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Trauma Lecture Series

Child Abuse Basics

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Objectives

~ **Epidemiology** , incidence and etiology of child maltreatment.

~ **Red flags** for a child abuse evaluation.

~**Understand sentinel injuries** and their significance.

~ Know which **laboratory and imaging studies** to obtain when child physical abuse is suspected.

~Understand the **legal obligation** to report children with injuries that are suspicious for physical abuse and develop a thoughtful approach to informing parents of this legal obligation.

Types of abuse:

Physical Abuse (Non Accidental trauma)- NAT

Neglect

Sexual Abuse

Medical Child Abuse (Munchausen)

Psychologic Maltreatment / Emotional abuse

NCANDS 2015 is the 26th edition

States provide the data for this report through the **National Child Abuse and Neglect Data System (NCANDS).**

NCANDS was established in 1988 as a voluntary national data collection and analysis program to make available state child abuse and neglect information.

Data has been **collected every year since 1991** and NCANDS now annually collects maltreatment data from child protective services agencies in the 50 states, the District of Columbia, and the Commonwealth of Puerto Rico.

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Key findings in this report (2015) include:

The national estimate of **children who received a child protective services investigation response or alternative response increased 9.0 percent from 2011 (3,081,000) to 2015 (3,358,000).**

- Three-quarters (75.3%) of victims were neglected, 17.2 percent were physically abused, and 8.4 percent were sexually abused.

- **For 2015, a nationally estimated 1,670 children died of abuse and neglect at a rate of 2.25 per 100,000 children in the national population.**

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Certain factors place a child at higher risk for physical child abuse based upon observational studies

While these factors clearly contribute to the occurrence of violent acts, and are crucial targets for prevention programs, they must not become the sole foundation for suspecting, evaluating or diagnosing abuse.

Child characteristics

- Speech and language disorders, learning disabilities, conduct disorders, and non-conduct psychiatric disease
- Failure to thrive
- Congenital anomalies, intellectual disability (mental retardation) or other handicaps, or chronic or recurrent illnesses
- Attention deficit disorder with hyperactivity children
- Prematurity and low-birth weight (conflicting data)
- Unplanned pregnancy, Unwanted child

Environment

- Unrelated adolescent or adult male in the household
- Domestic or intimate partner violence
- Animal cruelty
- Acute or chronic family stressors (eg, divorce or interpersonal conflict, illness, or job loss)
- Living in poverty
- Social isolation (distant or absent extended family)

Caregiver features

- Young or single parents
- Parents with lower levels of education
- Unrealistic expectations for child; poor knowledge of child development
- Negative perception of normal child behaviors
- Caregiver was abused or neglected as a child, leading to abuse or neglect of their own children as a learned behavior
- Substance or alcohol abuse

Prior CPS contact

- Psychiatric illness (eg, depression, impulse disorder)

While these factors clearly contribute to the occurrence of violent acts, and are crucial targets for prevention programs, they must not become the sole foundation for suspecting, evaluating or diagnosing abuse.

Parents who reverse parent-child roles and see children as a major source of family comfort are likely to be frustrated and disappointed when faced with the persistent neediness and dependence of children.

RED FLAG HISTORY

No history or denial of trauma despite severe injury
Implausible history for degree or type of injury* * Examples of implausible histories include major trauma attributed to a "fall down the stairs" or other short fall such as a fall from a sitting position or an injury mechanism that requires the child to have capability beyond their developmental level (eg, severe scald burns in a 12-month old attributed to the patient "turning on the hot water faucet").
Unexplained or excessive delay in seeking care
Injury attributed to in-home resuscitation efforts
Caregiver histories that change with retelling or conflict with versions from other observers
Severe injury explained as self-inflicted or blamed on other young children or pets

Thorough History taking

HPI:

Usually……..

Injuries in children **should be well explained** by their history in most situations.

Infants and young children **should be closely supervised** by adults.

They **also lack the independence and motor skills to get into dangerous circumstances without their caregiver's knowledge** unless they are being neglected.

. If there **are multiple caretakers**, it is best that each caretaker be **interviewed separately**, so that their histories can be compared.

It is best **to interview a verbal child** about a suspicious injury **without caregivers** present whenever possible

Must include the SOCIAL History:

Include

Family stressors,

Drug use,

Occurrence of domestic violence,

Prior involvement with a children's protective services

Often a social work consult is the best way to achieve this goal.

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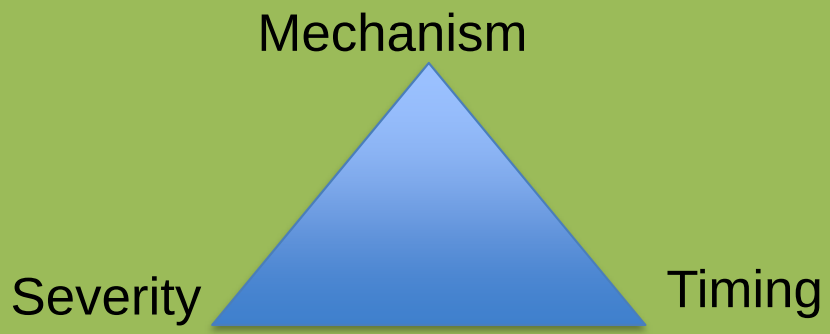
Know when to become concerned and use a clear approach to decision making

Most often, concern about physical abuse is generated by an unexplained or less-than-adequately explained injury rather than by the mere presence of a specific injury.

2-month-old infant who has multiple rib fractures and reportedly fell from a mattress 1 foot from the floor.



Child punishment

Many (pediatric) practitioners struggle with how to handle parental use of physical punishment.

The American Academy of Pediatrics is clear in its evidence-based opposition to the use of physical punishment

Most states allow for some degree of physical punishment within legal limits.

2-year-old child who has been spanked lightly on clothed buttocks for playing with the stove - No report is made

Vs

The same 2-year-old child who has been punched in the stomach for having a toileting accident would be represented differently

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When injury is identified by the initial assessment, the clinician should assess three issues:

- Does the injury **possess a shape or pattern** that indicates an abusive mechanism (loop-of-cord marks, slap marks, bites, immersion burns

Does the injury have **an elevated statistical association with abuse** such as subdural hematoma, rib fractures, femur fracture in non-walking children, pancreatic and proximal small bowel injury, immersion burn ?

- Does the given trauma **history match the nature of the injury, the time course** of the injury symptoms and healing, the history of other caretakers, and the child's **developmental capacities** ?

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Physical exam:

When Non accidental trauma is an active component of the differential diagnosis, a **thorough physical examination** should view and palpate all accessible surfaces of the body.

Special attention should be given to **the mouth, pinnae of the ears, the scalp, the buttocks and ano-genital region, and body folds** such as the neck.

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Seek Out and Use Additional Data

Conversation with the child's **primary care practitioner**, an examination by an **expert**, **laboratory** data (such as coagulation studies), and **radiographic studies**

PCP may:

Identify a pattern of multiple missed visits or documented social concerns that also may push the practitioner toward a decision to report a questionable presentation.

Bruising

Any bruising in infants **younger than six months** of age

More than one bruise in a pre-mobile infant and **more than two bruises** in a crawling child

Bruises located on **the torso, ear, neck, or buttocks**

Bruises with a **pattern of the striking object** (eg, slap, belt, or loop marks; spoons; spatulas; or other objects)

Human bite marks

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TEN-4

"TEN 4" is an easy way to identify bruises that are of concern for abuse:

T: torso; E: ear; N: neck; and

4 bruises in children less than or equal **to 4 years** of age and in **ANY infant under 4 months** of age.

Bruises are the most common type of injury in abused children

The age of a bruise cannot be determined accurately.

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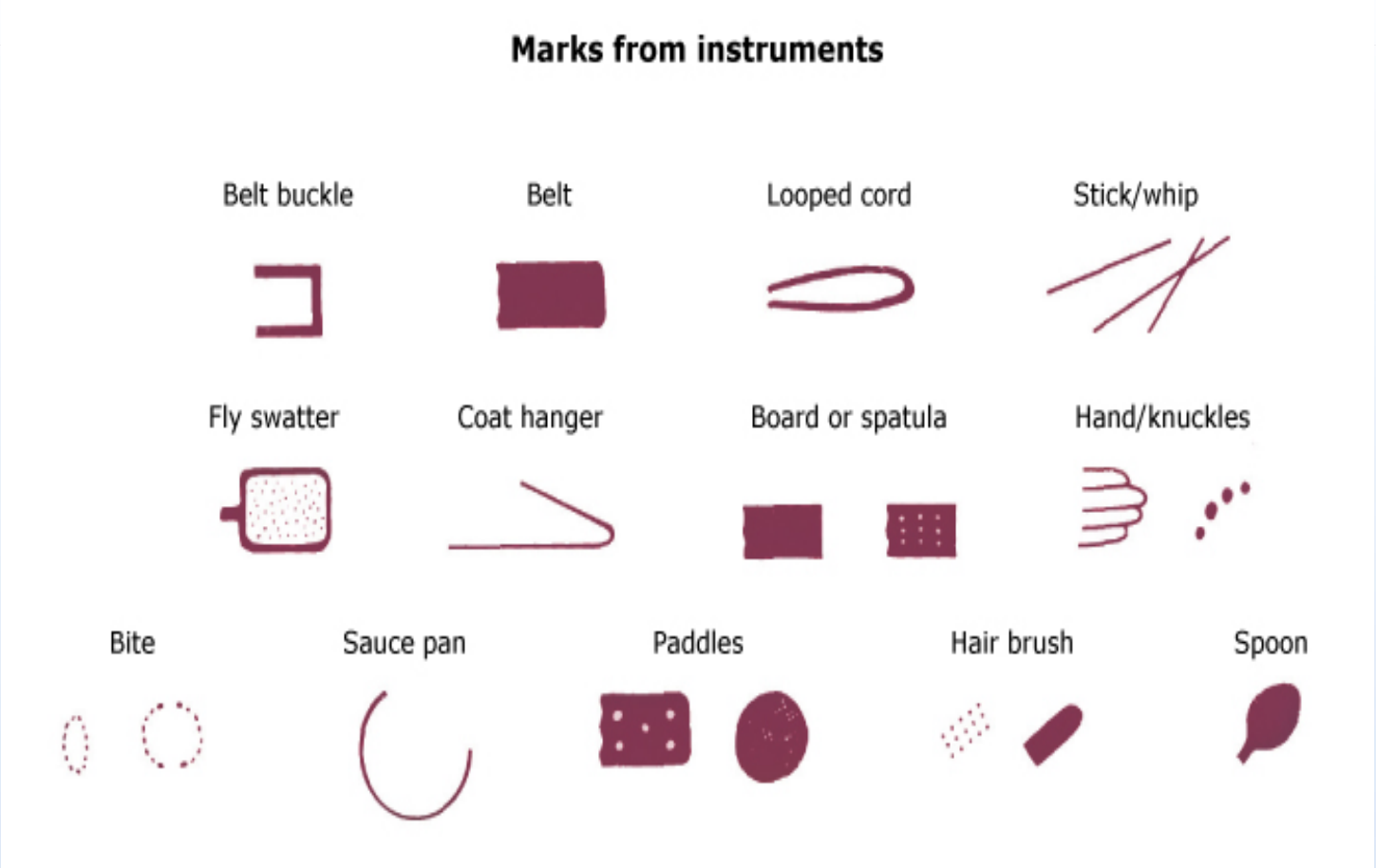
Bruising patterns that suggest child abuse



Reproduced from: Dubowitz H, Lane WG. Abused and neglected children. In: Nelson's Textbook of Pediatrics. Kliegman RM, Stanton BF, St. Geme JW, Schor NF (Eds), 20th ed, Elsevier: Philadelphia, 2015. Illustration used with the permission of Elsevier Inc. All rights reserved.

Source: Goldsmith LA, Katz SI, Gilchrest BA, Paller AS, Leffell DJ, Wolff K: *Fitzpatrick's Dermatology in General Medicine, 8th Edition*: www.accessmedicine.com

BRUISES — In addition to intentional and unintentional traumatic bruising, the differential diagnosis of bruising includes a number of medical disorders, including:

- Bleeding disorders
- Vitamin K deficiency
- Salicylate ingestion
- Henoch-Schönlein purpura (IgA vasculitis) and other vasculitides
- Mongolian spots
- Hemangiomas
- Delayed sub-aponeurotic fluid mass SFCs presenting after the neonatal period are usually associated with benign soft tissue swellings. Use of fetal scalp electrodes has been shown to cause cerebrospinal fluid (CSF) leakage in the neonatal period and may result in delayed SFC. This condition is benign, and the recommended course of treatment is conservative management.

Oral injuries

Lip lacerations or bruising, especially in nonambulatory infants

Lingual or labial frenulum tears, especially in nonambulatory infants

Tongue lacerations, especially in nonambulatory infants

Bruising or wounds of the buccal mucosa, gums, or palate, especially in nonambulatory infants

Missing or fractured teeth with an absent or implausible history

Maxillary or mandibular fractures with an absent or implausible history

Bruising, lichenification, or scarring at the corners of the mouth from being gagged

Cigarette burns

Inflicted cigarette burns are usually discreet circular burns 8 to 12 mm in diameter. **Sustained contact or displacement of the ash is necessary to produce a third-degree burn, identifying such burns as deliberately inflicted**

By contrast, with an **inadvertent cigarette burn**, the lit end of a cigarette, which can be several hundred degrees, is **typically insulated with a cooler ash**. Thus, when a child runs, walks, or falls against a lit cigarette, the resulting burn is typically irregular, isolated, and superficial.

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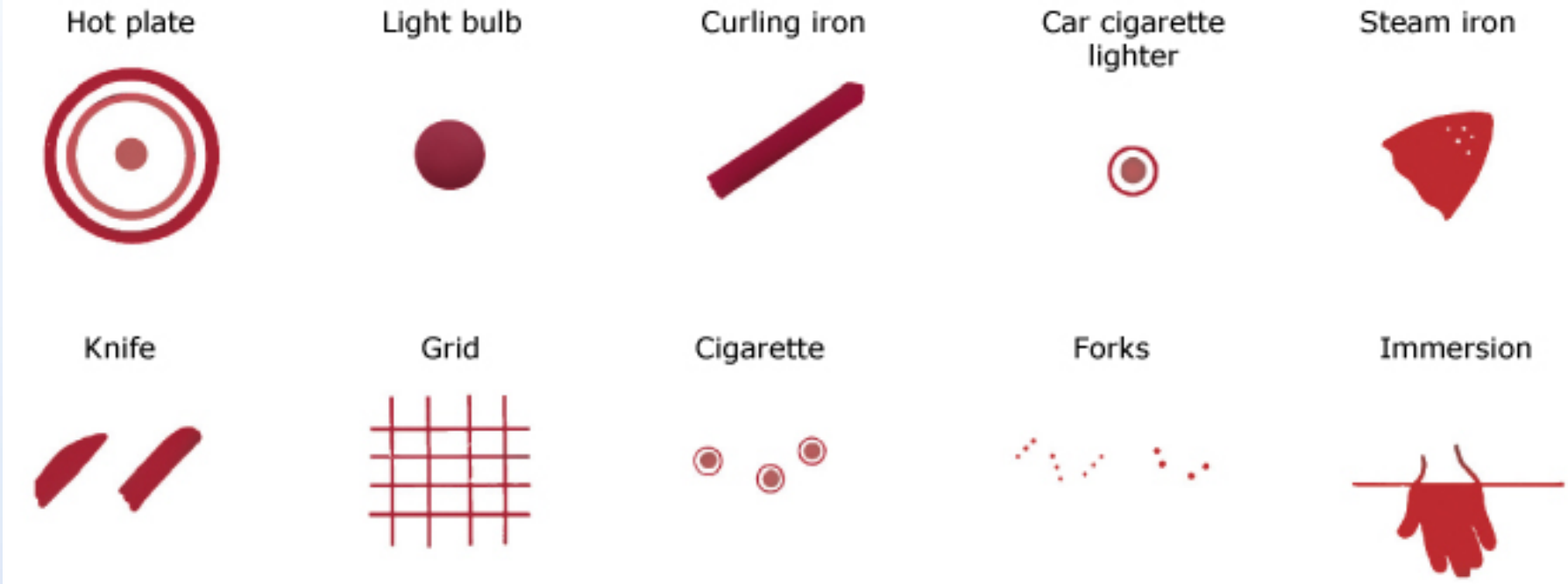
Burns and Scalds

- Scalds in **children <5 years of age that do not fit an unintentional spill pattern**
- Scalds **from hot tap water due to immersion**, demonstrating a sharp upper line of demarcation ("high tide mark"), affecting both sides of the body symmetrically, or involving the **lower extremities and/or perineum**
- Burns that have a **sharply demarcated edge** in the shape of the burning **object** (eg, clothing iron, spatulas, spoons, grates, metal hairdryer grids, curling irons, or the metal tops of butane cigarette lighters)
- **Cigarette burns** that appear as discreet circular burns 8 to 12 mm in diameter and are deep (eg, third degree burns)

Burn marks



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Note the sharp demarcation between the burn and normal skin and the absence of drip or splash marks, as well as the characteristic distribution on the buttocks and lower legs. Sparing of the thicker skin of palms or soles, and of skin folds where knees and hips are flexed, is also a common finding.

This pattern of deep symmetrical burns in a stocking distribution is typical for inflicted immersion injury.

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Fractures / Fracture patterns

Metaphyseal corner fractures

Rib fractures

Fractures of the **sternum, scapula, or spinous processes**

Long bone fracture in a **non-ambulatory infant**

Multiple fractures in **various stages of healing**

Bilateral acute long-bone fractures

Vertebral body fractures and subluxations in the absence of a history of high force trauma

Digital fractures in children younger than 36 months of age

Epiphyseal separations

Severe skull fractures in children younger than 18 months of age

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Serious injury without explanation*

Subdural hematoma or retinal hemorrhage in a young child, without a significant public trauma ssuch as a fall out a tall building window or a car crash

Other intracranial injury **without a clear trauma history**

Abdominal injury (perforation or hematoma of the bowel, pancreas, or bladder; solid organ [eg, liver, spleen, or kidney] hematoma or laceration)

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Injuries attributed to young children or pets — Siblings are known to injure each other, but serious injury inflicted by a sibling is a rare occurrence

Serious injury blamed on other young children may be a potential sign of abuse

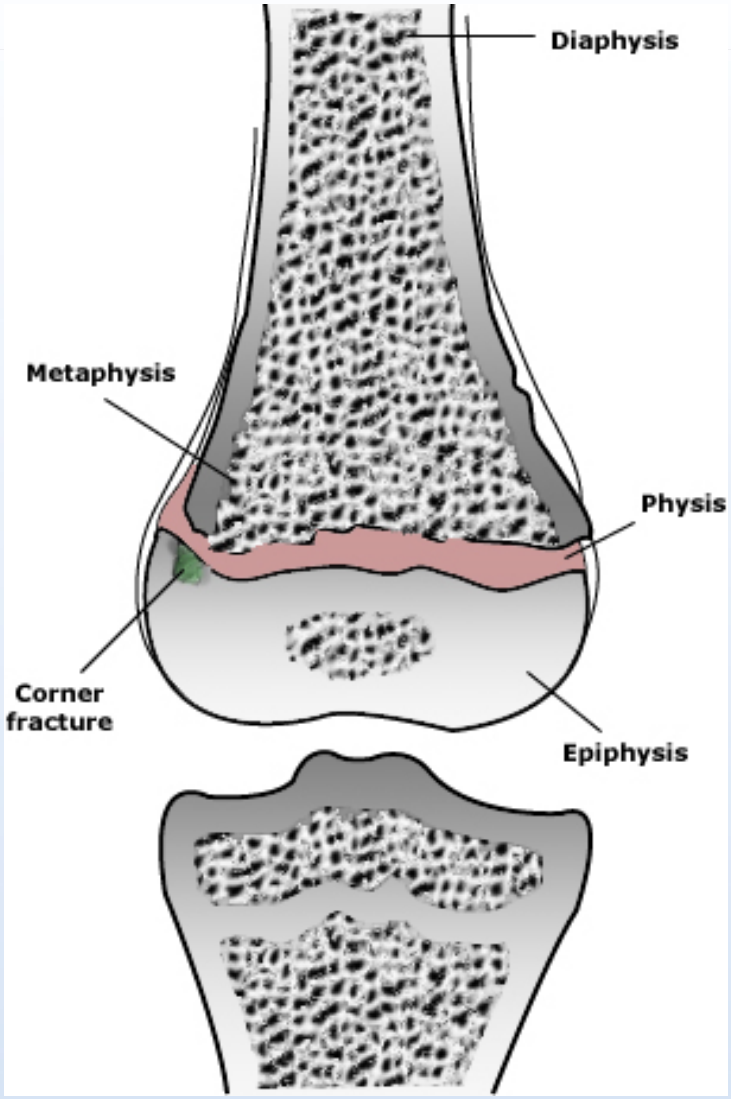
Although not well-described in the literature, expert experience suggests that pets are sometimes blamed for severe injuries (eg, "the dog knocked the child over").

Fractures

— Fractures that suggest child abuse may come to light as **an incidental finding during radiologic evaluation or as part of a skeletal survey** when a concern for abuse is present. The skeletal survey is widely regarded as the best method for detecting fractures in children who have been abused.

Concern for physical abuse in children younger than 24 months of age is an **absolute indication for obtaining a skeletal survey.**

Corner fracture



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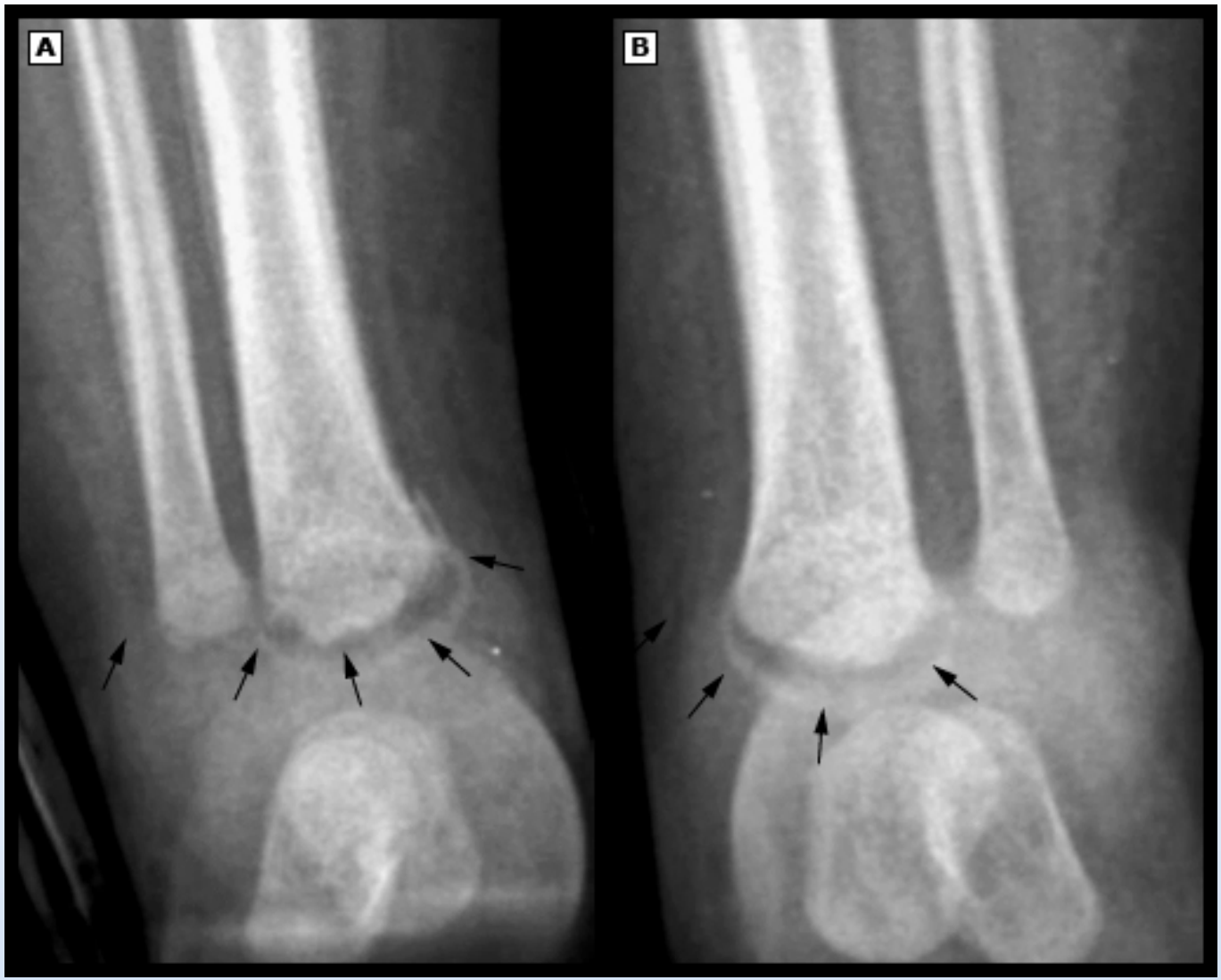
occurs when the extremity is pulled or twisted, or the child is shaken. The resultant shearing force undercuts an isolated fragment of the metaphysis that includes the subperiosteal bone collar. When viewed tangentially, the lesion appears as a triangular fragment of the metaphysis (ie, the "corner" fracture).

Epiphyseal separation



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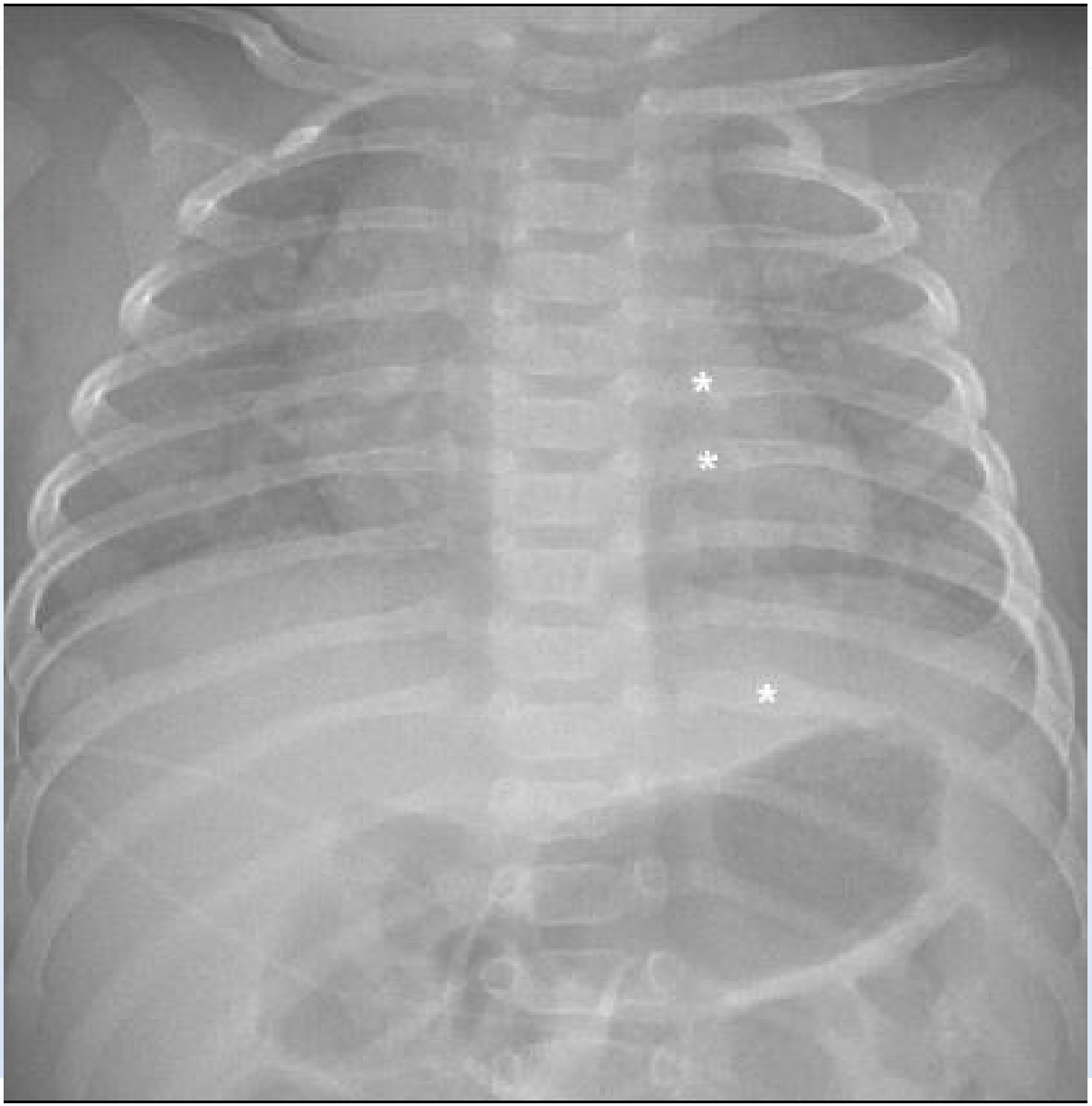
Rib fractures with callus



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Skeletal survey

According to the American Academy of Pediatrics (AAP) Section on Radiology and the American College of Radiology the **skeletal survey is "the method of choice for global skeletal imaging in cases of suspected child abuse" and is mandatory for all children younger than two years of age in whom child abuse is suspected**

At any age, when clinical findings point to a specific site of injury, the customary radiographic protocol for imaging that anatomic region should be used.

Skeletal survey

Soft-tissue injuries are the most common injuries identified in physical abuse and are present in as many as 92 percent of victims

Fractures are the second most common injury and are present **in as many as 55 percent of physically abused children**, depending upon the type of abuse and the method of fracture detection

Most inflicted fractures occur during infancy and early childhood with as many **as 85 percent occurring in children younger than three years, and 69 percent in children younger than one** year

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In a retrospective review of 258 patient visits with abusive fractures, 20 percent had at **least one previous physician encounter** for the fracture at which **the possibility of abuse was not raised**

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Indications for Obtaining a Skeletal Survey

All children **age </= 2years** with **obvious abusive injuries**

All **children 2 years or more with any suspicious injury**, including:

Bruises or other skin injuries **in nonambulatory Infants**

Oral injuries in **nonambulatory infants**

Injuries not consistent with the history provided

Infants with **unexplained, unexpected sudden death** (consult with medical examiner/coroner first)

Infants and young toddlers with unexplained intracranial injuries, including hemorrhage and hypoxic-ischemic injury

Infants and siblings aged <= 2 y and household contacts of an abused child

Twins of abused infants and toddlers

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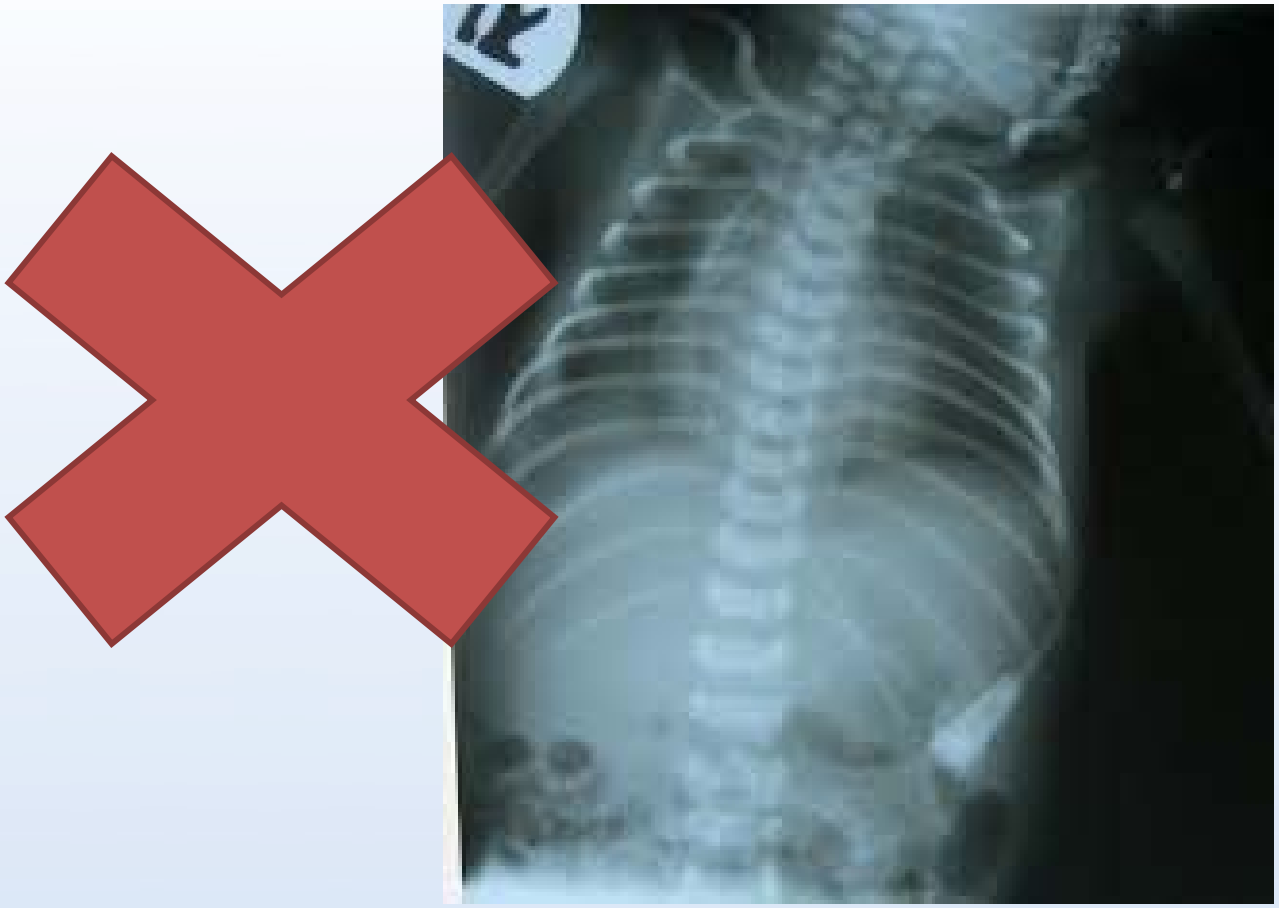
Fractures with <u>less specificity for abuse</u> include

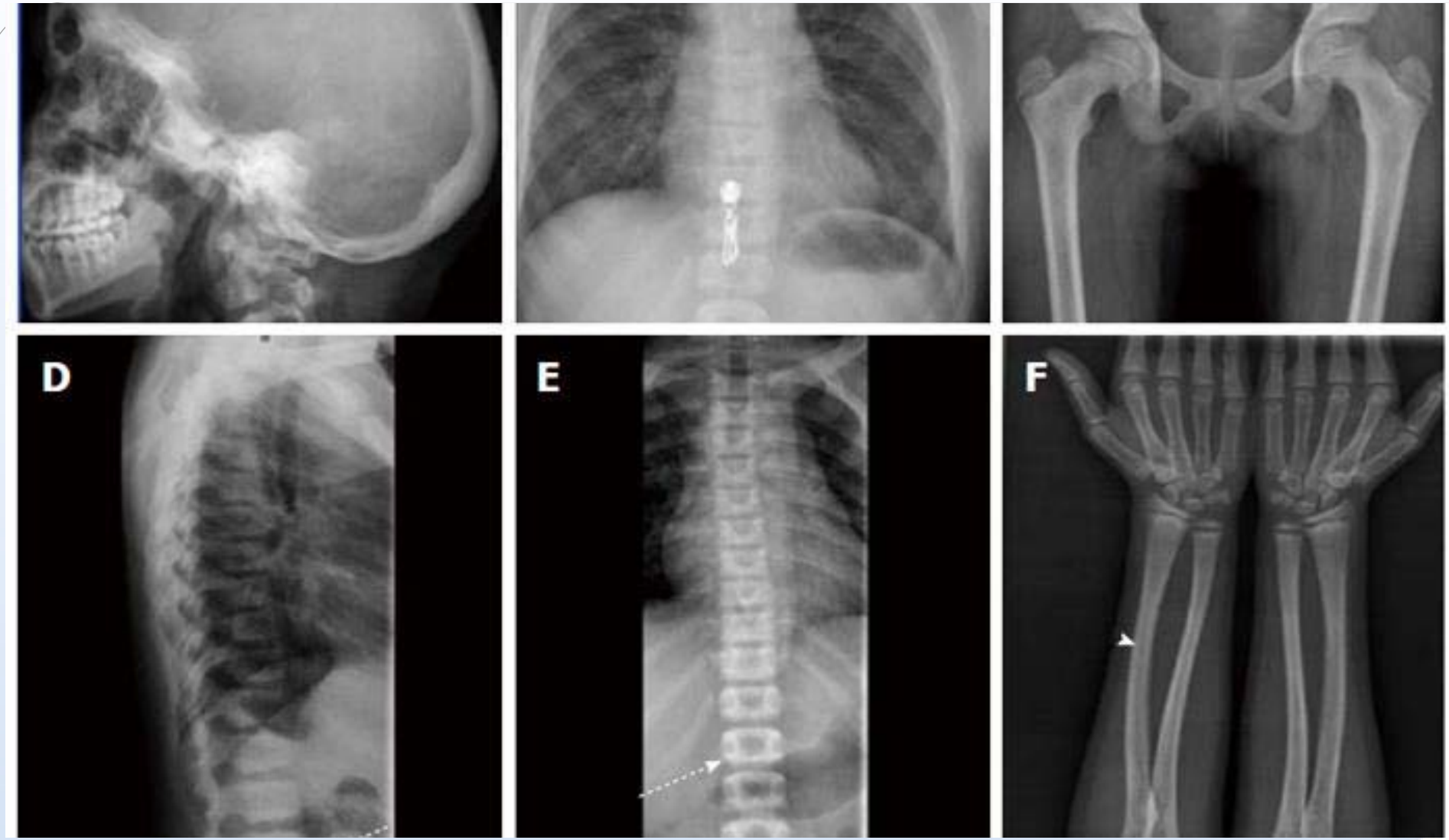
- Isolated long-bone fractures in ambulatory children
- Linear skull fractures
- Clavicle fractures
- Subperiosteal new bone formation

No babygrams !!



A single film (‘baby gram’) should be avoided as it gives an unsatisfactory exposure - combined views of chest abdomen pelvis and limbs should also be avoided.

Correct!!



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1.0 - SKELETAL SURVEY

What it is about???

Definition:

- "A systematically performed series of radiographic images that encompasses the entire skeleton or those anatomic regions appropriate for the clinical indications."

Purposes:

- To allow the detection of occult bony injuries in children with suspected non-accidental injury (NAI)
  - Obtain further information about a clinical injury,
  - Aid in the dating of bone injury
- Help in diagnosing the unknown abnormalities from the normal developmental changes and other anatomic variants
- Help in detection of any underlying skeletal disorder that may mimic the fractures

(The American College of Radiography, 2014)

Skeletal survey

Skeletal survey usually is not necessary in

verbal, **ambulatory** children **older than five years** of age, but it **may be** recommended in children with intellectual **disability (mental retardation)** or who are otherwise unable to give a history or indicate areas of trauma or pain.

Children **between the ages of two and five** years must be evaluated **on an individual basis**, and localized radiographs or skeletal survey may be warranted based upon clinical indications.

Complete skeletal survey

- Appendicular skeleton
  - Arms (AP)
  - Forearms (AP)
  - Hands (PA)
  - Thighs (AP)
  - Legs (AP)
  - Feet (PA or AP)
- Axial skeleton
  - Thorax (AP and lateral), to include thoracic spine and ribs
  - AP abdomen, lumbosacral spine, and bony pelvis
  - Lumbar spine (lateral)
  - Cervical spine (AP and lateral)
  - Skull (frontal and lateral)

In the largest study of inflicted fractures (429 fractures in 189 children), the median age was seven months (range <1 month to 13 years)

69 percent of the patients were **younger than one year of age,**

17 percent were between one and two years of age, and

14 percent were older than two years of age

This study also provided a description of some of the characteristic features of the fractures associated with child abuse, including the following:

- **50 percent of the patients had only a single fracture; 21 percent had two fractures, 12 percent had three, and 17 percent had more than three.**
- **Among the patients with a single fracture,** the femur was the most common location (35 percent), followed by the humerus (29 percent), and the skull (16 percent); all of the single long-bone fractures occurred in the middle one-third of the bone.
- **Among long-bone fractures, transverse fractures were most common** (48 percent), followed by **spiral** fractures (26 percent), **avulsion** fractures (16 percent), and **oblique** fractures (10 percent).

Spinal injury:

Presenting signs and symptoms of spinal injury may be entirely absent [or may include:

- Isolated irritability
- Slight abnormality of tone or posture
- Tender spinal mass
- Acute or subacute onset of paraplegia or quadriplegia with urinary retention, loss of anal tone, and loss of bulbocavernosus reflex
- Multiple other fractures that may be visualized on skeletal survey

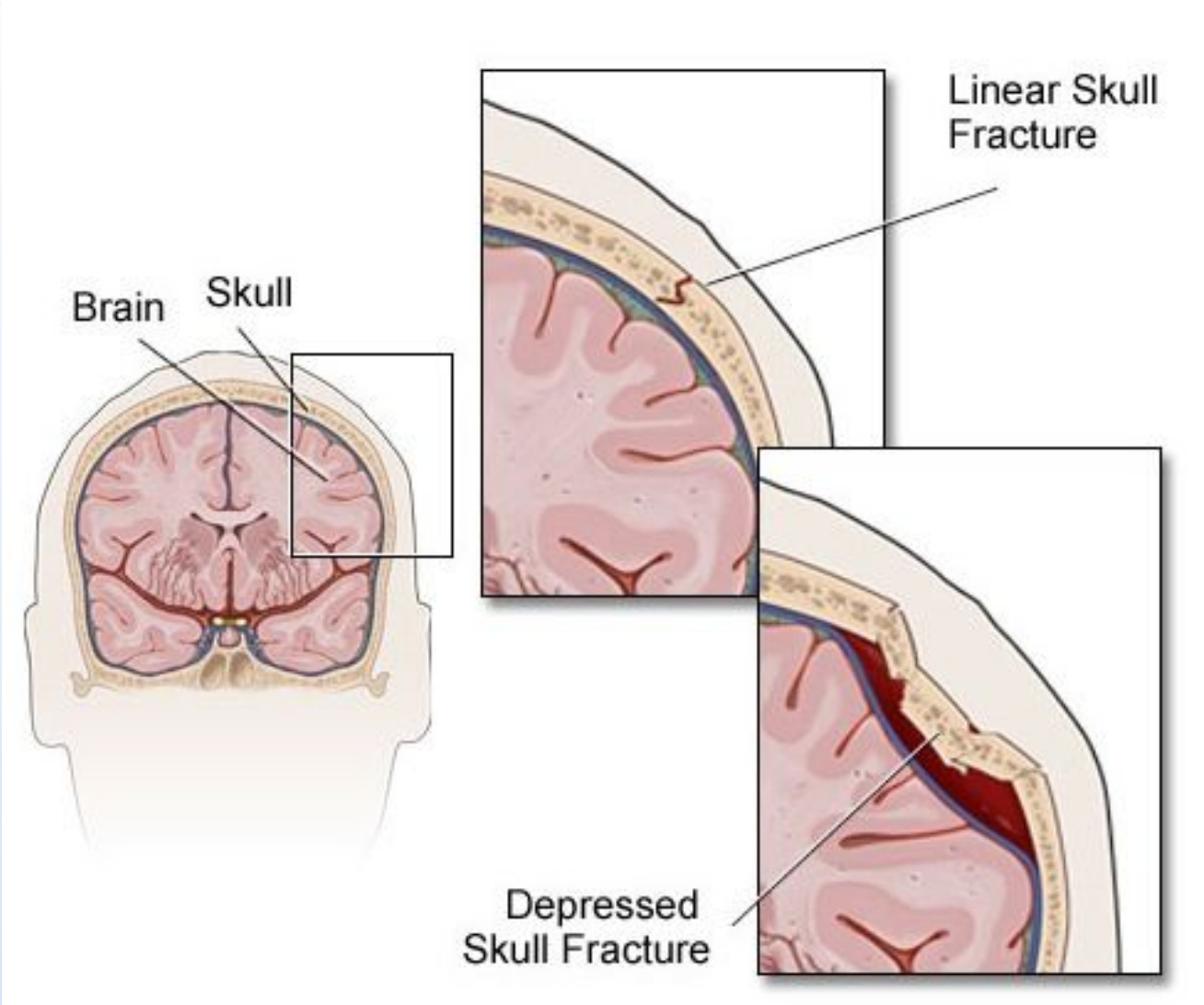
Skull fractures:

Skull fractures — Skull fractures are frequently seen in abused children.

Linear, parietal skull fractures are the most common type of skull injury following **both unintentional and inflicted** trauma.

Complicated/Complex skull fractures :

stellate, branching, multiple, bilateral, crossing suture lines, depressed, or diastatic are **suggestive** of abusive head trauma, but **also occur following unintentional injury.**


Linear Skull Fracture
Brain
Skull
Depressed Skull Fracture

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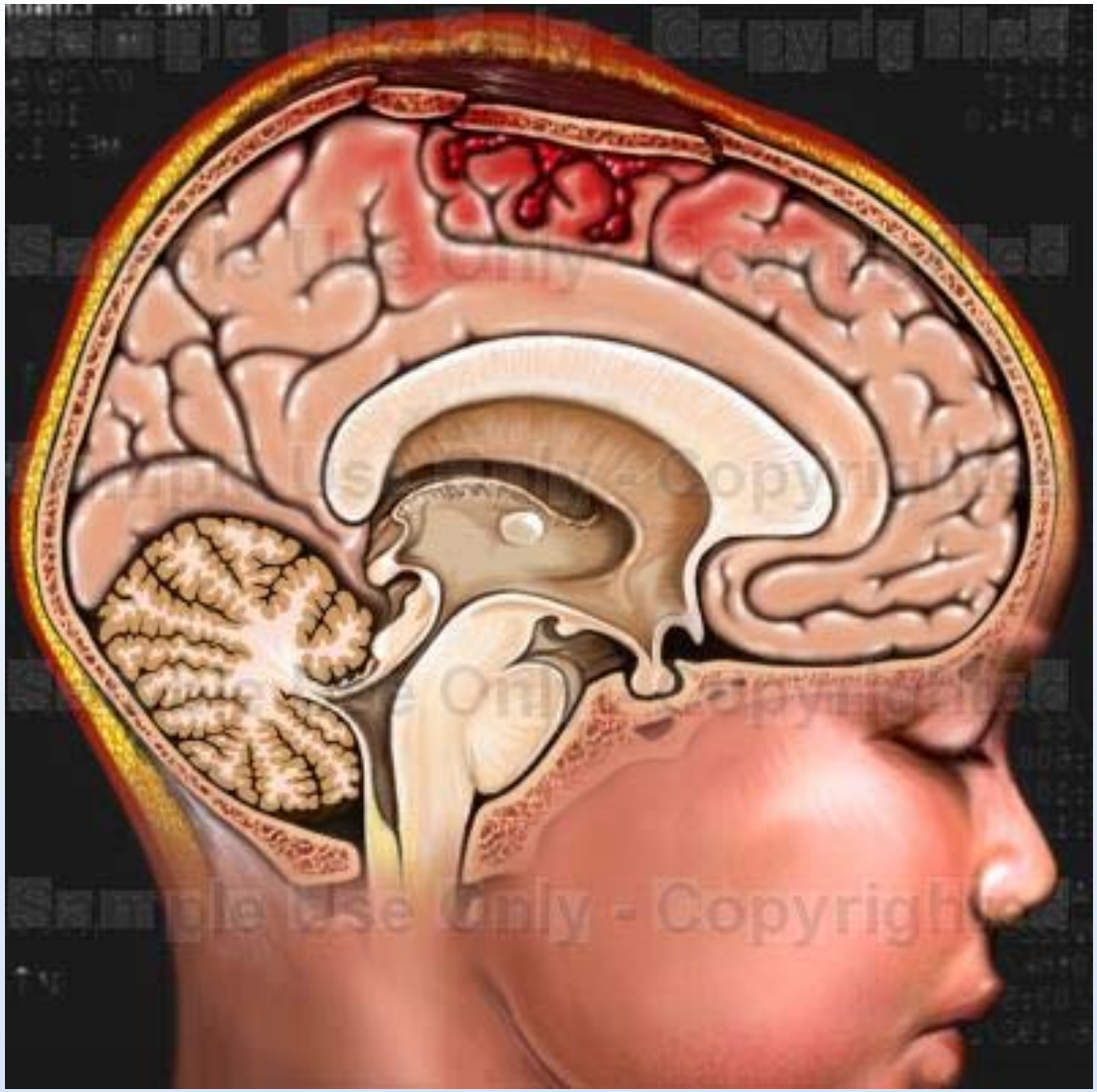
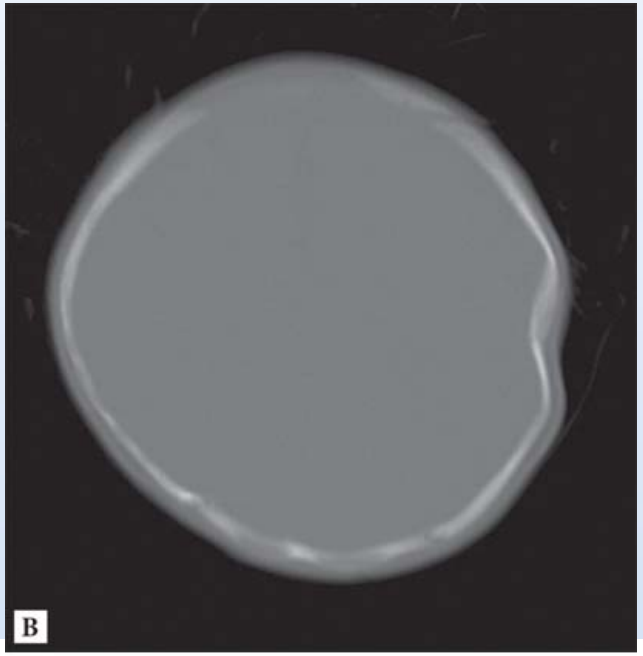
Depressed skull fracture, child



Akin to the greenstick fracture, a ping pong ball fracture occurs when a newborn or infant's relatively soft skull is indented by the corner of a table or similar object without causing a frank break in the bone.

CT demonstrates the ping pong ball effect.



Source: K.J. Knoop, L.B. Stack, A.B. Storrow, R.J. Thurman: The Atlas of Emergency Medicine, 4th Edition, www.accessemergencymedicine

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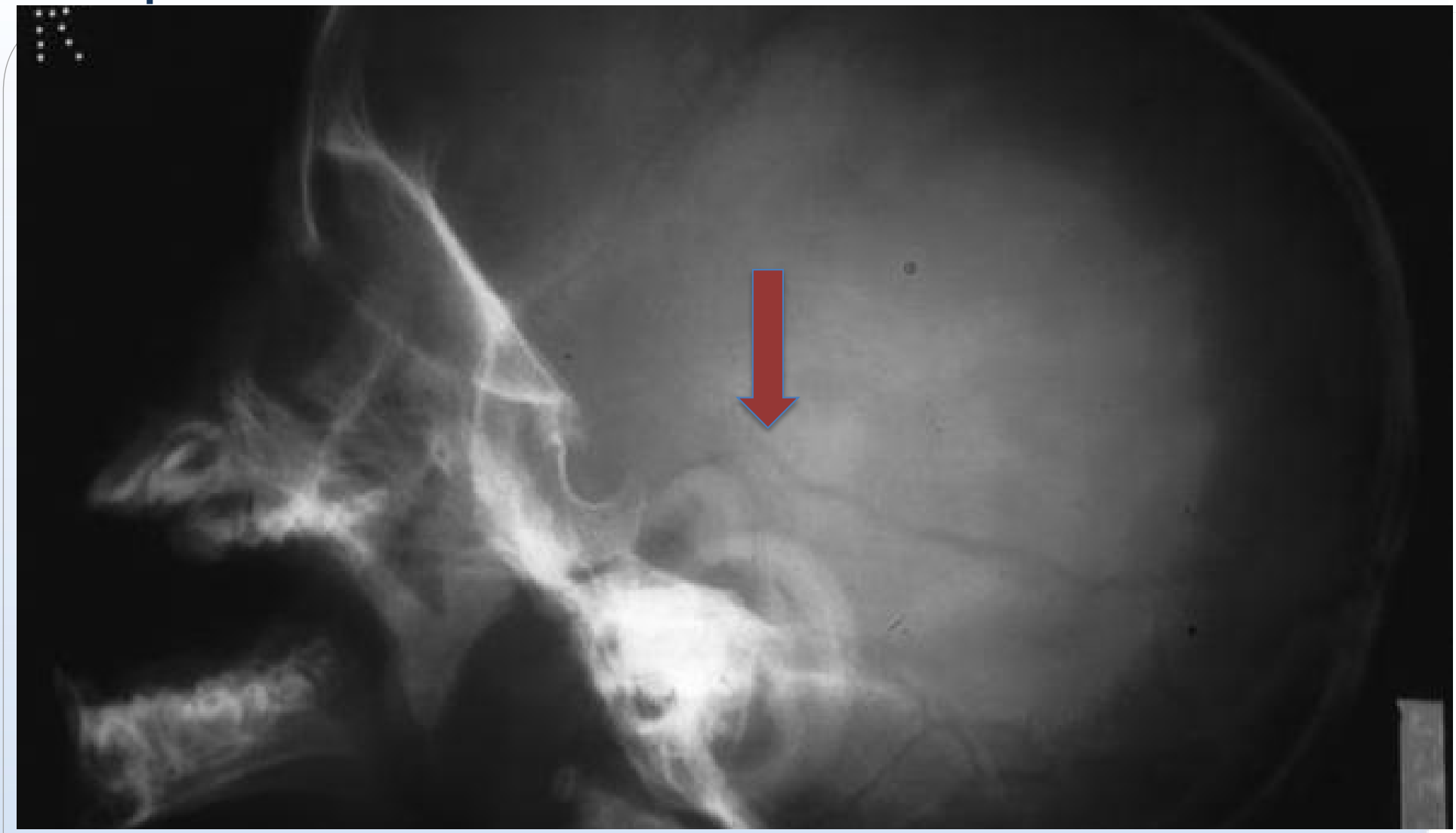
Linear skull fracture- midline through to occiput and temporal bone



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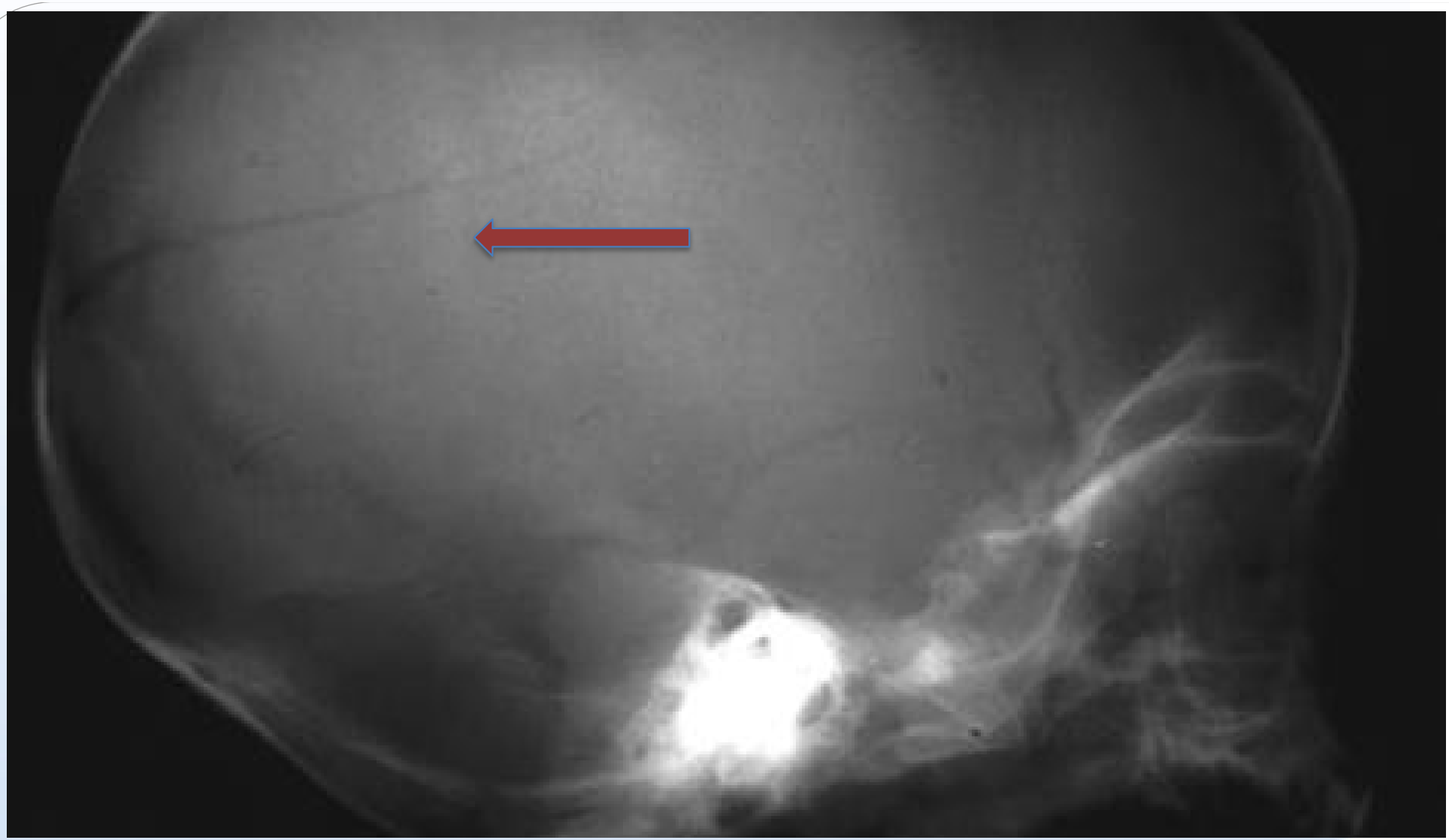
Not a vessel, not a suture line



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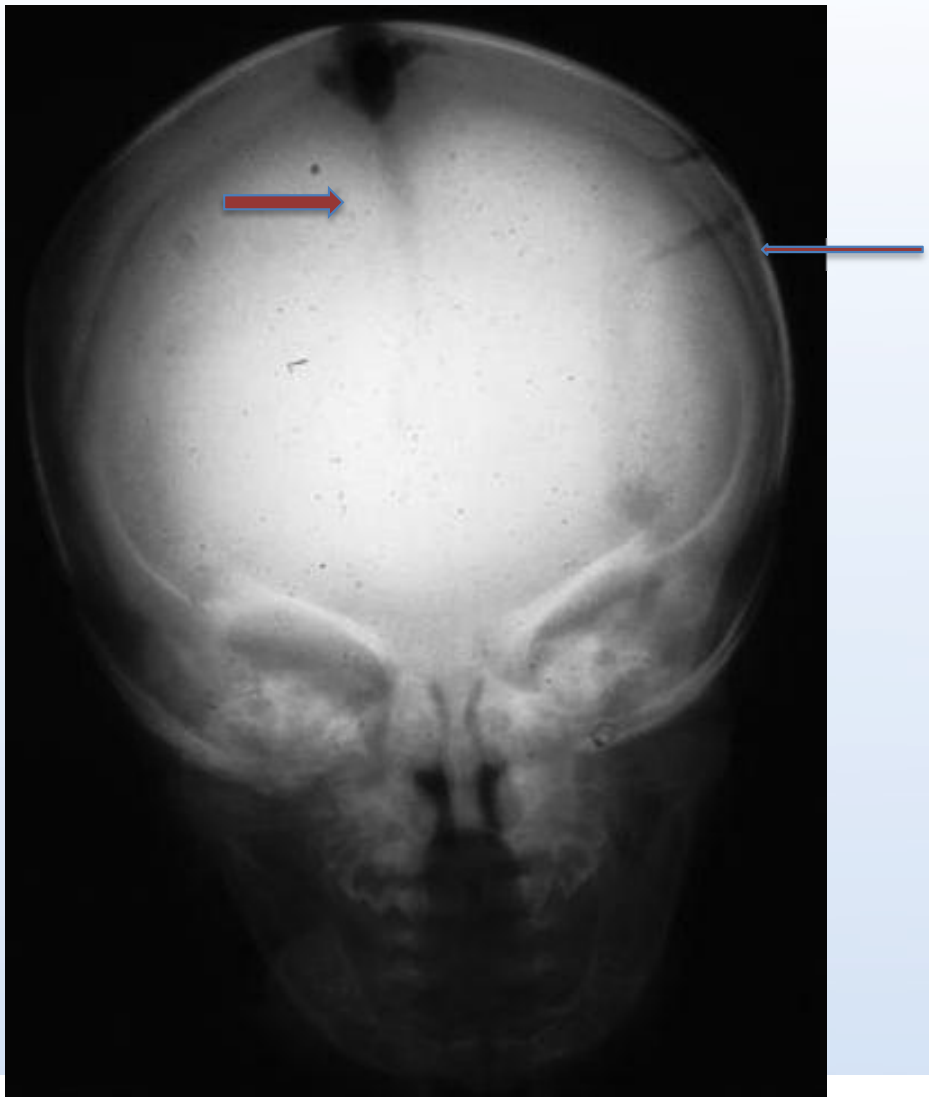
Complex fracture: **multiple fractures due to nonaccidental trauma show a diastatic fracture of the sagittal suture.**



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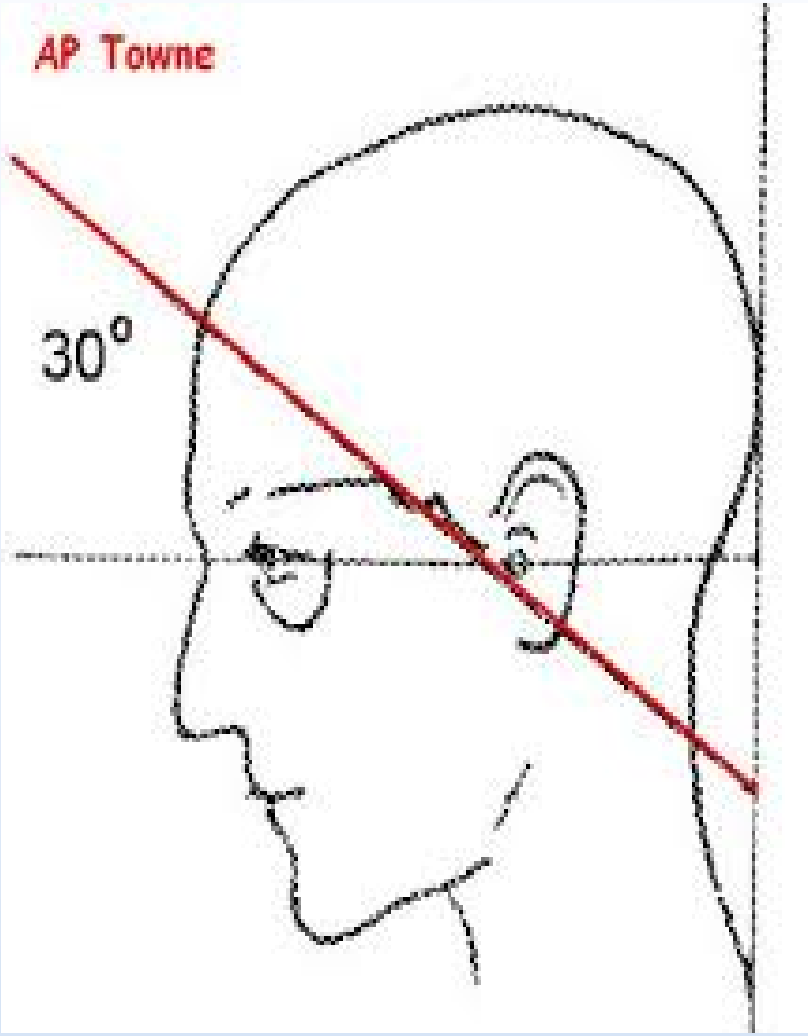
Skull (SXR) AP and lateral, plus Towne's view for occipital injury. --should be taken with a skeletal survey even if a CT scan has been performed.



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Body: AP/frontal chest (including clavicles)

Oblique views of the ribs (left and right)

AP Abdomen with pelvis and hips

Spine: Lateral spine - cervical and thoraco-lumbar

Limbs: AP humeri, AP forearms AP femurs, AP Tib/fib PA hands and AP feet Supplemented by:

Lateral views of any suspected shaft fracture.

Lateral coned views of the elbows/wrists/knees/ankles may **demonstrate metaphyseal injuries in greater detail than AP views of the limbs alone.**

The consultant radiologist should decide this, at the time of checking the films with the radiographers

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Brain imaging:

CT (brain and bone windows) is the method of choice in the acute phase.

A linear skull fracture may not be identified on CT (on bone windows)

MRIs

Interval MRI may give greater detail of subdural hematomas and parenchymal injury.

There is a body of opinion among Pediatric neuro-radiologists in the UK that a CT brain scan should be included routinely with the skeletal survey in suspected NAI for all pre-mobile young children.

UK:

It is recommended that a CT brain scan is considered for all small children in whom NAI is suspected - if CT is then judged not worthwhile or indicated in that individual case, it is advisable that this be documented in the notes.

Differential diagnosis of suspected child physical abuse - consult with Pediatrician / expert in Child abuse/ team

For fractures:

Bone health laboratory testing, including calcium, phosphorus, alkaline phosphatase • Consider 25-hydroxyvitamin D and PTH level • Consider serum copper, Vitamin C, and ceruloplasmin levels if child is at risk for scurvy or copper deficiency • Consider skin biopsy for fibroblast culture and/or venous blood for DNA analysis for osteogenesis imperfecta

Skeletal survey

Repeat skeletal survey in 2 wk for high-risk cases • Single whole-body films are unacceptable • Bone scintigraphy may be used to complement the skeletal survey

Differential diagnosis of suspected child physical abuse - consult with Pediatrician / expert in Child abuse/ team

For Bruises:

Tests for hematologic disorders: CBC, platelets, PT, INR, aPTT, VWF antigen, VWF activity (ristocetin cofactor), factor VIII level, factor IX level

Skeletal survey for nonambulatory infants with bruises and for infants and toddlers with suspicious bruising • Brain imaging for infants with suspicious bruising.

Useful when bleeding disorder is a concern because of clinical presentation or family history • Consultation with pediatric hematologist for any abnormal screen or other concern

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Differential diagnosis of suspected child physical abuse - consult with Pediatrician / expert in Child abuse/ team

For Abdominal trauma:

Liver enzyme tests: aspartate aminotransferase, alanine aminotransferase • Pancreatic enzymes: amylase, lipase; urinalysis

CT of abdomen with contrast

- Skeletal survey in children <2 y

Screening abdominal laboratory tests are helpful in diagnosing occult abdominal injury in young abuse victims • IV contrast should be used for CT scan and is preferable to PO

Differential diagnosis of suspected child physical abuse - consult with Pediatrician / expert in Child abuse/ team

For head trauma:

CBC with platelets, PT/INR/aPTT; factor VIII level, factor IX level, fibrinogen, d-dimer • Review newborn screen • Consider urine organic acids to screen for GA1

CT scan: head • MRI of head and spine • Skeletal survey

MRI may provide better dating of intracranial injuries than CT • MRI **more sensitive than CT for subtle intracranial injuries in patients with normal CT and abnormal neurologic examinations** • MRI **more sensitive** than plain radiographs and CT **for detecting cervical spine fractures/injury** • CT, and three-dimensional spiral CT enhance detection of skull fractures

Differential diagnosis of suspected child physical abuse - consult with Pediatrician / expert in Child abuse/ team

Tests can be **ordered judiciously** and **in consultation** with the appropriate genetics, hematology, radiology, and child abuse specialists.

Careful consideration of the patient's history, age, and clinical findings guide selection of the appropriate tests

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Images of patient with sub-aponeurotic CSF collection demonstrating a soft, non-tender and fluctuant scalp mass

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Plain radiograph demonstrating well-circumscribed smooth mass overlying the skull, consistent with sub-aponeurotic CSF collection. There were no signs of skull fracture, abnormal areas of lucency or sclerosis

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OPHTHALMOLOGIC FINDINGS —

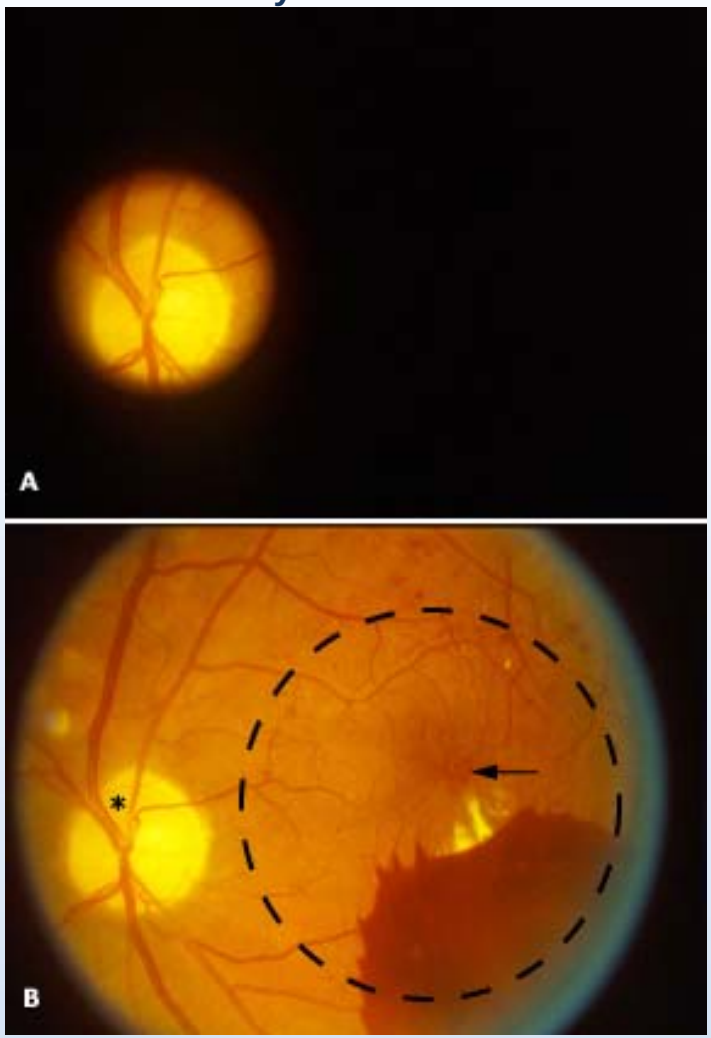
Retinal hemorrhage is most commonly found on autopsy and is least common among children with normal neurologic outcome.

The ophthalmologic findings of AHT may include retinal hemorrhages, retinal folds, retinoschisis (ie, splitting of the retina), vitreous hemorrhage, papilledema, optic nerve sheath hemorrhage and/or optic atrophy.

Retinal hemorrhages — Retinal hemorrhages have been reported in 47 to 100 percent of cases of AHT, with a frequency of approximately 85 percent in most case series

The finding of retinal hemorrhage on ophthalmologic examination significantly increases suspicion for inflicted injury, but does not necessarily confirm the diagnosis nor does the absence of retinal hemorrhage exclude the diagnosis

A newer type of handheld direct ophthalmoscope (the Pan Optic™ by Welch Allyn) increases the field of vision to 2 to 5 disc diameters and may increase the ability to detect retinal abnormalities with direct ophthalmoscopy; however, the view is still only two dimensional and not as wide as with an indirect ophthalmoscope



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Reporting suspected Child Abuse

The process that **begins when the clinician first feels concern** about a child's welfare and ends when he or she makes a report to CPS is one of the most challenging and disturbing that practitioners must undertake.

Reporting to CPS, perform difficult tasks (such as telling a child's parents about a report), and manage the challenging emotions that these cases can generate.

Understand Mandatory Reporting Laws

The clinician **need not be absolutely certain** that a child has been maltreated to make a report to CPS; in fact, waiting for diagnostic certainty can have severe consequences for a child.

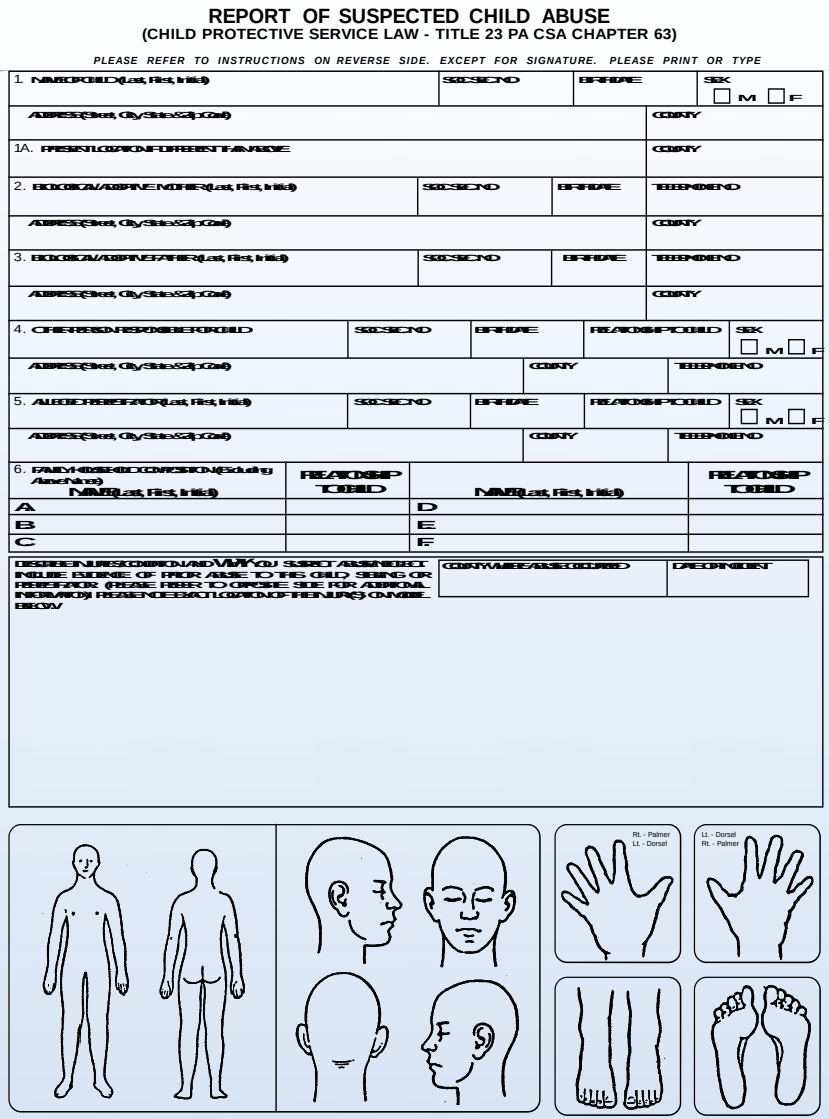
On the other hand, an investigation by child protection authorities generates significant stress for parents who have not harmed or neglected a child.

Understand Mandatory Reporting Laws

The mandatory reporting laws state that **once a practitioner has REASONABLE CAUSE to suspect that a child has been abused or neglected, he or she is obligated by state law to make a report to CPS.**

In cases of sexual or physical abuse, **CPS usually contacts police to investigate a possible crime.**

Failure to make a report can result in criminal penalty, action against a practitioner's professional license, or most dire, further injury to or death of a child.



REPORT OF SUSPECTED CHILD ABUSE
(CHILD PROTECTIVE SERVICE LAW - TITLE 23 PA CSA CHAPTER 63)

PLEASE REFER TO INSTRUCTIONS ON REVERSE SIDE. EXCEPT FOR SIGNATURE. PLEASE PRINT OR TYPE

1. NAME OF CHILD (Last, First, Initial) | SOCIAL SECURITY NO. | BIRTHDATE | SEX ☐ M ☐ F
ADDRESS (Street, City, State & Zip Code) | COUNTY
1A. PRESENT LOCATION IF DIFFERENT FROM ABOVE | COUNTY
2. MOTHER/ADOPTIVE MOTHER (Last, First, Initial) | SOCIAL SECURITY NO. | BIRTHDATE | TELEPHONE NO.
ADDRESS (Street, City, State & Zip Code) | COUNTY
3. FATHER/ADOPTIVE FATHER (Last, First, Initial) | SOCIAL SECURITY NO. | BIRTHDATE | TELEPHONE NO.
ADDRESS (Street, City, State & Zip Code) | COUNTY
4. OTHER PERSON RESPONSIBLE FOR CHILD | SOCIAL SECURITY NO. | BIRTHDATE | RELATIONSHIP TO CHILD | SEX ☐ M ☐ F
ADDRESS (Street, City, State & Zip Code) | COUNTY | TELEPHONE NO.
5. ALLEGED PERPETRATOR (Last, First, Initial) | SOCIAL SECURITY NO. | BIRTHDATE | RELATIONSHIP TO CHILD | SEX ☐ M ☐ F
ADDRESS (Street, City, State & Zip Code) | COUNTY | TELEPHONE NO.
6. FAMILY/HOUSEHOLD COMPOSITION (Including Alleged Perpetrator)

NAME (Last, First, Initial)	READ SPOKEN	NAME (Last, First, Initial)	READ SPOKEN
A		D	
B		E	
C		F	

DESCRIBE NATURE AND EXTENT OF INJURY OR ABUSE, INCLUDING ANY EVIDENCE OF PRIOR ABUSE TO THIS CHILD OR SIBLINGS, AND CIRCUMSTANCES WHICH MAY BE RESPONSIBLE FOR THE INJURY OR ABUSE. (USE REVERSE SIDE OR ADDITIONAL PAPER IF NECESSARY.)

COMPANY/AGENCY RECEIVED | DATE/INCIDENT

Rt. - Palmer
Lt. - Dorsel
Lt. - Dorsel
Rt. - Palmer

To report suspected child abuse, call ChildLine at

1-800-932-0313 TDD 1-866-872-1677

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Sexual abuse

Although a child may first disclose sexual abuse to a pediatric clinician, it is considerably more likely that the clinician will hear of a child's disclosure or behavior that led to concern about sexual abuse from an adult caregiver of the child.

In this situation, information about **what a child said or how he or she behaved should be obtained from the caregiver**.

The investigation of alleged sexual abuse is **undertaken best by both CPS and police to limit the number of times a child is questioned about alleged abuse and to avoid compromising the investigation of a possible crime**.

Sexual Abuse:

The report of a disclosure of sexual abuse from a child's caregiver **should prompt an immediate report to local CPS, even when the pediatric practitioner is not certain that sexual abuse has occurred**

Know When and How to Get Help

Obtaining a careful family and social history in the setting of a busy ED is a challenge;

Key **support staff such as social workers or nurses.**

working with a **social worker** may allow the gathering of important information to help the practitioner decide whether to report an injury.

Nurses may **witness parents attempting to "get their stories straight**" and should be asked about what they have observed; nurses often make **important observations about parent-child, parent- sibling, and parent-parent interactions**

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When available, a **pediatric child abuse expert** can be a valuable resource for cases in which a decision to report to CPS is particularly difficult.

Such experts may be available for telephone consultation, to review photographs and radiographs, or to evaluate children personally.

They can offer extremely useful input in difficult cases.

Confronting possible child maltreatment can generate multiple emotions in the clinician, including anger, sadness, disgust, and anxiety.

Consultation with another person can provide support to the clinician and may prevent difficult emotions from interfering with his or her ability to act in the best interest of the children for whom he or she cares.

Consider Hospital Admission

Remember That a Child May Have Siblings!

Tell Parents When a Report is Made

Next challenge is **when, where, and how to tell the child's parents.**

Many practitioners identify the act of telling a child's parents that a report to CPS has been or will be made as being among the most difficult tasks they face.

However, the person making a report (or causing a report to be made) is the best person to inform

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It is acceptable and advantageous to assure a child's safety first, but there should be no additional delay in telling parents about a report beyond the time that a child's safety is assured

Helpful to recall the mandatory reporting laws when communicating with parents about a report to CPS.

Remembering that a legal mandate goes into effect when concern for a child is raised (and communicating that legal obligation) may help the practitioner face the challenging task of informing parents of his or her suspicion of abuse.

The practitioner may say something such as, “Whenever we see bruises like this in an infant, we have to worry about possible abuse. When that happens, I am mandated by state law to make a report to child protective services.”

Continue to Advocate and Care for the Child and Family After Making a CPS Report

The practitioner should make every effort to continue to advocate for children and families after making a report to CPS.

This action comprises the final step in a successful approach to managing suspected child maltreatment.

An understanding of what is likely to happen after a CPS referral can help the practitioner provide support to families.

Medical terminology also should be explained carefully to both law enforcement and CPS personnel.

Use Clear, jargon-free language

Only a fraction of CPS reports result in **removal of a child from his or her home.**

Removal is most likely to occur in cases of **suspected serious injury or serious neglect.**

Even when removal occurs, reunification is always a goal and is considered in every case.

Many families who are reported to CPS do not lose custody of their child-- instead, they receive services through the auspices of CPS.

For example, the infant of a depressed mother who has failed to thrive because of caloric restriction may remain with his or her parents if intensive services, including mental health care, can be provided.

Removal is an option of last resort and is used only when a child's safety cannot be assured.

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When CPS decides that a child's safety is in imminent danger ……

The agency has two means by which to obtain custody of a child.

1. Temporary custody order. To obtain a temporary custody order, CPS must present evidence to a judge in court (called juvenile, family, or dependency court in different states) that a child's safety is at continued imminent risk.

If the temporary custody order is granted, CPS takes temporary custody of the child, and a future court date is specified, at which time the judge hears additional evidence and re-evaluates whether to continue custody with CPS or reunite the child with his or her parents (with or without specified services).

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At the hearing, evidence is presented by a CPS attorney and attorneys for the individual parents and the child. In some states, the child is assigned a guardian ad litem who tries to understand the child's situation and advises all involved parties about what would most benefit the child.

(A **guardian ad litem** is a unique type of **guardian** in a relationship that has been created by a court order only for the duration of a legal action.)

The second option is used on **weekends, holidays, or after work hours, when a judge is not available**.

In this situation, CPS still may take temporary custody of a child for several days under **what usually is called a "hold."**

Usually 96 hours, but the duration of the hold may vary from state to state.

Within whatever time frame a given state prescribes for a hold**, CPS must go to court to provide evidence** about the reason the hold was invoked and the necessity that the child not be allowed to be cared for by his or her parents.

For both a temporary custody order and a hold, CPS usually requests that **the practitioner caring for the child or consulting on the case provide documentation (often in the form of an affidavit) describing, in lay terms, the child's medical condition, the types of injuries seen, and the rea- sons that abuse or neglect is suspected**.

In addition, the **documentation states that the child's safety is at imminent risk** if he or she is allowed to return to the home.

Reasons Chosen not to report/ Barriers to Reporting:

Many practitioners **identify a concern about what may happen to children after a CPS report is made** as a reason for choosing not to report suspected maltreatment.

Concerns about the CPS underreacting (failing to substantiate a report) **or overreacting** (seeking removal of a child not believed by the clinician to be at high risk) **often are cited as barriers to reporting** to CPS a worrisome injury or behavior.

It is helpful to remember that CPS investigators often have far more information at hand than the medical practitioner.

Thank you!!

The app is free for Apple devices
at http://apple.co/1t6dGwB and Android devices
at http://bit.ly/25BrhJV.

References:

American Academy of Pediatrics Section on Child abuse and neglect:

http://www2.aap.org/sections/childabuseneglect/

Pediatrics in Review: AAP

http://www.aappublications.org/content/34/4/26

http://www.aappublications.org/content/33/3/20.1

AAP news: February 26, 2012

Pediatrics in Review Vol.31 No.2 February 2010

DHS PA.GOV documents:

http://www.dhs.pa.gov/cs/groups/webcontent/documents/report/c_208256.pdf

"Understanding Key Fractures Through Radiologic-Histopathologic Correlations," with Paul K. Kleinman, M.D., FAAP;

http://aapgrandrounds.aappublications.org/content/27/6/64 AAP Grand Rounds June 2012, VOLUME 27 / ISSUE 6

The Impact of Race and Socioeconomic Status on Diagnosing Abuse

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