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Type	Case Date	Doctor	Patient Service	Service Dept
CONSULT-IP-N EW	03/27/2014	MOHR, BETHANY ANNE	SCAN	PED

Re: Burns, Naomi
Reg No: 100289621
DOB: 01/07/2014
Date of Service: 03/27/2014

CHILD PROTECTION TEAM INPATIENT CONSULTATION

(PLEASE SEE "CHILD PROTECTION TEAM INPATIENT CONSULTATION-CONTINUED" FOR ADDITIONAL INFORMATION; INCLUDING MEDICAL COURSE SUMMARY)

TIME OF CONSULTATION: Morning of Thursday, March 27, 2014, at approximately 8:30 am.

CONSULTATION REQUESTED BY: Terry Murphy, MD, Pediatric Hospitalist.

REASON FOR CONSULTATION: Naomi Burns is an 11 week-old female infant who was recently discharged from the University of Michigan C.S. Mott Children's Hospital on March 24, 2014, in the morning. Naomi returned to the UMHS PED via EMS that night with continued vomiting, pallor, and bradycardia. During her extensive workup for possible genetic/ metabolic disorders, an ophthalmologic evaluation was obtained yesterday, Wednesday, March 26, 2014, in order to evaluate for a possible glycogen storage disease. However, upon ophthalmological evaluation, Naomi was noted to have bilateral, multilayered, retinal hemorrhages to the periphery. Secondary to Naomi's retinal hemorrhages and clinical presentation, physical abuse of Naomi is suspected.

INFORMATION SOURCE: Naomi's medical documentation from the University of Michigan Health System and St. Joseph Mercy Hospital Health System; and Naomi's parents, Brenda (08-24-76) and Joshua (05-15-1976) Burns.

Please note that University of Michigan Health System Child Protection Team social worker, Donna Schaefer, LMSW, was present during this consultation.

After examining Naomi and reviewing some of her medical documentation, I obtained the following history from Ms. Burns in the presence of Ms. Schaefer and a friend of the Burns' family, Nancy Belcher. Ms. Belcher is the Burns family's pastor's wife. Mr. and Ms. Burns permitted Ms. Belcher's presence upon obtaining the following history.

According to Ms. Burns, Naomi was born at St. Joseph Mercy Hospital at 40 5/7 weeks' gestation. Ms. Burns' pregnancy was complicated only by a false-positive toxoplasmosis test during pregnancy. Ms. Burns stated that she was concerned about possible toxoplasmosis infection due to her exposure to raccoons/raccoon feces and requested the test during pregnancy. Ms. Burns denied any alcohol or drug use during pregnancy; as well as tobacco use. Ms. Burns stated that her membranes were stripped in her OB's office and she then went into labor. Ms. Burns described Naomi's delivery as extremely difficult. Ms. Burns' labor began at approximately 6 p.m. on January 6, 2014, and Naomi was delivered at approximately 8:00 am on January 7, 2014. Ms. Burns reported that several vacuum attempts were made and Ms. Burns pushed for 4 hours; however, was unable to deliver Naomi vaginally. A C-section was then performed. Ms. Burns stated that Naomi had a significant hematoma on her scalp and developed jaundice, but did not require phototherapy. Naomi was not discharged from the hospital until 5 days of life secondary to difficulty latching. Ms. Burns stated that she worked with multiple lactation consultants who felt that Naomi had a "small chin" which was interfering with her latch. Naomi was reportedly supplemented with pumped breast milk and some formula in the hospital.

Per Ms. Burns, upon discharge home, Ms. Burns was pumping breast milk, breastfeeding and supplementing, but Naomi was gaining weight slowly and did lose weight upon one visit to her primary care physician. Ms. Burns stated that she stopped breastfeeding Naomi on February 19, 2014, and began solely pumping. Ms. Burns said she was pumping up to 17 times per day in order to increase her milk supply; and, at that point, was able to produce approximately 900 cc (30 ounces) of breast

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milk per day. Prior to Naomi's admission on March 18, 2014, she was reportedly drinking approximately 4 to 5 ounces of pumped breast milk 7 times per day. Naomi receives occasional formula.

According to Ms. Burns, Naomi would sleep for about 7 hours at night. At night, Naomi sleeps in a Pack N Play next to her parents' bed. During the day, she sleeps in her own room and parents have a video monitor.

Prior to March 16, 2014, Naomi reportedly did not have any spitting up. Ms. Burns stated that Naomi would spit up "every once in a while," but had very minimal spit up. Ms. Burns stated that Mr. Burns, who is a pilot, went on a trip and was gone for approximately 4 to 5 days. During that time, Ms. Burns cared for Naomi alone. Of note, however, the family does reportedly have significant support from their church community.

Mr. Burns returned home on 03/15/2014. Ms. Burns stated that, upon Mr. Burns' return home, Naomi was given some thawed breast milk which she refused. Ms. Burns stated that "they smelled the milk and the milk smelled bad." Subsequently, Naomi vomited. However, Ms. Burns stated that she is unsure if this occurred in the evening of March 14th or on March 15, 2014. Naomi subsequently was given breast milk that was not foul-smelling.

Of note, Mr. Burns reportedly had some diarrhea on 03/15/2014.

Ms. Burns denied that Naomi has sustained any trauma; including any falls or other possible injury since her birth, except for on March 15, 2014, when Naomi was in her father's care.

Ms. Burns stated that Naomi was baptized on March 16, 2014, and Ms. Burns went to get her hair cut on Saturday, March 15, 2014. Ms. Burns stated that upon paying for her hair cut, she was using Mr. Burns' debit card, as her debit card had been canceled due to possibly being compromised at Target. Mr. Burns reportedly told Ms. Burns that upon answering his cell phone, he took his hand off of Naomi and Naomi "lurched forward." Naomi was reportedly sitting on Mr. Burns' knee at that time. Ms. Burns stated that, according to Mr. Burns, he caught Naomi on her face. Ms. Burns stated that upon returning home, she noted a "fingerprint mark where he caught her" and noticed some redness around Naomi's eye on that same side. Ms. Burns also described that Naomi had "a line on her cheek." Ms. Burns stated that these marks were on the right side of Naomi's face, but she stated that she is unsure whether the marks were on the right or left side. Ms. Burns also reported seeing a tiny bruise on Naomi's face on the same side as the other injuries.

Upon taking Naomi to the Emergency Department at St. Joseph Mercy Hospital on Sunday, March 16, 2014, Ms. Burns stated that the medical providers also noted the facial injuries.

Ms. Burns stated that Naomi was doing well until March 16, 2014. Naomi had some issues with weight gain during her first month of life, but then began gaining weight well.

On March 16, 2014, Naomi vomited before church and then vomited, again, at church at the time of her baptism. Ms. Burns stated that upon vomiting again, Naomi was also pale.

Upon returning home, Naomi refused her bottle and also was "pale, cold, and clammy." Ms. Burns stated that she called the on-call physician for her primary care provider and, subsequently, took Naomi to the St. Joseph Mercy Hospital Emergency Department in the afternoon of March 16, 2014.

Upon review of the St. Joseph Mercy Hospital documentation from March 16, 2014, Naomi presented at approximately 14:35.

According to the history of present illness from the March 16, 2014, St. Joseph Mercy Hospital documentation, "Naomi is a 2 month-old healthy girl, presenting to the ED for evaluation after an episode of vomiting and paleness. Naomi woke up this morning and had 2 very large bowel movements which were of normal consistency and color, but large volume. After her feeding at 9:40 am., she had a large spit up, which her parents report is unusual for her because she does not tend to spit up. However, they do report that they were rushed today and did not burp her very well after that bottle. About an hour later, at church, Naomi had a large volume emesis which her parents state looked like milk with no blood or bilious coloration.

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Friends at the church commented that Naomi looked more pale than usual after vomiting. She then did well until about 1 p.m. when she refused her bottle and her parents thought she looked pale again. She had a temperature of 96.8 axillary at that time. Her mother called her pediatrician and was advised to come to the ED for further evaluation. Of note, Naomi's father is a commercial airline pilot and returned from a trip yesterday. He reports an episode of diarrhea yesterday morning (03/15), but states that he has been feeling fine since. There have been no other sick contacts. Yesterday afternoon, there was an episode where Naomi was sitting at her dad's lap and she slipped off his lap. He caught her with his palm on her face about half way to the ground. She did not hit her head on the ground and did not have any loss of consciousness or change in her behavior. Her parents deny cyanosis, difficulty breathing, choking, wheezing, fevers, or rash." Upon physical examination in the ED, Naomi was noted to have "an area light bruising on the left side of her forehead consistent with a fall from dad's lap yesterday." Otherwise, physical examination was documented as within normal limits. In the Emergency Department, Naomi took a bottle without difficulty. Naomi was discharged home and parents were advised to follow up with Naomi's primary care provider. Of note, Naomi had no evidence of bradycardia or respiratory distress on March 16, 2014, upon presentation to the St. Joseph Mercy Hospital Emergency Department and her weight on March 16, 2014, was recorded as 4.67 kilograms.

Naomi was taken to the St. Joseph Mercy Hospital Emergency Department, again, on March 17, 2014; arrival at 09:02. According to the history of present illness from the March 17, 2014, documentation, "2 month-old normally healthy patient was seen here yesterday for increasing episodes of emesis, some of which are projectile in nature. She fed well here and was discharged home. She did have a few small feeds yesterday which she tolerated, but then overnight developed emesis again. She has had three episodes of emesis since 7 am., nonbilious. No hematemesis. No diarrhea. Mother is concerned that she did have thawed breast milk prior to each of the emesis episodes. No fever, no diarrhea." Temperature at that time was within normal limits, 98.5 degrees rectally; heart rate 148 beats per minute; and oxygen saturation 100% on room air. Weight at that time was 4.72 kilograms, 28th percentile. Height 23.6 inches. Physical examination was documented as within normal limits; however, please note that for skin examination, only "warm" was documented. Medical decision-making documentation stated, "A 2 month-old with increasing emesis over the past 3 days, fontanelle down but not sunken, IV started, chemistries drawn, ultrasound performed to evaluate for pyloric stenosis." Abdominal ultrasound was documented as within normal limits. Naomi received 1 milligram of Zofran IV and was diagnosed with likely viral gastroenteritis. Naomi was discharged home at 13:27 on March 17, 2014.
She was advised to follow up with Dr. Bethany Hall in 2 days on March 19, 2014. Basic metabolic panel performed on March 17, 2014, at 10:12 am, was within normal limits. Hematocrit and hemoglobin 28.4 and 10, respectively, at that time; with a platelet count of 707,000 (increased).

Please note that according to Ms. Burns, on March 16, 2014, while in the St. Joseph Mercy Hospital Emergency Department, Naomi was diagnosed with a possible GI infection. Ms. Burns stated that Naomi was not necessarily having increased frequency of stools, but her stools were changed in color (greenish) with increased volume at times.

Because Naomi reportedly continued to vomit, Naomi was taken to a walk-in clinic on Tuesday, March 18, 2014. Please note that Ms. Burns stated that since Naomi has been vomiting, parents have also noted that she has a "new cry" (more "high pitched").

On March 18, 2014, after returning from the clinic, Ms. Burns reportedly took a nap and Mr. Burns fed Naomi some Pedialyte. Mr. Burns then told Ms. Burns, "Naomi is not right." Ms. Burns stated that, at that point, Naomi was having breathing which almost seemed "agonal" ("abnormal pattern of breathing characterized by gasping, labored breathing").

Naomi was then brought to the University of Michigan Pediatric Emergency Department in the late morning of March 18, 2014. Naomi was then admitted to the University of Michigan and was discharged, according to Ms. Burns, at approximately 11 am. on Monday, March 24, 2014.

Ms. Burns stated that, upon discharge, Naomi was doing well and was feeding well.

Ms. Burns stated that, upon taking Naomi home, Naomi fed at noon, 3 p.m., and 6 p.m. Naomi did not have any vomiting during the day on Monday, March 24, 2014; but Naomi was "fussy."

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Ms. Burns stated that she noted that Naomi's face appeared mottled at approximately 6 p.m.; and, when Ms. Burns woke Naomi up around 9 p.m. in order to give her phenobarbital, Naomi appeared to be a "funny color" and was fussy. Please note, however, that Ms. Burns stated that Naomi did smile while on the changing table. Ms. Burns stated that Naomi then was refusing her bottle, vomited, and had an episode of diarrhea. Again, Ms. Burns stated that the Naomi's stool was a different color and was foul-smelling, but Naomi did not have increased frequency of stools. At that point, Naomi was brought back to the University of Michigan Pediatric Emergency Department for further evaluation.

Ms. Burns said that she and Mr. Burns are Naomi's primary care providers. Naomi's maternal grandmother spent approximately 1 week with the Burns family in February.

Of note, Ms. Burns is from New York and Mr. Burns is from Colorado. Mr. and Ms. Burns moved to Detroit, as Mr. Burns is a pilot with Delta and Delta's hub is Detroit.

Ms. Burns stated that she was working as a nurse at St. Joseph Mercy Hospital with adults prior to Naomi's birth. Mr. Burns is a pilot and works with Endeavor Airlines, which is a subsidiary of Delta. Mr. Burns, due to his profession, is "gone for periods of time." However, he has only been gone once (for the 4 to 5 days) since Naomi's birth.

I, then, obtained the following history from Mr. Burns in the presence of Ms. Schaefer and Ms. Belcher.

I asked Mr. Burns, specifically, about Naomi's fall. Mr. Burns reported that on Saturday, March 15, 2014, before Naomi began vomiting, Ms. Burns called Mr. Burns and he answered his cell phone. Ms. Burns was getting a hair cut and Naomi was left in Mr. Burns' care. Mr. Burns stated that he should not have answered his cell phone while holding Naomi. Mr. Burns stated and demonstrated that he was holding Naomi while she was in a sitting position with his left hand on her back and his right hand on the anterior aspect of her torso. Naomi was facing Mr. Burns' right side. Mr. Burns stated that there was a coffee table to his right. Upon answering the phone, Mr. Burns reportedly took his right hand from Naomi's torso and, at some point, Naomi fell. Mr. Burns stated, however, that he does not know whether Naomi fell to the right or in front of him. Mr. Burns said he does not think that Naomi hit her head on the coffee table; Naomi did not fall to the floor. Mr. Burns stated that he did hit his hand on the coffee table. Mr. Burns stated that he grabbed the left side of Naomi's face upon her falling.

Please note that Mr. Burns mentioned that Ms. Burns resigned from her position at St. Joseph Mercy Hospital; and he took a position as a captain with increased pay, so that Ms. Burns could stay home with Naomi. However, the position is in New York, so will require Mr. Burns to be away from home for greater amount of time.

REVIEW OF SYSTEMS: Ten of 14 systems reviewed and negative except as noted in the above HPI.

PAST MEDICAL HISTORY:

MEDICAL PROBLEMS: Prior to admission on March 18, 2014, Naomi did not have any medical problems. Naomi had little to no spitting up prior to March 16, 2014.

BIRTH HISTORY: Please see above HPI.

PAST SURGICAL HISTORY: None.

MEDICATIONS: Naomi previously was given simethicone; however, this medication was discontinued. Naomi receives vitamin D supplementation once per day in breast milk.

IMMUNIZATIONS: Up to date. Naomi received her 2-month immunizations on March 7, 2014.

DEVELOPMENT: Prior to mid March, Naomi had a social smile and was active and alert. She was holding her head up. She was grabbing toys. She was able to hold her bottle and was grabbing her feet. She was able to track objects. She was smiling and very interactive. She tried to imitate sounds and was making lots of cooing sounds. When placed on her abdomen, she was able to move her head from side to side.

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ALLERGIES: No known drug allergies.

PCP: Dr. Bethany Hall; IHA-Livingston Pediatrics

FAMILY HISTORY: Negative for any genetic bone disorders or bleeding disorders. Mr. and Ms. Burns are healthy. Cancer and heart disease in older individuals in the family.

SOCIAL HISTORY: Please see above HPI for additional social history.

Ms. Burns stated that Mr. Burns received a DWI approximately 5 to 6 years ago. At that time, Mr. Burns was having issues with alcohol; however, according to Ms. Burns, he no longer drinks alcohol. Ms. Burns stated they "have no alcohol in their home" and do not drink. Ms. Burns denied drug use for both herself and Mr. Burns. Ms. Burns denied any prior law enforcement involvement for herself.
Ms. Burns denied any prior CPS involvement regarding Naomi and also denied that she has any other children. Ms. Burns also denied any CPS involvement as a child. Ms. Burns denied any history of physical and/or sexual abuse for herself, as well as neglect. Ms. Burns denied postpartum depression, but states that she has had issues with anxiety in the past and described herself as an anxious person. Ms. Burns stated that she took a medication in the past for anxiety, but is no longer taking this medication. Ms. Burns denied intimate partner violence in her relationship with Mr. Burns.

Mr. Burns denied law enforcement involvement except for in 2008 when he received a DWI. Mr. Burns stated that he no longer drinks alcohol and described himself as a "recovered alcoholic." Mr. Burns denied any past or current drug use and also denied any mental health issues. Mr. Burns denied intimate partner violence in his relationship with Ms. Burns and also denied any past history of physical and/or sexual abuse. Mr. Burns denied CPS involvement as a child. Mr. Burns denied that he has any other children.

Of note, Mr. Burns was a Bush Pilot in Alaska in the past.

PHYSICAL EXAMINATION:
VITAL SIGNS:
Temperature 36.9 degrees Celsius axillary.
Heart rate: 122 beats per minute.
Respiratory rate: 32 per minute.
Oxygen saturation 100% on room air.
WT: 4.89 kg (28th %ile)
Length: 57 cm (30th %ile)
HC: 40.5 cm (75th %ile)
GENERAL: Upon initiation of my examination, Naomi was sleeping. However, at the time of the examination, Naomi's EEG leads were being removed and she began crying. Naomi was fussy; however, she was n.p.o. prior to her scheduled MRI at 10 am. Naomi did not have dysmorphic facies. She appeared pale. However, was well-nourished and well-developed appearing. Naomi had a small amount of green, crusty discharge inferior to her left eye.
HEENT: Normocephalic, atraumatic. Naomi did have some adhesive still on her scalp. Anterior fontanelle was open, soft, and flat. She had no obvious scalp or head asymmetry. No areas of bogginess appreciated. Did not note any bruising or other lesions on her scalp. Extraocular movements appeared intact. Sclerae clear bilaterally. TMs were unable to be visualized; however, no blood in external auditory canals. Ears were clear with no bruising, no petechiae. Postauricular areas also clear. No nasal discharge. Oropharynx was clear.
Mouth: Mucous membranes moist. No lesions, no evidence of trauma. Upper and lower labial frenula, as well as lingual frenulum, intact. Edentulous.
NECK: Full range of motion, supple. No evidence of trauma noted.
CHEST: Tanner stage I breast development.
LUNGS: Clear to auscultation bilaterally with good air movement throughout.
CARDIOVASCULAR: Regular rate with no murmur noted. Capillary refill less than 2 seconds.
ABDOMEN: Soft, nontender, nondistended. No hepatosplenomegaly or masses noted.

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EXTREMITIES: Warm and well perfused. No clubbing, cyanosis, deformity, or edema. Ortolani and Barlow maneuvers were negative.

SKIN: Within normal limits. Naomi had some scattered bruising secondary to past IV placements and attempts. She also had a small circular lesion on the anterior aspect of her right lower leg where her intraosseous catheter had been placed on 03/18/2014. Small, yellow-brown bruise on lower back at the site of prior lumbar punctures.

GU: Tanner stage I pubic hair development. Labia majora and minora were within normal limits. Hymen was well visualized, which was within normal limits with no lacerations; specifically, no transections. Anus: Perianal folds within normal limits, no lacerations, no scarring, no anal discharge.

LABS: SEE "CHILD PROTECTION TEAM INPATIENT CONSULTATION-CONTINUED."

DIAGNOSTIC STUDIES:

Initial brain MRI performed on March 18, 2014, at 18:13.

This MRI was initially read as, "Prominent extraaxial CSF along the anterior frontal and temporal convexities, which may relate to benign external hydrocephalus. Otherwise, unremarkable MRI of the brain." However, upon further review of this MRI today, further findings were noted.

I, personally, reviewed Naomi's brain MRI from March 18, 2014, with Neuroradiology this morning. The MRI demonstrates bilateral frontal and anterior temporal subdural hemorrhage which appears chronic. The subdural hemorrhage is dark on T1 and bright on T2.

Cerebellar subdural hemorrhage, as well as bilateral posterior parietal subdural hemorrhage (R>L), also noted. Cerebellar and parietal SDH bright on T1 and iso/dark on T2, consistent with being approximately 4 to 7 days old. A blood fluid level in the cerebellar area was also noted.

Skeletal survey (March 27, 2014, at 1406): No acute or healing fracture anywhere within the skeleton. A faint, 2-millimeter round lucency seen within the proximal right tibia, 2.3 centimeters distal to the proximal growth plate, consistent with the previous intraosseous cannula. Identification band overlies the left lower leg. An intravenous cannula seen at the dorsum of the right foot near the ankle.

Ophthalmologic evaluation with dilated bedside fundus examination was performed on March 26, 2014, which revealed multiple preretinal hemorrhages, mainly concentrated in the posterior pole with deep intraretinal hemorrhages throughout fundus, including in periphery x 360 degrees (>>20 hemorrhages total) in the right eye. No retinal folds or notable schisis-like changes noted.

In the left eye, multiple preretinal hemorrhages noted, mainly concentrated in the posterior pole with deep intraretinal hemorrhages throughout fundus including in periphery x 360 degrees (>> 20 hemorrhages total). No retinal folds or notable schisis-like changes noted.

Impression and recommendations: "Numerous hemorrhages in multiple retinal layers, both eyes. These findings may be the result of nonaccidental trauma. No findings associated with glycogen storage disease. Suggest repeat examination with Peds Retina Service plus/minus examination under anesthesia with fluorescein angiography to evaluate for retinal ischemia within 1 month."

An ophthalmologic evaluation under anesthesia was, then, performed on March 27, 2014 (RetCam photos obtained).

Right eye (OD): Diffuse retinal hemorrhages distributed intraretinally, as well as preretinally; with a few areas of possible subretinal hemorrhage as well. Retinal hemorrhages extending all the way to the ora serrata; which were seen on scleral depression. No vitreous hemorrhage. The fovea was clear of any hemorrhage in the right eye.

Left eye (OS): Similar to the right side, there were extensive preretinal, as well as intraretinal hemorrhages, throughout the entire fundus. The hemorrhages extended all the way to the ora serrata for 360 degrees on scleral depression.

Following examination, fundus photography was performed with RetCam 130-degree lens as well as 80-degree lens. The fundus photography demonstrated the retinal hemorrhages, as well as the vascular tortuosity in both eyes.

Fluorescein angiogram was then performed using fluorescein. The angiogram demonstrated normal arterial and venous filling. There were numerous areas of focal block of fluorescein secondary to preretinal hemorrhages. There was no evidence of any significant retinal ischemia or capillary dropout in either eye.

ASSESSMENT AND RECOMMENDATIONS:

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1. Naomi Burns is an 11 week-old female infant who was incidentally noted to have bilateral, multilayered retinal hemorrhages extending to the periphery upon ophthalmological examination on 03/26/2014. Upon examination under anesthesia, these hemorrhages were redemonstrated with evidence of the hemorrhages to the ora serrata and possible additional subretinal hemorrhages in the right eye.
2. Upon review of Naomi's brain MRI from March 18, 2014, she is noted to have multiple areas of subdural hemorrhage, both in the frontal and temporal areas; as well as the parietal and cerebellar regions. Based upon the appearance of the cerebellar and parietal blood, there is concern that these subdural hemorrhages are of a different age than the bilateral frontal and anterior temporal subdural hemorrhage. Please note that Naomi's more chronic-appearing bilateral frontal and anterior temporal subdural hemorrhages could have occurred at the time of her birth. However, I cannot exclude the possibility of physical abuse also leading to these hemorrhages. Repeat Brain MRI today.
3. Based upon Naomi's presentation (with multiple ED visits and admission to the PICU on two occasions) with seizure activity, hypothermia, hypotension, bradycardia, apnea, and altered mental status in the setting of her cerebellar and parietal subdural hemorrhage and bilateral multilayered retinal hemorrhages extending to the periphery of each eye, abusive head trauma leading to Naomi's imaging findings, ophthalmologic findings and clinical presentation is most likely.
4. Please note that Naomi's reported fall (very short distance with no contact with a hard surface), in no way, provides a mechanism for Naomi's intracranial and ophthalmological findings.
5. Based upon the history provided by Ms. Burns and Mr. Burns, Naomi reportedly fell from Mr. Burns' lap on Saturday, March 15, 2014. At that time, Ms. Burns was not home. According to Mr. Burns, Naomi's head did not hit any object because he grabbed her face. According to Ms. Burns, Naomi sustained bruising and a "fingerprint mark" on her face as a result of Mr. Burns' grabbing her. I find it highly unusual that Naomi would sustain any injuries upon being prevented from falling in this manner; however, I do not have photodocumentation of her facial injuries. Please note that Naomi's facial injuries were described in the St. Joseph Mercy Hospital documentation from March 16, 2014, as "light bruising on left forehead." Naomi was evaluated in the ED the day following her reported "fall." Although a history was provided in order to explain this bruise, any bruising in a young infant should be highly scrutinized. Any bruising in an infant who is preambulatory is highly suspicious for physical abuse. Bruising in any region for an infant less than 4 months is highly predictive of physical abuse. Facial bruising in a preambulatory infant may be a precursor to abusive head trauma. Infant bruising may be considered a sentinel injury, and common, in infants who later present with severe physical abuse.
6. Please note that Naomi's vomiting and subsequent clinical signs began after she was in the care of Mr. Burns on Saturday, March 15, 2014. Although Naomi has been described as having diarrhea, based upon Ms. Burns' history, it seems that Naomi's main issue was vomiting and denied that Naomi had increased frequency of stooling.
7. I recommend that Pediatric Hematology be consulted in order to assess whether Naomi needs a hematologic workup in order to ensure that her retinal hemorrhages and intracranial hemorrhage are not related to an underlying bleeding diathesis. Also, to comment on Naomi's thrombophilia.
8. Skeletal survey was within normal limits with no evidence of fractures or other osseous injury.
9. I filed a 3200 with Children's Protective Services today secondary to Naomi's intracranial hemorrhage and her bilateral retinal hemorrhages and suspicion for physical abuse. I provided Joyce Mansfield, Washtenaw County CPS worker, with a verbal summary of my medical findings.
9. Please note that if Naomi is a victim of abusive head trauma, she is at risk of further injury, possibly death, in the environment in which the abuse occurred.

Please do not hesitate to contact me with regard to Naomi Burns.

********** Addendum **********

Addendum added: 3/28/2014 10:37

Please repeat skeletal survey in 2 weeks in order to evaluate for fractures or other osseous injury which may be unable to be visualized on current skeletal survey. Skull films may be excluded.

********** Addendum **********

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Addendum added: 3/28/2014 10:58

Please note that Naomi's retinal hemorrhages are not consistent with birth-related retinal hemorrhages. Although retinal hemorrhages commonly occur after instrumental deliveries (i.e. vacuum-assisted), these hemorrhges are predominantly intraretinal and in the posterior pole. The majority resolve within 10 days; not shown to persist beyond 58 days of life. Naomi is currently 11 weeks old and her hemorrhages extend all the way to the ora (360 degrees) and are multilayered (pre-, intra- and subretinal).

********** Addendum **********

Addendum added: 4/6/2014 9:09

Please note, regarding recommendation 7: "I recommend that Pediatric Hematology be consulted in order to assess whether Naomi needs a hematologic workup in order to ensure that her retinal hemorrhages and intracranial hemorrhage are not related to an underlying bleeding diathesis. Also, to comment on Naomi's thrombophilia;" Naomi has thrombocytosis.

Bethany Mohr, MD
Assistant Professor

//Electronically signed by Bethany Mohr, MD/10542 on 03/28/2014 10:20:13//

Dictated by: Bethany Mohr, MD/[redacted]
Dictate Date/Time: 03/27/2014 15:17:42
Sent to EHR Date/Time: 03/27/2014 19:12:05
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