CHILD ABUSE AND NEGLECT

INTRODUCTION (KATHERINE FULLERTON, M.D. 3/2020)
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Currently, there are more than 700,000 confirmed cases of child abuse per year in the U.S. Many cases are never reported, so actual figures are likely much higher. Child abuse consists of physical abuse, sexual abuse, emotional abuse and neglect. Most cases are neglect and physical abuse, with fewer cases of sexual & emotional abuse. The definitions below are as defined by CAPTA (The Child Abuse Prevention and Treatment Act, 1974. Reauthorized 2010) and New York State laws.

CHILD ABUSE: Abuse occurs when a child has suffered intentional physical or emotional injury caused by a caregiver, such as a parent, legal guardian, or teacher, which results in mental distress, disability,
disfigurement, or the risk of death.

CHILD NEGLECT: Neglect occurs when a child's physical, mental, or emotional condition has been endangered because the parents or legal guardians have failed to provide for basic needs (physical, mental, or emotional) including food, shelter, clothing, medical, dental, eye care and education or failure to provide proper supervision, including abandonment, parental substance abuse (excessive use of drugs or alcohol which interferes with the ability of the parent to supervise the child). Neglect includes neglectful supervision, medical neglect, physical neglect, abandonment and refusal to accept parental responsibilities.

PHYSICAL ABUSE: Physical abuse occurs when an inflicted physical injury results in injury, distress, disfigurement, or death of a child (e.g. punching, beating, kicking, biting, burning, shaking). CT findings
suggestive of abusive head trauma include: intra-hemispheric falx hemorrhage, subdural hemorrhage, non-acute extra-axial fluid collection and basal ganglia edema. Other lesions include: bruises, burns,
contusions, lacerations, hematomas and fractures.
EMOTIONAL ABUSE: Emotional abuse occurs when the parent or caregiver exhibits persistent behavior that assaults, demeans, diminishes, or debases the child, and interferes with the child's normal
development. Emotional abuse is present with all other forms of child abuse, but can also occur by itself.

SEXUAL ABUSE: Sexual abuse consists of using, persuading, or coercing a child to engage in any sexually explicit conduct (e.g. fondling, intercourse, rape, molestation, sodomy, exhibitionism). See information for Commercial Sexual Exploitation of Children.
See: PEM Guide: Child Protection: Sexual Abuse and Assault.
Family Stress, poverty, homelessness, unemployment.
Parent Abused as child, expectations mismatch child's development, single parent, psychiatric problems, impulsive behavior, substance abuse, developmental or intellectual delays, other domestic/family violence.

Social No supports (friends, family), violence learned/acceptable socially.
Child Stepchild, temperament, colic, child with special health or other needs (e.g. prematurity, chronic medical or psychiatric problems).

IDENTIFICATION OF SUSPECTED CHILD ABUSE

HISTORY: Some children may clearly detail abuse/neglect. Often the history is vague and doesn't match physical findings or the developmental abilities of the child. The history may change from one telling to
the next, or differ between caregivers. For neglect and other maltreatment, physical exam may be normal and the history is most important.

INTERACTIONS: Suspect abuse with arguments, lack of parent holding or making eye contact with child, parent has impaired speech/motor consistent with intoxication, overt yelling, threatening, striking
child in front of health care providers.

PHYSICAL EXAMINATION: Record full vital signs and growth parameters. Many cases of physical abuse occur without specific physical findings. Life threatening injuries may be occult. Thoroughly assess the neurologic, abdominal, skin and musculoskeletal systems. Certain injuries (facial bruises, pattern marks, specific fracture types) are 'sentinel' with high suspicion for abuse, particularly in young children.

CNS INJURIES: The term "shaken baby syndrome" or shaken impact syndrome has been replaced by abusive Head Trauma (AHT) as shaking is only one of the potential mechanisms of injury. AHT is the most common cause of abuse fatality and disability. Infants and younger children are at greatest risk given small size and development. For intracranial hemorrhage consider evaluation for bleeding disorders, birth and accidental trauma, and metabolic disease. Injury of brain parenchyma can lead to a
cascade of fibrinolysis and thrombosis resulting in abnormal coagulation (↑ PT, PTT) and disseminated intravascular coagulaton. A multicenter, prospective validation and refinement of the Pittsburgh Infant Brain Injury Score (PIBIS) rule (Berger, Pediatrics 2016, PubMed ID: 27338699) included 214 cases of abusive head trauma and 826 controls and identified 4 prognostic factors. At a score of 2, the sensitivity was 93.3% (95%
confidence interval 89.0%–96.3%) and a specificity of 53% (95% confidence interval 49.3%–57.1%).

ABDOMEN: Abdominal trauma is second most common cause of abuse fatality, more than half without external bruises. Need to adequately assess bowel sounds, tenderness, gastrointestinal history. Screen
for with liver function tests.

CUTANEOUS: Skin is the most commonly organ injured in child abuse. Look for cuts, scrapes, bruises (ecchymosis), lacerations, burns, bites, redness, and swelling. Typical abusive injuries include unusual

locations (inner thighs, cheeks, buttocks, lower back), patterned bruises/burns, multiple injuries, and different stages of healing.
Suspicious burns including multiple cigarette shaped burns (DDx: Staph impetigo) and "dip" burns (child is forced into a very hot bath sustaining circumferential burns to both feet and lower ankle and sometimes the buttocks. Splash burns (from tip over hot liquids from below), palmer burns (from grasping a hot object) and single irregularly shaped cigarette burns are likely accidental.

T Torso
E Ear
N Neck
4 Children less than 4 years of age and ANY bruise under 4 months of age
Bruises cannot be reliably dated. Pictures are essential

F Frenulum tear injury (sublingual or labial): forcefully pushing a bottle into mouth
A Angle of the jaw or Auricular area: forcefully grasping the face by the mandible
C Cheek (buccal) ecchymosis
E Eyelid ecchymosis
S Sclera (subconjunctival hemorrhage)

MUSCULOSKELETAL: Consider other causes (osteogenesis imperfecta). Skeletal surveys (SCAMP series) are usually indicated in children under age 2 years being reported for suspected physical abuse
but are usually only done during regular business hours because of staffing needs. Metaphyseal fractures occur at the junction of the meta-physis and physis and include metaphyseal chip (corner) fracture and "bucket handle" fractures. They result from traction/torsional forces when the infants
extremity is pulled and/or twisted forcefully. Chip (corner) fractures are seen as a discrete avulsion of the metaphysis. "Bucket handle" fractures are seen as a horizonal avulsion with discrete proximal and
distal segment.

MANAGEMENT

MEDICAL CARE: The physician must care for life or limb threatening medical and psychiatric problems as well as other medical needs. Admit only if there is a medical reason for admission. Safe discharge is
part of medical management.

REPORTING: All licensed physicians and other hospital staff are mandated reporters and must report (based on state law) suspicion of child abuse/neglect. Mandated reporters are required to report
suspected child abuse or maltreatment when they are presented with a reasonable cause to suspect child abuse or maltreatment in a situation where a parent, or other person legally responsible for the

child has caused or allowed to be caused the conditions identified. “Other person legally responsible” refers to a guardian, caretaker, or other person 18 years of age or older who is responsible for the care of the child.

SOCIAL WORK: The social worker will gather information, write the report, and make the report to the State Central Register. If the case is accepted, it will be referred to Administration for Children’s Services (New York City). The attending will need to provide the medical diagnosis and sign the report.

HOSPITAL POLICE: To provide for your safety and prevent the caregiver from eloping with the child. Hospitals can take **protective custody** if there is **imminent danger**. This should be discussed with the attending staff, and hospital police should be notified as soon a necessary. The Administration for Children’s Services (ACS) is called when this is needed.

DOCUMENTATION: Clearly and objectively include the history, physical, and tests that created the suspicion of abuse for the report. It is best to use the caregiver’s exact language for the history in “quotes” and exactly describe physical exam findings (photos should be taken by as well) and to avoid legal terms like “alleged” “rule out” or “perpetrator”. List the specific injuries and “suspected” physical abuse, neglect, or maltreatment as appropriate.

PLACEMENT OF CHILD WITH CHILD PROTECTIVE SERVICES

COMMUNICATING WITH CAREGIVERS

This is an emotionally charged situation. Expect caregivers to be upset, angry. Acknowledge and validate these emotions. Always ensure your own safety (have another healthcare provider with you, make sure you have ready access to an exit, have hospital police/security present). These discussions are best handled with/by the attending with Social Work involvement.

COMMUNICATING WITH INVESTIGATORS

These can be medically complex situations. Do not expect investigators to fully understand the significance of the injuries or the medical evaluation. It is best to be simple and clear by listing the injuries, medical evaluation planned, and potential causes and prognosis. Investigators may under or
over respond to what you perceive as the level of seriousness. If being discharged, follow-up plans, appointments and medications need to be carefully spelled out so the investigators and the hospital
team can assure proper follow-up. Discussions with investigators are best left to the Attending and Social Work to prevent miscommunications which could severely affect the investigation and safety of the child and family.