs, including an overall view then close-ups of the injury. This may require labial traction and/or knee-chest position with the child kneeling on all four limbs to allow another view of the hymen or the anus.

APPENDIX J

BASIC RADIOLOGY IN PHYSICAL ABUSE OF CHILDREN

Introduction:
Pediatric radiologist Dr. John Caffey first described the association of long bone fractures and chronic subdural hematoma with child abuse. Most abusive fractures occur in children less than 3 years old; 80% of such fractures occur in children younger than 18 months. Abusive fractures may be multiple, of different ages, or solely determined by radiologic imaging. Two thirds of abused children have a positive radiologic finding which may be the first sign to alert the physician of child abuse. The role of imaging in cases of child abuse is to identify the extent of physical injury when abuse occurs, as well as to elucidate all imaging findings that point to alternative diagnoses. Radiographs should not replace either a detailed history or a comprehensive physical examination. For this medalert, basic diagnostic imaging modalities useful for the detection, management and follow-up of suspected abusive trauma in children will be discussed.

What are the imaging modalities useful in diagnosing child abuse?
There are several imaging modalities that can be used such as:
1. Skeletal survey
2. Bone scan
3. CT scan
4. MRI

What is a skeletal survey?
This is the primary imaging study used in the global assessment of the skeleton in cases of suspected abuse used in children less than 2 years old. For patients more than 2 years old, x-rays of the specific sites of injury are done. However, it should be noted that as many as 50% of abused children would fail to show any skeletal injury at the time of presentation. Repeating limited views 2 weeks after the initial survey to reevaluate areas of concern is helpful to see healing of the fractures with callus formation.

The "baby gram" (a study that encompasses the entire infant or young child on 1 or 2 radiographic exposures) or abbreviated skeletal surveys have no role in the imaging of these subtle but highly specific bony abnormalities!

<table>
<thead>
<tr>
<th>Table 1: Components of a skeletal survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. AP and lateral skull</td>
</tr>
<tr>
<td>2. Lateral cervical spine</td>
</tr>
<tr>
<td>3. AP, lateral and oblique ribs</td>
</tr>
<tr>
<td>4. AP pelvis</td>
</tr>
<tr>
<td>5. Lateral thoracic-lumbar spine</td>
</tr>
<tr>
<td>6. Antero-lateral humeri, forearm, femurs, tibias and fibulas</td>
</tr>
<tr>
<td>7. Oblique hands</td>
</tr>
<tr>
<td>8. AP feet</td>
</tr>
</tbody>
</table>

Are there certain fractures in a child that are specific indicators of abuse?
Kleinman described fractures as having a high, moderate or low specificity for abuse as seen in Table 2.

<table>
<thead>
<tr>
<th>Table 2: Specificity of fractures for physical abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH</td>
</tr>
<tr>
<td>- Metaphyseal chip fractures</td>
</tr>
<tr>
<td>- Bucket handle fractures</td>
</tr>
<tr>
<td>- Rib fractures, especially posterior location</td>
</tr>
<tr>
<td>- Scapular fractures</td>
</tr>
<tr>
<td>- Spinous process</td>
</tr>
<tr>
<td>- Sternum</td>
</tr>
<tr>
<td>MODERATE</td>
</tr>
<tr>
<td>- Multiple or bilateral fractures</td>
</tr>
<tr>
<td>- Fractures of different ages</td>
</tr>
<tr>
<td>- Epiphyseal separations</td>
</tr>
<tr>
<td>- Vertebral body fractures and subluxations</td>
</tr>
<tr>
<td>- Digital fractures</td>
</tr>
<tr>
<td>- Complex or multiple skull fractures</td>
</tr>
<tr>
<td>COMMON BUT LOW</td>
</tr>
<tr>
<td>- Subperiosteal new bone formation</td>
</tr>
<tr>
<td>- Clevicle fractures</td>
</tr>
<tr>
<td>- Long bone shaft fractures</td>
</tr>
<tr>
<td>- Linear, simple skull fractures</td>
</tr>
</tbody>
</table>
Are there specific imaging recommendations for suspected abusive fractures based on age?

<table>
<thead>
<tr>
<th>Age</th>
<th>Imaging</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-12 months</td>
<td>Skeletal survey Follow-up skeletal survey (2 weeks)</td>
</tr>
<tr>
<td>12 months-2 years</td>
<td>Skeletal survey or Bone scan</td>
</tr>
<tr>
<td>2-5 years</td>
<td>Skeletal survey or bone scan in selected cases where physical abuse is strongly suspected</td>
</tr>
<tr>
<td>5 years and older</td>
<td>Radiograph of individual sites of injury suspected on clinical grounds</td>
</tr>
</tbody>
</table>

What is a bone scan or skeletal scintigraphy?
A bone scan helps diagnose subtle or hidden bone fractures that may not show up on routine X-ray. Tiny amounts of tracers or radionuclides are used which accumulate in certain tissues, such as bones. Once introduced into the body, tracers emit waves of radiation that are detected by a special gamma camera. This camera produces images that are interpreted by radiologists or nuclear medicine specialists. The tracers may accumulate in certain areas of the bone, indicating one or more hot spots which may be caused by a fracture that is healing, bone cancer, a bone infection, or a disease of abnormal bone metabolism.

Bone scans are useful in detecting diaphyseal injuries and rib fractures. However, bone scan has limited sensitivity in detecting classic metaphyseal lesions of abuse, particularly when the lesions are bilateral, as well as subtle spinal injuries, features that carry a high specificity for abuse in infants.

Can we or should we X-ray children who died of suspicious circumstances?
Yes! Diagnostic imaging plays a critical role in cases of suspected fatal child abuse. The indications for skeletal survey are much the same as those for the forensic autopsy. The goal is to assist in determining the cause and manner of death. Postmortem skeletal survey is best performed before the autopsy and is quite useful in documenting long bone fractures.

What are the uses of CT scan and MRI?
Computed tomography (CT) and Magnetic resonance imaging (MRI) are utilized in different parts of the body. CT without contrast should be done as initial imaging modality for the brain-injured infant and child. It is best for showing acute subdural, subarachnoid and interhemispheric hemorrhage routinely seen in shaken baby syndrome (SBS).

MRI is a useful adjunct to CT in evaluating head trauma, but its usefulness is limited by availability, difficult access in the critically ill patient and relative insensitivity to subarachnoid blood and fractures. MRI can detect intraparenchymal lesions such as shearing injury. It is also helpful when the CT is inconclusive.

Can a fracture be dated?
Radiologic dating of fractures is an inexact science. The radiologic estimates of bone healing occur as a continuum with considerable overlap. Radiologic estimates of the time of injury are made in terms of weeks rather than days and a proficient radiologist can clearly differentiate recent from old fractures.

Periosteal reaction is seen as early as 4 days and is present in at least 50% of cases by 2 weeks after the injury. Remodeling of a fracture appears 8 weeks after injury. Most radiologists date fractures on the basis of their personal clinical experience, and the literature provides little consistent data to act as a resource.

References:

APPENDIX K
ABUSIVE HEAD TRAUMA

CPU-Net MEDICAL ALERT
A Bi-Monthly Bulletin Published by the Child Protection Unit Network

Abusive Head Trauma (AHT)

A serious type of head injury that happens in an infant or toddler that results from extreme rotational cranial acceleration induced by violent shaking or shaking with impact. An algorithm for the medical work-up of SBS is presented here.

PRESSENTATION

Infant or toddler presented with:
- Apnea (93% PPV*)
- Altered mental status
- Seizure
- Bruises +/-

*PPV – Positive Predictive Value

SUBTLE SIGNS:
- Vomiting
- Irritability
- Poor feeding
- Failure to thrive
- Lethargy

HISTORY

Obtain a detailed, analytical but not accusatory history from the caretakers. Abusive parents will tell misleading stories about how the "accident" happened. It is important to probe gently and request for clarification about questionable portions of the history.

PHYSICAL EXAM

Physical exams should be thorough & comprehensive. All findings should be clearly documented using detailed diagram & photographs. Remember that certain physical findings may be similar to differential diagnosis presented above. The absence of fractures and bruises does not rule out abuse.

DIRECT & INDIRECT OPHTHALMOSCOPIC

Retinal hemorrhages (71% PPV) may be unilateral or bilateral.

LABORATORY EXAM

Cranial CT and/or MRI
Cranial CT Scan is the method of choice for initial imaging. Subdural or subarachnoid hemorrhages are commonly seen in SBS. MRI has shown to detect 50% more SDH than CT scan & can detect smaller injuries. MRI can be used to confirm injuries 2-3 days after CT scan but the cost & availability makes it more useful as a second study in the diagnosis of SBS.

Skeletal Survey for under 3 years old
Skeletal injuries noted are long bone fractures, posterior rib fractures, and classical metaphyseal lesions. Posterior rib fractures (73% PPV) can be seen by bone scan or on follow-up skeletal survey. Cervical injuries are present in 1-2% of cases. If initial X-Ray is normal and SBS is highly considered, repeat the radiologic exam after 2 weeks.

Coagulation Studies
PT prolongation occurs in > 50% of patients with parenchymal damage and 20% without parenchymal damage. Coagulation abnormality is a result of tissue factors released from the damaged parenchymal cells.

LFT and Amylase Test
Increased LFT and Amylase consider:
Blunt Abdominal Trauma

Coagulation Studies Normalized, consider Acquired Prothrombin Complex Deficiency (APCD)

Acute Head Trauma is the most common cause of neurotrauma in children younger than 2 years. It should be considered in all children presenting with neurotrauma unless the trauma is without doubt accidental (e.g., car accident).

Sieswerda-Hoogendoorn, Boos, Spivack et al. (2012)

References:
- Shaken Baby Syndrome: A Multidisciplinary Approach by Lazuritz & Palusci
- Child Abuse: Medical Diagnosis & Management by Reese 2nd ed.

END of Algorithm.
However, above differential diagnoses may co-exist with SBS.

Red Flags
- Cranial CT
- Skeletal Survey
- Coagulation Studies
- LFT and Amylase Test

Consider follow-up studies:
- Define abnormalities
- Determine timing of injuries
- Monitor evolution

= NO

Consider differential diagnosis such as:
- Accidental trauma
- Neuro disorder
- Metabolic disorder
- Coagulopathy
- Osteogenesis Imperfecta
- Hepatic disorder

= SBS
### APPENDIX L

#### DATE RAPE? DRUGGED?

**CPU-Net MEDICAL ALERT**

A Bi-Monthly Bulletin Published by the Child Protection Unit Network

April 2003  
Vol. 1 Issue 2

Date Rape? Drugged? Sexual abuse may occur when victims take drugs, either deliberately or unknowingly. Testing for the presence of drugs in the victim’s system is an important part of the medico-legal exam. This abbreviated table can help us recognize the possible drug used based on symptoms and how to test for each one.

<table>
<thead>
<tr>
<th>Toxidrome</th>
<th>Presentation</th>
<th>Causative Agents</th>
<th>Testing</th>
<th>Where to send</th>
</tr>
</thead>
</table>
| Hallucinogenic  | Disorientation, hallucinations, visual illusions, panic reaction, moist skin, tachycardia, tachypnea, hypertension | • Amphetamines  
                   • Marijuana  
                   • Cocaine  
                   • Phencyclidine (PCP)  
                   • LSD | Urine 60 mL (refrigerate; freeze if cannot test within 48 hours) | • UP Manila Pharma  
                   5264248  
                   • PNPChem  
                   7230401 loc 4366  
                   • NBI* Chem  
                   5238231 loc 5438 |
| Sedative/Hypnotic | Stupor, confusion, sedation, disinhibition | • Alcohol (Ethanol)  
                   • Barbiturates  
                   • Benzodiazepines (Rohypnol; flunitrazepam)  
                   • GHB (yOH-butyrate) | Blood (for alcohol level only 10 mL in tube with anticoagulant)  
                   Urine 60 mL | • PNP  
                   • NBI* |
| Sympathomimetic | Delusions, paranoia, sweating, dilated pupils, anxiety, tachycardia, hypertension | • Cocaine  
                   • Amphetamines  
                   • Methamphetamine (Shabu, Ice, crack, speed, go)  
                   • MMDA (Methylenedioxyamphetamine) Ecstasy, M, Lovers' Speed, XTC, M&M, MDM, E | Urine 60 mL (refrigerate; freeze if cannot test within 48 hours) | • UP Manila Pharma  
                   • PNP  
                   • NBI* |
| Anticholinergic | Delirium, flushed skin, dilated pupils, urinary retention, memory loss, tachycardia *Hot as a Hare, Dry as a Bone, Red as a Beet, Blind as a Bat, Mad as a Hatter* | Scopolamine (*Talamunay*) | None | |
| Opiate/Narcotic | Altered mental status, miosis, unresponsiveness, shallow breathing, bradycardia, hypothermia, hypotension | Opiates (heroin, morphine) | Urine 60 mL (refrigerate; if cannot test within 48 hours) | PNP (can test morphine only) |

APPENDIX M

AUTOPSY OF SUSPICIOUS CHILD DEATH & CHILDREN WHO DIED OF ABUSE OR MALTREATMENT

The Department of Justice (DOJ) released Circular No. 55 (appended) on September 11, 2002 authorizing all regional state, provincial and city prosecutors and their assistants to order the conduct of autopsy of a child who may have died of suspicious or abuse-related circumstances. DOJ Circular No. 87 (appended), on the other hand, approved the “Order of Autopsy” to implement DOJ Circular No. 55.

A. Child died of suspicious or abuse-related circumstances

B. Obtain and review written case summary from attending physician
   - Get informed consent for autopsy from next of kin
   - Inform Director of the Hospital in writing
   - Report to Police and DSWD orally and in writing

   Informed consent for autopsy given by next of kin?

   YES

   Have child’s body referred either to:
   - Your hospital pathologist, preferably forensic pathologist;
   - Philippine National Police (PNP); OR
   - National Bureau of Investigation (NBI) Medico-Legal Division

   NO

   C. Have body safeguarded by police or your institution’s security.
   - Police or NBI investigator can request directly from PNP or NBI Medico-legal for autopsy
   - Contact your regional state, provincial or city prosecutor and submit:
     - Clinical summary

   OR

   D. Prosecutor gives order of autopsy

   NO

   Submit report to DOJ

   YES

   Obtain copy of autopsy report.

PREPARATORY STEPS:
A. Contact your regional state, provincial or city prosecutor via a letter and remind them about DOJ Circulare 55 and 87. Provide them a copy of the “order of Autopsy” form. Do this as soon as possible before you actually encounter the need to use it.
B. Inform your hospital administration, department heads and physicians and other health personnel that you as Child Protection Specialist have to be contacted in cases of unnatural, unusual, suspicious or questionable child death as well as those who died of abuse-related circumstances.
C. Institute a procedure in your institution on where the body should be kept and who should safeguard the body until notice from the prosecutor has been received.
D. This may mean that you have to release the body to the next of kin if both the police and prosecutor won’t order an autopsy. The report to the Special Committee for the Special Protection of Children will conduct a review of procedure and case.
DEPARTMENT CIRCULAR NO. 55

TO: ALL REGIONAL STATE PROSECUTORS, PROVINCIAL AND CITY PROSECUTORS AND THEIR ASSISTANTS, STATE PROSECUTORS AND PROSECUTION ATTORNEYS

SUBJECT: Authority to order the conduct of autopsy on the body of a child who may have died under suspicious or abuse-related circumstances

It has come to the attention of the Special Committee for the Protection of Children under the Department that there are cases where children die under suspicious and abuse-related circumstances (i.e. shaken baby syndrome) that would need further medico-legal examination or autopsy, a procedure that will trigger an investigation on the cause of death of the child-victims. In most instances, the relatives of the victims refuse to consent for the conduct of such examination or autopsy. It cannot be ruled out, however, that the perpetrator may have been a relative or a close member of the family.

Presidential Decree No. 856 (Sanitation Code of the Philippines), insofar as pertinent, provides:

“Sec. 95. Autopsy and Dissection of Remains.- The autopsy and dissection of remains are subject to the following requirements:

"a. xxx xxx xxx

"b. Autopsies shall be performed in the following cases:

1. xxx xxx

2. Upon orders of a competent court, a mayor and a provincial or city fiscal;

xxx xxxxx xxx”
Pursuant to the above-quoted provision of law and in pursuit of the government's policy of protecting children from all forms of abuse, cruelty, neglect and discrimination, Provincial and City Prosecutors are hereby directed to order the conduct of autopsy on the body of child-victims, upon the request of any interested party, and upon proper showing that the child may have died under suspicious or abuse-related circumstances, there being no external signs to readily conclude that the child died as a result of violence or crime. "Any interested party" shall include but be not limited to a law enforcement officer, parent or legal guardian, or authorized physicians of the UP-PGH Child Protection Unit (CPU) and other government hospitals.

Strict compliance herewith is enjoined.

HERNANDO B. PEREZ
Secretary

Copy furnished:

All concerned.
OFFICE ORDER NO. 87

SUBJECT: APPROVED “ORDER TO CONDUCT AUTOPSY FORM” RE IMPLEMENTATION OF DEPARTMENT CIRCULAR NO. 55 DATED SEPTEMBER 11, 2002

In the interest of public service and pursuant to the provisions of existing laws, all Regional State Prosecutors, Provincial and City Prosecutors and their assistants, State Prosecutors and Prosecution Attorneys, are hereby directed to adopt the attached “Order of Autopsy” form in compliance and in the implementation of Department Circular No. 55 dated September 11, 2002 relative to the authority of the foregoing to order the conduct of the autopsy on the body of a child who may have died under suspicious or abuse-related circumstances.

For strict compliance.

JOVENCITO R. ZUNO
Chief State Prosecutor

Copy furnished:

All concerned.
ORDER OF AUTOPSY

By virtue of Section 95 of the Sanitation Code of the Philippines (P.D. No. 856), pursuant to Department Circular No. 55 authorizing all prosecutors to order the conduct of autopsy on the body of a child who may have died under suspicious or abuse-related circumstances, to perform autopsy based on the suspicious death of:

Name
Age
Sex
Date of Birth
Date of Death
Place of Death
Possible cause of Death
Location of Cadaver
Person in custody of cadaver

Pursuant to this order, the person or institution in custody of the cadaver is hereby restrained from releasing the said cadaver prior to the performance of the said autopsy.

This order is issued in the City of __________, Republic of the Philippines on ________________.

Strict compliance herewith is enjoined.

NAME & SIGNATURE  
PROSECUTOR
APPENDIX N

SCI: SUSPICIOUS CHILD INJURY AND DEATH INVESTIGATION

The investigation of suspicious child deaths is in its infancy in the Philippines. In the present situation even if the child was brought to the hospital, a suspicious child death may not be reported by physician for various reasons. Physicians may fail to recognize and report child abuse and may be ignorant of the referral system. The work-up may be limited by prohibitive cost and the question of who will pay for them.

Criminal investigation of a child death caused by a caretaker is also unique for police investigators, since the perpetrator is legally responsible for the child and has continuous access to the victim. This contrasts with the majority of adult homicides where the victim and perpetrator are not living together at the time when the injury causing death is perpetrated. Deaths due to abuse or neglect of children by their parents who are expected to love and provide for the child victim’s needs may also be difficult to comprehend for any physician, social worker or police.

In the United States, most suspicious child deaths occur among very young children with 50% of victims under 1 year old. These young victims may have no previous hospital records or their medical records are not accessible to death investigation.

Another major concern in suspicious child death investigation is doing an autopsy. Autopsies of young children require a specialized understanding of pediatrics, pathology, child abuse and forensic investigation. However, most of the autopsies done in our country are conducted by physicians with no formal pathology training, much less specialization in forensic pathology. The issue of consent to an autopsy by next of kin of a child whose primary suspect is the parent or caretaker has already been settled with a Department of Justice Memo instructing prosecutors to issue an “Order to Conduct Autopsy” upon request by a physician who suspects that the child’s death may be due to abuse.

Very few investigators have any training on crime scene investigation in cases of suspicious child death. As a result investigators rely solely on the doctor’s report.

All of these factors contribute to inadequate investigation, underreporting, misclassification, and mismanagement of suspicious child death. Thus, during the CPU-Net 2004 conference on CSI Philippines, physicians, social workers, law enforcement investigators, members of the judiciary and other child advocates came up with a multi-disciplinary protocol to address the investigation of suspicious child injuries and deaths whether by abuse or neglect.

MEDICAL DOCTOR, SOCIAL WORKER & LAW ENFORCEMENT PROTOCOL FOR SUSPECTED NONACCIDENTAL INJURY IN CHILDREN

Child brought to ER. Abuse is suspected.

Condition of child?

Dead

MD request for AUTOPSY

With consent

AUTOPSY

Without consent

DOJ or Police request

SOCO
Note: Immediate CSI warranted

Call police station with jurisdiction of crime scene & confer with lead investigator

COURT

File complaint

Preliminary investigation

MD refers to Medical/Hospital Social worker

Report to nearest Police station (Can be by phone)

Medical stabilization of the patient is priority

Alive

Ask

- Who are caregivers?
- What was the behavior of the child prior to the incident?
- Interaction of family members
- Prior incidents

Report to DSWD or LGU

Immediate home visit by hospital SW and/or DSWD LGU

CASE CONFERENCE

- PNP
- MD
- Medical/Hospital Social Worker
- DSWD/LGU
- Lawyer

Collateral information:
- History of domestic violence
- Risk & safety assessment of siblings
- Level of functioning/ parental capability
- Dynamics of family relationship

Protective custody? Discharge

Safe to go home?

NO

Placement

SHELTER

YES

Review case

Foster care

Relative

AFTER CARE
WHAT IS PEER REVIEW?
Peer review is a process of examination of professional or academic efficiency, and competence by others in the same field. In cases of child abuse, the peer review would be the process whereby child protection specialists would examine forensic evidence in order to analyze findings of the physician-examiner in the absence of examiner and reviewer bias.

WHY DO WE NEED TO DO PEER REVIEW?
Peer review or peer support is a non-judgmental learning tool that is proving to be beneficial for all the people involved. It is a way for everyone to learn from each other and share ideas.

Each person has valuable input to contribute while working together toward the improvement of outcomes for children and families. As more child abuse cases are heard in Philippine courts and as judges and lawyers become more sophisticated in their litigation, the interpretation of findings as well as the expertise of the physician examiner may be put to question by either the defense or prosecution by virtue of examiner bias. The advantage of a case that has undergone review by experts is that it can be considered a forensically defensible legal case in court by excluding this bias.

HOW DO WE CONDUCT THE PEER REVIEW?
Medicine including the practice of child protection encompasses a range of appropriate differences in opinion. There may be differences in views on many issues with the minority view not being less than legitimate as compared to the majority view. However, child protection specialists should base their pronouncements on reasonably current knowledge after conducting a thorough and impartial review of the facts.

The process of peer review involves discussions that are frank, open, complete and undertaken in an environment that supports such discussions. The information divulged either orally or in written form, must be confidential as these involve child abuse allegations.

The peer review team is composed of child protection specialists. Team members who are new to the peer review process are paired with experienced reviewers. A brief summary but without any patient identification will be presented during the review. The discussion should also include photo documentation and other forensic evidence that may have been gathered about the case.

RECOMMENDED QUALIFICATIONS FOR THE PEER REVIEW TEAM:
1. The physician examiner is the doctor who actually examined the child and took the photographs and/or collected other forensic evidence
2. The peer review team is composed of child protection specialists who have been fully trained in the recognition and management of child abuse cases
3. The peer review team should be familiar with the clinical practice of this specialty including the subject matter of the case and has been in active practice in cases of child protection.

RECOMMENDED GUIDELINES DURING THE PEER REVIEW:
1. The case is presented by the physician examiner and should include the facts of the case without identifying the child. These facts are presented in a thorough and objective manner. Data should not be excluded that would favor either the defense or the prosecution’s case. The facts may include the age of the child, the time of incident(s) and the time of examination.
2. Photo-documentation is then presented to the team.
3. The members of the review team should then give their opinion based on the facts presented.
4. The physician examiner may then concur or disagree with the findings regarding the case.
When a child is caught up in sexual abuse, that child develops an adjustment pattern to the abuse that is widely known as the accommodation syndrome. An understanding of this “normal” behavior pattern is vital to understanding why a child victim is behaving in a particular way, especially if s/he keeps the abuse secret for a long time, recants a previous statement, or casts blame on herself for the abuse. The accommodation syndrome is often considered as a progression of five stages:

- **SECRECY**
  - Children are told not to tell. Threats of physical violence, but often promises of withdrawal of love and affection, are all that are needed to secure a dependent child’s silence. The child fears disapproval or punishment. Attempts to tell often confirm their worst fears. Retaliation certainly occurs.
  - Older children understand the implications for the family of a police investigation: possible imprisonment of family member, loss of income, shame and the possibility that they may be held responsible.
  - The logical solution for most children is to maintain the conspiracy of secrecy and silence.

- **HELPLESSNESS**
  - Children are unable to stop the abuse in most case. Although they may resist at least initially, they find that it is less trouble to lie still, pretend to be asleep and “switch off.” In this way they attempt to protect themselves.
  - Children will not cry out or struggle to protect themselves and this is often misinterpreted as willing compliance, both by the abuser and society at large. The cost that the child pays for the abandonment of active resistance is insecurity, victimization, and a loss of psychological well-being.
  - This behavior is often reflected in the case with which CSA victims are medically examined. During the examination, some children even go to sleep.

- **ACCOMMODATION**
  - In a position of helplessness and secrecy, the child feels utterly trapped. The only active role the child can play is to hold herself responsible and, in sensing the wrongness of what is happening, attempt to make amends.
  - Self-blame and guilt are feelings shared almost universally by sexually abused children. In addition the child faces other pressures.
    - The need to protect other children, siblings
    - The need to protect the other parent
    - The need to protect the family home and integrity of the family
    - The cost that the child has the power to destroy the family, but the responsibility to keep it together. Parent and child roles have, in effect, reversed.
    - Once in this pseudo-adult position, child may be viewed as a consenting and willing participant in the abuse. The parent, in a child-like position, may simply deny the child’s statement if later the truth is revealed. The child who is able to accommodate effectively to the abuse will cover up the reality in order to protect the parent, but also to allow herself space for survival.
    - It is not unusual, for example, for children to flourish at school where they feel protected and safe, effectively splitting off that part of the life from the threats and insecurity of home.
<table>
<thead>
<tr>
<th>SECRECY</th>
<th>HELPLESSNESS</th>
<th>ACCOMODATION</th>
<th>DELAYED DISCLOSURE</th>
<th>RETRACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>The logical solution responsible.</td>
<td>The family of a police member, loss of income, imprisonment of family, shame and the possibility that they may be held responsible.</td>
<td>Children understand what they are told often confirm their worst fears. Retaliation threats of physical punishment. Attempts to protect themselves.</td>
<td>Many disclosures seem to arise almost by chance. Incidents when a chance remark is made by a child when defenses are down, picked up by a sensitive listener and carefully expanded upon are common.</td>
<td>Whatever children say about sexual abuse, there is a strong likelihood that they will reverse it under pressure, especially the pressure of a cross examination in an intimidating courtroom. This pattern is most clearly seen when the abuser is a trusted caregiver, parent or parent figure.</td>
</tr>
<tr>
<td>To maintain the conspiracy for most children is to</td>
<td>• Overwhelmingly impossible situation at home</td>
<td></td>
<td></td>
<td>For the child, sexual abuse is laden with ambivalence, guilt and self-doubt. A hostile response by family members or the community soon lets children know that they had better recant their disclosure and claim they fabricated the whole thing.</td>
</tr>
<tr>
<td></td>
<td>• Presence of a sensitive friend, teacher or counselor</td>
<td></td>
<td></td>
<td>The fact that children cannot and do not readily make up stories of explicit sexual activity is quickly forgotten by all concerned as the threat of the child’s disclosure recedes. The retraction reassures, encourages disbelief of the original disclosure, and may lead to inaction.</td>
</tr>
<tr>
<td></td>
<td>• Absence, temporary or permanent, of the abuser</td>
<td></td>
<td></td>
<td>While retraction should be viewed as a normal and expected part of the psychological adjustments of sexually abused children, overly quick acceptance of retractions should also reveal that people are happier to believe that children lie than that they are sexually abused.</td>
</tr>
<tr>
<td></td>
<td>• Educational initiatives, telephone “hotlines” (e.g., Bantay Bata 163)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Many disclosures seem to arise almost by chance. Incidents where a chance remark is made by a child when defenses are down, picked up by a sensitive listener and carefully expanded upon are common.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Contrary to the popular view that children are more likely to disclose upon entering adolescence, experience has shown that disclosure is not particularly favored at any age.</td>
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</tr>
<tr>
<td>Disclosure is, however, often delayed. The abuse will have been going on for some time and the child fears that he or she will not be viewed sympathetically. The disclosure, therefore, may sound unconvincing, and includes details of only one or two incidents. The types of activity described will often be the less intrusive and upsetting ones for the child. Ambiguities may exist that the child can not readily resolve.</td>
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</tbody>
</table>


APPENDIX Q
IMMEDIATE SAFETY ASSESSMENT

SAFETY FACTORS (Specify the applicable parent(s) and/or child(ren) to which the risk factor applies)

1. Caretaker(s) explanation for the injury to the child(ren) is questionable or inconsistent with type of injury, and the nature of the injury suggests that the child(ren)’s safety may be of immediate concern.
   Information supporting safety factor: ______________________
   Yes □  No □  Not Known □

2. Child’s whereabouts cannot be ascertained and/or there is reason to believe that the family is about to flee.
   Information supporting safety factor: ______________________
   Yes □  No □  Not Known □

3. Parent has caused serious physical harm to the child or has made a plausible threat that would result in physical harm to the child.
   Information supporting safety factor: ______________________
   Yes □  No □  Not Known □

4. Child sexual abuse is suspected and circumstances suggest that child safety may be an immediate concern.
   Information supporting safety factor: ______________________
   Yes □  No □  Not Known □

5. Parent has previously harmed this or any child, and the severity of the harm, or the parent’s prior response to the incidents, suggests that the child’s safety maybe an immediate concern.
   If caretaker(s) has or may have previously maltreated child(ren) in their care, check all that apply:
   _____ Prior death of a child(ren)
   _____ Prior serious harm to child(ren)
   _____ Prior report of abuse
   _____ Termination of parental rights
   _____ Prior removal of children

   Information supporting safety factor: ______________________
6. Child is fearful of people living in or frequenting the home.
   Information supporting safety factor:  
   Yes [ ]  No [ ]  Not Known [ ]

7. Alleged perpetrator has access to the child and no available and responsible adult who is willing to protect the child.
   Information supporting safety factor:  
   Yes [ ]  No [ ]  Not Known [ ]

8. Parent describes or acts toward child in predominantly negative terms or has extremely unrealistic expectations.
   Information supporting safety factor:  
   Yes [ ]  No [ ]  Not Known [ ]

9. Domestic violence exist in the home and poses a risk of serious physical and/or emotional harm to the child(ren).
   Information supporting safety factor:  
   Yes [ ]  No [ ]  Not Known [ ]

10. Parent has not, or is unable to meet the child’s immediate needs for food, clothing, shelter, and/or medical care.
    Information supporting safety factor:  
    Yes [ ]  No [ ]  Not Known [ ]

11. Child’s physical living conditions are hazardous and may cause serious harm.
    Information supporting safety factor:  
    Yes [ ]  No [ ]  Not Known [ ]

12. Parent’s drug or alcohol use seriously affects his or her ability to supervise, protect, or care for the child.
    Information supporting safety factor:  
    Yes [ ]  No [ ]  Not Known [ ]

13. Parent’s mental/emotional/physical health status seriously affects his or her ability to supervise, protect, or care for the child.
    Information supporting safety factor:  
    Yes [ ]  No [ ]  Not Known [ ]
14. Parent has not, or will not, provide sufficient supervision to protect child from potentially serious harm
   Information supporting safety factor:

   __________________________________________________________________________________________________
   __________________________________________________________________________________________________

15. Others (specify)

   __________________________________________________________________________________________________
   __________________________________________________________________________________________________
   __________________________________________________________________________________________________
   __________________________________________________________________________________________________
   __________________________________________________________________________________________________

Brief Family Background:

   __________________________________________________________________________________________________
   __________________________________________________________________________________________________
   __________________________________________________________________________________________________
   __________________________________________________________________________________________________
   __________________________________________________________________________________________________

SAFETY DECISION

☐ No safety factors were identified at this time. Based on currently available information, there are no children
  likely to be in immediate danger of serious harm.

☐ One or more safety factors are present, and protecting safety interventions have been planned or taken. Based on
  protecting interventions, child(ren) will remain in the home at this time.

☐ One or more safety factors are present, and placement is the only protecting intervention possible for one or
  more children. Without placement, one or more children will likely be in danger or immediate or serious harm.

       ______  All children placed.
       ______  The following children were placed:
IMMEDIATE SAFETY PLAN
(Consider the child’s age and vulnerability, location and access of alleged offender to the child, parental willingness to protect, family and community supports when developing the Immediate Safety Plan.)

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

INTERVENTIONS / ACTIONS TAKEN: | DATE IMPLEMENTED: | REMARKS:
---|---|---
___ Contact DSWD for protective custody | | |
___ Immediate placement | | |
___ Home visit | | |
___ Endorse case | | |
___ Barangay/Police Blotter | | |
___ Medical care for child | | |
___ Psychiatric Evaluation/Treatment | | |

Other interventions:

RECOMMENDATIONS
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

SOCIAL WORKER’S SIGNATURE: ______________________
DATE:_________________________

Source: Philippine General Hospital-Child Protection Unit Immediate Safety Assessment Form (PGH Form No. Q-660006)
APPENDIX R

PSYCHOLOGICAL TRAUMA ASSESSMENT QUESTIONNAIRE

Cynthia R. Leynes, MD

Introduction:
This assessment questionnaire is designed to aid the rater screen for psychological trauma among Filipino children 6-18 years old who have been victims of abuse. The rater must be a social worker or mental health professional who has had experience with abused children. Previous training on the use the questionnaire must be done before actual use on a patient.

Materials needed: Questionnaire, pencil, cue cards that say “Hindi nangyayari”, “Bihira”, “Paminsanminsan”, “Madalas” and “Palagi”

Instructions:
The questionnaire is administered after asking the parent or guardian information regarding the circumstances of the abuse. The child is then asked the first 24 questions and then the mother is asked the last six questions.

The cue cards are placed in front of the child. The rater introduces the questionnaire by saying, “Magbabasa ako ng mga salaysay tungkol sa mga sintomas na maaring nangyari sa iyo o hindi nangyari sa iyo kailanan man. Para malaman ko kung kailangan mo magpatingin sa psychiatrist o psychologist, kailangan mong sabihin sa akin kung gano kadalas nangyayari ang mga sintomas. Sa bawat salaysay paki sabi mo sa akin kung hindi, bihira, paminsanminsan, madalas o palagi nangyayari sa iyo. Pwede mo din ituro yon card kung ayaw mo magsalita.” Rater then reads each question to the child by starting each question with “Mula noong ___ Gaano kadalas ...? (Each question is anchored in terms of time to nearest year/mnth/week/day as appropriate to length of time from first abuse)

The rater scores each item on the questionnaire using the following scale:
0 - Hindi nangyayari
1 – Bihira (1 X sa isang buwan)
2 – Paminsanminsan (1 X sa isang linggo)
3 – Madalas (3-4 X sa isang linggo)
4 – Palagi (araw-araw)

The rater then adds the total of all items.

* Permission for use may be obtained from Cynthia R. Leynes, MD, Philippine General Hospital Child Protection Unit
Patient: ________      Date:________

PART 1

Mula noong __/__/__ (Indicate date of first incidence of abuse), gaano kadalas..
(The following should have newly occurred after incident or be more disturbing after the incident.)

1. naaalala ang nangyari 0 1 2 3 4
2. nagbago ang pagtulog 0 1 2 3 4
   (hirap matulog, mas maigsi, mababaw, pagising- gising)
3. napapanaginipan ang nangyari 0 1 2 3 4
4. kinakabahan na may masamang mangyayari 0 1 2 3 4
5. madaling magulat 0 1 2 3 4
6. takot sa tao 0 1 2 3 4
7. iniwisan ang mga bagay na nagpapaalala sa nangyari 0 1 2 3 4
8. walang tiwala sa tao 0 1 2 3 4
9. tulala o natitigilan 0 1 2 3 4
10. nahihirapan mag- isip (in school or in making conversation) 0 1 2 3 4
11. magulo ang isip (confused, maraming iniisip, di makadesisyon) 0 1 2 3 4
12. may pakiramdam na naiiba o nagbago ang paligid 0 1 2 3 4
13. walang ganang kumain 0 1 2 3 4
14. malungkutin 0 1 2 3 4
15. makalimutin 0 1 2 3 4
16. madaling umiyak 0 1 2 3 4
17. ayaw lumabas/ walang gana maglaro 0 1 2 3 4
18. nawawalan ng pagasa sa buhay 0 1 2 3 4
19. may pakiramdam/ iniisip na may ginawang kasalanan masama 0 1 2 3 4
20. may pakiramdam na nasira ang buhay 0 1 2 3 4
21. may pakiramdam na nagiisa sa problema 0 1 2 3 4
22. naiisip na mas mabuti pang mamatay 0 1 2 3 4
23. may nararamdaman sa katawan 0 1 2 3 4
24. ayaw/walang gana magaral 0 1 2 3 4
Patient: ________     Date:__________

The following are to be asked from parent/ guardian:

25. matigas ang ulo     0 1 2 3 4
26. madaling mainis o magalit/ irritable     0 1 2 3 4
27. palaaway (verbal or physical)     0 1 2 3 4
28. may kilos sexual na di angkop sa edad     0 1 2 3 4
29. may kuwentong sexual na di angkop sa edad     0 1 2 3 4
30. may pambahirang kilos na nakakabahala     0 1 2 3 4

Specify________________________ (eg. palakad- lakad, naglalayas, paulit ulit ang

              ginagawa)

Part II

If any of the following occur, an emergency referral should be made. Give a score of 120 automatically. Please check box:

☐ May balak magpakamatay /Nagtangkang magpakamatay
☐ Nagwawala/Nanakit ng tao
☐ Bumubulong/ magasalita/ tumatawa magisa
☐ May nakikita o naririnig na hindi nakikita o naririnig ng iba
☐ May pagbabago sa dating ginagawian

Number of items with a score of 1  _______ X 1 = _______
Number of items with a score of 2  _______ X 2 = _______
Number of items with a score of 3  _______ X 3 = _______
Number of items with a score of 4  _______ X 4= _______

TOTAL  _______

Signature of Rater:____________________  Date__________________

Printed Name of Rater:____________________
### Instructions for use of the **Psychological Trauma Assessment Questionnaire** (Leynes, 2015)

<table>
<thead>
<tr>
<th>Age of child</th>
<th>6-18 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualification of rater</td>
<td>Must have basic knowledge of dynamics of child abuse; must have been trained on the use of questionnaire</td>
</tr>
<tr>
<td>Time reference for manifestation of symptoms</td>
<td>One week. (Symptoms must be present during the last week.) If abuse occurred less than a week ago, symptoms must have occurred from the abuse incident.</td>
</tr>
</tbody>
</table>
| Respondent | Questions 1-24 must be addressed to the child.  
Questions 25-30 must be addressed to the parent/adult caregiver.  
Emergency symptoms may be elicited from either child or parent or both. |
| Severity of symptoms | Rate symptoms according to frequency of occurrence as follows:  
0- Hindi nangyayari  
1– Bihira (1 X sa isang buwan)  
2– Paminsanminsan (1 X sa isang linggo)  
3- Madalas (3-4 X sa isang linggo)  
4- Palagi (araw- araw) |
| Symptoms | Should have newly occurred or became worse after the incident.  
1. naaalala ang nangyari | recurring thoughts of the incident  
2. nagbago ang pagtulog | difficulty in initiating or maintaining sleep; sleep shorter than usual; light or not restful sleep  
3. napapanaginipan ang nangyari | recurrent dreams or nightmares of the incident  
4. kinakabahan na may masamang mangyayari | fearful that something bad may happen  
5. madaling magulat | easy startle |
<table>
<thead>
<tr>
<th></th>
<th>Tagalog</th>
<th>English</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>takot sa tao</td>
<td>afraid of or avoids people</td>
</tr>
<tr>
<td>7.</td>
<td>iniwiisan ang mga bagay na nagpapaalala sa nangyari</td>
<td>avoids reminders of the event</td>
</tr>
<tr>
<td>8.</td>
<td>walang tiwala sa tao</td>
<td>distrust people</td>
</tr>
<tr>
<td>9.</td>
<td>tulala o natitigilan</td>
<td>dazed or stupefied</td>
</tr>
<tr>
<td>10.</td>
<td>nahihirapan mag-isip</td>
<td>cannot concentrate in school or cannot focus on conversation</td>
</tr>
<tr>
<td>11.</td>
<td>magulo ang isip</td>
<td>confused, has many thoughts entering the mind, cannot make decision</td>
</tr>
<tr>
<td>12.</td>
<td>may pakiramdam na naiiba o nagbago ang paligid</td>
<td>feelings of unreality</td>
</tr>
<tr>
<td>13.</td>
<td>walang ganang kumain</td>
<td>loss or decrease of appetite, food is tasteless</td>
</tr>
<tr>
<td>14.</td>
<td>malungkutin</td>
<td>sad</td>
</tr>
<tr>
<td>15.</td>
<td>makalimutin</td>
<td>forgetful</td>
</tr>
<tr>
<td>16.</td>
<td>madaling umiyak</td>
<td>cries easily</td>
</tr>
<tr>
<td>17.</td>
<td>ayaw lumabas/walang gana maglaro</td>
<td>isolates self or does not socialize/ refuses to play</td>
</tr>
<tr>
<td>18.</td>
<td>nawawalan ng pagasa sa buhay</td>
<td>feels there is no hope in life</td>
</tr>
<tr>
<td>19.</td>
<td>may pakiramdam/iniisip na may ginawang kasalanan masama</td>
<td>feels guilty or thinks that she did something bad</td>
</tr>
<tr>
<td>20.</td>
<td>may pakiramdam na nasira ang buhay</td>
<td>feels that one’s life has been destroyed; there is no future</td>
</tr>
<tr>
<td>21.</td>
<td>may pakiramdam na nagiisa sa problema</td>
<td>feels alone or cannot turn to anyone for the problem</td>
</tr>
<tr>
<td>22.</td>
<td>naiisip na mas mabuti pang mamatay</td>
<td>wishes to die <em>(This is in contrast to the emergency symptom of having made plans to kill self.)</em></td>
</tr>
<tr>
<td>23.</td>
<td>may nararamdaman sa katawan</td>
<td>body symptoms- aches, pains or feeling unwell</td>
</tr>
<tr>
<td>24.</td>
<td>ayaw/walang gana magaral</td>
<td>refuses to attend school or has lost interest in school</td>
</tr>
<tr>
<td>25.</td>
<td>matigas ang ulo</td>
<td>hard- headed or disobedient</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>---</td>
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<td></td>
</tr>
<tr>
<td>26. madaling mainis o magalit/ irritable</td>
<td>easily angry or irritable</td>
<td></td>
</tr>
<tr>
<td>27. palaaway (verbal or physical)</td>
<td>gets into verbal or physical fights</td>
<td></td>
</tr>
<tr>
<td>28. may kilos sexual na di angkop sa edad</td>
<td>manifests sexual behavior that is not appropriate for age</td>
<td></td>
</tr>
<tr>
<td>29. may kuwentong sexual na di angkop sa edad</td>
<td>tells stories with sexual content not appropriate for age</td>
<td></td>
</tr>
<tr>
<td>30. may pambihirang kilos na nakakabahala</td>
<td>behavior that is unusual and disturbing like restlessness, running away, repetitive acts</td>
<td></td>
</tr>
<tr>
<td>May balak magpakamatay /Nagtangkang magpakamatay</td>
<td>Made plans to kill self/ attempted to kill self</td>
<td></td>
</tr>
<tr>
<td>Nagwawala/Nanakit ng tao</td>
<td>Out of control/ Aggressive or hurting others</td>
<td></td>
</tr>
<tr>
<td>Bumubulong/ magsasalita/ tumatawa magisa</td>
<td>Talking or laughing to self</td>
<td></td>
</tr>
<tr>
<td>May nakikita o naririnig na hindi nakikita o naririnig ng iba</td>
<td>Seeing or hearing things that others do not experience</td>
<td></td>
</tr>
<tr>
<td>May pagbabago sa dating ginagawian</td>
<td>Loss of functioning as evidenced by dysfunction in school or social relations</td>
<td></td>
</tr>
<tr>
<td>Scoring</td>
<td>Children with scores 40 and above must be referred to psychiatrist/ psychologist. Children with scores less than 40 (and their parents) must be given psycho-education. Instructions on what to watch out for and what to do when problems arise must be given.</td>
<td></td>
</tr>
</tbody>
</table>


