



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.

HISTORY OF PREVIOUS EDITIONS

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 injuries¹. 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 WCPUs. As of December 2014, there are 72 WCPUs 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.

¹ Castillo M. Legal Outcomes of Sexually Abused Cases Evaluated at the Child Protection Unit Philippine General Hospital. *Child Abuse Negl.* 2009;33:193-202.

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 Consensus. 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							
Patient's Name	Cruz, Ana Maria R.	Age	14	DOB	08/22/2000	Sex	F
Patient's Address	307 De los Santos St., Bgy. 44, Malate, Manila						
Civil Status	Single	Occupation	Grade 3 student	Nationality	Filipino		
Requesting Party	Maria Leonora R. Cruz (mother)	Place, Time & Date of Exam	September 12, 2014 4:20 PM				
<input checked="" type="checkbox"/> Acute Evidentiary Examination (within 72 hours of incident)				<input type="checkbox"/> Non-Acute Examination			
Date & Time of Most Recent Incident: September 10, 2014 11:00 PM							
Place of Incident: Malate, Manila							

FINDINGS			
GENERAL PHYSICAL FINDINGS			
Height	150 cm	Weight	60 kg
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	<p>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.</p> <p>Breasts Tanner Stage: 4</p> <p>ABDOMEN: Umbilical - Enlarged with fundic height of 20 cm. Fetal movements appreciated; fetal heart tones 140/minute on right lower quadrant.</p> <p>LMP: April 25, 2014 G1P0</p>		

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).

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 <hr style="width: 50%; margin: 0 auto;"/> 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
- ✓ Extragenital 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)

PROFILE

Update Case Profile:

Last Name CRUZ	First Name ANA MARIA	Middle Name REYES	<input checked="" type="radio"/> Birthdate 08/22/2000 14 years old <input type="radio"/> Approximate <input type="text"/> yrs <input type="text"/> mos	Gender <input type="radio"/> Male <input checked="" type="radio"/> Female	Find Delete Save Discard
Consent Signed on 09/12/2014 03:00pm		Primary Diagnosis Sexual Abuse <input type="button" value="v"/>		<input type="checkbox"/> Reabuse?	
Date Initiated <input type="text"/>		Others <input type="text"/>			
Guardian ...		Comorbid Abuse			
Name CRUZ, MARIA LEONORA REYES Relationship Mother		<input type="checkbox"/> Child Trafficking <input checked="" type="checkbox"/> Emotional/ Psychological/ Verbal Abuse <input type="checkbox"/> Neglect <input type="checkbox"/> None <input checked="" type="checkbox"/> Physical Abuse <input type="checkbox"/> Physical and Sexual Abuse <input type="checkbox"/> Sexual Abuse			
Informant ...		Intake Social Worker			
Name CRUZ, MARIA LEONORA REYES Relationship Mother		MACABABBAD, LIEZEL <input type="button" value="v"/>			
Hospital No. 123456 Inpatient? <input type="radio"/> Yes <input checked="" type="radio"/> No Other Companion <input type="text"/>		Assigned Social Worker			
		MACABABBAD, LIEZEL <input type="button" value="v"/>			
		Assigned Physician			
		VILLANO, SARA <input type="button" value="v"/>			
Referral Source Self <input type="button" value="v"/>		Trainee <input type="text"/>		Add Delete	
Services Sought Full Evaluation <input type="button" value="v"/>					

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.

MEDICO-LEGAL CERTIFICATE

DEMOGRAPHIC DATA							
Patient's Name	Cruz, Ana Maria R.	Age	14	DOB	08/22/2000	Sex	F
Patient's Address	307 De Los Santos St., Bgy. 44, Malate, Manila						
Civil Status	Single	Occupation	Grade 3 student		Nationality	Filipino	
Requesting Party	Maria Leonora R. Cruz (mother)	Place, Time & Date of Exam		September 12, 2014 4:20 PM			

INTERVIEW

INFORMATION

Update Interview: CRUZ, ANA MARIA REYES 2000-08-22

Find Delete Save Discard

Info Child's Behavior Interview

Patient Name: CRUZ, ANA MARIA REYES 2000-08-22 CPU Case No.: 13849 Date: 09/12/2014 03:00PM Interview No.: 1

Interviewed by: Social Worker: MACABBABAD, LIEZEL Physician: VILLANO, SARA Trainee:

Source: ☐ Child ☐ Sworn Statement ☐ Historian ☐ No Info ☒ Both

Historian: Name: CRUZ, MARIA LEONORA REYES Relationship: Mother

Interviewed before by: Add Delete Relative:

Interview deferred? Add Delete CPU has statement Child Upset Developmentally unable to disclose Not Disclosing Other Previous Statement Taken By Dswd Previous Statement Taken By Nbi Previous Statement Taken By Pmp

Other observers interview:

Appointments:

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).

CHILD'S BEHAVIOR

Update Interview: CRUZ, ANA MARIA REYES 2000-08-22

Find Delete Save Discard

Info Child's Behavior Interview

☒ Able To Narrate Incident ☒ Appropriate Affect ☐ Clinging To Caretaker ☐ Combative, Hostile ☒ Cooperative ☐ Crying, Very Upset ☐ Depressed Affect ☐ Flat Affect, Blank Stares ☐ Hyperactive, Anxious ☐ Others ☐ Psychotic Symptoms ☐ Responsive To Most Questions ☐ Short Attention Span ☐ Silent, Unresponsive ☐ Unable To Narrate Incident

Care taker present during interview? ☐ Yes ☒ No

Describe child's behavior and interaction with interviewer/ caretaker:
The child is inattentive but answers when asked questions by the interviewer.

Further developmental assessment needed: ☒ Neglected Schooling ☐ Other ☐ Physical Disabilities ☐ Probable Developmental Delay (For Age Below 7) ☒ Probable Learning Problems (For School-Aged) ☐ Probable Moderate To Profound Mental Retardation ☐ Sensory Impairment

Other remarks:

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:

	MOTOR DELAY	LANGUAGE DELAY	PSYCHOSOCIAL DELAY	COGNITIVE DELAY
INFANCY Birth to 1 year	Poor head control by 3 months		No social smile by 3 months	Not alert to mother at 2 months
	Hands still fisted by 4 months			
	Unable to hold objects by 7 months	Does not turn to sound by 6 months	Not laughing in playful situations by 6 months	Not searching for dropped objects at 6 months
	Does not sit independently by 10 months	Does not babble or use gestures by 1 year	Hard to console, stiffens to approach by 1 year	No object permanence at 1 year
TODDLER 1 to 3 years		No single word utterance by 16 months	In constant motion, resists discipline	No interest in cause-and-effect games at 18 months
		No two-word phrases by 2 years		Does not categorize similarities at 2 years
	Cannot stand on one leg by 3 years	No three-word phrases by 3 years	Does not play with other children at 3 years	Does not know full name at 3 years
PRE-SCHOOL 3 to 5 years		No simple sentences at 3 years		Cannot count sequentially at 4 ½ years
		Speech not understandable to an unfamiliar adult less than half of the time at 3 ½ years		Does not know letters or colors at 5 years
		Not able to tell or retell a familiar story at 4 ½ years		Does not know own birthday or address at 5 ½ years
		Speech not fully understandable to an unfamiliar adult at 5 years		

SCHOOL-AGED CHILDREN

- Slow to remember facts
- Slow to learn new skills, relies heavily on memorization
- Poor coordination, unaware of physical surroundings and prone to accidents
- May be awkward and clumsy, has trouble with fine motor skills

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).

SUPREME COURT DECISION

**PEOPLE V RUBIO, G.R. NO. 195239,
MARCH 7, 2012**

"A medical examination of the victim is not indispensable in a prosecution for rape inasmuch as the victim's testimony alone, if credible, is sufficient to convict the accused of the crime".

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

New Interview: CRUZ, ANA MARIA REYES 1999-08-22

InfoChild's BehaviorInterview

Patient's Interview

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

Informant's Interview

The questions asked and the child's responses must be documented verbatim.

FindDeleteSaveClose

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).

SUPREME COURT DECISION

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

"The credible disclosure of a minor that the accused raped her is the most important proof of sexual abuse."

SUPREME COURT DECISION

**PEOPLE V SALUDO, G.R. NO. 178406,
APRIL 6, 2011**

"...a rape victim cannot be expected to mechanically keep and then give an accurate account of the traumatic and horrifying experience she had undergone."

CASE INFORMATION

CHIEF COMPLAINT: The child's interview begins with asking if she knows the purpose of the examination (Appendix D).

New Case Information CRUZ, ANA MARIA REYES 1999-08-22

Complaint Disclosure Incident Alleged Perp Acts Described Incident-Perp-Acts Past Abuse Comorbid Abuse Case Closed

Patient Name: CRUZ, ANA MARIA REYES 1999-08-22 CPU Case No: 13849

Chief Complaint: Sexual

None
☐ None

Disclosure Of Abuse
☐ Emotional
☐ Neglect
☐ Physical
☒ Sexual

Behavioral Changes
☐ Aggression/Anger
☐ Anxiety
☐ Changes In Social Relationship
☐ Delusions
☐ Disturbed Sleep
☐ Easily Startled
☐ Expressions Of Low Self-Esteem
☐ Fearfulness
☐ Grossly Inappropriate Behavior
☐ Hallucinations
☐ Hyperactivity
☐ Hypervigilance
☐ Irritability
☐ Loss Of Appetite
☐ Nightmares
☐ Other
☐ Palpitations
☐ Recurrent Thoughts
☐ Running Away From Home
☐ Sadness
☐ Self-Mutilation

Physical Complaints
☐ Sexual Knowledge Beyond Age
☐ Sexualized Behavior
☐ Staring Spells
☐ Suicidal Thoughts/Attempt
☐ Tearfulness/Crying Spells
☐ Truancy/Problems At School
☐ Withdrawal

Neglect
☐ Abandonment
☐ Delayed Development
☐ Dirty, Unkempt
☐ Failing To Thrive
☐ Lack Of Supervision

Neglected Schooling
☐ Other
☐ Undernourished
☐ Untreated Medical Problems

Others
☐ Other
☐ Sibling Of Abused Child
☐ Witnessed Child Abuse
☐ Witnessed Physical Abuse
☐ Witnessed Sexual Abuse

Parental/Guardian Request
☐ Parental/Guardian Request

Pregnancy
☐ Pregnancy

Find
Delete
Save
Close

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.

Update Case Information of CRUZ, ANA MARIA REYES 2000-08-22

Complaint Disclosure Incident Alleged Perp Acts Described Incident-Perp-Acts Past Abuse Comorbid Abuse Case Closed

Occurrence
☐ Unknown if abuse occurred
☐ Single episode of abuse
☐ Multiple episodes of abuse
☒ Unknown no. of episodes

Child disclosed to: Add Delete
CRUZ, MARIA LEONORA REYES

Patient disclose?
☐ Yes - Voluntary ☐ No
☒ Yes - Elicited ☐ N/A

Patient recant?
☐ Yes ☐ N/A
☒ No

Describe circumstances surrounding initial disclosure:
Ana's mother noticed the "hickey" on her neck and asked her how she got it. She disclosed that their neighbor has been sexually abusing her for the past several months and the last incident was two days ago.

Find
Delete
Save
Discard

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."

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).

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 was 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).

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.

Update Case Information of CRUZ, ANA MARIA REYES 2000-08-22

Complaint	Disclosure	Incident	Alleged Perp	Acts Described	Incident-Perp-Acts	Past Abuse	Comorbid Abuse	Case Closed	Find	Delete	Save	Discard
<div><div><div>Year: 2014</div><div>Date: September 10</div><div>Remarks:</div><div>Time: 11:00 PM</div><div>Remarks:</div><div>Site of Abuse: Perpetrator's</div><div><div>Enter by City/ Municipality</div><div>Province: Metro Manila</div><div>City/ Muni: Manila</div><div>Barangay:</div></div><div>Specific Site:</div></div><div><div>Incident</div><div>2014, September 10</div><div>Clear Delete</div></div></div> <div><div>Witnesses</div><div></div><div>Who reported to authorities</div><div>CRUZ, MARIA LEONORA REYES</div></div> <div><div>Add</div><div>Delete</div></div>												

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.

Update Case Information of CRUZ, ANA MARIA REYES 2000-08-22

Complaint	Disclosure	Incident	Alleged Perp	Acts Described	Incident-Perp-Acts	Past Abuse	Comorbid Abuse	Case Closed
-----------	------------	----------	---------------------	----------------	--------------------	------------	----------------	-------------

Search...

Last Name: GUZMAN
 First Name: ROMEO
 Middle Name:
 Birthdate:
 Approx age: 46 yrs 0 mos
 Age unknown:
 Relationship: NEIGHBOR
 Others:
 Male:
 Female:
 Unknown:
 Nick Name:
 Occupation: Driver
 Current location: In jail, Police custody
 Alleged perpetrator's address/ location:
 Other Info about the perpetrator:
 History of substance abuse:
 History of violence?:
 Criminal History:
 Perpetrator: GUZMAN, ROMEO

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

Update Case Information of CRUZ, ANA MARIA REYES 2000-08-22

Complaint	Disclosure	Incident	Alleged Perp	Acts Described	Incident-Perp-Acts	Past Abuse	Comorbid Abuse	Case Closed
Incident				Perpetrator				Find
2014, September 10				GUZMAN, ROMEO				Delete
								Save
								Discard
Acts done by GUZMAN, ROMEO during incident 2014, September 10								
Sexual Abuse	Physical Abuse	Neglect	Emotional Abuse					
Anal Contact With Foreign Object	<input type="radio"/> Child <input type="radio"/> Historian <input type="radio"/> Both <input type="radio"/> Sworn Statement <input checked="" type="radio"/> N/A							
Anal Contact With Penis	<input type="radio"/> Child <input type="radio"/> Historian <input type="radio"/> Both <input type="radio"/> Sworn Statement <input checked="" type="radio"/> N/A							
Child Is A Sex Worker	<input type="radio"/> Child <input type="radio"/> Historian <input type="radio"/> Both <input type="radio"/> Sworn Statement <input checked="" type="radio"/> N/A							
Ejaculation	<input type="radio"/> Child <input type="radio"/> Historian <input type="radio"/> Both <input type="radio"/> Sworn Statement <input checked="" type="radio"/> N/A							
Exhibitionism	<input type="radio"/> Child <input type="radio"/> Historian <input type="radio"/> Both <input type="radio"/> Sworn Statement <input checked="" type="radio"/> N/A							
Fondling	<input type="radio"/> Child <input type="radio"/> Historian <input type="radio"/> Both <input type="radio"/> Sworn Statement <input checked="" type="radio"/> N/A							
Force Or Weapon Used	<input checked="" type="radio"/> Child <input type="radio"/> Historian <input type="radio"/> Both <input type="radio"/> Sworn Statement <input type="radio"/> N/A							
Genital Contact With Finger	<input type="radio"/> Child <input type="radio"/> Historian <input type="radio"/> Both <input type="radio"/> Sworn Statement <input checked="" type="radio"/> N/A							
Genital Contact With Foreign Object	<input type="radio"/> Child <input type="radio"/> Historian <input type="radio"/> Both <input type="radio"/> Sworn Statement <input checked="" type="radio"/> N/A							
Genital Contact With Penis/Vagina	<input checked="" type="radio"/> Child <input type="radio"/> Historian <input type="radio"/> Both <input type="radio"/> Sworn Statement <input type="radio"/> N/A							
Given Substance To Change Consciousness	<input type="radio"/> Child <input type="radio"/> Historian <input type="radio"/> Both <input type="radio"/> Sworn Statement <input checked="" type="radio"/> N/A							
Intoxicated/Drunk	<input type="radio"/> Child <input type="radio"/> Historian <input type="radio"/> Both <input type="radio"/> Sworn Statement <input checked="" type="radio"/> N/A							
Licking Or Kissing	<input type="radio"/> Child <input type="radio"/> Historian <input type="radio"/> Both <input type="radio"/> Sworn Statement <input checked="" type="radio"/> N/A							
Masturbation Of Assailant By Self	<input type="radio"/> Child <input type="radio"/> Historian <input type="radio"/> Both <input type="radio"/> Sworn Statement <input checked="" type="radio"/> N/A							
Masturbation Of Assailant By Victim	<input type="radio"/> Child <input type="radio"/> Historian <input type="radio"/> Both <input type="radio"/> Sworn Statement <input checked="" type="radio"/> N/A							
Oral Copulation Of Genitals Of Assailant By Victim	<input type="radio"/> Child <input type="radio"/> Historian <input type="radio"/> Both <input type="radio"/> Sworn Statement <input checked="" type="radio"/> N/A							
Oral Copulation Of Genitals Of Victim By Assailant	<input type="radio"/> Child <input type="radio"/> Historian <input type="radio"/> Both <input type="radio"/> Sworn Statement <input checked="" type="radio"/> N/A							
Other sexual abuse	<input type="radio"/> Child <input type="radio"/> Historian <input type="radio"/> Both <input type="radio"/> Sworn Statement <input checked="" type="radio"/> N/A							
Photos/Videos Taken/Shown	<input type="radio"/> Child <input type="radio"/> Historian <input type="radio"/> Both <input type="radio"/> Sworn Statement <input checked="" type="radio"/> N/A							
Unconscious/Asleep	<input type="radio"/> Child <input type="radio"/> Historian <input type="radio"/> Both <input type="radio"/> Sworn Statement <input checked="" type="radio"/> N/A							
Verbal Threats	<input checked="" type="radio"/> Child <input type="radio"/> Historian <input type="radio"/> Both <input type="radio"/> Sworn Statement <input type="radio"/> N/A							

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

Update Case Information of CRUZ, ANA MARIA REYES 2000-08-22

Complaint	Disclosure	Incident	Alleged Perp	Acts Described	Incident-Perp-Acts	Past Abuse	Comorbid Abuse	Case Closed
Notes on comorbid abuse								Find
Ana's father is an alcoholic. He is very authoritative and becomes physically and emotionally abusive when he is under the influence of alcohol.								Delete
								Save
								Discard

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)

MEDICAL EXAMINATION

INFORMATION

New Medical Exam: CRUZ, ANA MARIA REYES 1999-08-22

Info	General Survey	Symptoms	Extragenital Exam	Anogenital Exam	Laboratory Record	Child's Behavior	Findings	Impressions	Pictures	Find								
<table><tr><td>Patient Name:</td><td>CPU Case No.</td><td>Date:</td><td>Med Exam No.</td></tr><tr><td>CRUZ, ANA MARIA REYES 1999-08-22</td><td>13849</td><td>09/12/2014 04:20PM</td><td></td></tr></table>										Patient Name:	CPU Case No.	Date:	Med Exam No.	CRUZ, ANA MARIA REYES 1999-08-22	13849	09/12/2014 04:20PM		Save Close
Patient Name:	CPU Case No.	Date:	Med Exam No.															
CRUZ, ANA MARIA REYES 1999-08-22	13849	09/12/2014 04:20PM																
Physician: VILLANO, SARA		Examined before by:		<div>Remarks</div> <div>Date Examined</div> <div>Examined before by</div> <div>CPU DOJ DSWD NBI None Other PNP Private MD</div>														
Trainee:		Remarks																
RN: DE LEON, EVA		Date Examined																
Persons present during exam Ma. Leonora R. Cruz (mother)				Exam requested by: Ma. Leonora R. Cruz (mother)														
<input type="checkbox"/> Defer Exam?																		
Appointments																		

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.

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

Info | **General Survey** | Symptoms | Extragenital Exam | Anogenital Exam | Laboratory Record | Child's Behavior | Findings | Impressions | Pictures

Find
Save
Discard

Temperature celsius Height cm > 5% and <= 10%
Heart rate /min Weight kg > 75% and <= 90%

Current medication:

☒ Menarche? If yes, start age:
Date of last period:

General Survey
☒ Ambulant
☐ Non-Ambulant
☒ Not in Respiratory Distress
☐ Others
☐ Respiratory Distress

Describe past hospitalization:

Pertinent medical history
(+) Urinary tract infection - June 2014, treated with unrecalled antibiotics

Mental status

General Survey Remarks

Summary of non-abuse findings:

NUTRITIONAL STATUS

The WHO Child Growth Standards and Growth reference have been adopted for use in the Philippines to monitor the growth of children and adolescents by virtue of the National Nutrition Council Governing Board Resolution No. 2, series of 2008 and No. 3, series of 2009. For children from birth to 5 years, the WHO Child Growth Standards are available at: <http://www.who.int/childgrowth/standards/en/>. For older children and adolescents, 5-19 years, the WHO Reference 2007 is available at <http://www.who.int/growthref/en/>.

The general survey, weight and height are documented in the Medico-legal Certificate.

MEDICO-LEGAL CERTIFICATE

FINDINGS			
GENERAL PHYSICAL FINDINGS			
Height	150 cm	Weight	60 kg
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

Info | **General Survey** | Symptoms | Extragenital Exam | Anogenital Exam | Laboratory Record | Child's Behavior | Findings | Impressions | Pictures

Find
Save
Discard

Temperature celsius Height cm > 5% and <= 10%
Heart rate /min Weight kg > 75% and <= 90%

Current medication:

☒ Menarche? If yes, start age:
Date of last period:

General Survey
☒ Ambulant
☐ Non-Ambulant
☒ Not In Respiratory Distress
☐ Others
☐ Respiratory Distress

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 Remarks

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).

CHILD'S BEHAVIOR

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

Info	General Survey	Symptoms	Extragenital Exam	Anogenital Exam	Laboratory Record	Child's Behavior	Findings	Impressions	Pictures	Find
<input type="checkbox"/> Clinging To Caretaker <input type="checkbox"/> Combative, Hostile <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Crying Very Upset <input type="checkbox"/> Fearful Of Anogenital Contact <input type="checkbox"/> Frightened Of Colposcope <input type="checkbox"/> Psychotic Symptoms <input type="checkbox"/> Silent, Unresponsive										Save
Describe child's behavior during the exam (including spontaneous utterances).										Discard

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.

MEDICO-LEGAL CERTIFICATE

DEMOGRAPHIC DATA							
Patient's Name	Cruz, Ana Maria R.	Age	14	DOB	08/22/2000	Sex	F
Patient's Address	307 De los Santos St., Bgy. 44, Malate, Manila						
Civil Status	Single	Occupation	Grade 3 student	Nationality	Filipino		
Requesting Party	Maria Leonora R. Cruz (mother)	Place, Time & Date of Exam	September 12, 2014 4:20 PM				
<input checked="" type="checkbox"/> Acute Evidentiary Examination (within 72 hours of incident)				<input type="checkbox"/> Non-Acute Examination			
Date & Time of Most Recent Incident: September 10, 2014 11:00 PM							
Place of Incident: Malate, Manila							
FINDINGS							
GENERAL PHYSICAL FINDINGS							
Height	150 cm		Weight	60 kg			
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						

ANOGENITAL AND BEHAVIORAL SYMPTOMS

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

Info	General Survey	Symptoms	Extragenital Exam	Anogenital Exam	Laboratory Record	Child's Behavior	Findings	Impressions	Pictures	Find
<div> Anogenital Behavioral Corporal Other Symptoms </div>										
Amenorrhea	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Constipation	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Diarrhea	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Dysuria	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Genital Bleeding	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Genital Discharge	<input checked="" type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input type="radio"/> N/A						
Genital Itching	<input checked="" type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input type="radio"/> N/A						
Incontinent Stool, Encopresis	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Other	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Pelvic Pain	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Pregnancy	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Rectal Bleeding	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Rectal Pain	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Urinary Tract Infection	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Vulva/Penile/Discomfort/Pain	<input checked="" type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input type="radio"/> N/A						
Enuresis(Day Or Night)	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Other symptoms described										

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

Info	General Survey	Symptoms	Extragenital Exam	Anogenital Exam	Laboratory Record	Child's Behavior	Findings	Impressions	Pictures	Find
<div> Anogenital Behavioral Corporal Other Symptoms </div>										
Aggression/Anger	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Anxiety	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Changes In Social Relationship	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Delusions	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Easily Startled	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Expressions Of Low Self-Esteem	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Fearfulness Of	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Grossly Inappropriate Behavior	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Hallucinations	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Hyperactivity	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Hypervigilance	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Irritability	<input type="radio"/> Child	<input type="radio"/> Historian	<input checked="" type="radio"/> Both	<input type="radio"/> N/A						
Loss Of Appetite	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Nightmares	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Other	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Palpitations	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Problems At School / Truancy	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Recurrent Thoughts	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Running Away From Home	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Sadness	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Self-Mutilation	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Other symptoms described										

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

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

Info	General Survey	Symptoms	Extragenital Exam	Anogenital Exam	Laboratory Record	Child's Behavior	Findings	Impressions	Pictures																																													
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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.

MEDICO-LEGAL CERTIFICATE

FINDINGS			
GENERAL PHYSICAL FINDINGS			
Height	150 cm	Weight	60 kg
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

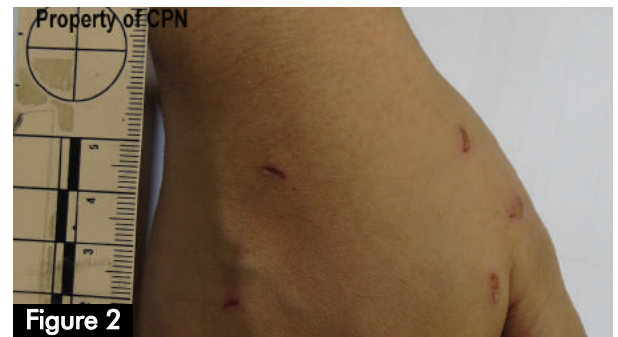
Contrary to commonly held beliefs, the exact time a bruise was inflicted cannot be determined accurately based on appearance. A systematic review of studies on aging of bruises in children by Maguire et al. in Archives of Disease in Childhood 2005 showed there are only very few studies that have been 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.



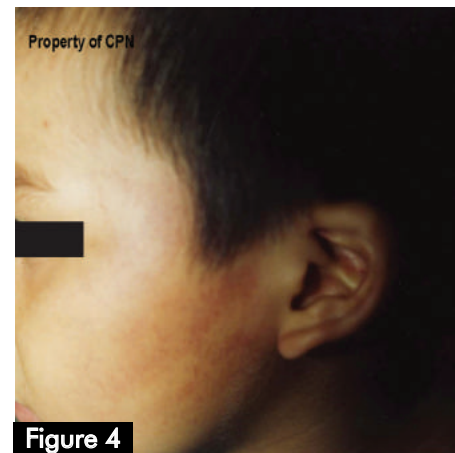
FINGERTIP BRUISES. These are caused by the forceful application of fingertips. They usually appear with as 1-2 cm oval or round shaped clusters of three to four bruises. There may also be a linear or curved abrasion from the fingernail pressing into the skin.



PETECHIAL 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:

IMPRESSIONS
"Findings noted on <i>(site on the body)</i> are consistent with <i>(suction marks, fingertip bruises, bite marks, etc.)</i> "

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:

IMPRESSIONS
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.

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

IMPRESSIONS
Injuries sustained on the <i>(part of the body)</i> are consistent with the imprint of a <i>(implement)</i> .

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.

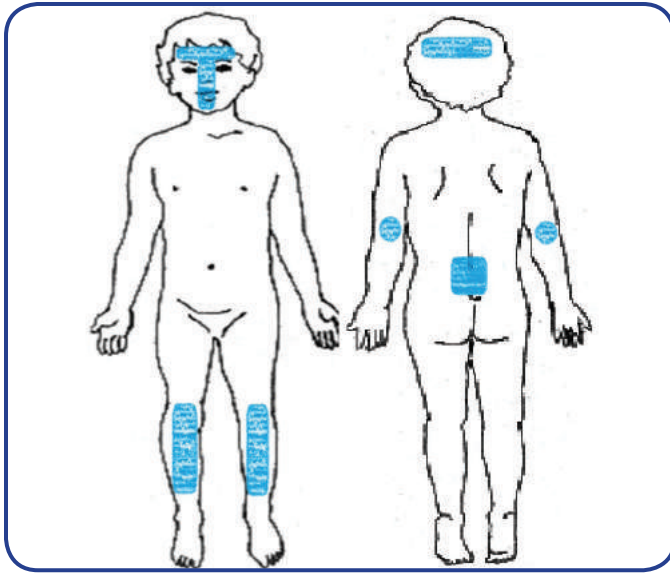


Figure 7. Accidental bruising pattern

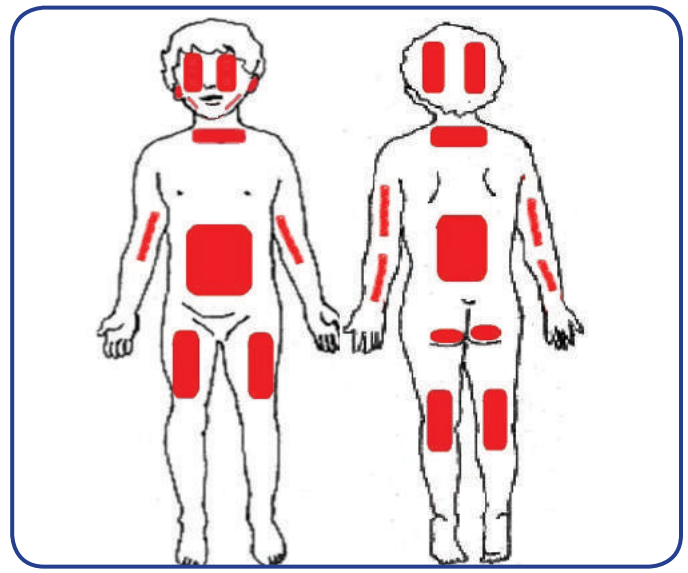


Figure 8. Abusive bruising pattern

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



Figure 9. 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:

Branding/dry contact burns showing the imprint of hot objects



Figure 10. Flat iron burn



Figure 11. Cigarette burn

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

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

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 <i>(site on the body)</i> 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

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

Info	General Survey	Symptoms	Extragenital Exam	Anogenital Exam	Laboratory Record	Child's Behavior	Findings	Impressions	Pictures	Find																																													
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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

Pertinent Physical Findings/ Physical Injuries	<p>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.</p> <p>ABDOMEN: Umbilical - Enlarged with fundic height of 20 cm.</p> <p>Fetal movements appreciated; fetal heart tones 140/minute on right lower quadrant. LMP: April 25, 2014 G1P0</p>
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ANOGENITAL EXAMINATION

New Medical Exam: CRUZ, ANA MARIA REYES 1999-08-22

Info | General Survey | Symptoms | Extragenital Exam | **Anogenital Exam** | Laboratory Record | Child's Behavior | Findings | Impressions | Pictures

Method: 72 hrs | Tanner Stage | Anogenital Exam | Used

☒ Colposcope
☒ Direct Visualization
☐ Other
☒ Photos
☐ Sedation
☐ Speculum
☐ Toluidine Blue
☐ Water

Other methods used

See Appendix I: Abuse Documentation Using Conventional Photography, Colposcopy and Digital Photography and Appendix I-1: Forensic Photography.

Find
Save
Close

MEDICO- LEGAL CERTIFICATE

DEMOGRAPHIC DATA							
Patient's Name	Cruz, Ana Maria R.	Age	14	DOB	08/22/2000	Sex	F
Patient's Address	307 De los Santos St., Bgy. 44, Malate, Manila						
Civil Status	Single	Occupation	Grade 3 student	Nationality	Filipino		
Requesting Party	Maria Leonora R. Cruz (mother)	Place, Time & Date of Exam	September 12, 2014 4:20 PM				
<input checked="" type="checkbox"/> Acute Evidentiary Examination (within 72 hours of incident)				<input type="checkbox"/> Non-Acute Examination			
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:

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

Info	General Survey	Symptoms	Extragenital Exam	Anogenital Exam	Laboratory Record	Child's Behavior	Findings	Impressions	Pictures	Find
Method: 72 hrs Tanner Stage Anogenital Exam										Save Discard
For exams within 72 hrs of the incident, record post-assault hygiene. Collect and preserve all evidence.										
Activity before exam: <input checked="" type="checkbox"/> Within 72hrs?										
Bath / Shower	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Brushed Teeth	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Changed Clothing	<input checked="" type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input type="radio"/> N/A						
Defecated	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Genital Wipe / Wash	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Oral Gargle / Swish	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Other	<input type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input checked="" type="radio"/> N/A						
Urinated	<input checked="" type="radio"/> Child	<input type="radio"/> Historian	<input type="radio"/> Both	<input type="radio"/> N/A						
Other activity: <input type="text"/>										
In cases of sexual assault w/in 72 hrs, collect and preserve the ff medical evidence										
<input checked="" type="checkbox"/> Anal Swabs	<input type="checkbox"/> Any Clothing Or Fibers	<input type="checkbox"/> Blood (Dna Typing)	<input type="checkbox"/> Blood (Tox Screen)	<input checked="" type="checkbox"/> Buccal Swab	<input checked="" type="checkbox"/> External genitalia swab	<input type="checkbox"/> Fingernail Scrapings	<input checked="" type="checkbox"/> Other	<input type="checkbox"/> Penile Swabs	<input type="checkbox"/> Pubic Hair Combing	<input type="checkbox"/> Urine Sample
						<input checked="" type="checkbox"/> Vaginal Swabs				
Other evidence	Body surface (neck) swab									
Purpose	<input checked="" type="checkbox"/> for DNA <input type="checkbox"/> for Storage									

CHAIN OF CUSTODY

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

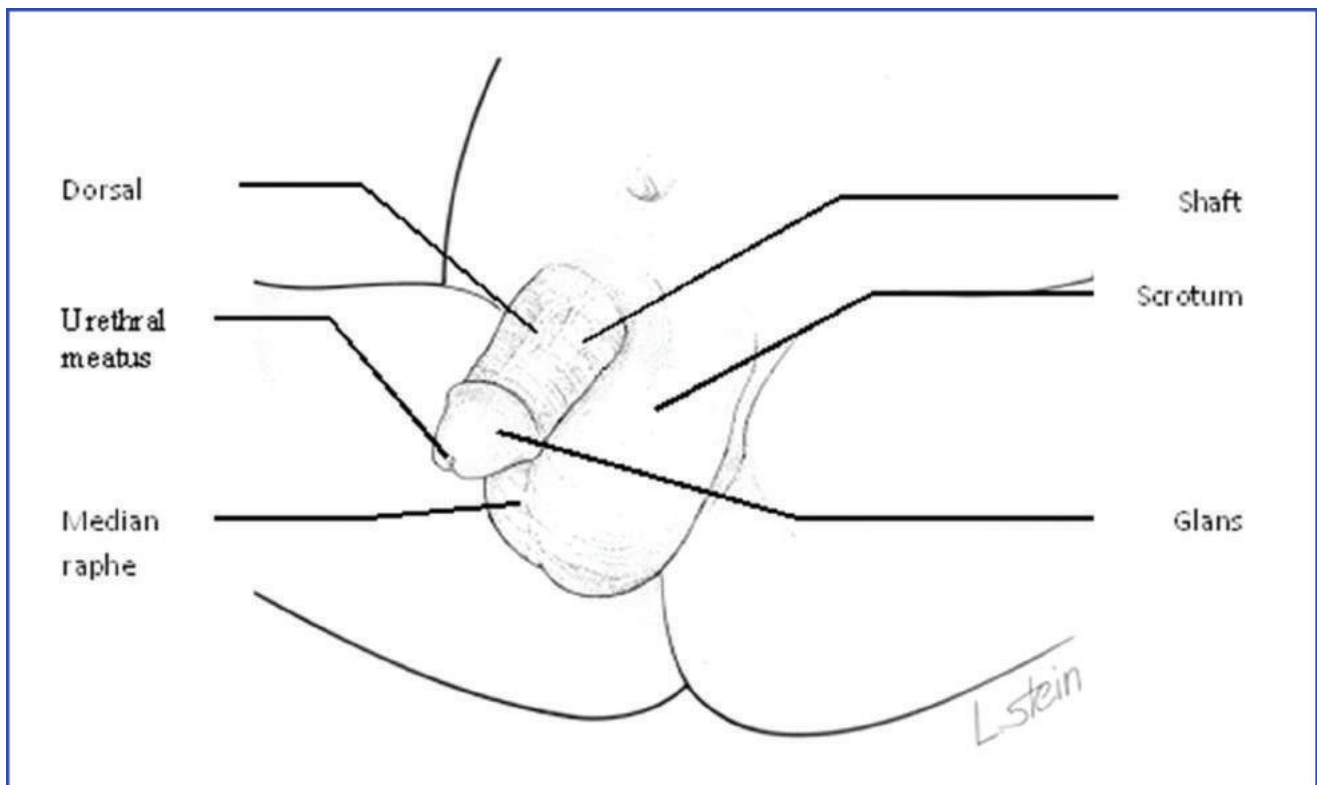


Figure 12. Male Genital Anatomy

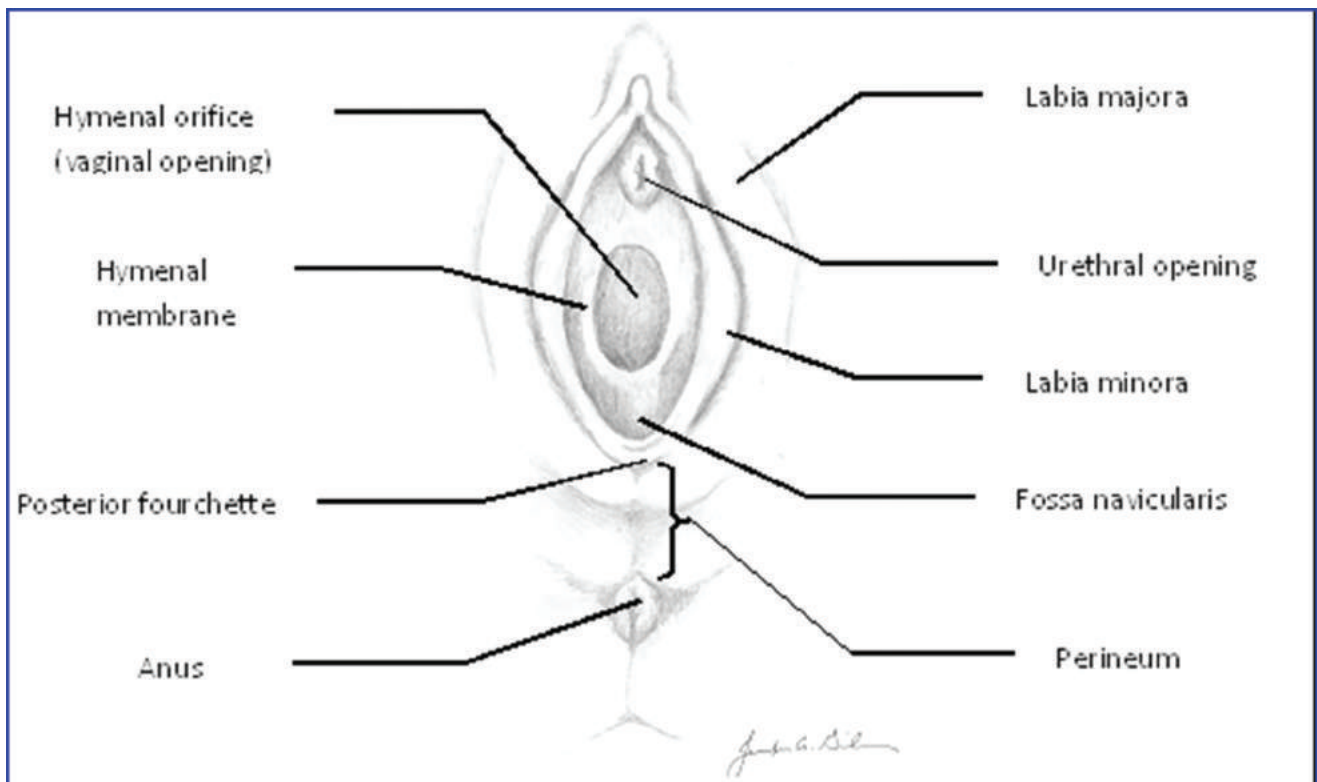


Figure 13. Female Genital Anatomy

ASSESSMENT OF PUBERTAL DEVELOPMENT

New Medical Exam: CRUZ, ANA MARIA REYES 1999-08-22

Info

General Survey

Symptoms

Extragenital Exam

Anogenital Exam

Laboratory Record

Child's Behavior

Findings

Impressions

Pictures

Method72 hrsTanner StageAnogenital Exam

Breasts

Tanner Stage

☐ 1

☐ 2

☐ 3

☒ 4

☐ 5

☐ NA

External genitalia

Tanner Stage

☐ 1

☐ 2

☐ 3

☒ 4

☐ 5

☐ NA

Hymen

Tanner Stage

☐ 1

☐ 2

☐ 3

☒ 4

☐ 5

☐ NA

Find

Save

Close

THE TANNER DEVELOPMENT STAGES

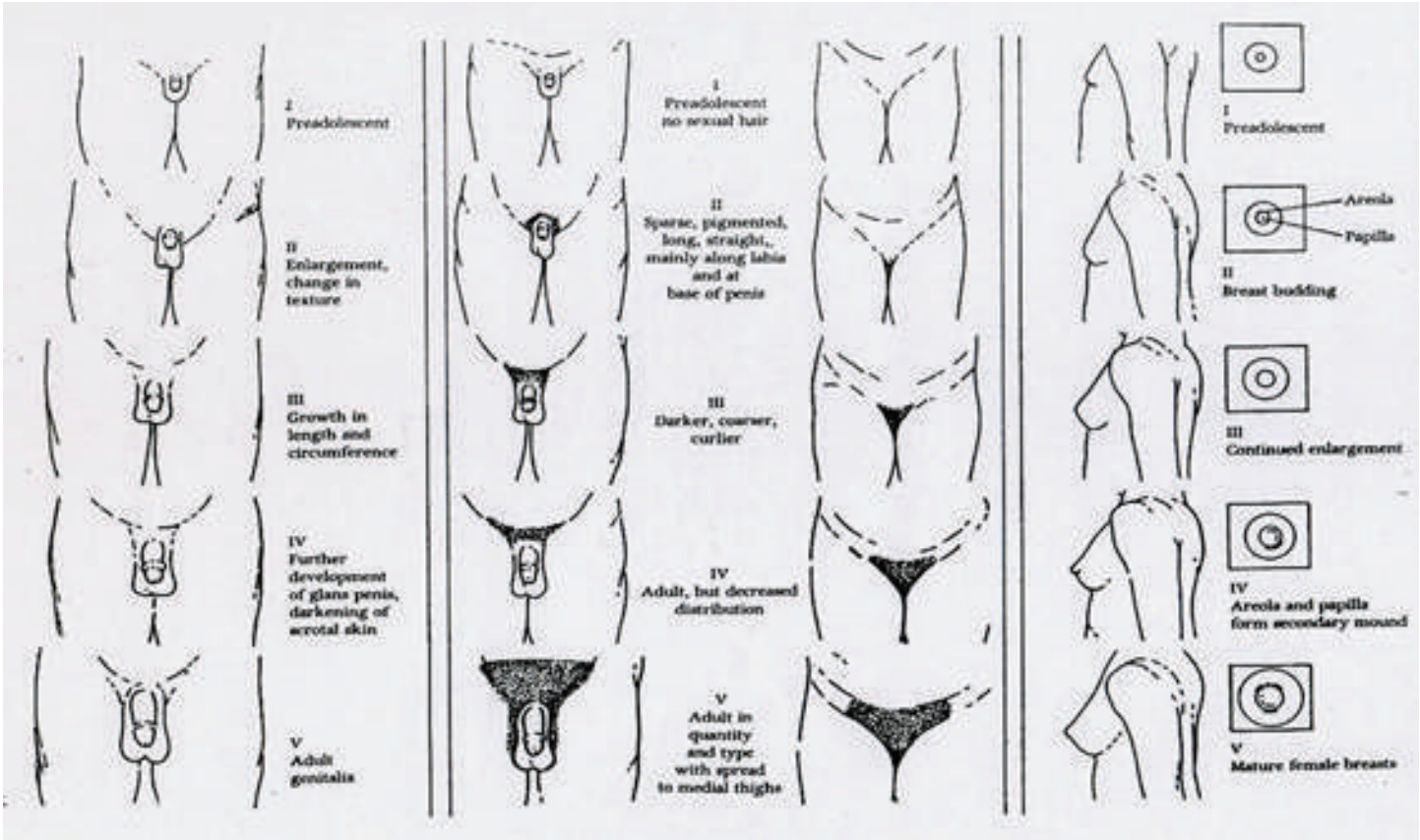






Figure 14. Sexual Maturity Rating (Tanner Staging)
Source: reference (18)

TABLE 2. The Huffman Stages of Estrogen Effect on Female Genitalia

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

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

Info	General Survey	Symptoms	Extragenital Exam	Anogenital Exam	Laboratory Record	Child's Behavior	Findings	Impressions	Pictures	Find
Method	72 hrs	Tanner Stage	Anogenital Exam							Save
External Genitalia	Urethral and Perihymenal Area	Hymen	Perineum	Discharge	Speculum Exam	Anal Examination				Discard
		Normal	Abnormal	Description						
Pubic Hair		<input checked="" type="radio"/>	<input type="radio"/>							
Labia Minora		<input checked="" type="radio"/>	<input type="radio"/>							
Labia Majora		<input checked="" type="radio"/>	<input type="radio"/>							
Mons Pubis		<input checked="" type="radio"/>	<input type="radio"/>							
Posterior Fourchette		<input checked="" type="radio"/>	<input type="radio"/>							
Clitoris		<input checked="" type="radio"/>	<input type="radio"/>							
Vestibule		<input checked="" type="radio"/>	<input type="radio"/>							

URETHRAL AND PERIHYMENAL AREA

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

Info	General Survey	Symptoms	Extragenital Exam	Anogenital Exam	Laboratory Record	Child's Behavior	Findings	Impressions	Pictures	Find
Method	72 hrs	Tanner Stage	Anogenital Exam							Save
External Genitalia	Urethral and Perihymenal Area	Hymen	Perineum	Discharge	Speculum Exam	Anal Examination				Discard
		Normal	Abnormal	Description						
Urethral Meatus		<input checked="" type="radio"/>	<input type="radio"/>							
Periurethral Area		<input checked="" type="radio"/>	<input type="radio"/>							
Perihymenal Area		<input checked="" type="radio"/>	<input type="radio"/>							
Fossa Navicularis		<input checked="" type="radio"/>	<input type="radio"/>							

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 dehiscence 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:

IMPRESSIONS	
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).	

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							
Patient's Name	Cruz, Ana Maria R.	Age	14	DOB	08/22/2000	Sex	F
Patient's Address	307 De los Santos St., Bgy. 44, Malate, Manila						
Civil Status	Single	Occupation	Grade 3 student	Nationality	Filipino		
Requesting Party	Maria Leonora R. Cruz (mother)	Place, Time & Date of Exam	September 12, 2014 4:20 PM				
<input checked="" type="checkbox"/> Acute Evidentiary Examination (within 72 hours of incident)				<input type="checkbox"/> Non-Acute Examination			
Date & Time of Most Recent Incident: September 10, 2014 11:00 PM							
Place of Incident: Malate, Manila							

FINDINGS	
GENERAL PHYSICAL FINDINGS	
Height	150 cm
Weight	60 kg
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

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

Info	General Survey	Symptoms	Extragenital Exam	Anogenital Exam	Laboratory Record	Child's Behavior	Findings	Impressions	Pictures	Find	
Method	72 hrs	Tanner Stage	Anogenital Exam								Save
External Genitalia Urethral and Perihymenal Area Hymen Perineum Discharge Speculum Exam Anal Examination										Discard	
Exam Position <input checked="" type="checkbox"/> supine <input type="checkbox"/> knee-chest											
Type of Hymen <input type="radio"/> NA <input type="radio"/> annular <input type="radio"/> crescentic <input type="checkbox"/> fimbriated <input checked="" type="checkbox"/> estrogenized <input checked="" type="checkbox"/> redundant <input type="checkbox"/> others (Pls add remarks in hymenal findings.)											
Normal Abnormal Description											
Hymenal Findings <input checked="" type="radio"/> <input type="radio"/>											
Hymenal Findings Add Delete											

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."

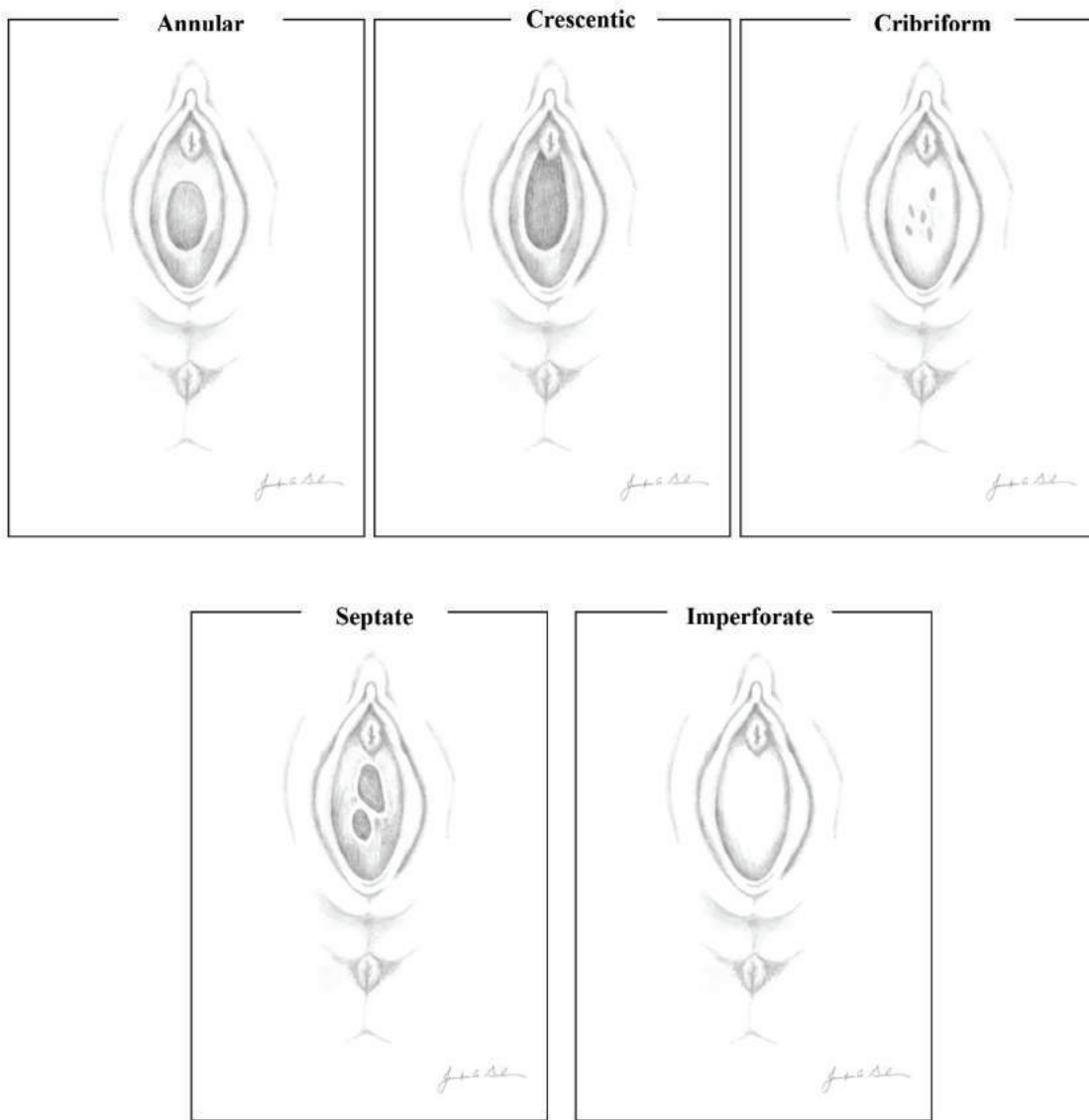


Figure 15. Congenital Variants in Hymen Appearance

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.

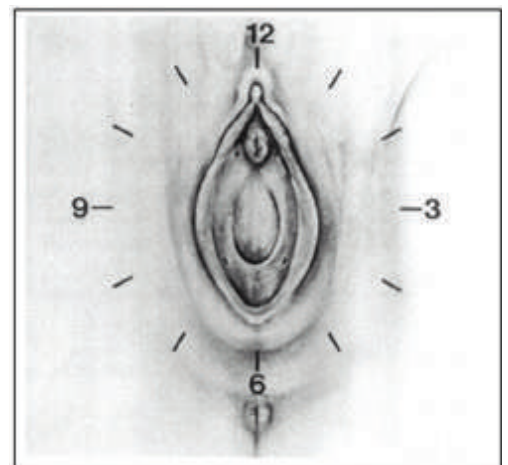


Figure 16: Clock position reference for location hymen injuries

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 care-taker. 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

McCann et al. did not find a “time sequence” or “pattern” in the healing process that could be used to determine the age of an injury in their study entitled “Healing of Hymenal Injuries in Prepubertal and Adolescent Girls: A Descriptive Study” and published in Pediatrics in 2007 (20). Healing was determined by the severity of injury. In this study, all hymenal injuries healed rapidly with little or no evidence of previous trauma and no scar tissue was noted. The rapid disappearance of petechia (within 48 to 72 hours) and persistence of blood blisters up to one month were the only “markers” observed that could be used to date an injury.

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:

- **Abrasion** – 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



Figure 17. Hematoma at 3 o'clock position and petechiae at 6 o'clock and 8 o'clock positions of the hymen.

- **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).



Figure 18. Notch at 5 o'clock position of the hymen

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.

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."

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.

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

SUPREME COURT DECISION

**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."

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).

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."

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.

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.

MEDICO-LEGAL CERTIFICATE

DEMOGRAPHIC DATA							
Patient's Name	Cruz, Ana Maria R.	Age	14	DOB	08/22/2000	Sex	F
Patient's Address	307 De los Santos St., Bgy. 44, Malate, Manila						
Civil Status	Single	Occupation	Grade 3 student	Nationality	Filipino		
Requesting Party	Maria Leonora R. Cruz (mother)	Place, Time & Date of Exam	September 12, 2014 4:20 PM				
<input checked="" type="checkbox"/> Acute Evidentiary Examination (within 72 hours of incident)				<input type="checkbox"/> Non-Acute Examination			
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

New Medical Exam: CRUZ, ANA MARIA REYES 1999-08-22

Info	General Survey	Symptoms	Extragenital Exam	Anogenital Exam	Laboratory Record	Child's Behavior	Findings	Impressions	Pictures
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Method | 72 hrs | Tanner Stage | **Anogenital Exam**

External Genitalia | Urethral and Perihymenal Area | Hymen | **Perineum** | Discharge | Speculum Exam | Anal Examination

	Normal	Abnormal	Description
Urogenital Triangle	<input checked="" type="radio"/>	<input type="radio"/>	
Anal Triangle	<input checked="" type="radio"/>	<input type="radio"/>	
Perineal Body	<input checked="" type="radio"/>	<input type="radio"/>	
Medial Aspect Of Proximal Thigh	<input checked="" type="radio"/>	<input type="radio"/>	

Find
Save
Close

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

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

Info	General Survey	Symptoms	Extragenital Exam	Anogenital Exam	Laboratory Record	Child's Behavior	Findings	Impressions	Pictures	Find	
Method	72 hrs	Tanner Stage	Anogenital Exam								Save
External Genitalia Urethral and Perihymenal Area Hymen Perineum Discharge Speculum Exam Anal Examination										Discard	
			No	Present Yes	Description						
Vaginal Discharge			<input type="radio"/>	<input checked="" type="radio"/>	Minimal, yellowish, foul-smelling						

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 / Muroid / 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.

INTERNAL AND SPECULUM EXAMINATION

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

Info	General Survey	Symptoms	Extragenital Exam	Anogenital Exam	Laboratory Record	Child's Behavior	Findings	Impressions	Pictures
Method	72 hrs	Tanner Stage	Anogenital Exam						
External Genitalia	Urethral and Perihymenal Area	Hymen	Perineum	Discharge	Speculum Exam	Anal Examination			

	Normal	Abnormal	Description
IE And Speculum Examination	<input type="radio"/>	<input type="radio"/>	

Find

Save

Discard

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).

ANAL EXAMINATION

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

Info	General Survey	Symptoms	Extragenital Exam	Anogenital Exam	Laboratory Record	Child's Behavior	Findings	Impressions	Pictures	Find	
Method	72 hrs	Tanner Stage	Anogenital Exam								Save
External Genitalia Urethral and Perihymenal Area Hymen Perineum Discharge Speculum Exam Anal Examination										Discard	
	Normal	Abnormal	Description								
Buttocks	<input checked="" type="radio"/>	<input type="radio"/>									
Perianal Skin	<input checked="" type="radio"/>	<input type="radio"/>									
Anal Opening	<input checked="" type="radio"/>	<input type="radio"/>									
Anal Verge, Folds, Rugae	<input checked="" type="radio"/>	<input type="radio"/>									
Gluteals	<input checked="" type="radio"/>	<input type="radio"/>									
Exam Position <input type="checkbox"/> supine <input checked="" type="checkbox"/> lateral decubitus <input type="checkbox"/> prone											
Anus Open? <input checked="" type="radio"/> Yes <input type="radio"/> No											
<input type="checkbox"/> With traction? <input checked="" type="checkbox"/> Stool present in ampulla? Time to dilate <input type="radio"/> < 30 sec <input checked="" type="radio"/> > 30 sec Opening diameter <input checked="" type="radio"/> < 20 mm <input type="radio"/> > 20 mm											

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.

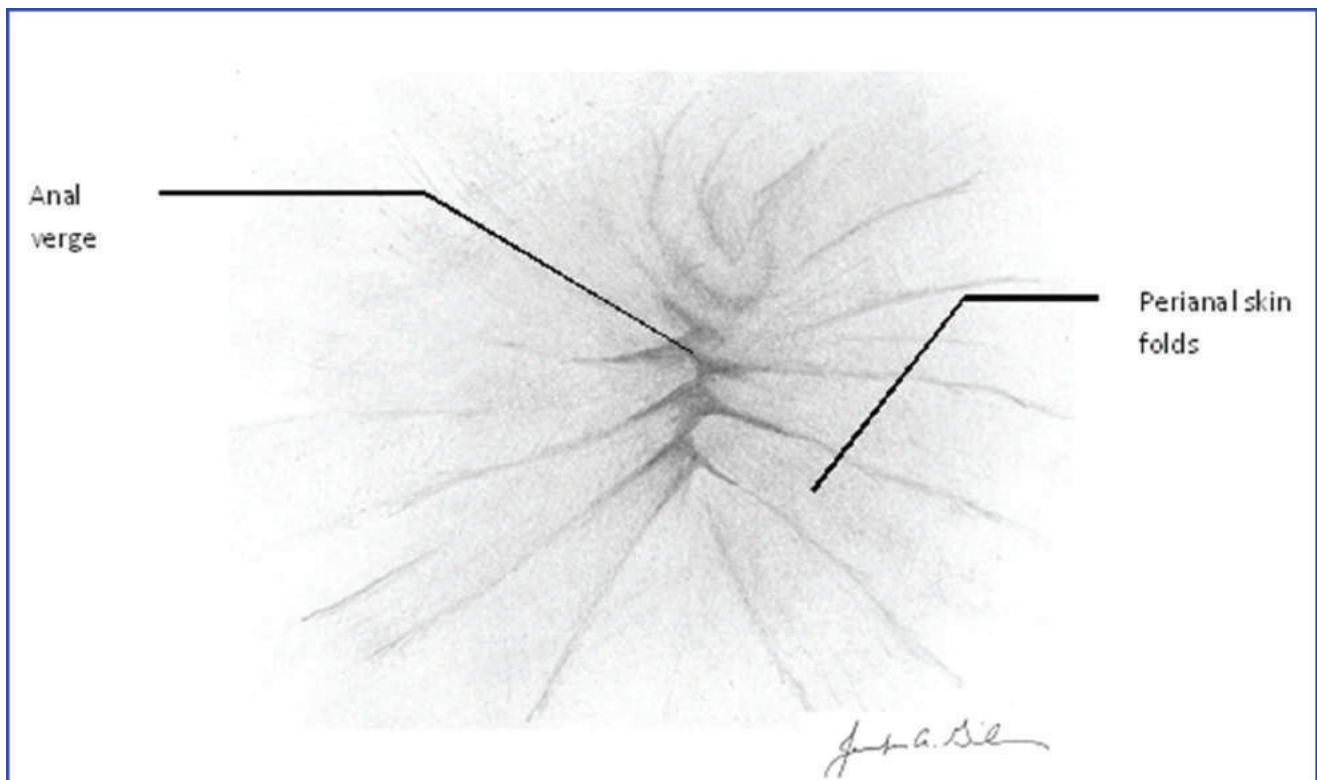


Figure 19. Anatomy of the Anus

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:

IMPRESSIONS
Anogenital findings are indicative of blunt force or penetrating trauma to the anus.

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:

IMPRESSIONS
Anogenital findings may suggest previous anal penetration.

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



Figure 20. Lichen sclerosus



Figure 21. Urethral prolapse



Figure 22. Failure of midline fusion

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

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

Info	General Survey	Symptoms	Extragenital Exam	Anogenital Exam	Laboratory Record	Child's Behavior	Findings	Impressions	Pictures																																																																																																																														
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Other laboratory findings <div></div>																																																																																																																																							

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

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

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:

IMPRESSIONS
Medical evaluation is diagnostic of sexual contact or sexual abuse.

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
<p>"...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".</p>
<p>"The presence or absence of spermatozoa is immaterial because the presence of spermatozoa is not an element of rape".</p>

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

INITIAL AND TWO-WEEK FOLLOW-UP EXAMINATIONS	
Visual inspection of the genital, perianal, and oral areas for genital discharge, bleeding, odor, irritation, warts and ulcerative lesions.	
Specimen collection for <i>N. gonorrhea</i>	Data on the use of Nucleic Acid Amplification Tests (NAATs) for detection of <i>N. gonorrhoeae</i> 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 <i>Neisseria</i> 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.
	Gram stains are inadequate to evaluate prepubertal children for gonorrhea and should not be used to diagnose or rule out gonorrhea.
	Specimen collection for culture for <i>N. gonorrhoeae</i> 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.
Specimen collection for <i>C. trachomatis</i>	Cultures for <i>C. trachomatis</i> can be collected from the rectum in both boys and girls and from the vagina in girls.
	NAATs can be used for detection of <i>C. trachomatis</i> 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.
Specimen collection for <i>T. vaginalis</i> infection	Culture and wet mount of a vaginal swab specimen.
Testing for antibodies to <i>T. pallidum</i> , HIV and HBV	Collection of serum sample for immediate evaluation and to be used as a baseline for comparison with follow-up serologic tests.
FOLLOW-UP EXAMINATION	
If there is concern for transmission of syphilis, HIV or Hepatitis B but baselines tests were negative	Follow-up examination six weeks, three months and six months after the last sexual exposure should be done.

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:

IMPRESSIONS

The presence of (cite infection) confirms mucosal contact with infected and infective bodily secretions, most likely due to sexual contact or sexual abuse.

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:

IMPRESSIONS

Anogenital findings may suggest sexual contact or sexual abuse.

IMAGING PROCEDURES

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

Info	General Survey	Symptoms	Extragenital Exam	Anogenital Exam	Laboratory Record	Child's Behavior	Findings	Impressions	Pictures	Find
<div>Sexual Abuse</div> <div>Physical Abuse</div> <div>Other</div>										
		Taken by	Date in	Date due	Date out	Results	Remarks			
<input type="checkbox"/>	X-Rays Head		__/__/__	__/__/__	__/__/__	C C				
<input type="checkbox"/>	X-Rays Extremity		__/__/__	__/__/__	__/__/__	C C				
<input type="checkbox"/>	Skeletal Survey		__/__/__	__/__/__	__/__/__	C C				
<input type="checkbox"/>	CT Scan Head		__/__/__	__/__/__	__/__/__	C C				
<input type="checkbox"/>	CT Scan Abdomen		__/__/__	__/__/__	__/__/__	C C				
<input type="checkbox"/>	Bone Scan		__/__/__	__/__/__	__/__/__	C C				
<input type="checkbox"/>	Ultrasound		__/__/__	__/__/__	__/__/__	C C				
<input type="checkbox"/>	Coagulation Screen		__/__/__	__/__/__	__/__/__	C C				
<input type="checkbox"/>	Tox Screen - Blood		__/__/__	__/__/__	__/__/__	C C				
<input type="checkbox"/>	Tox Screen - Urine		__/__/__	__/__/__	__/__/__	C C				
<input type="checkbox"/>	Other		__/__/__	__/__/__	__/__/__	C C				

Save

Discard

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

Appendicular skeleton	Humeri (AP); Forearms (AP); Hands (PA); Femurs (AP); Lower legs (AP); Feet (AP)
Axial skeleton	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)

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

New Medical Exam: CRUZ, ANA MARIA REYES 1999-08-22

Info | General Survey | Symptoms | Extragenital Exam | Anogenital Exam | **Laboratory Record** | Child's Behavior | Findings | Impressions | Pictures

Sexual Abuse | Physical Abuse | **Other**

	Taken by	Date in	Date due	Date out	Results + -	Remarks
<input type="checkbox"/> Surgical Procedure		//	//	//	C C	
<input type="checkbox"/> Autopsy		//	//	//	C C	
<input type="checkbox"/> Other		//	//	//	C C	

Other laboratory findings

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).

IMPRESSIONS

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

Info	General Survey	Symptoms	Extragenital Exam	Anogenital Exam	Laboratory Record	Child's Behavior	Findings	Impressions	Pictures
<div> <div> <div>Disclosure of</div> <div> <input checked="" type="checkbox"/> Sexual Abuse <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Neglect <input type="checkbox"/> Emotional Abuse </div> </div> <div> <div>To</div> <div> <input type="checkbox"/> NBI <input type="checkbox"/> PNP <input checked="" type="checkbox"/> CPU <input type="checkbox"/> Private MD <input checked="" type="checkbox"/> Other <input type="checkbox"/> DOJ <input type="checkbox"/> None <input type="checkbox"/> DSWD </div> </div> <div> <div>Classification of genital findings (in sexual abuse cases)</div> <div> <input type="radio"/> Clear Evidence Of Blunt Force Or Penetrating Trauma <input type="radio"/> Findings not related to sexual abuse <input type="radio"/> None (Click this if anogenital area was not examined.) <input checked="" type="radio"/> Normal Genital Findings <input type="radio"/> Normal Variant Or Non-Specific Genital Findings <input type="radio"/> Suggestive Of Abuse </div> </div> </div>									
<div>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.</div>									

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

New Plan

Patient Name:
CRUZ, ANA MARIA REYES 2000-08-22

CPU Case No.
13849

Social Worker Intervention

Medical Intervention

Psych Intervention

Dev Intervention

Legal Intervention

Plans	Date Scheduled	Appointment w/	Remarks
<input checked="" type="checkbox"/> Medical certificate issued	09/12/2014	VILLANO, SARA	
<input checked="" type="checkbox"/> test for sexually transmitted infections	09/12/2014	VILLANO, SARA	
<input type="checkbox"/> Final medical certificate issued	__/__/__		
<input checked="" type="checkbox"/> Advice on perineal hygiene	09/12/2014	VILLANO, SARA	
<input type="checkbox"/> Medications - Antibiotics	__/__/__		
<input type="checkbox"/> Medications - Emergency Contraception	__/__/__		
<input checked="" type="checkbox"/> Follow-up lab results	09/19/2014	VILLANO, SARA	
<input checked="" type="checkbox"/> Medical follow-up	09/19/2014	VILLANO, SARA	
<input type="checkbox"/> Medical Exam	__/__/__		

Save

Close

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 <i>* 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.</i>	Azithromycin 1g orally in a single dose or doxycycline 100 mg orally twice daily for 7 days <i>*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.</i>
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

Recommended regimen	Levonorgestrel-only regimen 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).
Alternative regimen	Combination Oral Contraceptive (OC) regimen or “Yuzpe method” 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).

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).

New Immediate Safety Assessment: CRUZ, ANA MARIA REYES 2000-08-22

Info	Safety Factor	Safety Decision and Plan	Rationale
<p>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 maybe of immediate concern. Yes No Unknown SF</p> <p>Information supporting safety factor:</p> <div></div>			
<p>2. Child's whereabouts cannot be ascertained and/or there is reason to believe that the family is about to flee. Yes No Unknown SF</p> <p>Information supporting safety factor:</p> <div></div>			
<p>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. Yes No Unknown SF</p> <p>Information supporting safety factor:</p> <div></div>			
<p>4. Child sexual abuse is suspected and circumstances suggest that child safety may be an immediate concern. Yes No Unknown SF</p> <p>Information supporting safety factor:</p> <div></div>			
<p>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. Yes No Unknown SF</p> <p>Information supporting safety factor:</p> <div></div>			

New Immediate Safety Assessment: CRUZ, ANA MARIA REYES 2000-08-22

Info	Safety Factor	Safety Decision and Plan	Rationale
<p>Risk Codes: Yes: <input type="text" value="0"/> No: <input type="text" value="13"/> Unknown: <input type="text" value="2"/></p> <p><input type="radio"/> 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.</p> <p><input checked="" type="radio"/> 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.</p> <p><input type="radio"/> 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.</p>			

APPENDIX A

CONSENT (PAHINTULOT)

By signing this form, you authorize WCPU physicians to perform the medical exam requested by the child, parent, and/or guardian. Parental consent for an examination is not legally required in cases of known or suspected child abuse. A social worker, or other adult acting as the child's guardian, may authorize the exam in place of the child's parent(s). If you have questions, please contact your local Department of Social Welfare and Development office.

Ang paglagda sa papel na ito ay nangangahulugang pinahihintulutan ang mga doktor ng WCPU na magsagawa ng pagsisiyasat pang-medikal ayon sa kahilingan ng pasyente, magulang, at/o tagapag-alaga. Hindi kinakailangan ang pahintulot mula sa magulang sa mga kasong tinitiyak o pinaghihinalaan na may naganap na pang-aabuso. Maaaring magbigay ng pahintulot ang isang social worker o sino mang nakatatanda na tumatayong tagapag-alaga sa bata. Kung may mga katanungan, maaari pong makipag-ugnayan sa DSWD sa inyong lugar.

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 ahensiya 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)

Patient right
thumb mark

Date (petsa) ____ / ____ / ____ Time (oras) _____

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).

Source: Committee for the Special Protection of Children. Protocol for Case Management of Child Victims of Abuse, Neglect and Exploitation. Manila (PH): Committee for the Special Protection of Children; 2013. 42 pp.

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

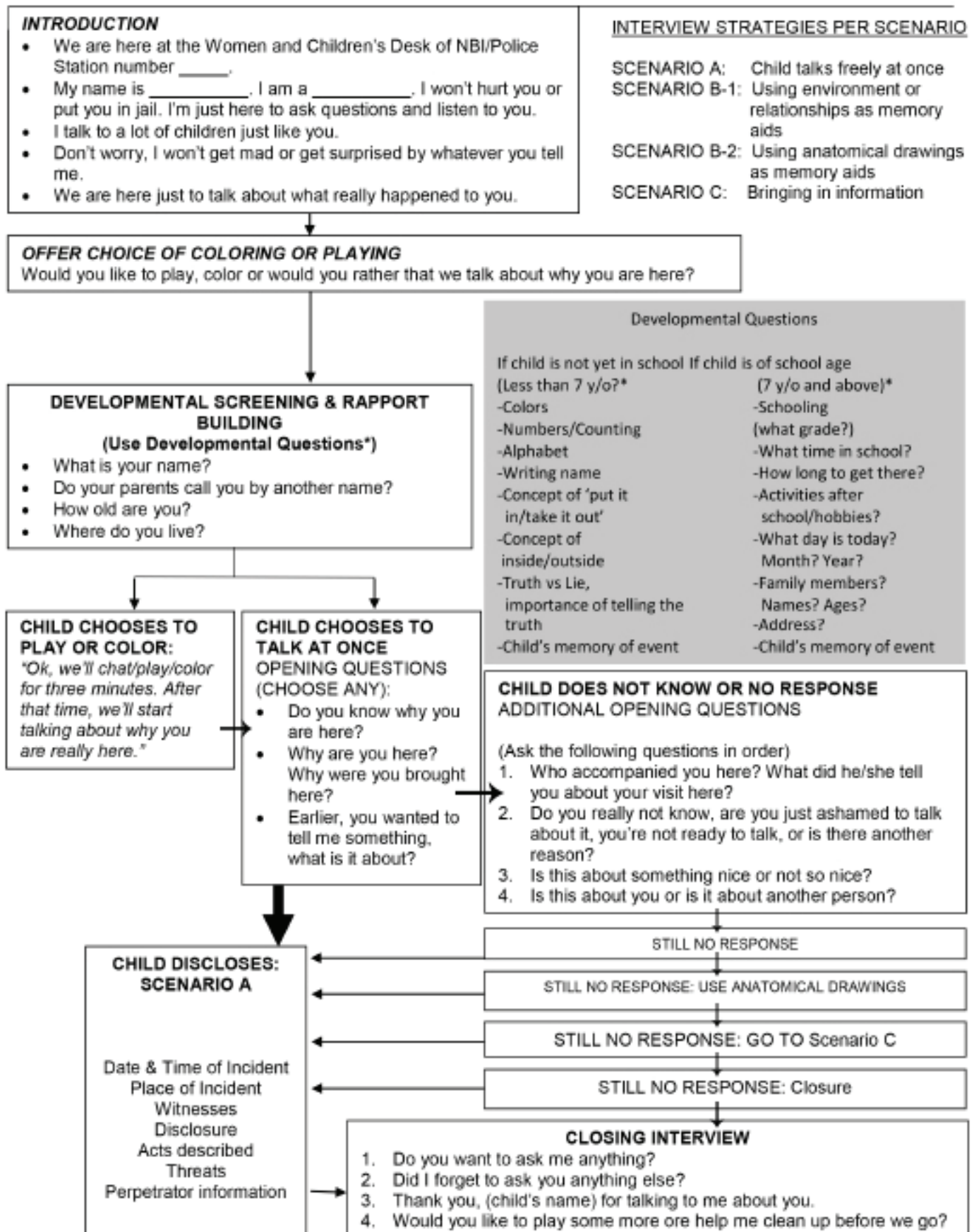
Adolescence (13-17 years)

- 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

Source: Walker AG. Handbook on Questioning Children: A Linguistic Perspective. Washington (DC): ABA Center on Children and the Law; 1994.

APPENDIX D

ALGORITHM OF THE DUTCH SCENARIO MODEL INTERVIEW



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 from 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.

Source: Child Protection Network Foundation, Inc. A Manual on Taking the Sworn Statement of Children Based on a Child-Friendly Investigative Interview. Manila (PH): Child Protection Network; 2004.

APPENDIX E

THE “TOP-TO-TOE” PHYSICAL EXAMINATION

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).

STEP	OBSERVATIONS	OTHER
Step 1	Note the child’s general appearance, demeanor, and developmental stage.	Take vital signs, height, weight, and head circumference when appropriate.
Step 2	Inspect the head and scalp. Observe for areas of missing hair, and evidence of bruising/petechiae on the scalp.	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.
Step 3	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.	Palpate the neck for subcutaneous emphysema. Any of these signs may indicate a strangulation event has occurred.
Step 4	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.	
Step 5	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.	Collect oral swabs, as indicated.

STEP	OBSERVATIONS	OTHER
Step 6	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.	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.
Step 7	Assess the child's hands inspecting all sides for injury, and observe general appearance; observe the wrists for signs of ligature marks.	Collect trace evidence from fingernails as appropriate.
Step 8	Inspect the forearms for injuries, appropriate circulation, sensation, and motion; any injuries or intravenous puncture sites should be noted.	Palpate for tenderness.
Step 9	Inspect the inner surfaces of the upper arms and axilla for signs of injury appropriate circulation, sensation, and motion.	Children who have been restrained by hands may have "fingertip" bruising from the perpetrators hands on the arms.
Step 10	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.	Swab areas for saliva if indicated. Auscultate the lungs.
Step 11	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.	Observe for injury, bruising, and be sure to palpate for areas of tenderness.
Step 12	Complete the abdominal examination, including inspection, auscultation, and palpation to exclude any internal trauma.	If body fluid or saliva is suspected to be present, swab for evidence.
Step 13	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.	Collect foreign materials if present, palpate for tenderness, limited range of motion.
Step 14	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.	Any biological evidence should be collected with moistened swabs (for semen, saliva, blood) or gloved hands (for hair, fibers, grass, soil).
Step 15	Obvious physical deformities should be noted.	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).

Source: Day K, Pierce-Weeks J. *The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs*. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources,

APPENDIX F

PHYSICAL AND BEHAVIOURAL INDICATORS OF CHILD SEXUAL ABUSE

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

^a Considered diagnostic if perinatal and iatrogenic transmission can be ruled out.

^b 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.

Source: Adapted from World Health Organization. *Guidelines for medico-legal care for victims of sexual violence*. Geneva (CH): World Health Organization; 2003. Chapter 7, Child sexual abuse; p 75-93. Available from: <http://whqlibdoc.who.int/publications/2004/924154628x.pdf>

APPENDIX G

EXAMPLES OF SEXUAL BEHAVIORS IN CHILDREN 2 TO 6 YEARS OLD

Normal, Common Behaviors	Less Common Normal Behaviors ^a	Uncommon Behaviors in Normal Children ^b	Rarely Normal ^c
<ul style="list-style-type: none"> • Touching / masturbating genitals in public / private • Viewing / touching peer or new sibling genitals • Showing genitals to peers • Standing / sitting too close • Tries to view peer / adult nudity • Behaviors are transient, few, and distractible 	<ul style="list-style-type: none"> • Rubbing body against others • Trying to insert tongue in mouth while kissing • Touching peer / adult genitals • Crude mimic of movements associated with sexual acts • Sexual behaviors that are occasionally, but persistently, disruptive to others • Behaviors are transient and moderately responsive to distraction 	<ul style="list-style-type: none"> • Asking peer / adult to engage in specific sexual act(s) • Inserting objects into genitals • Explicitly imitating intercourse • Touching animal genitals • Sexual behaviors that are frequently disruptive to others • Behaviors are persistent and resistant to parental distraction 	<ul style="list-style-type: none"> • Any sexual behaviors that involve children who are 4 or more years apart • A variety of sexual behaviors displayed on a daily basis • Sexual behavior that results in emotional distress or physical pain • Sexual behaviors associated with other physically aggressive behavior • Sexual behaviors that involve coercion • Behaviors are persistent and child becomes angry if distracted

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

^bAssessment of situational factors and family characteristics (violence, abuse, neglect) is recommended.

^cAssessment of all family and environmental factors and report to child protective services is recommended.

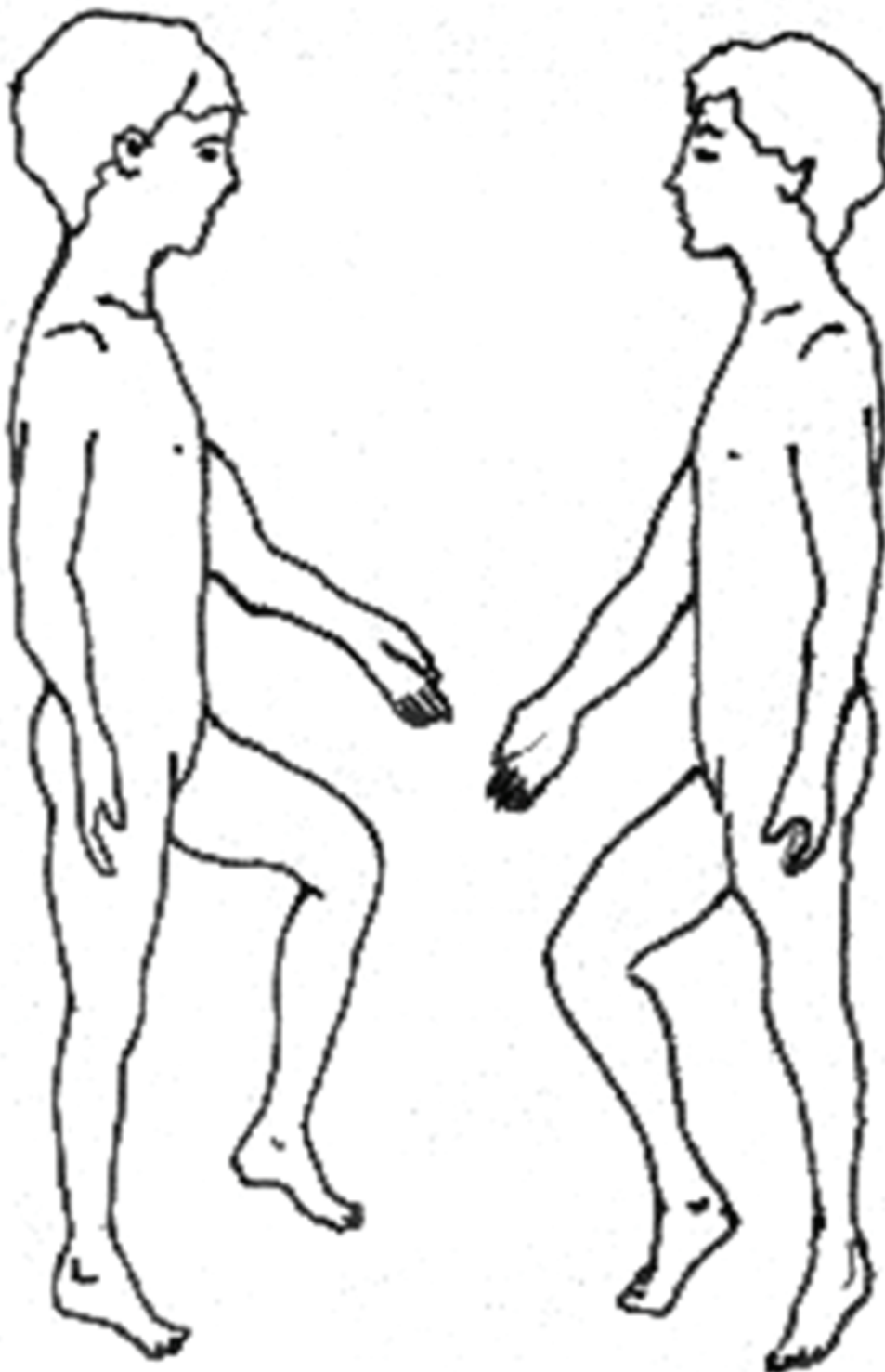
Source: Kellog, ND and the Committee On Child Abuse And Neglect. Clinical Report—The Evaluation of Sexual Behaviors in Children. *Pediatrics* [Internet]. 2009 Aug 31 [reaffirmed 2013 March; cited 2014 Nov 24];124(3):992-98. Available from: <http://pediatrics.aappublications.org/content/124/3/992>

DOI: 10.1542/peds.2009-1692

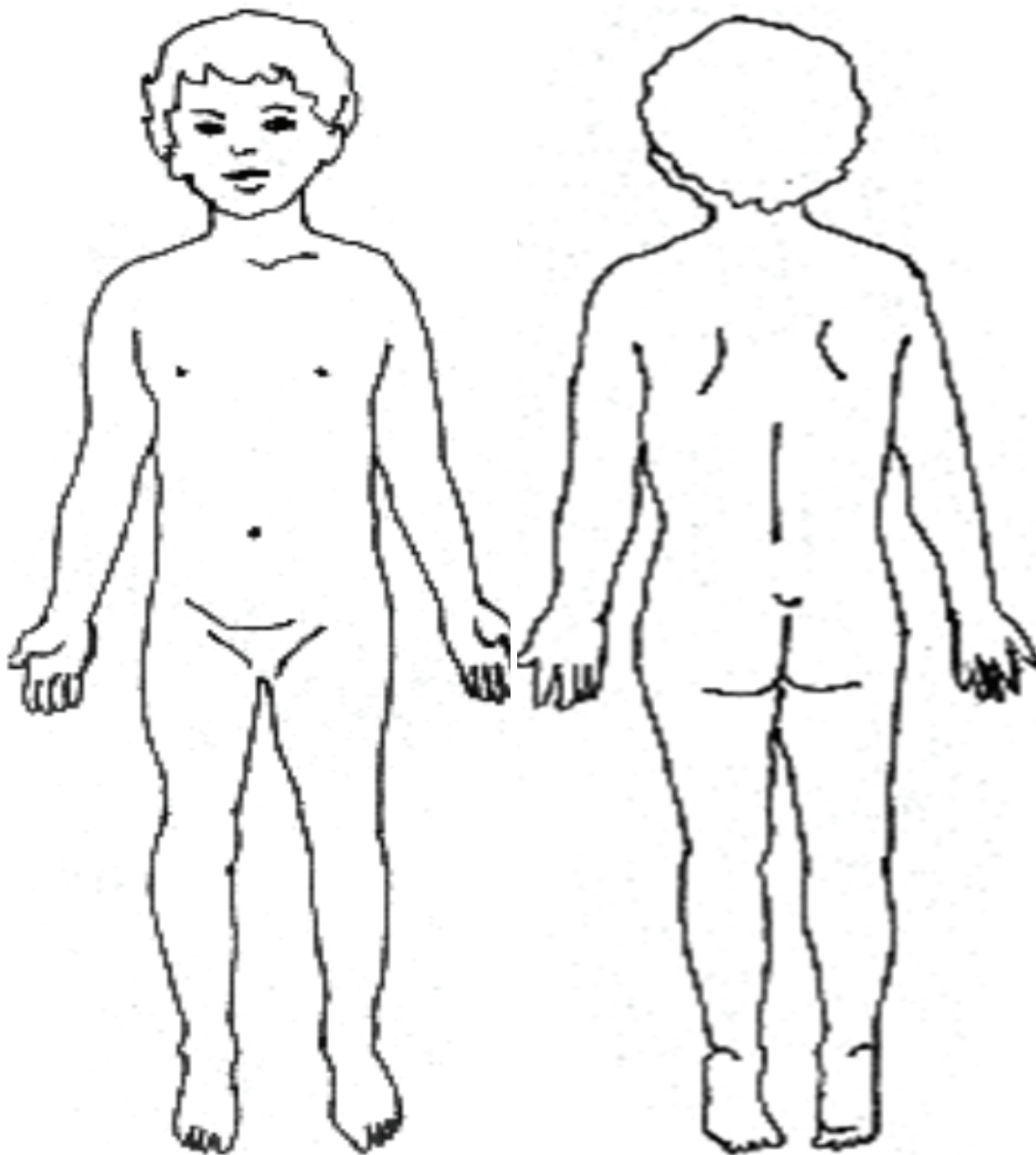
APPENDIX H

DIAGRAMS TO DOCUMENT PHYSICAL INJURIES

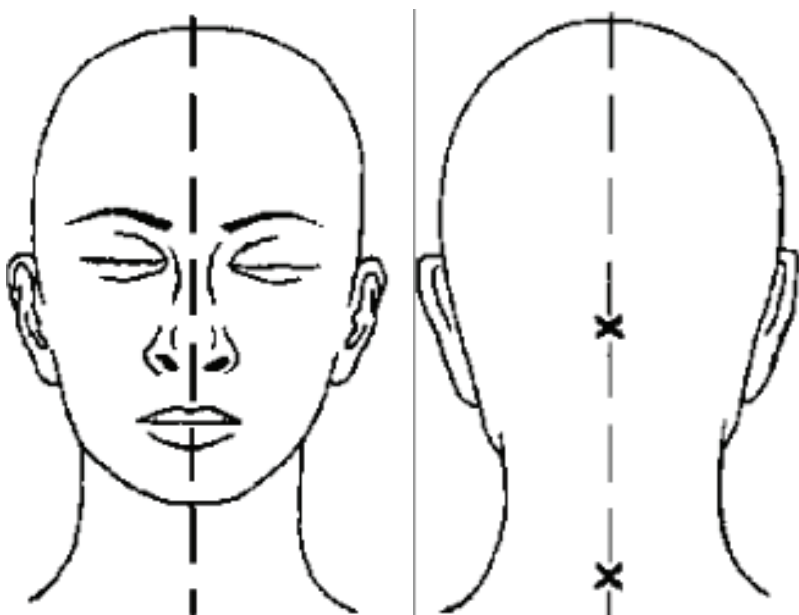
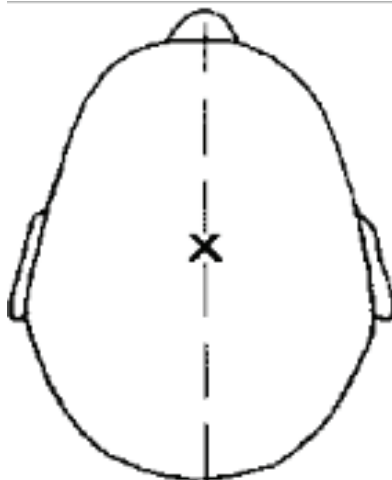
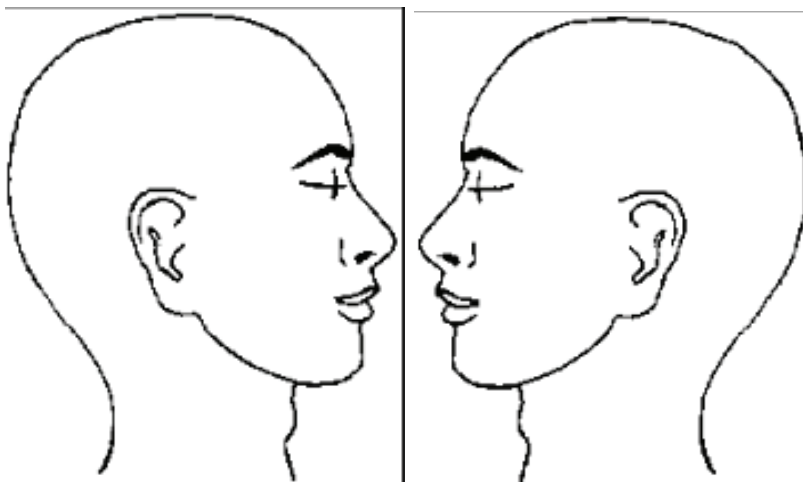
Patient Name:	Date & Name of Exam:
Age / Sex:	Examining Physician:
Case Number:	Photographs Taken: <input type="checkbox"/> YES <input type="checkbox"/> NO



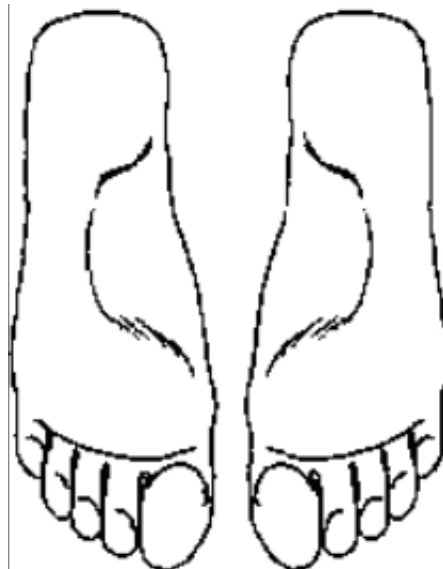
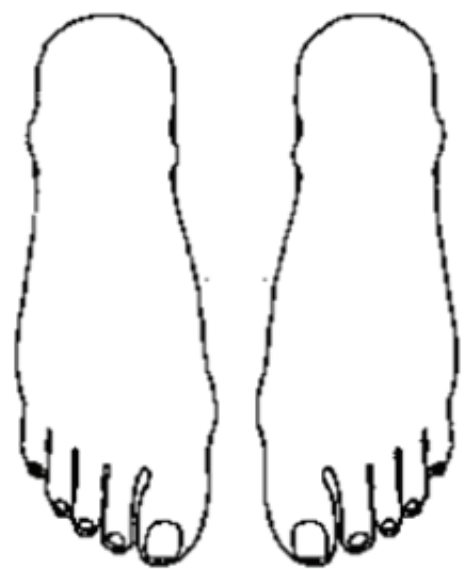
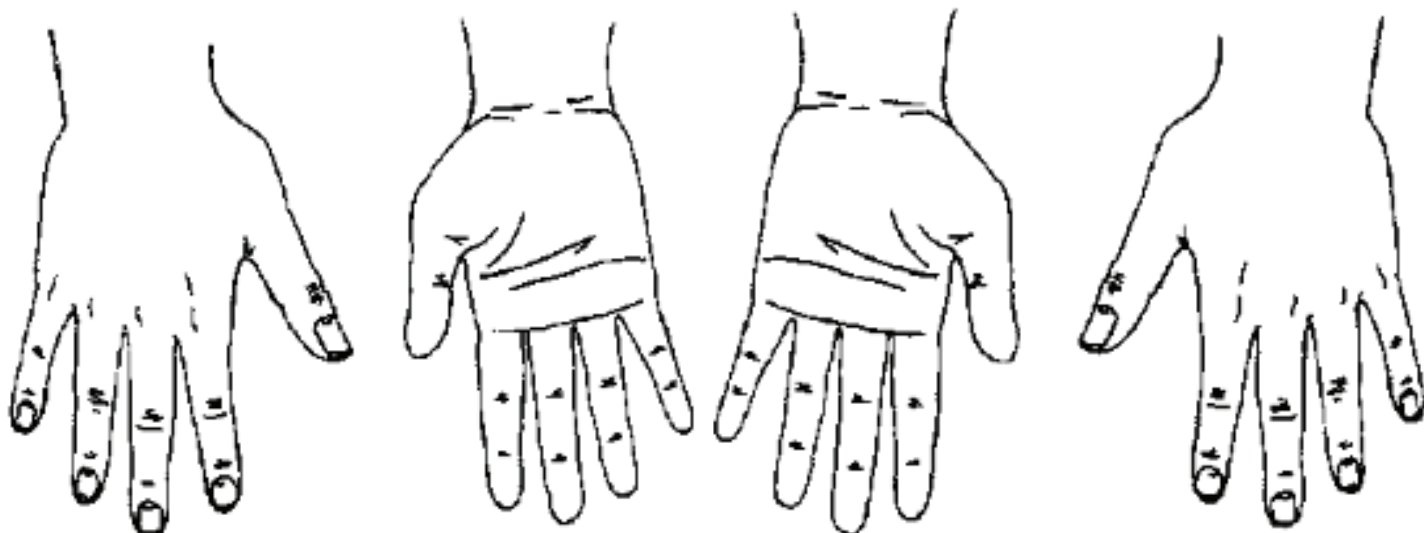
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Age / Sex:	Examining Physician:
Case Number:	Photographs Taken: <input type="checkbox"/> YES <input type="checkbox"/> NO



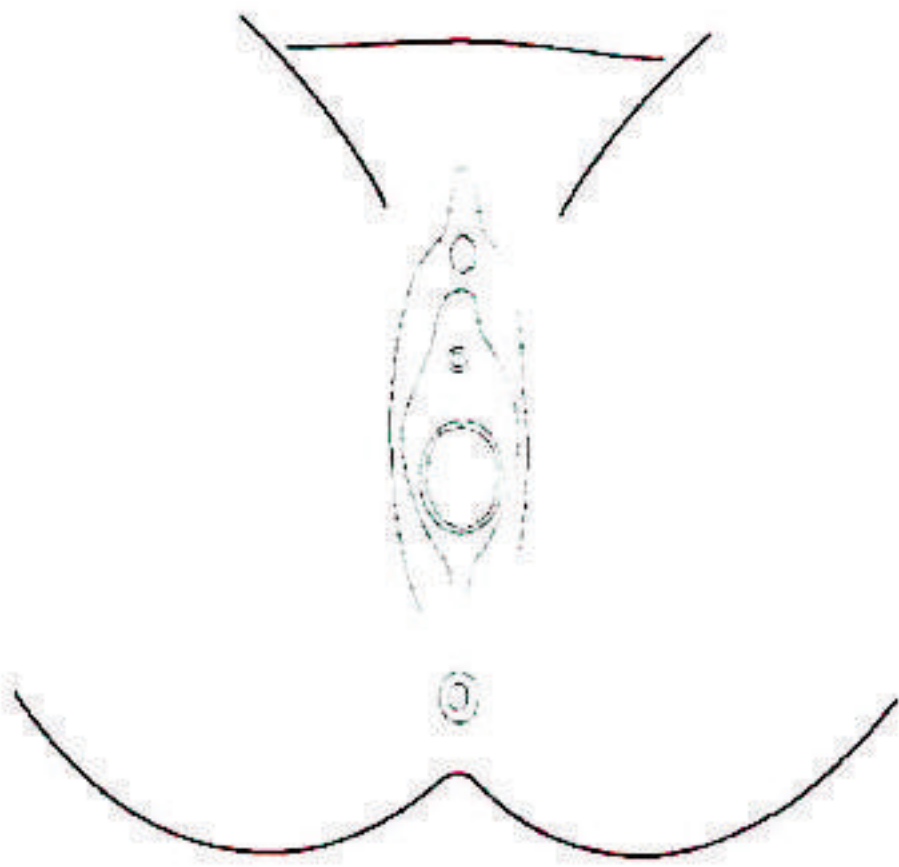
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Case Number:	Photographs Taken: <input type="checkbox"/> YES <input type="checkbox"/> NO



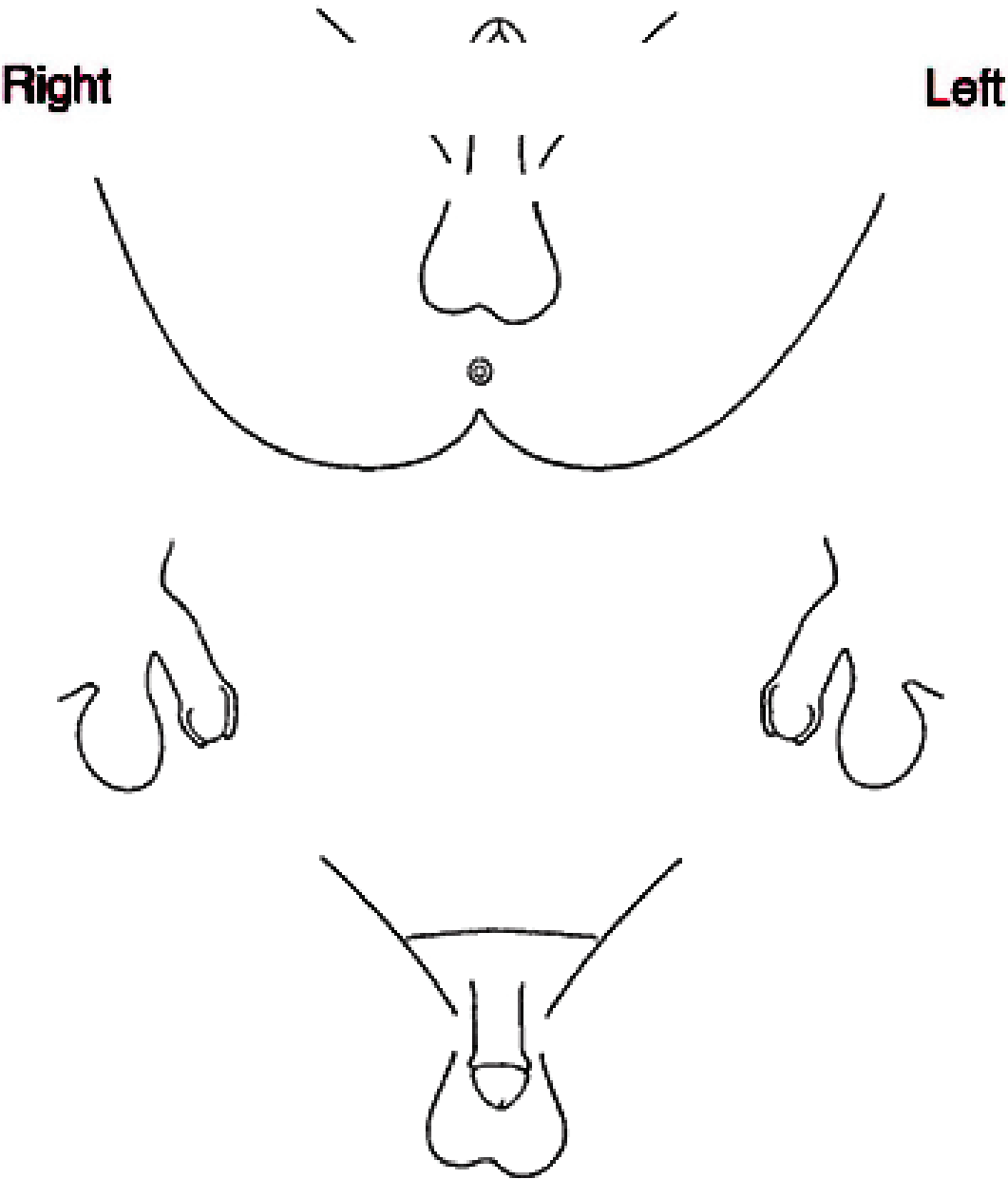
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Right

Left



Patient Name:	Date & Name of Exam:
Age / Sex:	Examining Physician:
Case Number:	Photographs Taken: <input type="checkbox"/> YES <input type="checkbox"/> NO



APPENDIX I

ABUSE DOCUMENTATION USING CONVENTIONAL PHOTOGRAPHY, COLPOSCOPY AND DIGITAL PHOTOGRAPHY

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 a 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

APPENDIX I-1



CPU-Net MEDICAL ALERT

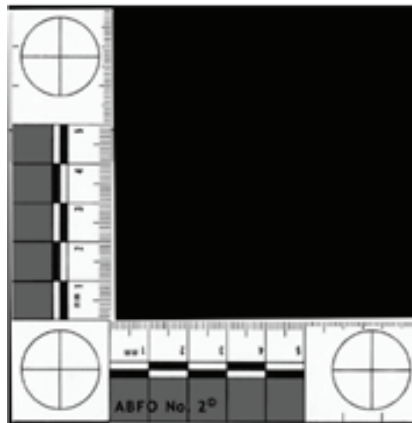
A Bi-Monthly Bulletin Published by the Child Protection Unit Network

Sept-Oct 2005
Vol. 3 Issue 5

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 maybe 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.

Source: Child Protection Network Foundation, Inc. Forensic Photography. CPU-Net Medical Alert [Internet]. 2005 Sep-Oct [cited 2014 Dec 22];3(5):1-2. Available from: http://childprotectionnetwork.org/wp-content/uploads/2013/06/ForensicPhotography_oct2005.pdf

APPENDIX J

BASIC RADIOLOGY IN PHYSICAL ABUSE OF CHILDREN



CPU-Net MEDICAL ALERT

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Vol. 3 Issue 2

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 medical alert, 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 1: Components of a skeletal survey

1. AP and lateral skull
2. Lateral cervical spine
3. AP, lateral and oblique ribs
4. AP pelvis
5. Lateral thoracic-lumbar spine
6. Antero-lateral humeri, forearms, femurs, tibias and fibulas
7. Oblique hands
8. AP feet

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 2: Specificity of fractures for physical abuse

HIGH	<ul style="list-style-type: none">• Metaphyseal chip fractures• Bucket handle fractures• Rib fractures, especially posterior location• Scapular fractures• Spinous process• Sternum
MODERATE	<ul style="list-style-type: none">• Multiple or bilateral fractures• Fractures of different ages• Epiphyseal separations• Vertebral body fractures and subluxations• Digital fractures• Complex or multiple skull fractures
COMMON BUT LOW	<ul style="list-style-type: none">• Subperiosteal new bone formation• Clavicle fractures• Long bone shaft fractures• Linear, simple skull fractures

Are there specific imaging recommendations for suspected abusive fractures based on age?

Table 3: Imaging recommendation for skeletal injury ¹

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

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

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.

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.

References:

1. Kleinman PK. Diagnostic Imaging of Child Abuse. St Louis MO: Mosby 1998.
2. Prosser I, Maguire S, Harrison SK, Mann M, Sibert JR, Kemp AM. "How old is this fracture? Radiologic dating of fractures in children: a systematic review." *American Journal of Radiology*.184; 2005: 1282-1286.
3. Sirontnak A, Grigsby T, Krugman R. "Physical abuse." *Pediatric in Review*. 25; 2004: 264-277.
4. American Academy of Pediatrics. "Diagnostic imaging of child abuse." *Pediatrics*. 105; 2000: 1345-1348

Source: Child Protection Network Foundation, Inc. Basic Radiology in Physical Abuse of Children. CPU-Net Medical Alert [Internet]. 2005 March-April [cited 2015 Jan 11];3(2). Available from http://childprotectionnetwork.org/wp-content/uploads/2013/06/BasicRadiologyinPhysicalAbuse_apr2005.pdf

APPENDIX K

ABUSIVE HEAD TRAUMA



CPU-Net MEDICAL ALERT

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

June 2003
Vol. 1 Issue 3
Revised 2014 by
Child Protection
Network
Foundation

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.



PRESENTATION

Infant or toddler presented with:

- Apnea (93% PPV*)
- Altered mental status
- Seizure
- Bruises +/-

SUBTLE SIGNS:

- Vomiting
- Irritability
- Poor feeding
- Failure to thrive
- Lethargy

*PPV – Positive Predictive Value

1 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.

2 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.

3 DIRECT & INDIRECT OPHTHALMOSCOPY

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

4 RED FLAGS

- Are there any red flags?
- Unsubstantiated stories e.g. falling off the bed, sibling stepped on child, rolling onto child asleep in bed
 - Injuries not compatible with history
 - Changing history from different caretakers
 - Retinal hemorrhage seen

= YES

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

Deranged Coagulation Studies. Give Vit K

Repeat Coagulation Studies

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

= NO

Consider differential diagnosis such as:

- Accidental trauma
- Neuro disorder
- Metabolic disorder
- Coagulopathy
- Osteogenesis Imperfecta
- Hepatic disorder

END of Algorithm.

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

Retinal Hemorrhage

+ combination of abnormal CT/MRI or Skeletal Survey

= SBS

Consider follow-up studies:

- Delineate abnormalities
- Determine timing of injuries
- Monitor evolution

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 Reece 2nd ed.
- ❖ Maguire S, Pickard N, Farewell D, Mann M, Tempest V, Kemp AM. Which clinical features distinguish inflicted from non-inflicted brain injury? A systematic review. Arch Dis Child. 2009;94:860-867.
- ❖ Sieswerda-Hoogendoorn T, Boos S, Spivack B, Bilo R, van Rijn RR. Abusive Head Trauma Part 1. Clinical aspects. Eur J Pediatr. 2012;171:415-423. DOI: 10.1007/s00431-011-1598-z.

APPENDIX L

DATE RAPE? DRUGGED?



CPU-Net MEDICAL ALERT

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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.

Toxidrome	Presentation	Causative Agents	Testing	
			What to test	Where to send
Hallucinogenic	Disorientation, hallucinations, visual illusions, panic reaction, moist skin, tachycardia, tachypnea, hypertension	<ul style="list-style-type: none"> Amphetamines Marijuana Cocaine Phencyclidine (PCP) LSD 	Urine 60 mL (refrigerate; freeze if cannot test within 48 hours)	<ul style="list-style-type: none"> UP Manila Pharma 5264248 PNPChem 7230401 loc 4366 NBI* Chem 5238231 loc 5438
Sedative/Hypnotic	Stupor, confusion, sedation, disinhibition	<ul style="list-style-type: none"> Alcohol (Ethanol) Barbiturates Benzodiazepines (<i>Rohypnol</i>; flunitrazepam) GHB (γOH-butyrate) 	<ul style="list-style-type: none"> Blood (for alcohol level only 10 mL in tube with anticoagulant) Urine 60 mL 	<ul style="list-style-type: none"> PNP NBI*
Sympathomimetic	Delusions, paranoia, sweating, dilated pupils, anxiety, tachycardia, hypertension	<ul style="list-style-type: none"> Cocaine Amphetamines Methamphetamine (Shabu, Ice, crack, speed, go) MMDA (Methylene-dioxymethamphetamine) Ecstasy, M, Lovers' Speed, XTC, M&M, MDM, E) 	Urine 60 mL (refrigerate; freeze if cannot test within 48 hours)	<ul style="list-style-type: none"> UP Manila Pharma PNP NBI*
Anticholinergic	Delirium, flushed skin, dilated pupils, urinary retention, memory loss, tachycardia <i>Hot as a Hare, Dry as a Bone, Red as a Beet, Blind as a Bat, Mad as a Hatter</i>	Scopolamine (<i>"Talampunay"</i>)	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)

Source: Child Protection Network Foundation, Inc. *Date Rape? Drugged? CPU-Net Medical Alert* [Internet]. 2003 April [cited 2014 Dec 22];1(2). Available from: http://childprotectionnetwork.org/wp-content/uploads/2013/06/Date-Rape_Drugged_April2003.pdf

APPENDIX M

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



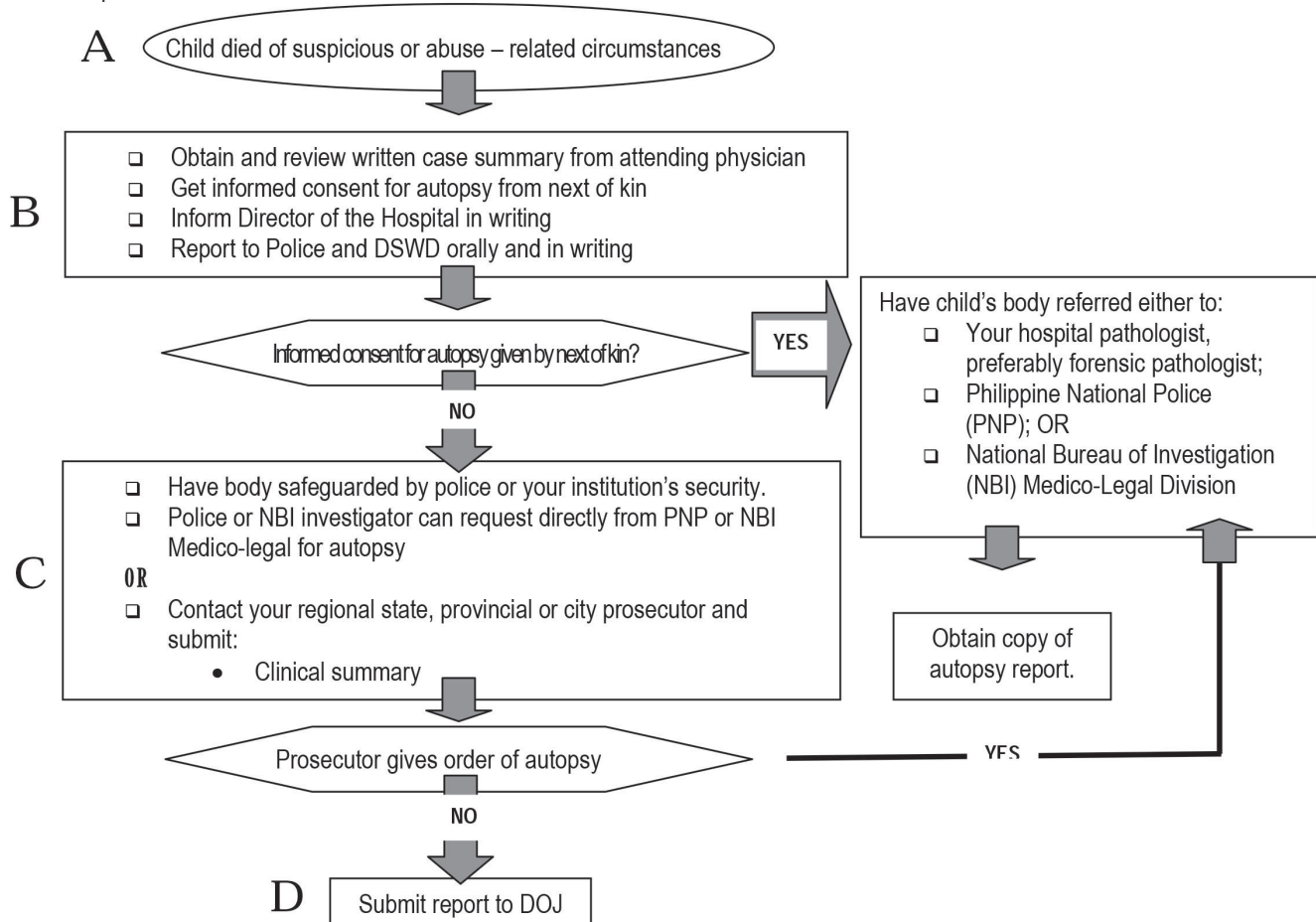
CPU-Net MEDICAL ALERT

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

December 2003
Vol. 1 Issue 6

AUTOPSY OF SUSPICIOUS CHILD DEATH AND 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.



PREPARATORY STEPS:

- Contact your regional state, provincial or city prosecutor via a letter and remind them about DOJ Circulars 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.
- 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 die of abuse-related circumstances.
- 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.
- 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.

Source: Child Protection Network Foundation, Inc. *Autopsy of Suspicious Child Death and Children Who Died of Abuse or Maltreatment*. CPU-Net Medical Alert [Internet]. 2003 December [cited 2014 Dec 15];1(6). Available from http://childprotectionnetwork.org/wp-content/uploads/2013/06/AUTOPSY-OF-SUSPICIOUS-CHILD-DEATH-AND-CHILDREN-WHO-DIED-OF-ABUSE-OR-MALTREATMENT_December2003.pdf

APPENDIX M-1

DEPARTMENT OF JUSTICE CIRCULAR NO. 55



Republika ng Pilipinas
KAGAWARAN NG KATARUNGAN
Department of Justice
Manila

11 SEP 2002

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.

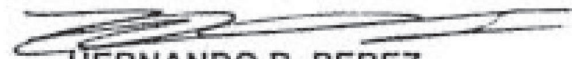
Presidential Decree No. 856(Sanitation Code of the Philippines), insofar as pertinent, provides:

"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 xxxx 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.

APPENDIX M-2

DEPARTMENT OF JUSTICE CIRCULAR NO. 87



Republika ng Pilipinas
KAGAWARAN NG KATARUNGAN
Department of Justice
Manila

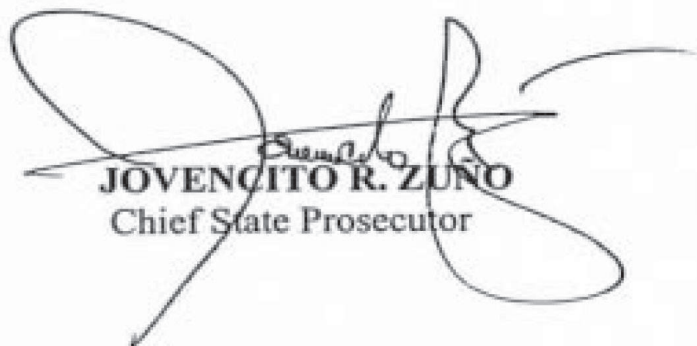
05 SEP 2003

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



CPU-Net MEDICAL ALERT

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

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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.

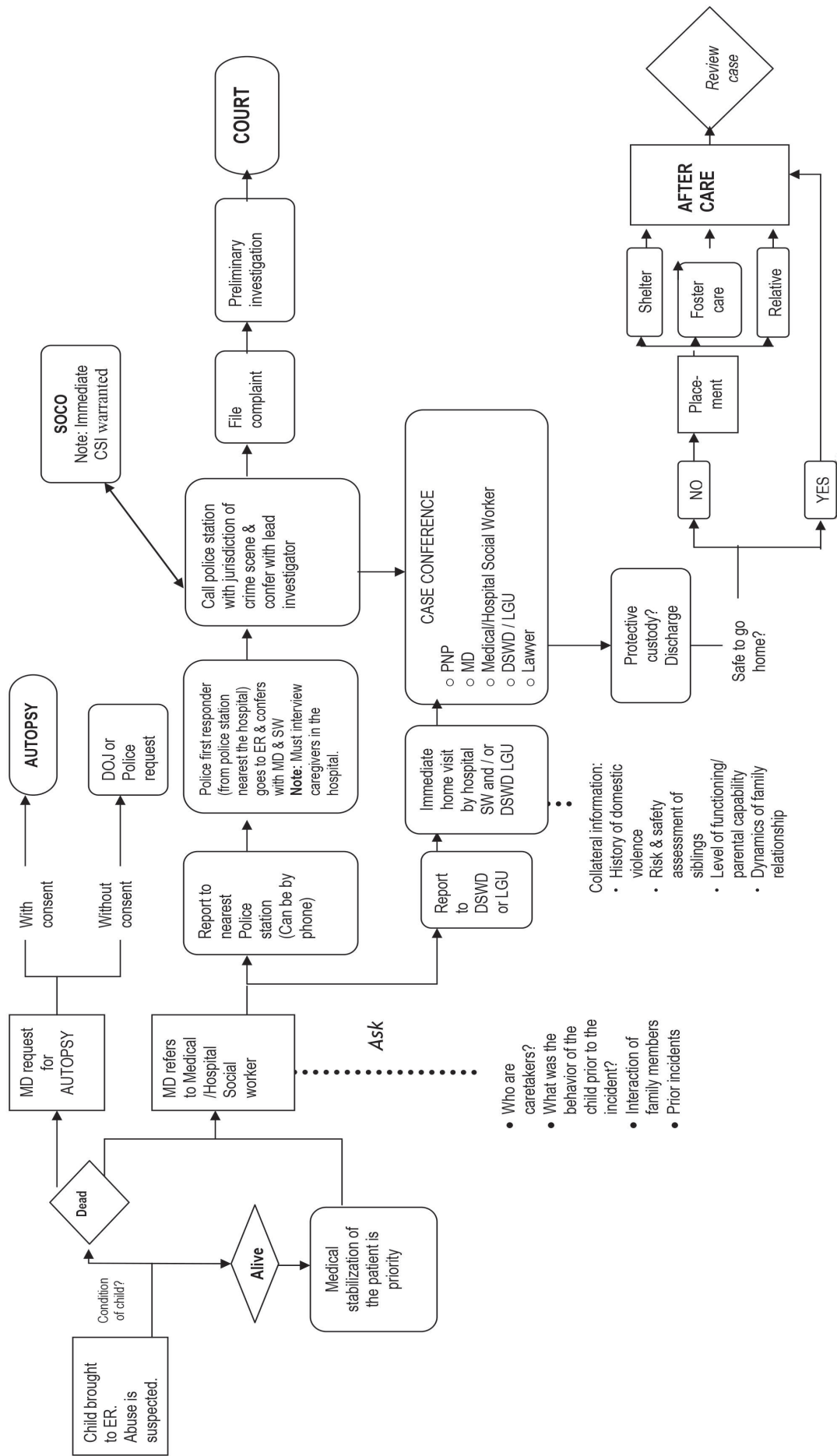
Another major concern in suspicious child death investigation is doing an autopsy. Autopsies of young children require a specialized understanding of pediatrics, pathology, child abuse and forensic investigation. However, most of the autopsies done in our country are conducted by physicians with no formal 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.

Source: Child Protection Network Foundation, Inc. Suspicious Child Injury and Death Investigation. CPU-Net Medical Alert [Internet]. 2004 December [cited 2014 Dec 15];2(6). Available from http://childprotectionnetwork.org/wp-content/uploads/2013/06/SCI-Suspicious-Child-Injury-Death-Investigation_dec04.pdf

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



APPENDIX O

PEER REVIEW

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.

APPENDIX P

CHILD SEXUAL ABUSE ACCOMMODATION SYNDROME

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	HELPLESSNESS	ACCOMMODATION
<p>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.</p> <p>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.</p> <p>The logical solution for most children is to maintain the conspiracy of secrecy and silence.</p>	<p>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.</p> <p>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.</p> <p>This behavior is often reflected in the case with which CSA victims are medically examined. During the examination, some children even go to sleep.</p>	<p>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 herself.</p> <p>Self-blame and guilt are feelings shared almost universally by sexually abused children. In addition the child faces other pressures.</p> <ul style="list-style-type: none"> • 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 <p>The child has the power to destroy the family, but the responsibility to keep it together. Parent and child roles have, in effect, reversed.</p> <p>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.</p> <p>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.</p>

SECRECY ➡ HELPLESSNESS ➡ ACCOMODATION ➡ DELAYED DISCLOSURE ➡ RETRACTION

DELAYED DISCLOSURE

It is likely that many children never disclose their sexual abuse. They may attempt to within the family or (less frequently) outside the family. Disclosure is favored by:

- Overwhelmingly impossible situation at home
- Presence of a sensitive friend, teacher or counselor
- Absence, temporary or permanent, of the abuser
- Educational initiatives, telephone "hotlines" (e.g., Bantay Bata 163)

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.

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.

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.

RETRACTION

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.

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.

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.

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.

Source: UPCM-PGH Child Protection Unit. *The Interpretation and Limits of Medical Evidence In Child Abuse Cases* [Internet]. Manila (PH): Child Protection Network. p. 22-3. Available at: <http://childprotectionnetwork.org/wp-content/uploads/2013/06/The-Interpretation-and-Limits-of-Medical-Evidence-in-Child-Abuse.pdf>

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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. Yes ☐ No ☐ Not Known ☐
Information supporting safety factor:

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

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. Yes ☐ No ☐ Not Known ☐
Information supporting safety factor:

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

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:
<input type="checkbox"/> Contact DSWD for protective custody		
<input type="checkbox"/> Immediate placement		
<input type="checkbox"/> Home visit		
<input type="checkbox"/> Endorse case		
<input type="checkbox"/> Barangay/Police Blotter		
<input type="checkbox"/> Medical care for child		
<input type="checkbox"/> 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*”, “*Paminsanmins*” “*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, paminsanmins, 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 - *Paminsanmins (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: _____
PART 1

Date: _____

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 (hirap matulog, mas maigsi, mababaw, pagising- gising)	0	1	2	3	4
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. iniawasan 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 pambihirang 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/ magsasalita/ 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 _____

mm/dd/yyyy

Printed Name of Rater: _____

Instructions for use of the **Psychological Trauma Assessment Questionnaire** (Leynes, 2015)

Age of child	6-18 years
Qualification of rater	Must have basic knowledge of dynamics of child abuse; must have been trained on the use of questionnaire
Time reference for manifestation of symptoms	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.
Respondent	<p>Questions 1- 24 must be addressed to the child.</p> <p>Questions 25- 30 must be addressed to the parent/adult caregiver.</p> <p>Emergency symptoms may be elicited from either child or parent or both.</p>
Severity of symptoms	<p>Rate symptoms according to frequency of occurrence as follows:</p> <p>0- <i>Hindi nangyayari</i> 1- <i>Bihira (1 X sa isang buwan)</i> 2- <i>Paminsanminsang (1 X sa isang linggo)</i> 3- <i>Madalas (3-4 X sa isang linggo)</i> 4- <i>Palagi (araw- araw)</i></p>
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

6. takot sa tao	afraid of or avoids people
7. inihiwasan ang mga bagay na nagpapaalala sa nangyari	avoids reminders of the event
8. walang tiwala sa tao	distrust people
9. tulala o natitigilan	dazed or stupefied
10. nahihirapan mag- isip	cannot concentrate in school or cannot focus on conversation
11. magulo ang isip	confused, has many thoughts entering the mind, cannot make decision
12. may pakiramdam na naiiba o nagbago ang paligid	feelings of unreality
13. walang ganang kumain	loss or decrease of appetite, food is tasteless
14. malungkutin	sad
15. makalimutin	forgetful
16. madaling umiyak	cries easily
17. ayaw lumabas/ walang gana maglaro	isolates self or does not socialize/ refuses to play
18. nawawalan ng pagasa sa buhay	feels there is no hope in life
19. may pakiramdam/ iniisip na may ginawang kasalanan masama	feels guilty or thinks that she did something bad
20. may pakiramdam na nasira ang buhay	feels that one's life has been destroyed; there is no future
21. may pakiramdam na nagiisa sa problema	feels alone or cannot turn to anyone for the problem
22. naiisip na mas mabuti pang mamatay	wishes to die (This is in contrast to the emergency symptom of having made plans to kill self.)
23. may nararamdaman sa katawan	body symptoms- aches, pains or feeling unwell
24. ayaw/walang gana magaral	refuses to attend school or has lost interest in school
25. matigas ang ulo	hard- headed or disobedient

26. madaling mainis o magalit/ irritable	easily angry or irritable
27. palaaway (verbal or physical)	gets into verbal or physical fights
28. may kilos sexual na di angkop sa edad	manifests sexual behavior that is not appropriate for age
29. may kuwentong sexual na di angkop sa edad	tells stories with sexual content not appropriate for age
30. may pambihirang kilos na nakakabahala	behavior that is unusual and disturbing like restlessness, running away, repetitive acts
May balak magpakamatay /Nagtangkang magpakamatay	Made plans to kill self/ attempted to kill self
Nagwawala/Nanakit ng tao	Out of control/ Aggressive or hurting others
Bumubulong/ magsasalita/ tumatawa magisa	Talking or laughing to self
May nakikita o naririnig na hindi nakikita o naririnig ng iba	Seeing or hearing things that others do not experience
May pagbabago sa dating ginagawian	Loss of functioning as evidenced by dysfunction in school or social relations
Scoring	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.

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