MINISTRY OF HEALTH MALAYSIA

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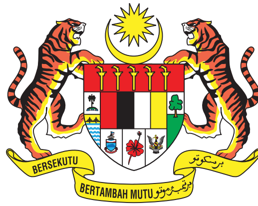
GUIDELINES FOR THE HOSPITAL MANAGEMENT OF CHILD ABUSE AND NEGLECT

MEDICAL DEVELOPMENT DIVISION,
MINISTRY OF HEALTH, MALAYSIA



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Medical Development Division, Ministry of Health Malaysia

The Guidelines For The Hospital Management of Child Abuse and Neglect
was prepared by
the Obstetric & Gynaecological and Paediatric Services Unit of the Medical Services Development Section, Medical Development Division, Ministry of Health Malaysia, in collaboration with Drafting Committee on Guidelines For The Hospital Management of Child Abuse and Neglect

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The Guidelines For The Hospital Management of Child Abuse and Neglect was approved by the Director General of Health Malaysia, Ministry of Health Malaysia

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February 2009

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DRAFTING COMMITTEE ON GUIDELINES FOR THE HOSPITAL MANAGEMENT OF CHILD ABUSE AND NEGLECT

(i). Technical Working Group for Guidelines on Hospital and SCAN Team Organisation in 2007 91

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(iii). Working Group for Standard Operating Procedure for the Hospital Management of Child Abuse and Neglect in 2003 95

ACKNOWLEDGEMENT

THE DIRECTOR GENERAL OF HEALTH MALAYSIA

As childhood mortality drops with improving social development and health care, child care is increasingly focused on the quality of children's lives, their rights as human beings and inevitably child abuse and neglect. In Malaysia, the number of new child abuse cases reported has increased from 930 in the year 2000 to 2,005 cases reported in 2006. It is not just the health, well-being and happiness of generations of children that are at stake if child abuse or neglect is left unattended, but the future of the society which the children will construct out of their childhood experiences. As such, child abuse prevention is one of the tasks being addressed by the Ministry of Health together with other sectors of government.

Unlike most health problems, the aetiology of child abuse appears to be embedded in psychological and social factors in the complex societies in which

people live. Attitudes and beliefs of the child's family, the community and the health worker impact on the diagnosis, the reporting and the availability of care to the abused. This adds a unique complexity to the handling of child abuse cases which involves legal, moral, religious and child rights aspects, issues not as commonly handled in a hospital setting. A common definition of child abuse amongst agencies and the community is also important to ensure reliable and prompt recognition and reporting of suspected child abuse.

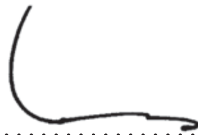
It is thus important to ensure that all hospital staff involved in the care of abused children are guided in their management and reporting mechanism to legal and welfare agencies which provide legal instruments to prevent further abuse and provide services for the child and family. A multi-agency and a multi-disciplinary approach in a coordinated and timely manner is necessary to provide physical and mental assessment and treatment, social services, physical separation from the abuser where safety is a concern, counseling services and community support.

An abused child may be seen in emergency department or may present to the burns, neurosurgical, pediatrics, surgical, obstetrics and gynecology, psychiatry or forensic units. A high index of suspicion is required for recognition of child abuse. This set of guidelines is there to assist in the recognition and management of the abused child as well as in interaction with the police and welfare agencies to ensure safety and prevention of further abuse.

This set of guidelines was drafted by and from the perspective of the specialists working in pediatrics, gynecology, emergency medicine and mental health disciplines, and then formalized by the Working Committee chaired by Dato' Dr. Noorimi binti Haji Morad, former Deputy Director General of

Health (Medical) and Dr. Teng Seng Chong, Senior Deputy Director, Medical Development Division. It was presented and accepted at the Head of Pediatric Departments meeting in 2007. Of note, this guideline complements the guideline for the management of child abuse at the level of public health staff.

I would like to extend my thanks to all those who have collaborated and worked on developing this standard operating procedures for the management of suspected child abuse. I look forward to see its utilization by hospital staff and a subsequent update as multi-agency collaboration and additional services evolve.



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TAN SRI DATUK DR. HAJI MOHD ISMAIL MERICAN

Director General of Health Malaysia

Ministry of Health Malaysia

1.0 Introduction

There were 2,005 cases of suspected child abuse and neglect (SCAN) cases reported to the Jabatan Kebajikan Masyarakat (JKM) in the year 2006. While Ministry of Health (MOH) hospitals are the main health providers for abused and neglected children, more can be done to provide a timely and effective system of response. This document is meant to serve as a guide towards the establishment, development and enhancement of 'child abuse' services within hospitals.

Services are most supportive to children, families and hospital staff when delivered as a centralised, multidisciplinary team in the hospital which shall be referred to as called the SCAN (Suspected Child Abuse and Neglect) Team.

Management of the suspected abused child can be offered in the One Stop Crisis Center in each hospital, as an inpatient or in the specialty clinic.

2.0 Definitions

2.1 CHILD – all those aged below 18 years

- Child Act 2001

2.2 CHILD ABUSE or NEGLECT

Constitutes all forms of physical abuse and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm, to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.

- WHO Violence Injury and Prevention Team, 1999

2.3 SUSPECTED CHILD ABUSE AND NEGLECT (SCAN) TEAM

This is a multidisciplinary team of hospital staff comprising pediatricians, gynecologists, mental health professionals, accident and emergency staff, forensic pathologists, nurses, and medical social workers who work closely with designated Welfare Officers from Jabatan Kebajikan Masyarakat (JKM) and police officers in the management of abused or neglected children. The SCAN Team hospital members will be or have been identified by the hospital and trained to evaluate and manage child abuse cases. One of the doctors from this team can also be the medical team member of the district/state JKM Child Protection Team.

2.4 ONE-STOP CRISIS CENTRE (OSCC)

This is a 24-hour one-stop crisis center which is generally located at the emergency department/unit. One of its services is to serve as the entry point of child abuse cases to the hospital, providing a private area where the child and family can be interviewed by the health personnel, welfare officers or police, and initial medical examination performed. In most instances, the child will be subsequently admitted to the hospital for further assessment, treatment of any physical injuries and counselling.

The OSCC also serves as a one-stop centre for adult survivors of domestic and sexual violence. OSCC team members comprise a multi-disciplinary team of health staff, police, medical social workers, counsellors, and Non-Government Organisations (NGO's).

3.0 Objectives

3.1 To define hospitals' responsibilities regarding management of SCAN cases

3.2 To provide a guide to the development of hospital protocols & procedures

3.3 To define organisational structure and role of SCAN teams and members, at various levels of hospital care

4.0 Hospital Accountability

4.1 Identification of the abused child

4.2 Diagnosis and documentation

4.3 Provision of a safe environment while medical evaluation and social assessment is taking place

4.4 Treatment of any injuries and mental health assessment / counseling

4.5 Drawing up a management plan in consultation with JKM and / or police, prior to discharge

4.6 Follow-up and review

5.0 Protocol and Procedure Development

It is recognized that not all hospitals will have the full range of resources necessary for complete management and assessment of child abuse cases and that, in some instances, referral to a larger and more comprehensive centre is advisable.

Each hospital should customise its protocol for the assessment and management of abused children, according to the hospital's resources and infrastructure.

Hospital protocols to include:

- Organizational structure and administrative arrangements;
- Medical staff roles and responsibilities;
- Patient care policies and procedures;
- Mechanism for reporting to the Police / Welfare Department ;
- Policies and procedures which support follow up by JKM officers and investigations by police.

The protocol should include formal mechanisms for handling cases of actual and suspected child abuse or neglect through:

- The designation of an individual or group of individuals as the responsible agent for dealing with such cases;
- The development and implementation of procedures to be followed by hospital personnel; and,
- The development and maintenance of clear lines of communication and responsibility with the other agencies involved both in the immediate community, and with referral institutions elsewhere.

6.0 SCAN Team Composition

Abused children benefit when professionals coordinate their efforts to investigate cases and protect the children involved.

A multi-disciplinary approach does not require a formal center. It does require that the professionals make efforts to communicate from the earliest opportunity, coordinate investigations, limit repeat interviews by different agencies and by multiple interviewers, and continue to share information throughout the pendency of the case. All agencies involved in the investigation of child abuse are encouraged to use a multi-disciplinary approach whenever possible. The goal of this approach is to reduce trauma to the child, improve coordination of service delivery, ensure forensic defensibility of services [i.e., medical examination and interview components], and enhance the courts' ability to protect families .

Multi-disciplinary team professionals should view their function as part of a team.

SCAN teams should thus include the JKM officer and police officer as well as networking with support groups within the community they serve. The extent to which each hospital can meet the needs for diagnosis and treatment of the abused or neglected child will vary in accordance with resources available, and the degree of community collaboration. To assist hospitals in determining the level in composition of their SCAN teams, hospitals can be divided into three categories :

Level A	:	Hospital Kuala Lumpur (HKL) and state Hospitals
Level B	:	Other Hospitals with specialists
Level C	:	Hospitals without specialists

6.1 Level A Hospitals (HKL and state hospitals) :-

- Headed by Pediatrician
- A medical social worker responsible for the pediatric department
- JKM officer (Child Protector)
- Police Officer (Inspector or higher rank)
- Specialist(s) from the Pediatric Department, Emergency Department, O&G, Psychiatry and Forensic department
- A Pediatric and/or OSCC nurse (Sister)
- Counselor, psychologist, if available
- Additional members may be added to the team as appropriate (e.g. Deputy Public Prosecutor, Hospital/School counselors)

6.2 Level B Hospitals (Other hospitals with specialists):-

- Headed by Pediatrician
- Specialists / Medical Officer from O&G, Emergency Department, Psychiatric, Forensic Department
- Medical social worker
- JKM officer (Child Protector)
- Police Officer
- Nurse, preferably Sister of the Pediatric ward or equivalent in authority and/or experience.

6.3 Level C Hospitals (Hospitals without specialists):

- Headed by the Family Medicine Specialist /Hospital Director
- Senior nurses / Medical Assistants
- JKM officer (Child Protector) should also be a member, wherever possible, and/or a police officer (preferably the same members of the District Child Protection Team)

Level A SCAN teams :-

- provide consultation/support to other professionals who are not specialized in handling cases of suspected child abuse and/or neglect.
- identify gaps in services and to participate in long-term planning for child protection services, and cooperation/ consultation with other community agencies.
- accept referrals from level B and C hospitals, or direct referrals

Level B SCAN teams :-

- the provision of such care as in Level A Hospitals although this may involve the referral of the child to Level A hospitals which have more specialized services or for complex cases.

Level C SCAN teams :-

- are expected to consult or refer all cases of SCAN to hospitals with specialists. These SCAN teams can communicate welfare and police investigation findings to the referral hospital.

7.0 Functions Of The SCAN Team In Hospitals With Specialists

7.1 General Functions

- To serve as a multi-disciplinary referral team within the hospital
- To assess the likelihood of abuse or neglect for referred cases
- To provide coordination amongst the various agencies in case evaluation, management and reporting of child abuse cases
- To develop and review hospital policies and procedures for the handling of suspected or actual cases of child abuse and/or neglect
- To provide and organize echo training for the state
- To maintain a database on the cases handled by the team
- To enhance community awareness on the prevention and reporting of SCAN cases

Each hospital with specialist should aim towards having a secretariat to manage the multi-agency and multidisciplinary communications and database. Level C hospitals are expected to refer all cases of child abuse and neglect to hospitals with specialists. *As much history, assessment of the child's safety needs and social history should be obtained as far as possible prior to referral*. The secretariat would most appropriately be based in the Pediatric SCAN Unit/OSCC.

7.2 Roles of various members of SCAN Team

7.2.1 Hospital Professionals

7.2.1.1 Doctors

- To examine and evaluate for suspected child abuse and neglect
- To treat physical injuries and mental health problems consequent to abuse/neglect
- To work with welfare officer and police to protect the child
- To meet the needs of the criminal justice and child protection system by careful documentation of injuries, collection of evidence and interpretation of findings
- To provide reports and opinions of medical examination, including that of a psychiatric assessment of emotional trauma that can be used as evidence in care or criminal proceedings.(Section 1,2 and Appendix 5,6,7)
- To represent the hospital in JKM Child Protection Teams

7.2.1.2 Nurse

- To foster awareness among the nursing staff, particularly in the emergency and pediatric departments, of the signs of possible child abuse in order that detection of cases is made as early as possible
- To maintain close communication with the social worker/police and the doctor in the handling of a case

- To ensure close observation and documentation of the child's behaviour with staff, parents and visitors, and the parents' attitude/bonding towards the child and family relations
- To coordinate the SCAN meetings and relevant activities (secretariat)

7.2.1.3 Medical Social Worker

- To do social assessment and conduct home visit if necessary
- To assist the doctors in reporting and coordinating with JKM
- To maintain data on child abuse and neglect cases handled by hospitals
- May also be the secretariat for the SCAN meeting and follow up with other agencies

7.2.2 JKM Officer (Child Protector)

- Investigation and social assessment of whether child is in need of further care and protection
- Ensure protection of child and placement of child in a safe environment
- Assist in rehabilitation of child and family
- Provide financial assistance, assistance for schooling and other social support
- To provide data to the National Registry on all identified/ suspected cases of child abuse or neglect

7.2.3 Police

- Provide immediate protection to child and non-abuser parent or family members
- Investigation of offences and assisting prosecution of the offender

7.3 Role of Specific Hospital Departments

Some departments are more likely to be involved in the investigation and/or treatment of child abuse cases than others. Apart from the paediatric department, these include the emergency department, gynaecology, psychiatric and psychological services, and the laboratory as well as surgical units such as orthopaedic, neurosurgery and burns units. In all departments, documentation is of utmost importance, since such evidence is often crucial in establishing proof of abuse in court.

7.3.1 Pediatric Department

The patient is often admitted to the pediatric wards for examination, treatment and assessment of child and family. The ward also provides a place of safety while the JKM officer investigates the home situation. Bonding and parent-child interaction are also to be noted during the hospital stay.

7.3.2 Obstetric and Gynecological Department

Staff in this department examine alleged sexual abuse cases, provide immediate management of acute sexual abuse and continued care of pregnant teenagers.

7.3.3 Emergency Department

It is in the emergency department that many cases of child abuse are first seen. A high index of suspicion is required of the staff in this department in order to not miss the diagnosis of child abuse. The emergency department staff is also best placed to observe the reactions of the child and the accompanying adult in the acute situation, often when the abuse has been freshly committed.

7.3.4 Psychiatric and Mental Health Services

Many abused children are likely to present with behavioural or psychological problems, and may first come to the attention of mental health providers. Aside from this diagnostic function, staff will be involved in the care and therapy of children who have been abused.

7.3.5 Forensic Services

Some child fatalities may actually be due to child abuse or homicide e.g. in suffocation. Cases of child fatality especially those brought in dead can be brought for discussion at SCAN Team meetings. Post-mortem findings together with clinical findings of the child in the ward will help to complete the medical evaluation of a suspected child abuse fatality. Forensic department staff should be closely involved in the development of the hospital's Sexual Assault Kit.

7.3.6 Laboratory Services

In seeking to prove a charge of child abuse/neglect, the chain of evidence which uses laboratory results is vulnerable to allegations of mislabelled specimens and improper procedures being used. The various departments should draw up, in consultation with forensic department, strict protocols to be followed and records to be made in the collection, labelling and handling of specimens collected from children in which the possibility of abuse is being considered. This is particularly important in the case of specimens which need to be sent to laboratories outside the hospital for analysis, e.g. DNA studies. Help in developing such protocols should be available from the staff of the referral laboratories, forensic department and the police who are familiar with the procedures required.

8.0 Liability And Confidentiality

Cooperating with outside agencies, especially in situations where legal action is likely to be involved, often raises questions of the liability of hospital staff, and of the legal status of hospital information, i.e. confidentiality issues.

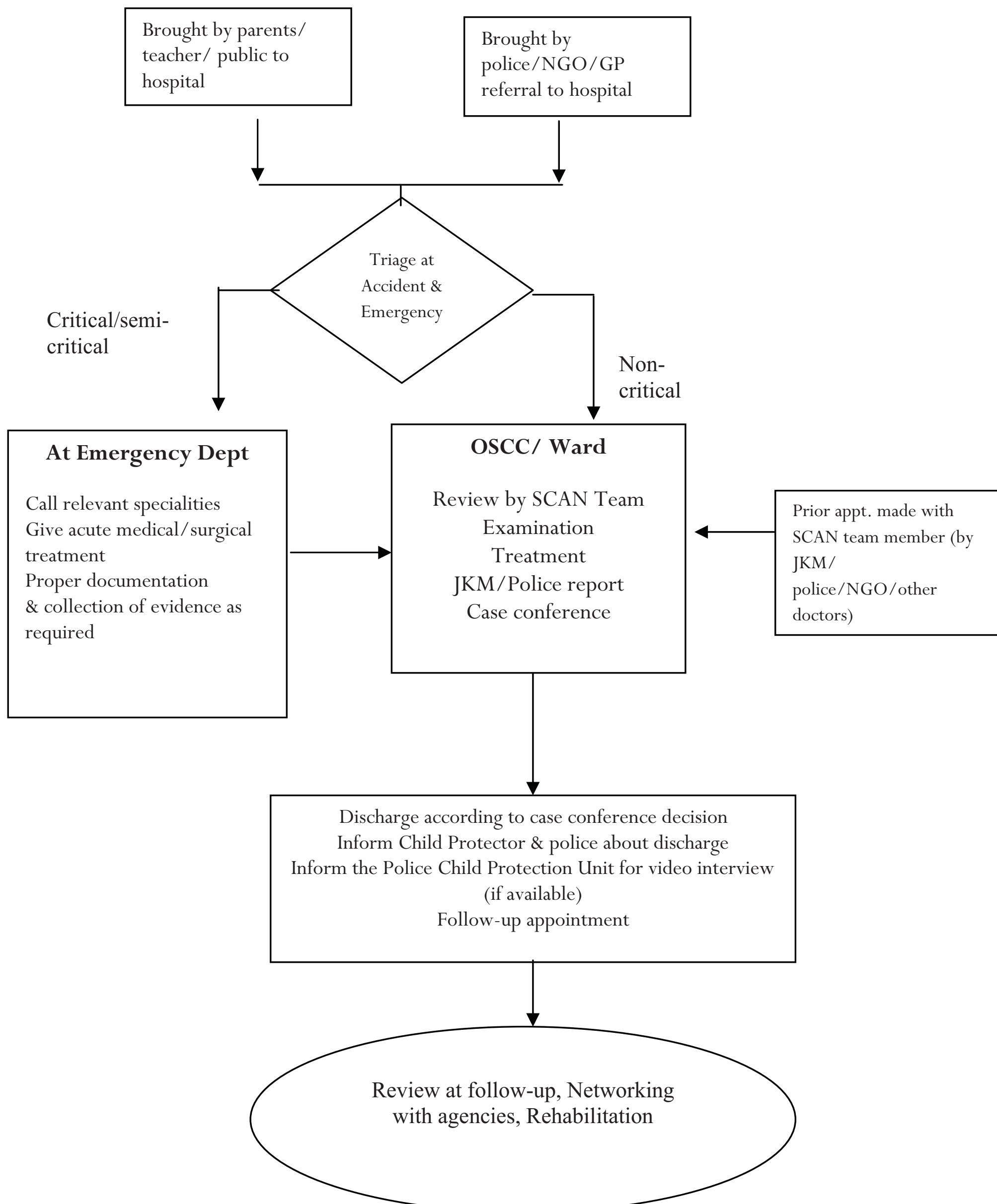
There is a mandatory requirement of doctors to report suspected child abuse/neglect and/or protection needs to the Child Protector (empowered JKM officer) under the Child Act 2001 and, under the Act, the identity of the reporter will not be revealed without consent unless ordered by Court. "Legal action shall not be brought against doctors who have made the report in good faith, in the reasonable belief that the child was abused" under the Child Act 2001 Clause 123.

Should the doctor receive a written request from the Police or Court to examine the child or take body specimens for DNA analysis, he is obliged to do so with or without the consent of the parent/guardian, and he is protected from liability under the Child Act 2001 Clause 21.

PROCEDURES & GUIDELINES

PROCEDURES FOR HANDLING SCAN CASES

Flow chart



1. Referral

It is important to recognize that an abused child can present in various ways to the hospital.

An abused or neglected child may initially have been referred for a :-

- *Medical illness (e.g. convulsion, per vaginal discharge, fracture)*
- *Behavioural problem*
- *Psychological problem (e.g. depression, anxiety attacks)*
    - *Or a Request for genital examination*
    - *Disclosure of sexual contact*
    - *Parental anxiety about "loss of virginity"*
    - *Alleged sexual abuse in custody case*
- *Or Alleged abuse/ assault*
- *Or Found abandoned* (as in abandoned babies) or wandering unattended in public places

2. Triage System at Emergency Department (ED)

Triage system is a procedure where patients are sorted out, prioritized and specific management instituted

2.1 FOR CRITICALLY OR SEMI-CRITICALLY ILL PATIENT

- Children who are in a critical or semi-critical condition should be attended to in the acute area of ED and subsequently transferred to the ward for further management.

- Police report must be done urgently for all cases of sexual abuse which has occurred less than 72 hours after the alleged incident, and for all cases of physical abuse or neglect where the child's life is at risk.

- The medical officer should lodge a police report in such cases if a parent is not immediately available or unwilling to lodge one. In cold cases (> 72 hours) of sexual abuse, police reports can be lodged within 24-48 hours after examination (see Notification below)

Child Act 2001

Medical examination and treatment
Section 21 A medical officer before whom a child is presented under subsection 20 (1) or (4)-

(a) Shall conduct or cause to be conduct an examination of the child;

(b) may, in examining the child and if so authorized by a Protector or police officer, administer or cause to be administered such procedures and tests as may be necessary to diagnose the child's condition; and

(c) May provide or cause to be provided such treatment as he considers necessary as a result of the diagnosis.

The medical officer in the Emergency Department has to :-

- Treat any life-threatening condition
- Do an overall examination and stabilize the patient
- Take care so as not to tamper with any possible forensic evidence, such as cleaning up the patient before the medical examination
- Examine the child together with the relevant doctor from the specialist team, e.g. from pediatric, gynecology, surgery, forensic departments
- Document all examination findings in the patient's notes
- Take the relevant specimens, ensure they are labeled correctly with the patient's name and other particulars and passed to the police

- Forensic evidence is given directly to the police officer to maintain the chain of evidence. The name of the police officer should be documented in the patient's notes, and OSCC/SCAN protocol notes.

- The police officer may wish to take photos before the wounds are cleaned up, provided the patient has been stabilized. Medical officer to document examination findings in patient notes.

The patient is then transferred to the relevant ward or OSCC

2.2 FOR STABLE PATIENT

- If the child is stable at the point of triage, she or he will be directed to the OSCC/ ward where the child will first be attended to by the nurse. The doctor from ED /Pediatric Department will contact the relevant team-on-call and the other disciplines that need to be involved.

2.3 MEDICAL ASSESSMENT

- All cases of suspected child abuse should be referred to Pediatric team-on-call. The medical officer should inform specialist-on-call

- To obtain history and conduct physical examination

- To assess the mental and developmental functioning of the child
- To assess the needs of the child and the capacity of parents to meet the child's needs
- To go through the checklist before child is discharged (see Child Protection Management and Discharge Checklist, Appendix 2)
- Recognize children (whether abused or not) in need of support and/or safeguarding, and those parents who may need extra help in bringing up their children

(For further information, refer Section 2)

3. Cases That Will Require Admission Are :-

- Where the child requires medical treatment

- Where safety is a concern (as in intra-familial abuse or other concerns about physical safety or neglect or lack of supervision)

- All cases of child sexual abuse :-
  - for medical management of acute physical and emotional trauma
  - for examination by experienced medical staff and when the child is more settled (especially in cases of chronic sexual abuse where the last incident is more than 72 hours prior to presentation)
  - to obtain further information from the child survivor
  - to rule out possible incest
  - for post-traumatic stress counseling of child and family
  - for counseling of social and legal ramifications following the abuse
  - to determine the most suitable placement for the child

- Presentation after office hours to enable review by the SCAN Team and to ensure a satisfactory initial assessment and safe placement of child

Child Act 2001

Authorization of hospitalization
Section 22. If the medical officer who examines a child under section 21 is of the opinion that the hospitalization of the child is necessary for the purposes of medical care or treatment, a Protector or police officer may authorize the child to be hospitalized

Section 27(3) If the registered medical practitioner referred to in subsection 27(1) is a medical officer, he may take the child referred to in that subsection into temporary custody until such time as the temporary custody of the child is assumed by a Protector or police officer.

All children admitted or seen as an outpatient in the hospital should have a consultation with the SCAN team and given a follow-up appointment.

4. Documentation

There should be clear and complete documentation in the patient's notes regarding:-

- Timing of examination
- Examination findings and circumstances involved
- Photography and video-colposcopy of abnormal physical and genital examination (if available). Note that written consent by parent/guardian is required if photography taken by hospital staff.

The name of the photographer and time should be documented. The photos and videotapes should be properly labeled and secured. Photographs for Court should be taken by the investigating police officer.

Forensic specimens sent should be correctly and completely labeled. There should be documentation in terms of the name of the doctor who took the specimens, the police officer who received and dispatched the specimens, time of specimen taking by the doctor and specimen collection by the police.

- Fill in the preliminary medical report form issued by the police officer for sexual abuse cases (See Appendix 5) or give a medical report as soon as possible to the police officer

- Police report no., police officer-in-charge and JKM officer-in-charge of the patient should be noted

- Should the police or JKM wish to bring the child out of the ward, e.g. to the 'scene of incident', 'witness identification' or to Court, there should be an official letter from the department requesting permission. The name of the police officer, police identification number or name of JKM officer and office branch should be documented in patient's notes.

5. Consent For Medical Examination And Treatment

The medical officer can be instructed to examine or treat the child, this includes examination of the genitalia, under the following circumstances:

- Consent from parent or guardian
- By police officer with a written order for examination (Borang P59)
- If ordered to by a Child Protector (gazetted JKM Officer)
- A child is brought for examination by parents or guardian e.g. for pain in the genitalia or on passing urine, parental consent is implied as in part of a full physical examination for medical illness. Police reports are not required per se in this instance where the child has not given a history of sexual abuse. Parent(s) should be around during the time of examination and this should be documented in the patient's notes. Doctors should lodge a police report themselves after the examination if there is a strong suspicion of sexual abuse and the parent or guardian remains reluctant to lodge a police report.

- Consent and/or cooperation by child, not in a legal sense, is essential before any examination (so as not to further emotionally traumatize the child). Examination under anaesthesia (EUA) may be necessary in the younger distressed children.

Child Act 2001

Authorization of medical treatment
Section 24(1) If, in the opinion of a medical officer, the child referred to in section 21, requires treatment for a minor illness, injury or condition, a Protector or police officer may authorize such treatment

Section 24(2) If, in the opinion of a medical officer, the child referred to in section 21, is suffering from a serious illness, injury or condition, or requires surgery or psychiatric treatment, a Protector or police officer –

(a) shall immediately notify or take reasonable steps to notify and consult the parent or guardian of the child or any person having authority to consent to such treatment; and
(b) may, with the written consent of the parent or guardian or such person, authorize such medical or surgical or psychiatric treatment as may be considered necessary by a medical officer

Section 24(3) If a medical officer has certified in writing that there is immediate risk to the health of a child, a Protector may authorize, without obtaining the consent referred to in subsection (2), such medical or surgical or psychiatric treatment as may be considered necessary by the medical officer but only under any of the following circumstances:

(a) that the parent or guardian or any person having authority to consent to such treatment has unreasonably refused to give, or abstained from giving consent to such treatment
(b) that the parent or guardian or person referred to in paragraph(a) is not available or cannot be found within a reasonable time or
(c) the Protector believes on reasonable grounds that the parent or guardian or person referred to in paragraph (a) has ill-treated, neglected, abandoned or exposed or sexually abused, the child

6. Forensic Issues In Sexual Abuse

- Forensic evidence is best be obtained from physical examination as soon as possible after the incident, and should not be delayed even if it is still within 72 hours post-incident (ie. an acute case)

- Prior to examination, child should not shower or change clothing and parents/child should be advised accordingly

- Each item of clothing worn during the incident to be packed in bags provided, labeled correctly with child's name in the presence of police

- Forensic swabs are taken before swabs for sexually transmitted diseases

- Use swabs and slides provided in the medical rape kit

- Make sure forensic swabs are thoroughly air-dried before sealing in the kit

- Police officer should be available to receive the forensic specimens before examination of acute alleged sexual abuse cases

- Specimens for confirmation of sexually transmitted disease, HIV or Hepatitis will not be taken nor required by the police and should be sent by ward staff to hospital laboratory

- Careful documentation can be made in a form such as in Appendix 6

7. JKM Notification

- Doctors are mandated by law to report to JKM (use Borang 9, Appendix 2). This should be accompanied by a report giving reasons for suspicion or diagnosis of child abuse. This may be followed up subsequently by a more comprehensive medical report in complicated cases.

Child Act 2001

Duty of medical officer or medical practitioner

Section 27(1) If a medical officer or a registered medical practitioner believes on reasonable grounds that a child he is examining or treating is physically or emotionally injured as a result of being ill-treated, neglected, abandoned or exposed, or is sexually abused, he shall immediately inform a Protector.

Section 27(2) Any medical officer or registered medical practitioner who fails to comply with subsection (1) commits an offence and shall on conviction be liable to a fine not exceeding five thousand ringgit or to imprisonment for a term not exceeding two years or to both.

- Determine JKM office responsible (from address of child)

- Fax JKM Borang 9 and preliminary medical report by Medical Officer to JKM office followed by phone call by the Medical Social worker/ ward staff

- Key worker in SCAN team coordinates management and notification

7.1 JKM Borang 9 & Medical Report To JKM

- Particulars required are :-
    - Name of child, address, name of parents, telephone number
    - Name of informant/doctor and contact
    - Type of abuse based on supportive findings or history; OR as a request for JKM investigation into possibility of abuse
    - Urgency and reason for concern

- Copies kept in SCAN/OSCC file and patient notes

- JKM Borang 9 and preliminary medical report forms should be available in all OSCCs, pediatric, ICU, neurosurgical, surgical, orthopedic wards, pediatric clinics and accident and emergency centre.

8. Police Report Should Be Made :-

- For all sexual abuse cases
- For severe or chronic physical abuse
- In children with severe neglect
- Urgently in life-threatening situations or if other children are at immediate risk
- Where there is a risk for future substantial harm to the child or other children under the care of the alleged perpetrator

Decision to make a police report should be made in consultation with senior staff.

Preliminary medical reports for alleged sexual abuse can be submitted to the attending police officer, as soon as examination findings are available (using form Appendix 4), to be followed by a more detailed medical report on psychological or mental health aspects if required.

9. Writing Of Medical Reports :-

- Complete relevant medical examination. Avoid medical jargon. Include relevant negative findings as well as positive physical examination findings.

- To include any adverse emotional or psychological impact on the child and, if relevant, disability consequent to the abuse

- Record and document all positive and relevant negative physical findings well

- Record time and date patient seen and examined

- Standardized recording format should be available at each hospital

- Diagrams are useful

- Photography (with name, RN, date and time taken & photographer's name) – for physical or sexual abuse cases usually kept as a reference for the doctor rather than to be submitted to police

- Names of all staff involved to be written legibly or name chop used

- Do not write detailed history as given by patient but rather the reason for examination e.g. alleged sexual abuse, as an introduction, unless the history is given in the context of a report of whether the young child's history is consistent and whether the child is 'fantasising or not'

- Do not write "no evidence of sexual abuse" where examination findings are normal as the history given by the child may be strongly suggestive of sexual abuse. No evident injury may be present at the time of examination but physical evaluation alone cannot exclude sexual abuse

- To include a report from psychiatrist if deemed useful as in custody cases

10. Case Conference & Case Review

Case conference means discussion of cases between the agencies involved:

- Assessment is made by the doctors and welfare officers in combination with feedback from the police investigations, as to the probability of child abuse and further risk to the child and other children

- To discuss management, legal measures, child care and child and adult psychiatric referral, and a decision on temporary placement if the child needs a place of safety

- The decision on the discharge and placement of the child should preferably be formalized and documented

This can be done over the phone or face-to-face meetings.

- Reports by various agencies should be exchanged and follow-up maintained

- Ensure that the protection plan for the child is in place or the safety of the child has been evaluated by the Child Protector or welfare officer before discharging the child [especially if discharge is to the alleged offending parent(s)]

- There should be case reviews after discharge from hospital (at the SCAN team or Child Protection team meetings) to determine: progress of the case; new evidence or change in history or testimony; the safety and needs of the child and family; further treatment required for child or family members

GUIDELINES FOR MEDICAL OFFICERS IN THE MANAGEMENT OF CHILD ABUSE AND NEGLECT

All doctors dealing with children should understand the local procedures given in Section 1. Doctors should not work alone in the management of abused children or evaluation for abuse. All cases of child abuse and neglect should not be the sole responsibility of house officers. Examination should be conducted and medical reports written by specialists unless there is no specialist available as in district hospitals.

1. Physical abuse

1.1 History

- Complete history taken by medical officer (MO) /specialist with regards to:-
  - Timing and nature of injuries
  - Full developmental history
  - Social history

1.2 Physical examination

- Careful documentation of all bruising and external injuries, and history given by guardian as to cause of injury :-
  - Comment on number, site, size, shape, surrounding tissue (bruise, swelling), colour, course (eg. direction of force applied), any foreign material in wound. Observe pattern of injury e.g. cane marks, cigarette burns, fingertip bruises, bite marks

- Bruises - It must be emphasized that the current consensus view is that the age of a bruise cannot be determined with any degree of accuracy. Associated findings of tenderness, swelling, lacerations add to greater accuracy of a fresh injury.
    - The apparent colour may be affected by skin pigmentation
    - The site of bruising is not necessarily the site of trauma e.g. bruising may extend beyond the site of impact, bruising may appear at a site distant from the impact, visible bruising may be absent despite considerable force (as in abdominal injuries)
    - The size of the bruise is not necessarily proportional to the amount of force delivered
    - Bruises resolve faster on parts of the body which have better vascular supply such on the face as compared to the buttocks and thus bruises on buttocks remain blue/purple for longer than a similar bruise on the face
    - Dating of a bruise should refer to associated tenderness or swelling rather than on colour alone

- Check ears, oral cavity (including frenulum), fundi for injury or haemorrhage

- Assessment of growth and development, emotional and physical maturity, personal hygiene & evidence of neglect

1.3 Investigations

- Platelet count and coagulation screen in presence of any bruising

- Skeletal survey as required (should be done in children below 2 years of age)

- Photographs of injuries

- Others as indicated :-
  - e.g. head injuries - CT SCAN for suspected shaken baby syndrome
  - Ultrasound for intra-abdominal injuries -free fluid & hematomas
  - X-rays for fractures (only if clinically indicated in children >2 years old)

1.4 Others

- Proper documentation in text and diagram

- Take photographs, if possible

- Photos must be labeled according to the number in roll of film or filed according to name and date in digital form

- Examine other siblings or children in home, as relevant

- Direct observation of child-parent/guardian interaction

2. Acute sexual assault or abuse

2.1 History-taking

Interviews are inevitably part investigation, part assessment and part therapeutic. The therapeutic needs of the child are not the same as the requirements of the legal system, e.g. the doctor need only establish that sexual abuse has probably occurred once or more than once and need not pursue the exact time and place as opposed to the police who require the time, date and place of the incident(s) reported.

Children may be helped to talk using play materials and be in a suitable and conducive environment. In helping the child to tell, the possibilities are :-

- The abuse has occurred and the child is speaking of it
- The abuse has occurred and the child is unable to speak of it or is denying it
- The abuse has not occurred and the child cannot speak of it
- History about the incident should initially be obtained from the person who first brought in the child (sometimes the police officer). It is also helpful to obtain relevant knowledge of the child and his or her family, child's level of development, behavioural problems and distress about the incident from the parents or other carers before interviewing the child.

- Have non-judgmental style, use open-ended questions
- Establish rapport with child
- Take the briefest history necessary initially prior to physical examination if child already underwent or about to undergo in-depth interview with another doctor/police later
- Assess state of distress, credibility, developmental level and related emotional or behavioural problems
- Child may disclose further information about abuse in later interviews
- Disclosure interview (to determine if abuse has occurred) or forensic interview(for police investigation) should be conducted by trained personnel
- Parent or caregiver should be interviewed separately from child from the beginning

- Full medical and social history:-
  - Details of past history, including any accidental injury (especially to genitalia or area of alleged trauma)
  - In adolescent child :-
    - Menstrual history
    - Tampon usage
    - Previous sexual experience
    - Contraceptives and pregnancy

2.2 Examination for sexual abuse

- In most cases, there is no urgency in examination

- Calm the parents by keeping them informed

- Arrange appointment with trained doctor. Avoid repeated vaginal examinations

- Doctor should inform the child the reason an examination is required and what it entails, according to the child's developmental level

- Medical setting for examination :-
  - child-orientated
  - adequately equipped
  - quiet, informal and private

- Never use any form of force or coercion to perform the medical examination

- The absence of abnormal physical findings NEVER excludes the possibility of child sexual abuse

2.3 Urgent examinations

- Urgent treatment needed for the child when :-
  - there is obvious physical trauma or suspected internal trauma
  - there are signs or symptoms of systemic illness or local signs and symptoms especially significant genital discharge or bleeding or ano-genital pain

- Acute sexual assault/last incident within 72 hours before presentation
  - As forensic evidence may be present for only a matter of hours

- Extreme distress either of child or parent may influence timing of examination

- It is appropriate for the primary care doctor (in context of vaginal bleeding/ acute trauma) to do limited examination to determine urgency of referral followed by an examination by the specialist BUT only one medical report from the hospital is to be submitted

2.4 Non-urgent examinations :-

- With a disclosure where the last incident was more than 72 hours prior to arrival
  - Most involve long-term abuse. Examination should be planned with family's needs in mind and as part of SCAN team evaluation
  - Disclosure interview should preferably be conducted first

- Without a disclosure in cases where
  - There is general concern about the possibility of sexual abuse but no specific indication e.g. dysuria or pain in genitalia
  - Pediatric assessment finds physical suspicions e.g. purulent vaginal discharge
  - Psychological assessment shows indicative behavioural problems e.g. the child goes around kissing strangers

2.5 Examination under anesthesia

- If child is distraught and examination considered essential to further protect the child

- Painful injuries e.g. vaginal wall tear

- Risk of sexually transmitted diseases and child unable to allow adequate swabbing

- Strong possibility that forensic swabs would be useful and child unable to comply

- If there is a suspected foreign body

DO NOT's:

- DO NOT conduct a genital examination unless you are trained

- DO NOT attempt to interview the child with the aim of getting a disclosure when there is no initial history from the child, beyond a gentle inquiry as to the possibility of an unwelcome touch e.g. in child with dysuria

- DO NOT show the child you are shocked or angry by what he/she says

3. Management of Sexual Abuse of Adolescents

1. Examination done by O&G doctor as soon as possible if < 72 hours after incident.

2. Medical treatment initiated if indicated. e.g. abrasion or laceration wound - dressing or pain relief.

3. Prophylaxis indicated :-

   (i) Emergency contraception - Medically and legally warranted.

   - 4 tabs of Microgynon 30/ 2 doses apart stat and 12H later
   - Explain the complication of medication
     a) Severe nausea and vomiting
        Oral metoclopromide 10mg tds if necessary
     b) Breast tenderness

   (ii) Antibiotics for high risk group
   Increased risk of infection in rape compared to consensual sex
   a) Rape- more genital trauma and bleeding
   b) Multiple assailants
      Rx: Tab Doxycylin 100mg bd & tab Metronidazole 200mg tds

(iii) HIV Prophylaxis

- Is indicated if assailant is probable HIV+(high risk of infection)
- Probable risk of HIV infection:-
  a) Intravenous drug usage (IVDU)
  b) Bisexual/Homosexual activities
  c) Practices unsafe sex
  d) High sero-prevalence population-prison, rehabilitation centers
- Counseling to be done before starting treatment
- Discuss with Adolescent or/and Infectious Disease Specialist if necessary.
- Rx: AZT 250mg bd & Lamivudine 150mg bd
- If assailant status is known HIV +ve

  Rx: Zidovudine 250mg bd, Lamivudine 150mg bd & Indinavir 800mg tds.

(iv) If suicidal risk or symptom of depression is present

- make a referral to a psychiatrist

4. Documentation

■ *Information gathered should be :-*

- Written up immediately after each communication
- Factual, concise
- Accurately recorded, in child's words as far as possible
- Signed, with clearly written name below and dated

5. Preventative Interventions

- If the child has not been abused but there is cause for concern (e.g. poor coping ability of parents), preventative interventions may be provided by:
  - Public health nurses
  - Medical social workers
  - Mental health workers
  - Community agency (government or NGO)

6. Crisis Support

- Important to anticipate the wide range of reactions and provide support

- Other family members may disclose their own abuse for the first time and require counseling

- Explain to family their critical role in providing healing for their child. Be aware that this is at a time when they may be dealing with their own feelings of denial, guilt, anger or humiliation

- Be conversant with your local system and community resources and provide the child and family access to a trained counselor

DO NOT's:

- DO NOT criticise the alleged abuser in front of the child

- DO NOT promise to keep what you are told a secret. Inform which parts you may need to disclose to those who need to know, such as police or Child Protector

- DO NOT inform the parents that you intend to report your suspicions when abuse is intra-familial or you suspect a parent will be unsupportive before investigations are completed. This is to prevent pressure that may be applied to child to maintain secrecy.

7. Support And Informing Family

- *Consideration should be given to making contact with supportive parent or person identified by child (as in cases where the child is brought in by JKM officer from school)*

- *Parents/ caregivers should be informed as early as possible about referral to JKM or police report*
    - Before this, consider the safety of child, impact on family and identification of suspected abuser

- Liaise with Medical Social Worker

8. Trained Counselor Or Medical Social Worker Can Provide

- *Crisis work:*
  - Initial support
  - Patient advocacy during assessment
  - Support during medical examination
  - Assistance at court hearing, when child and family can become acutely dysfunctional (use JKM child witness support service, if available in your area)

- *Longer term therapy for child and family members to provide information and skills to equip an abused child to deal with later problems in an effective manner*

9. In Acute Crisis Child Is At Greatest Risk From

- Re-abuse, including physical abuse, by alleged perpetrator for disclosing abuse

- Retraction of claim due to physical and psychological pressure by perpetrator or family

- Revenge or threat from other family members

10. Refer To Child Psychiatrist

- Some children may require a referral to a child psychiatrist as determined by the paediatrician

- In the sexual abuse of very young children, parents may need to be referred if they themselves are anxious or depressed

- If there is a history of dysfunctional family or if parents/ guardian have poor coping or parenting skills

- Suspected perpetrators who are children

- In some custody cases

11. Refer To Medical Social Worker

- All cases of child abuse or neglect including abandoned babies, infants born to single or teenage mothers

- Especially important where families have complex social problems, such as poverty, isolation, neglect of education, single parent, substance abuse, domestic violence, intra-familial sexual abuse, with children with emotional or behavioural problems

- Evaluation of home environment required

12. The Doctor's Role In Police Investigations & Court Proceedings

- The doctor who has examined the child victim should ensure proper documentation of the findings of the medical examination and give the medical report to the investigating police officer as soon as possible. The name of the investigating officer (obtained from the police request for examination) should be documented in the patient notes

- The doctor may be asked to give a statement to the police. This is for the prosecuting officer to determine the amount of evidence available and the severity of the abuse or neglect. This is turn will determine whether the alleged perpetrator is charged and the nature of the charge laid on the alleged perpetrator

- The doctor may not be called to testify in court should the medical report be of sufficient clarity, understandable and sufficient from the Court's point of view. It is preferable to keep a personal copy of the medical report in addition to copies kept with Medical Records

- The doctor may be called to testify in court when necessary. He should be adequately prepared by reviewing his notes and medical report of the case concerned. Confirm attendance with the police officer-in-charge of the case. If he is unable to attend the Court, he should inform the prosecuting officer or police officer concerned in writing as soon as possible

- Should a child suspected of abuse die, the post-mortem should be conducted by a forensic medicine specialist.

13. Follow-Up By Health Staff After Discharge

- A follow-up will be given for the child and non-offending parent(s) to be seen by the pediatrician and/or psychiatrist/child psychologist/counselor. All abused children should be followed up. This is particularly important for the child :-
  - who has been chronically abused
  - who has been sexually abused
  - who has been removed from the family and fostered or placed in institutions
  - who is emotionally traumatized or show behavioural problems later
  - with failure to thrive or emotional neglect

- who lives in families :-
  - who are dysfunctional
  - with domestic violence or substance abuse
  - with poor parenting skills
  - where there is a perceived high risk of danger
  - where there are multiple victims

This follow-up is important to ensure that the potential of the child is optimized. The doctor and hospital/health team should :-

- Address concerns of the child and family which may not have been fully expressed during admission or only arose after discharge

- Give treatment for any short-term emotional or physical or disability problems. This may also involve referrals to appropriate specialist services

- Evaluate the abused or neglected child for any short or long-term impact of the abuse

- Evaluate for any social, financial or educational problems arising from the abuse or the disclosure itself or previously present and re-inform the Child Protector and report to the police or educational authorities as required

Family Medicine Specialists and community nurses may be involved in the follow-up after discharge. The JKM officer should be informed prior to discharge.

14. Summary

The health, welfare and protection of the child take precedence over other considerations. To do this, health staff should ensure that :-

- Competent evaluation takes place, including evidential history and careful expert medical assessment with collection of objective forensic evidence
- They minimize trauma to the child from multiple questioning or examinations (especially of the genitalia)
- They work with the other agencies to ensure that appropriate decisions are made concerning legal action and protection measures
- Assessment of psychological needs is made
- There is provision of therapy and follow-up
- The best possible relationship between child and non-offending parent is maintained

APPENDIX

NUMBER OF SCAN TEAM AVAILABLE IN KEMENTERIAN KESIHATAN HOSPITALS

STATE	GOVERNMENT
Perlis	Hospital Tuanku Fauziah, Kangar
Kedah	Hospital Sultanah Bahiyah, Alor Setar Hospital Sultan Abdul Halim, Sg. Petani Hospital Kulim
P.Pinang	Hospital Pulau Pinang
Perak	Hospital Raja Permaisuri Bainun, Ipoh
Selangor	Hospital Tengku Ampuan Rahimah, Klang
N. Sembilan	Hospital Tuanku Jaafar, Seremban
Melaka	Hospital Melaka
Johor	Hospital Sultan Ismail, Pandan Hospital Batu Pahat
Pahang	Hospital Tengku Ampuan Afzan, Kuantan
Terengganu	Hospital Sultanah Nur Zahirah, Kuala Terengganu
Kelantan	Hospital Raja Perempuan Zainab II, Kota Bharu
Sabah	Hospital Likas
Sarawak	Hospital Umum Sarawak
WP Kuala Lumpur	Hospital Kuala Lumpur

CHILD PROTECTION MANAGEMENT AND DISCHARGE CHECKLIST

- ❑ Check immediate safety
- ❑ Document concerns
- ❑ Consult with specialist on call/ SCAN Team member
- ❑ Support by a person of same race or religion or a concerned person, if no supportive guardian available
- ❑ Inform family and/or child/young person of concerns. Discuss likely process with child/young person/family
- ❑ Notify Jabatan Kebajikan Masyarakat (using Borang 9 and give preliminary report)
- ❑ If police report to be made, ask parent/guardian to make police report
  - Police report must be done urgently for all cases of sexual abuse less than 72 hours after the alleged incident and for selected cases of physical abuse or neglect especially where the child's life/ safety is at risk.
  - Doctor should be the one to lodge the police report if the parent is not immediately available or uncooperative or where intra-familial abuse suspected
- ❑ Arrange medical assessment with specialist unit/doctor (e.g. gynaecology, orthopedic, ophthalmological, neurosurgical units)
- ❑ Consent from parent/guardian if patient under 18 years of age or with legal authority (police/JKM officer), as required
- ❑ Arrange non-urgent medical appointment & investigations (sexually transmitted infections (STI) screen, skeletal survey)
- ❑ Psycho-social assessment

- ❑ Follow-up arranged
  - Health follow-up– to check healing of injuries, STD's adequately treated, monitor developmental progress
  - Social follow-up – at times of future crisis, as child develops, socio-economic, education
  - Safety follow-up- further abuse can occur when the offender rejoins the family or when family loyalties change

- ❑ Inform family of arrangements (after consultation with SCAN Team/ social worker)

- ❑ Identify key worker (medical social worker/pediatrician/psychiatrist/ gynecologist)

- ❑ Reply to referring doctor, if any (by ward medical officer/pediatrician)

- ❑ Complete medical report in patient's case notes (by doctors from relevant medical discipline). Medical report, accompanied if necessary, by psycho-social report, to be submitted to police as soon as medical examination has been done and investigations are completed. A copy of the report is to be sent to medical records and SCAN records.

- ❑ Complete SCAN patient record forms

- ❑ Check correct name and address details. If unsure of completeness of address, ask JKM or medical social worker to check prior to discharge

- ❑ Obtain alternative contact address

- ❑ Confirmation of discharge by SCAN team key worker & ward doctor.
  - Letter from JKM may be required in cases where safety of child post discharge is an issue
  - Inform police of discharge if a police report has been made

- ❑ Send patient BHT to OSCC to photostat a copy of relevant documents

- ❑ Add to database

APPENDIX 3

BORANG 9
AKTA KANAK-KANAK 2001 (Act 611)

Seksyen 27
PERATURAN-PERATURAN KANAK-KANAK(BORANG DAN DAFTAR) 2002

PEMBERITAHUAN OLEH PEGAWAI PERUBATAN ATAU PENGAMAL PERUBATAN BERDAFTAR

Kepada,

____

____
(Nama dan alamat Pelindung)

Saya ______________________________ No. Kad Pengenalan ______________

seorang* Pegawai Perubatan/Pengamal Perubatan berdaftar

____

____
(Nama dan alamat hospital atau klinik)

2. Saya telah memeriksa atau merawat seorang kanak-kanak yang dikenali sebagai ______________________________ *lelaki/perempuan, umur: ________ yang beralamat di ____

____

Saya mempercayai atas alasan yang munasabah bahawa kanak-kanak itu dicederakan dari segi fizikal atau emosi teraniaya, terabai terbuang atau didedahkan, atau teraniaya dari segi seks*.

3. Oleh yang demikian, saya telah mengambil hal ini kepada Pelindung, Jabatan Kebajikan Masyarakat untuk tindakan lanjut.

4. *Untuk makluman tuan, saya telah mengambil kanak-kanak itu ke dalam jagaan sementara.

Bertarikh ______________________________

____
(Tandatangan dan cop rasmi
Nama Pegawai Perubatan/Pengamal Perubatan Berdaftar*)

** Potong mana yang tidak berkenaan*

Borang Rujukan

Tarikh : ____________________

Kepada : Pengarah,
Bahagian Kanak-Kanak,
Jabatan Kebajikan Masyarakat
Daerah ____________________

Nama Pesakit:______________________ Jantina: Lelaki/Perempuan Umur:______

Bangsa: ____________________ RN:____________ Wad:__________________

Nama Ibu:____________________________________ No. KP: ________________

Nama Bapa:___________________________________ No. KP: ________________

Alamat:______________________________________ Tarikh Masuk Wad:________

Tel rumah:___________________________________ Tel bimbit:______________

Laporan Awal:

Sebab disyaki penderaan:

Pemeriksaan:

Risiko:

Nama Doktor:__________________________ Jawatan: ______________________

s.k Pegawai Kerja Sosial Hospital

APPENDIX 4

SCAN PATIENT ASSESSMENT AND TREATMENT RECORD

Name :... Police Report No. :.....................................

RN/NPR: .... M.I.C.:...

Birth Cert. No. :................................. Date of Birth:..

Sex :...................... Race:.................. Age:................... LMP: ....

Date/time of Admission/Seen:.................. Date discharged:..

Place of examination : ....

Informant/Case notified by :...

Accompanying case to hospital :

Ward (i):...

(ii) :...

Tel. No. :..

Doctor-in-charge : Social worker in –charge

....

....

Tel. No :... Tel. No:...

Investigation Officer: School :

....

Report No. :...............................

Tel. No.:... Tel. No.:.....................................

Parents/ Guardian:

Name	Relationship	Age	Education	Employment	Income

Siblings:

Name	Age	Sex	Health status

Suspected Abuse / Neglect By:

Name	Relationship	Age	Education	Employment	Income

Type of Abuse : (Physical/Sexual/Emotional/Cognitive)

Factors leading to abuse/neglect ;

1. ....
2. ....
3. ....
4. ....

MEDICAL REPORT
(INCLUDING GYNAECOLOGICAL OPINION)

HISTORY:

Date/ Time of Incident(s) : ______________________________

Suspected Perpetrator : ______________________________

Nature of Incident(s) : ______________________________

Other relevant history : ______________________________

Social / Family History : ______________________________

Medical history : ______________________________

PHYSICAL EXAMINATION:

General: ______________________________

External examination of genitalia: ______________________________

Diagrammatic findings- use diagram below

Photographs taken: Yes/No

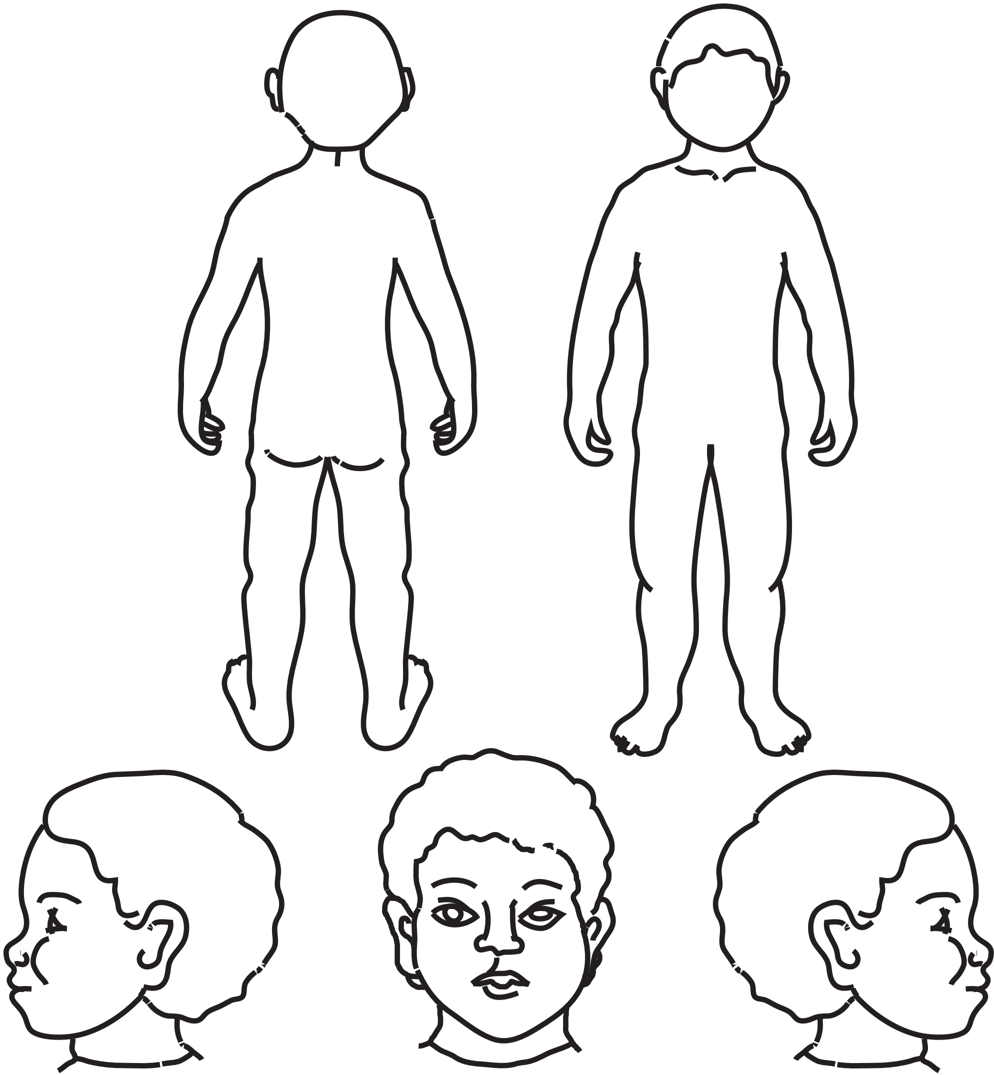
Diagnosis : ______________________________

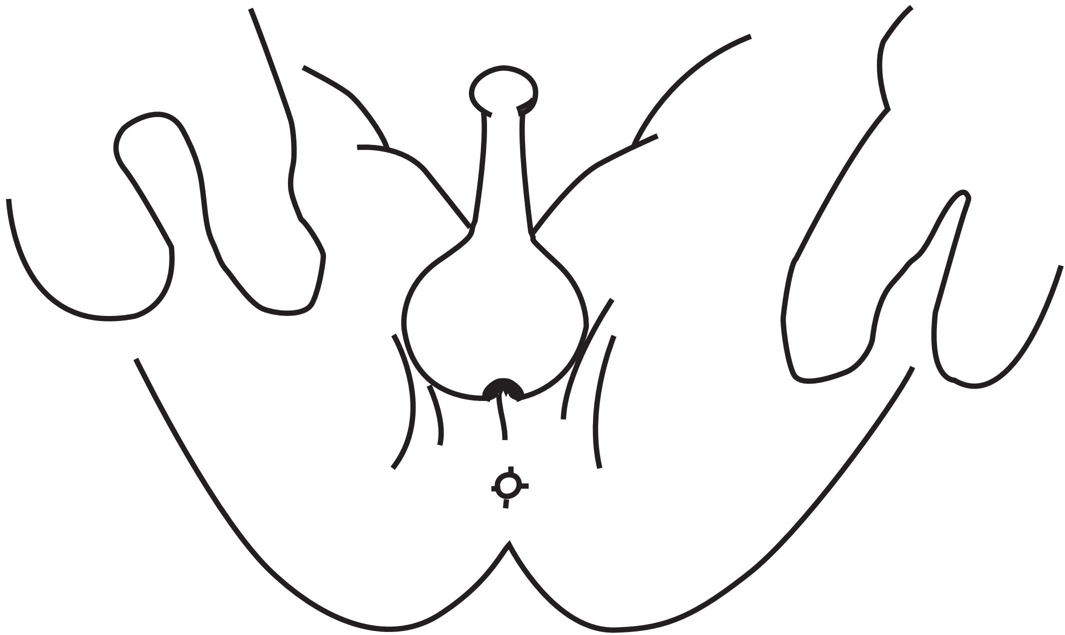
Conclusion: ______________________________

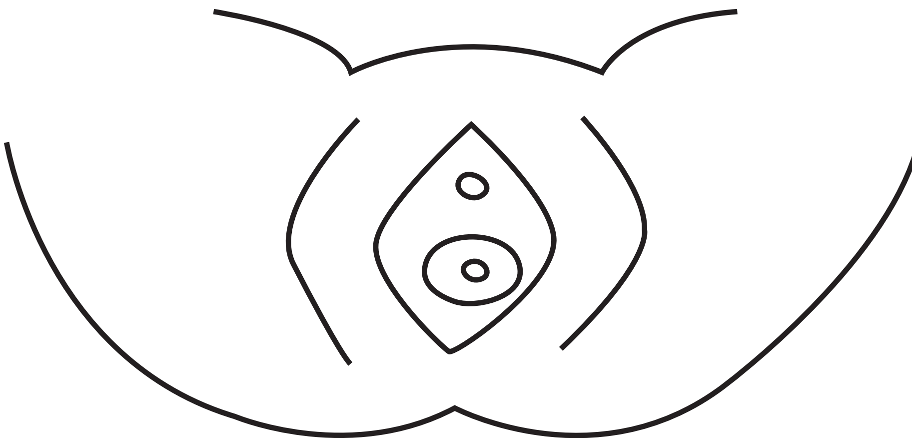
Management : ______________________________

Reported by Doctor (Name and Designation): ....

....







PSYCHOLOGICAL AND DEVELOPMENT REPORT (INCLUDING BEHAVIOURAL OBSERVATION BY NURSES WHILE IN WARD)

Report by Psychiatrist

____
Name of Psychiatrist

Report by Psychologist/ Psychology counselor

____
Name of Psychologist/Psychology Counselor

SOCIAL WELFARE EVALUATION
(INCLUDING HOME VISIT)

Social Welfare Worker : ....

Case Discussion date : ....

CONCLUSION REACHED BY MULTIDISCIPLINARY TEAM :

PROGNOSIS OF FUTURE RISK :

RECOMMENDATIONS :

DISCHARGED to: Home:______________________________________

Others (specify):____

REVIEW (date) :____

PERCAKAPAN DAN PEMERIKSAAN AWAL PEGAWAI PERUBATAN

Percakapan dan pemeriksaan awal Pegawai Perubatan ke atas pesakit/ mangsa bernama :-

________________________________ ***KPT*** __________________ **UMUR:** ______

saya telah memeriksa pesakit sebagaimana yang tersebut di atas pada tarikh ________________

Sebarang kecederaan diperoleh dari badan pesakit?

J: ____

S: Apakah kecederaan yang dialami?

J: ____

S: Adakah 'hymen'pesakit masih 'intact' atau koyak?

J: ____

S: Jika terdapat kesan koyak pada 'hymen' samada kesan koyak lama atau baru?

J: ______________________________________

____

____

____

(Lakaran kasar 'hymen' mangsa)

S: Apakah yang menyebabkan kesan koyak pada 'hymen' (jika ada)?

J: ____

S: Pada pandangan tuan / puan, adakah pesakit aktif dalam perhubungan seks?

J: ____

Tandatangan Pegawai Perubatan

____

Nama: ....

No. Tel. pejabat:.....................................No. Tel. Rumah: ....

No. Tel. bimbit: ....

Jabatan: ....

Hospital: ....

SPECIMEN COLLECTION FORM

Specimen Collection: Date______________ Time from_________ to__________

Samples from Vulva/Vagina/Cervix/Rectum	***Required***	***Received by***	
	Yes or No	***Name***	***Signature***
o Rectal swab for spermatozoa			
o Wet Smear from Introitus for Spermatozoa			
o Wet Smear from Fornix for Spermatozoa			
o HVS FEME and C/S			
o LVS FEME and C/S			
o Vaginal swabs for DNA			

Blood Investigations	***Required***	***Received by***	
	Yes or No	***Name***	***Signature***
DNA			
Blood Group			
HIV Serology			
Hepatitis B and C			
VDRL			

Foreign Materials	***Required***	***Received by***	
	Yes or No	***Name***	***Signature***
Scraping from nails			
Pubic hair			
Scalp hair			
Clothing for blood/semen			

	Name	Designation	Signature
All Specimen bottles labelled by			
Specimens A1 taken by			
Specimens A2 to A6 taken by			
Specimens B taken by			
Specimens C taken by			
All specimens packed & sealed by			
All specimens handed over to			

All specimen bottles are labelled prior to examination. The relevant specimen is then placed in the appropriate labelled container

Do not leave any column in the above form blank

List of Abbreviations

AZT	-	Azidothymidine
BHT	-	Bed Head Ticket
bd	-	Twice Daily
c/s	-	Culture & Sensitivity
DNA	-	Deoxyribonucleic Acid
ED	-	Emergency Department
HKL	-	Hospital Kuala Lumpur
HIV	-	Human Immunodificiency Virus
HVS	-	High Vaginal Swab
ICU	-	Intensive Care Unit
IVDU	-	Intravenous Drug User
JKM	-	Jabatan Kebajikan Masyarakat
LVS	-	Low Vaginal Swab
MO	-	Medical Officer

MOH	-	Ministry of Health
mg	-	Milligram
NGO	-	Non-Governmental Organisation
O&G	-	Obstetric & Gynaecology
OSCC	-	One-Stop Crisis Centre
RN	-	Registration Number
Rx	-	Treatment
SCAN	-	Suspected Child Abuse & Neglect
STD	-	Sexually Transmitted Disease
STI	-	Sexually Transmitted Infection
Tabs	-	Tablet
tds	-	Three Times Daily
VDRL	-	Venereal Disease Research Laboratory

References

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