Objectives

• Recognize sentinel injuries of child maltreatment
• Describe the elements of a clinical practice for possible child maltreatment
• Identify necessary elements needed for mandatory reporting
• Develop a draft Clinical Practice for recognizing and reporting child maltreatment in your setting
Statistics

– Child abuse is not rare
  • 9.1 victims per 1,000 children
  • 23.1 per 1,000 children < 1 year of age
– Child abuse is serious
  • 18.09 fatalities per 100,000 children < 1 year of age
  • In 2015, an estimated 1,670 children died from abuse and neglect in the United States.
  • 4 to 5 children die each day in US from Child Abuse
    – Real incidence is much higher
– 87 children (<18 y/o) died from Child Maltreatment in Arizona in 2015

Impact of Abuse and/or Neglect on Children

• Adverse Childhood Experiences
  Untreated acute health problems
  Exacerbation of chronic disease
  Poor nutritional status, growth and development
  Poor school performance
  Long term disability
  Death
• Risks are cumulative

Child Abuse Is Sad

• Missing a child abuse case puts the child at risk for re-injury and/or death
  – 50% of missed kids will be re-injured
  – 10% will die from their abuse
Types of abuse

- Physical abuse
- Sexual abuse
- Neglect
- Emotional abuse
- Exploitation

Physical Child Abuse: non-accidental acts that results in physical injury to a child

- Punching
- Beating
- Kicking
- Shangulation
- Bling
- Burning
- Fractures
  - Skull
  - Long bones
- Ribs
- Hair pulling
- Shaking a baby

Bruises

- What bruises are normal?
- What bruises should raise concern?
Bruises in Infants and Toddlers

- Study of kids < 3 years old who presented to a pediatric ED
- 11/511 (2.2%) not yet cruising had bruises
  - Babies < 6 months old
  - 17.8% cruisers and 51.9% walkers had bruises

- Sugar et al, Arch Pediatr Adolesc Med, 1999

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T E N - 4

- Any bruising in suspicious body regions in children < 4 yrs old:
  - Torso (includes, chest, abdomen, back, buttocks, g/u and hip);
  - Ears
  - Neck

- Any bruising in infant 4 months of age and younger

“Those who don’t cruise rarely bruise”

Congenital dermal melanocytosis

Mongolian Spots
SEXUAL ABUSE

- Misuse of a child for sexual pleasure or gratification
- Children often don't disclose for weeks, months or years
  - May disclose if a trust relationship develops
- If a child does disclose don't ask for details
  - Who, what happened, where, when?

- Prevalence: 4.3 to 16% of men, 12.8 to 27% of women
- 9.1% of all child abuse cases are a result of sexual abuse
CHILD NEGLECT

Acts of Omission

- Physical neglect
- Emotional neglect
- Medical/dental neglect
- Educational neglect
- Failure to supervise
- Exposure to dangerous or violent environments
  - Domestic violence, guns

"Hunger and neglect often do much more damage than outright dislike."  
J. K. Rowling
“Clinical” Practice: Introduction

- **Title**
  - “Clinical” can also be “Organization” or “Client” or another word that describes your setting’s practice best
  - “Practice” could be also be a “Policy”
- **Person responsible for Practice**
- **Date Practice is adopted**
- **Brief description**
  - “Child abuse is common and we may see some signs of child maltreatment in our clients (or their children). This Clinical Practice will define how to recognize and respond to a child in our facility (or another word that best describes your facility) who may be the victim of child abuse”

Template Key Points

- **Title:** (person responsible, date of implementation)
- **Practice Statement:** a brief description of the purpose of the Clinical Practice
- **Rationale:** why it’s important to do it (statistics, historical info, a story)
- **Clinical Presentation:** physical findings, disclosure
- **History:** who, what happened, when, where
- **Demographics**
- **Phone call to parents / guardians**
- **Documentation:** “just the facts, ma’am”
- **Using exact words in quotes when possible**
- **Exam visible findings, consider documenting emotional state**
- **Testing/Consults:** if a medical clinic
- **Treatment:** if a medical clinic, or call 911 or 911 if appropriate
- **Mandatory Reporting:** per policy or create one
- **References:** what material you used to support your practice
Title: Clinical Practice: Identification and Management of Suspected Child Physical Abuse and Neglect

Brief Description:

All pediatric patients suspected of being victims of child abuse and neglect will be stabilized and then evaluated, including a careful and well-documented history, physical examination with detailed documentation, and a thorough search for other signs that may suggest a non-accidental cause. Consultation with a child abuse pediatrics, pediatric specialists, or pediatrician experienced in this area, if available, may be helpful in determining the best way to proceed with assessment.

Practice Statement

All pediatric patients suspected of being victims of child abuse and neglect will be stabilized and then evaluated, including a careful and well-documented history, physical examination with detailed documentation, and a thorough search for other signs that may suggest a non-accidental cause. Consultation with a child abuse pediatrics, pediatric specialists, or pediatrician experienced in this area, if available, may be helpful in determining the best way to proceed with assessment.

Rationale:
The prevalence of physical abuse and neglect in children is striking. It is estimated that approximately 100,000 American children are abused and neglected each year. Among pediatric patients presenting to the ED, rates of physical abuse are particularly high. San-Francisco (1991) suggested that approximately 10% of the patients ED volume are victims of child abuse or neglect. Patients with a history of an abused child have a 50% chance of experiencing recurrent abuse and a 10% chance of death. It is imperative that providers are able to recognize suspicious injuries, conduct a comprehensive and careful examination with appropriate ancillary tests, critically assess the explanation provided for the injury or injuries, and establish whether the explanation coincides with the pattern, severity, and/ or age of the injuries. The provider is responsible for reporting suspected abuse, documenting his or her opinion clearly, and providing the necessary information and expertise to investigative and legal personnel as indicated, if appropriate.

CLINICAL APPROACH:

Clinical Presentation: Methods to recognize possible child victims

- Bruises: history doesn’t account for suspicious bruises
- Number and pattern of bruises
- Burns: history doesn’t account for suspicious burns
- Patterned burn or burns
- Vertical discoloration
- Neglect

Medical History if pertinent

Physical exam
- If appropriate, determine basic physical condition of child

Psychosocial Evaluation

Treatment
- If appropriate
- Call Law Enforcement or 911 if necessary
- Keep child safe until resources arrive
Recognizing Child Maltreatment

Clinical Presentation

In cases of child abuse, medical documentation can be highly scrutinized, and therefore should be factual and unbiased using quoted statements made by the victim as much as possible.

Medical History

Once the child is stabilized, a thorough and well-documented history is the most critical element of the medical evaluation. Using quotation wherever possible, the physician should document descriptions of the mechanisms of injury or injury, initial and progression of symptoms, and the child's developmental capabilities. This child's verbal cues are critical to determining past and present trauma as well as their thoughts and feelings. Noting open-ended questions. A complete interview by a trained child abuse interviewer is recommended as soon as the child's status and ability to participate in the investigation process.

Explanations that are concerning for inflicted trauma include:
1. Explanations that are significant to injury to systems or mechanisms
2. An important detail of the explanation changes significantly between providers or encounters
3. An account that is inconsistent with the history, age, or severity of the injury or injuries
4. An explanation that is inconsistent with the child's physical and/or developmental capabilities
5. Differences in the documentation descriptions between providers or cases for the injury or injuries

Documentation

In cases of child abuse, medical documentation can be highly scrutinized, and therefore should be factual and unbiased using quoted statements made by the victim as much as possible.

Exam

Examination should also be performed as soon after the suspected incident of abuse as possible. DNA evidence is most often recovered when the exam is performed within 24 hours.

A meticulous physical exam should be performed. This includes, but is not limited to, complete skin assessment that includes the head, neck, and hands for palmar, palmar, axillary, submental, genital, and buccal, and palpation of the extremities, trunk, and chest for bony deformities and pain.

The physical examination should include detailed documentation, either by body diagrams from the child's medical record or by note taking. This includes skin and skin testing that may suggest a traumatic cause for the patient's condition.

Providers must also consider that unusual events, including accidents, do happen to children and may produce injuries that are not necessarily seen from accidental trauma. An injury pattern is noted pathogenic for abuse versus accident, causing judgment of the examination procedure. In addition, both inflicted and accidental injuries may be seen simultaneously in a child.

If abuse is a concern after the preliminary evaluation, consultation with a child abuse pediatrician, pediatric surgeon, or pediatrician in this area is available. Any child with suspicion of inflicted injury requires complete evaluation for abdominal trauma, including laboratory and radiology imaging (e.g., CT with contrast).

Any child with suspicion of internal hemorrhage should be evaluated for a bleeding disorder, retinopathy, and complete blood panel (e.g., CBC) when stable.
Treatment
-- call LE or 911
-- other as applicable

Mandatory Reporting
-- may include
details here or
may have a
separate policy

References

REFERENCES:


Elements of Mandatory Reporting
Demographics

- Name
- Age
- Household Language
- Overall child development/health
- Parent/Guardian information
- Household membership(age/relationship to child) and Family Identification
- Child's school/childcare information
- Social stressors...DV, mental health, drug use, etc

Information gathering

- YOU DO NOT HAVE TO INVESTIGATE!
  - “Reasonable Belief”
- 5 main questions: who, what, where, when, how (context)
  - Never WHY
- Get context...
  - may require call to parent, depending on situation
  - “It happened at home”
    - Could mean parents pinched in punishment
    - Could mean sister pinched playing rough, sister disciplined, appropriate care for child
    - Use professional judgment
    - Again, you don’t have to determine if accident or not, but “Does it warrant further investigation?”

Mandatory Reporting of Suspected Child Abuse: A.R.S. § 13-3620

Any person who reasonably believes that a minor is or has been the victim of physical injury, abuse, child abuse, a reportable offense or neglect that appears to have been inflicted on the minor by other than accidental means or that is not explained by the available medical history as being accidental in nature or who reasonably believes there has been a denial or deprivation of necessary medical treatment or surgical care or nourishment with the intent to cause or allow the death of an infant who is protected under section 36-2281 shall immediately report or cause reports to be made of this information to a peace officer or to child protective services in the department of economic security, except if the report concerns a person who does not have care, custody or control of the minor, the report shall be made to a peace officer only.

Call: 1 888 SOS CHILD
1 888 767 2445
Who Reports?

- Medical workers
- Social workers
- Clergy
- Peace officers
- School personnel
- Photo processors
- **Any other person who has responsibility for the care or treatment of the minor!!

   – Parent/guardian

PROCESS OF REPORTING

1-888-SOS-CHILD

Process of Reporting continued

- For potential “Criminal Conduct” call law enforcement agency where the incident occurred ie: If it happened at home and they live in Tempe- call Tempe PD
- If unknown where the incident occurred or where the family lives, call your local law enforcement agency
- PD for abuse that occurred by someone who is NOT a caregiver for the child (ie: family friend, daycare, etc)
- May or may not also require DCS report if it’s felt there is neglect by parent/guardian placing child in known inappropriate care
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- References: what material you used to support your practice

Break-Out Session

15 minutes

WORK ZONE
BREAK OUT SESSION IN PROGRESS
PARTICIPATION REQUIRED
REFERENCES:

REFERENCES:

- Stratman E., Melski J. Scald Abuse. Arch Derm 2002;138:318-320