Child Abuse and Neglect 5 Hr

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PURPOSE

The purpose of this course is to educate and reinforce the knowledge of Nurses; ARNP, RN, LPN, Therapists and CNA /HHA who are working in the health care environment, as well as other students/ individuals regarding Child Abuse and Neglect, strategies for recognizing and preventing abuse, clinical manifestation of abuse, risk factors associated with child abuse, interventions, education campaigns to prevent abuse, review of some ways in which Pediatricians and other health professionals can screen for child abuse. This course also provides a review of laws regarding child abuse, neglect, dependency and physical injury; who should report, when to report to the Department for Community Based Services, review of the 72hr hold by physicians and hospital administrators and review of the emergency custody order (ECO) and what to expect after making a report.

OBJECTIVES/ GOALS:

After successful completion of this course the Professionals /students will be able to:

1. Define child abuse and Neglect
2. Discuss Pediatric Abusive head trauma (shaken baby syndrome) and preventative strategies.
3. Describe clinical manifestation of abuse
4. Discuss strategies for recognition abuse
5. Discuss laws regarding child abuse, neglect, dependency and physical injury
6. Discuss risk factors associated with child abuse
7. Discuss strategies and interventions, education campaigns to prevent abuse
8. Describe some ways in which Pediatricians and other health professionals can screen for child abuse.

INTRODUCTION

CHILD ABUSE

According to Florida Statutes chapter 827:

827.03 Abuse, aggravated abuse, and neglect of a child;

(a) “Aggravated child abuse” occurs when a person:

1. Commits aggravated battery on a child;
2. Willfully tortures, maliciously punishes, or willfully and unlawfully cages a child; or
3. Knowingly or willfully abuses a child and in so doing causes great bodily harm, permanent disability, or permanent disfigurement to the child.

(b) “Child abuse” means:

1. Intentional infliction of physical or mental injury upon a child;
2. An intentional act that could reasonably be expected to result in physical or mental injury to a child; or
3. Active encouragement of any person to commit an act that results or could reasonably be expected to result in physical or mental injury to a child.

(c) “Maliciously” means wrongfully, intentionally, and without legal justification or excuse. Maliciousness may be established by circumstances from which one could conclude that a reasonable parent would not have engaged in the damaging acts toward the child for any valid reason and that the primary purpose of the acts was to cause the victim unjustifiable pain or injury.

(d) “Mental injury” means injury to the intellectual or psychological capacity of a child as evidenced by a discernible and substantial impairment in the ability of the child to

function within the normal range of performance and behavior as supported by expert testimony.

(e) "Neglect of a child" means:

1. A caregiver's failure or omission to provide a child with the care, supervision, and services necessary to maintain the child's physical and mental health, including, but not limited to, food, nutrition, clothing, shelter, supervision, medicine, and medical services that a prudent person would consider essential for the well-being of the child; or

2. A caregiver's failure to make a reasonable effort to protect a child from abuse, neglect, or exploitation by another person.

Except as otherwise provided in this section, neglect of a child may be based on repeated conduct or on a single incident or omission that results in, or could reasonably be expected to result in, serious physical or mental injury, or a substantial risk of death, to a child.

According to the Centers For Disease Control and Prevention (CDC);

Prevalence: 1 in 4 children suffer abuse.

- An estimated 702,000 children were confirmed by child protective services were victims of abuse and neglect (2014).
- At least 1 in 4 children have experienced child neglect or abuse (including physical, emotional, and sexual) at some point in their lives, and 1 in 7 children experienced abuse or neglect in the last year.

THE EFFECTS

Child abuse and/ or neglect affect the children now and later in life. Often resulting in:

- Improper brain development
- Blindness from head trauma,
- cerebral palsy from head trauma
- Lower language development
- Anxiety
- Impaired cognitive/ learning ability and social and emotional skills
- Higher risk for heart, lung and liver diseases,
- Higher risk for high blood pressure, obesity and high cholesterol
- Smoking,
- Alcoholism
- Drug abuse

PHYSICAL EFFECTS

The Centers For Disease Control and Prevention (CDC) reports that:

- In 2014, approximately 1,580 children died from abuse and neglect across the country (a rate of 2.13 deaths per 100,000 children).

- Children may experience severe or fatal head trauma as a result of abuse. Nonfatal consequences of abusive head trauma include various degrees of visual impairment (for example blindness), motor impairment (for example cerebral palsy) and cognitive impairments.

- Abuse and neglect during infancy and/ or early childhood can result in regions of the brain forming and functioning improperly with long-term consequences on cognitive and language abilities, mental health and socioemotional development.

- Children who experience abuse and neglect are also at increased risk for adverse health effects and certain chronic diseases as adults, including heart disease, chronic lung disease, liver disease, obesity, high blood pressure, and high cholesterol and other diseases/abnormalities.

PSYCHOLOGICAL EFFECTS

According to the Centers For Disease Control and Prevention (CDC), in one long-term study, as many as 80% of young adults who had been abused met the diagnostic criteria for at least 1 psychiatric disorder at age 21.

These young adults exhibited many problems, including:

Depression,

Anxiety,

Eating disorders,

Suicide attempts.

The stress due to chronic abuse may lead to anxiety and may make the individuals (victims) more vulnerable to issues/problems, for example;

- Post-traumatic stress disorder (PTSD),
- conduct disorder,
- learning difficulties,
- attention difficulties,
- memory difficulties.

BEHAVIORAL EFFECTS

Studies have found that abused and neglected children are at least 25% more likely to experience problems such as teen pregnancy, low academic achievement and delinquency.

According to the Centers For Disease Control and Prevention (CDC), a longitudinal study found that physically abused children were at greater risk of being arrested as juveniles, being a teen parent, and less likely to graduate high school.

Children who experience abuse and neglect; as adults they are at high risk for:

- Smoking
- Alcoholism
- Drug abuse
- Engaging in high risk sexual behaviors.

Individuals with a history of child abuse and neglect are 1.5 times more likely to use illicit drugs, especially marijuana.

According to the Centers For Disease Control and Prevention (CDC), a National Institute of Justice study indicated that being abused or neglected as a child, increased the likelihood of being arrest as a juvenile by 59%. Abuse and neglect also increased the likelihood of adult criminal behavior by 28% and violent crimes by 30%.

ECONOMIC EFFECTS

The CDC reported that the total lifetime economic burden resulting from new cases of fatal and nonfatal child abuse and neglect in the United States in 2008 is approximately $124 billion in 2010 dollars.

The estimated average lifetime cost per victim of nonfatal child abuse and neglect was $210,012 (in 2010 dollars), including:

- Child welfare cost
- Childhood health care cost
- Adult medical cost
- Productivity loss
- Criminal justice cost
- Special education cost

The estimated average lifetime cost per death is $1,272,900, including productivity losses and medical costs.

Research recommends that the benefits of effective prevention likely outweigh the costs of child abuse and neglect.

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INDICATORS OF ABUSE, NEGLECT AND DEPENDENCY

Some forms of abuse and/or neglect are sometimes more difficult to detect than others, but there are always signs or indicators which, may suggest that a child is in need of help.

NEGLECT

Kentucky defines neglect as inadequate or dangerous child-rearing practices. You may not see visible signs, and it usually occurs over a period of time. Neglect is the failure or lack of prudent care for a child's well-being through lack of adequate food, supervision, clothing, medical care, shelter or education.

Some examples include:

- Denying the child of the necessities of life, such as clothing, water, food.
- Lack of proper supervision
- Abandonment
- Failure to see that the child attends school
- Denial of medical treatment
- Failure to thrive
- Malnutrition.

SOME INDICATORS INCLUDE:

PHYSICAL

- Lack of adequate supervision
- Lack of safe, sanitary shelter
- Abandonment
- Lack of necessary dental or medical care
- Lack of good care/ hygiene
- Lack of adequate food/ nutrition.

BEHAVIORAL

- Poor attendance at school
- Falling asleep in school
- Failure to thrive among infants
- Chronic fatigue or hunger
- Begging food from other children
- stealing food from other children
- Engaging in sexual behavior/ conduct
- Parent/caregiver abusing alcohol or drugs

PHYSICAL ABUSE

Physical abuse is the injury by other than accidental means of a child under 18 years of age which is the result of actions by a parent, guardian, or other designated (temporary or permanent) caregiver.

SOME EXAMPLES INCLUDE:

- Hitting
- Kicking
- Biting
- Harmful restraints such as choking
- Beating such as repeated hits, blows
- Use of weapons or instruments
- Action leading to substantial pain

SOME INDICATORS INCLUDE:

PHYSICAL

- Injuries to the head with absence of hair noted, bruising beneath scalp, excessive vomiting, subdural hematoma, jaw fracture or nasal fracture, and retinal hemorrhage.
- Bruises on the body, with unusual pattern, in different stages of healing, or on the infant.
- Fractures /broken bones
- Pattern of injury that reflects the use of an object for example a paddle or an extension cord.

- Burns note from cigarette, immersion, rope, dry burn caused by an iron or other types of electrical appliances.

- Loosened or missing teeth

- Abrasions and lacerations observed on the eyes, lips, any part of the infant's face, on gum tissues; from forcing feedings or on the external genitals.

- Internal injury leading to duodenal hematoma, ruptured inferior vena cava, and peritonitis due to the hitting or kicking.

A child who has been abused severely and frequently, at an early age may exhibit low profile behaviors/ characteristics such as:

BEHAVIORAL

- Fearful/afraid of physical contact
- Lack curiosity
- Excessively self-controlled
- May appear to be autistic
- May be overly compliant to avoid any confrontation
- Enjoy little or nothing.

The children who are less severely or less frequently abused, and are a little older at onset, may exhibit some of the following behavioral characteristics:

- Frightened easily, timid.

- Experience language delay.

- Have psychosomatic complaints, for example vomiting and enuresis

- Experience difficulty with school
- Craving affection
- Assume the role of parent in the parent-child relationship or
- Is extremely mature in parent-child interactions.
- Show indiscriminate attachment to strangers (without careful judgment).

For children who are mildly or infrequently abused at an older age may be more likely to exhibit the following characteristics:

- Show rage / violent anger temper tantrums
- Hurt other children
- Show extreme aggressiveness
- Severe personal problems, for example alcoholism, drug addiction, mental illness
- Social isolation of family
- Developmentally delayed
- Child seen as different or seen as difficult
- Parental characteristics stemming from own childhood abuse
- Parents unaware of appropriate behavior for child/children at given age.

CHARACTERISTICS OF ABUSIVE PARENTS

- Rigidity
- compulsiveness
- Fear of authority
- Poor self-concept
- Hostility
- Aggressiveness
- Undue fear of spoiling child /children
- Believe harsh physical discipline is necessary
- Unreasonable expectations for child/ children
- Emotional dependency of non-abusive spouse so that he/she will not intervene and will protect the abusive spouse
- Lack skills to meet their own emotional need (s).
- Accept violence as a means of communication

RISK FACTORS ASSOCIATED WITH CHILD ABUSE

According to the Centers For Disease Control and Prevention (CDC), child abuse and neglect is associated with several risk factors. Risk for child abuse and neglect perpetration and victimization is influenced by a number of individual, family, and environmental factors, all of which interact to increase or decrease risk over time and within specific contexts (CDC 2016).

Risk factors for victimization include:

- Child age and special needs that may increase caregiver burden such as intellectual and developmental disabilities, mental health issues, and chronic physical diseases/illnesses.

Risk factors for perpetration include:

- Young parents/ parental age,
- Many dependent children,
- low parental income,
- parent with substance abuse,
- parent with mental health issues,
- single parent family,
- parental history of abuse or neglect,
- social isolation,
- family disorganization,
- parenting stress(es),

- intimate partner violence IPV),
- poor parent-child relationship,
- community violence,

Also concentrated neighborhood disadvantage such as:

- High poverty
- high unemployment rates
- Residential instability.

PROTECTIVE FACTORS

Factors that protect the children or buffer children from being abused or neglected are referred to as protective factors. Social networks and supportive family environments consistently emerge as protective factors also other factors for example adequate housing, parents employment, access to health care and social service(s) may also serve to protect against child abuse and neglect.

CHILD GROWTH AND DEVELOPMENT

What is Normal as the child grows?

As the children grow older, they will develop in several different ways. Child development includes:

- Physical changes,
- Intellectual changes,
- Social changes,
- Emotional changes.

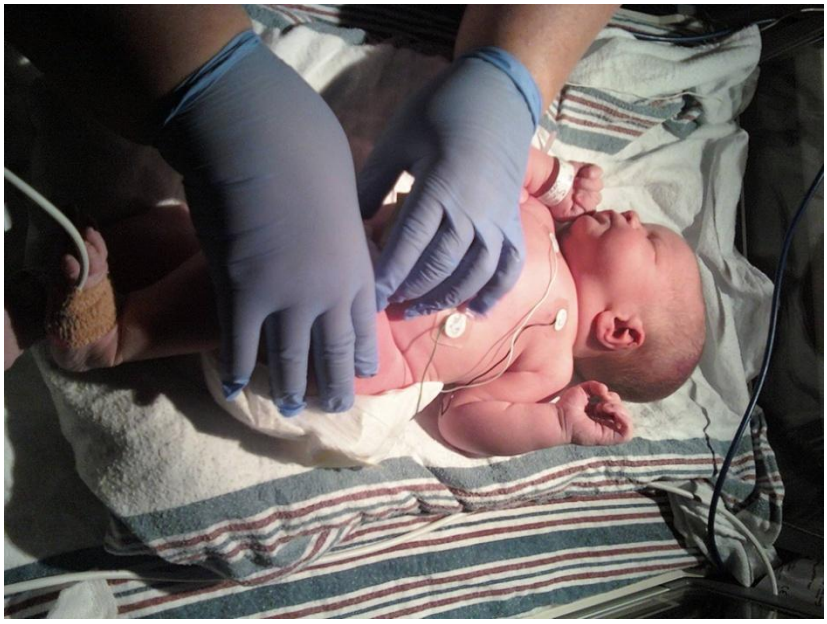
Children will also grow and mature at different rates. There will be differences in weight, height and build among the children. Some factors that are involved include:

- Diet,
- Genes and
- Exercise.

A child's growth and development can be divided into 4 periods:

- Infancy
- Preschool years
- Middle childhood years
- Adolescence

Shortly after birth, infants normally lose about five percent to ten percent of their birth weight. However, by about 2 weeks old, the infant should start to gain weight and develop quickly.



By age 4 - 6 months, the infant's weight should be double the birth weight and during the second half of the first year, growth is not as fast.

Between the ages of 1 – 2, a toddler may gain only about 5 pounds and weight gain may remain about 5 pounds per year between the ages of 2 - 5.

Between the ages of 2 - 10 years, a child should continue to grow at a steady pace. Then the final growth spurt begins at the beginning of puberty; which is sometime between the ages of 9 and 15.

NUTRIENT NEEDS

The nutrient/ nutritional needs of the children correspond with the changes in growth rates;

The infant needs more calories in relation to size than a preschooler or school-age child needs. Nutrient need increases again as the child grows closer to adolescence.

A healthy child will follow a growth curve, even though the nutrient intake may be different for every child.

Caregivers, parents and guardians need to provide a diet with a wide variety of foods/ nutritional intake that is suited to the children's age. Healthy eating habits needs to start during infancy.

This will help to prevent disorders or diseases for example;

- High blood pressure,
- Type 2 diabetes,

- Obesity
- Problems with intellectual development.

INTELLECTUAL DEVELOPMENT AND DIET

Poor nutrition can contribute to problems with the children's intellectual development. Children with poor nutritional intake may become tired and not able to learn while they are at school.

Poor nutritional intake may also cause the children to become more susceptible to illness and when they are ill they will miss days of school.

Breakfast has been published as very important factor to start your day. This is also true for the children. The children who do not eat a good

breakfast may feel fatigued, tired or lack energy or motivation to start the day or to participate in normal activities.

There are now government programs in place to ensure that each child has at least one healthy, nutritional /balanced meal each day. This meal is usually the breakfast, because the relationship between breakfast and improved learning has been clearly shown. Programs are available in underserved and poor areas within the United States of America.

Developmental milestones record for the 4 month old

Typical 4-month-old infants are expected to develop certain physical and mental skills (milestones).

PHYSICAL AND MOTOR SKILLS

The typical 4-month-old baby should:

- Weigh 2 times more than their birth weight
- Have almost no head droop while in a sitting position
- Be able to sit straight if propped up
- Raise head 90 degrees when placed on stomach
- Be able to roll from front to back
- Hold and let go of an object

- Play with a rattle when it is placed in their hands, but will not be able to pick it up if dropped
- Be able to grasp a rattle with both hands
- Be able to place objects in the mouth
- Sleep 9 to 10 hours at night with 2 naps during the day (total of 14 to 16 hours per day)

SENSORY AND COGNITIVE SKILLS

A 4-month-old baby is expected to:

- Have well-established close vision
- Increase eye contact with parents and others
- Have beginning hand-eye coordination
- Be able to coo
- Be able to laugh out loud
- Anticipate feeding when able to see a bottle (if bottle-fed)
- Begin to show memory
- Demand attention by crying/ fussing
- Recognize parent's voice or touch

PLAY

Encourage development through play:

- Place the baby in front of a mirror.
- Provide bright-colored toys to hold.
- Repeat sounds the infant makes.
- Help the infant roll over.
- Play on the stomach

Developmental milestones record - 9 months

At 9 months, a typical infant will have certain skills and reach growth markers (milestones).

PHYSICAL CHARACTERISTICS AND MOTOR SKILLS

A 9-month-old has usually reached the following milestones:

- Gains weight at a slower rate, about 15 grams (half an ounce) per day, 1 pound per month
- Increases in length by 1.5 centimeters (a little over one-half inch) per month
- Bowel and bladder become more regular
- Puts hands forward when the head is pointed to the ground (parachute reflex) to protect self from falling
- Is able to crawl
- Sits for long periods
- Pulls self to standing position
- Reaches for objects while sitting
- Bangs objects together
- Can grasp objects between the tip of the thumb and index finger
- Feeds self with fingers
- Throws or shakes objects

SENSORY AND COGNITIVE SKILLS

The 9-month-old typically:

- Babbles
- Has separation anxiety and may cling to parents
- Is developing depth perception
- Responds to simple commands
- Responds to name
- Understands the meaning of no
- Imitates speech sounds
- May be afraid of being left alone
- Plays interactive games, such as peek-a-boo and pat-a-cake
- Waves bye

PLAY

To help the 9-month-old develop:

- Provide picture books.

- Provide different stimuli by going to the mall to see people, or to the zoo to see animals.
- Build vocabulary by reading and naming people and objects in the environment.
- Teach hot and cold through play.
- Provide large toys that can be pushed to encourage walking.
- Sing songs together.
- Avoid television time until age 2.
- Try using a transition object to help decrease separation anxiety.

Developmental milestones record - 12 months

The typical 12-month-old child will demonstrate certain physical and mental skills (developmental milestones).

PHYSICAL AND MOTOR SKILLS

A 12-month-old child is expected to:

- Be 3 times their birth weight
- Grow to a height of 50% over birth length
- Have a head circumference equal to that of their chest
- Have 1 to 8 teeth
- Stand without holding on to anything
- Walk alone or when holding 1 hand

- Sit down without help
- Bang 2 blocks together
- Turn through the pages of a book by flipping many pages at a time
- Pick up a small object using the tip of their thumb and index finger
- Sleep 8 to 10 hours a night and take 1 to 2 naps during the day.

SENSORY AND COGNITIVE DEVELOPMENT

The typical 12-month-old:

- Begins pretend play (such as pretending to drink from a cup)
- Follows a fast moving object
- Responds to their name
- Can say momma, papa, and at least 1 or 2 other words
- Understands simple commands
- Tries to imitate animal sounds
- Connects names with objects
- Understands that objects continue to exist, even when they cannot be seen
- Participates in getting dressed (raises arms)
- Plays simple back and forth games (ball game)
- Points to objects with the index finger

- Waves bye
- May develop attachment to a toy or object
- Experiences separation anxiety and may cling to mom and/or dad
- May make brief journeys away from parents to explore in familiar settings.

PLAY

You can help the 12-month-old develop skills through play such as:

- Provide picture books.
- Provide different stimuli, such as going to the mall or zoo.
- Play ball.
- Build vocabulary by reading and naming people and objects in the environment.
- Teach hot and cold through play.
- Provide large toys that can be pushed to encourage walking.
- Sing songs.
- Have a play date with a child of a similar age.
- Avoid television and other screen time until age 2.
- Try using a transitional object to help with separation anxiety.

DEVELOPMENTAL MILESTONES RECORD - 18 MONTHS

The typical 18-month-old child will demonstrate certain physical and mental skills/ developmental milestones.

PHYSICAL AND MOTOR SKILL MARKERS

The typical 18-month-old:

- Has a closed soft spot on the front of the head
- Is growing at a slower rate and has less of an appetite compared to the months before
- Is able to control the muscles used to urinate and have bowel movements, but may not be ready to use the toilet
- Runs stiffly and falls often
- Is able to get onto small chairs without help
- Walks up stairs while holding on with 1 hand
- Can build a tower of 2 to 4 blocks
- Can use a spoon and cup with help to feed self
- Imitates scribbling
- Can turn 2 or 3 pages of a book at a time.

SENSORY AND COGNITIVE MARKERS

The typical 18-month-old:

- Shows affection
- Has separation anxiety
- Listens to a story or looks at pictures
- Can say 10 or more words when asked
- Kisses parents with lips puckered
- Identifies 1 or more parts of the body
- Understands and is able to point to and identify common objects
- Often imitates
- Is able to take off some clothing items, such as gloves, hats, and socks
- Begins to feel a sense of ownership, identifying people and objects by saying – MY.

PLAY

- Encourage and provide the necessary space for physical activity.
- Provide safe copies of adult tools and equipment for the child to play with.

- Allow the child to help around the house and participate in the family's daily responsibilities.
- Encourage play that involves building and creativity.
- Read story/ books to the child.
- Encourage play dates with children of the same age.
- Avoid television and other screen time before age 2.
- Play simple games together, such as puzzles and shape sorting.
- Use a transitional object to help with separation anxiety.

Developmental milestones record - 2 years

Physical and motor skill markers:

- Able to turn a door knob
- Can look through a book turning one page at a time
- Can build a tower of 6 to 7 cubes
- Can kick a ball without losing balance
- Can pick up objects while standing, without losing balance (This often occurs by 15 months. It is a cause for concern if not seen by 2 years).
- Can run with better coordination (May still have a wide stance).
- May be ready for toilet training
- Should have the first 16 teeth (The actual number of teeth can vary widely).

- At 24 months, will reach about half final adult height

SENSORY AND COGNITIVE MARKERS:

- Able to put on simple clothing without help (often better able to remove clothing than putting them on)
- Able to communicate needs such as thirst, hunger, need to go to the bathroom
- Can organize phrases of 2 - 3 words
- Can understand 2-step command
- Has increased attention span
- Vision is fully developed
- Vocabulary has increased to about 50 - 300 words (Healthy children's vocabulary can vary widely.)

Play recommendations:

- Allow the child to help around the house and take part in the daily family chores.
- Encourage active play and provide enough space for healthy physical activity.
- Encourage play that involves building and creativity.
- Provide safe copies of adult tools and equipment. Many children like to mimic activities such as cutting the grass or sweeping the floor.
- Read books to the child.

- Television: control both the content and quantity of television viewing. Limit screen time to less than 3 hours per day. One hour or less is better. Avoid programming with violent content. Redirect the children to reading or play activities.

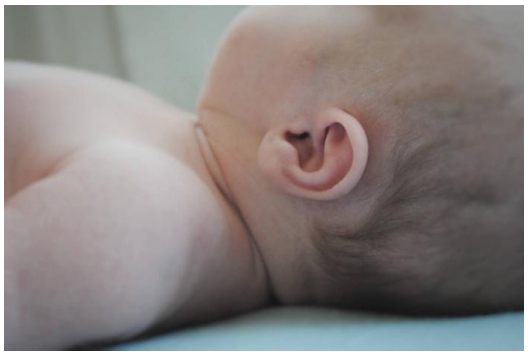
- Control the type of games the child plays.

PREVENTING CHILD ABUSE

As mentioned before, child abuse and neglect is preventable. There has be many approaches, education/ teaching and progress that has been made in understanding prevention of child abuse and neglect.

The prevention of child abuse and neglect requires a comprehensive focus that involves key sectors of the society such as government, social services, public health, education, and justice. There is also a vital need to increase the capacity of local and state governments to implement more effective interventions that can assist in reducing and preventing child abuse and neglect.

PEDIATRIC ABUSIVE HEAD TRAUMA "SHAKEN BABY SYNDROME"



Pediatric Abusive head trauma (shaken baby syndrome) is a preventable and severe form of physical child abuse that results in an injury to the brain of a baby/ infant or child.

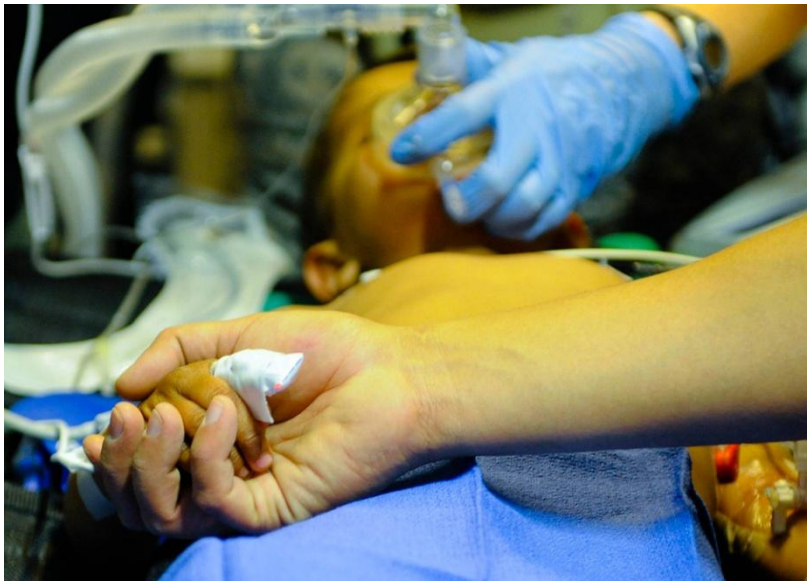
Abusive head trauma is most often seen in children under age 5, with children under 1 year of age at most risk. The resulting injury can lead to bleeding around the brain or on the inside back layer of the eyes.

Nearly all victims of Abusive head trauma suffer serious, long-term health consequences for example problems with vision, physical disabilities, developmental delays and hearing loss.

At least 1 of every 4 babies who experience Abusive head trauma dies from this form of child abuse.

RESEARCH

Research has shown that Abusive head trauma frequently occurs when a parent or caregiver becomes frustrated or angry because of the child's crying. The caregiver/parent then shakes the child and/or slams or hits the child's head into something in an effort to stop the child from crying. Teach /remind parents and caregivers that crying, which includes long bouts of inconsolable crying, is normal behavior in babies/infants.



PREVENTING ABUSIVE HEAD TRAUMA

There are various ways in which abusive head trauma can be prevented, individuals can play an important role in preventing Abusive head trauma by:

- Being aware of / knowing the risk factors for abuse,
- Being aware of / knowing the triggers for abuse,
- Understanding the dangers of violently shaking or hitting a baby's head into something,
- Finding ways to support / assist the parents and the caregivers within the community.

EDUCATE / TEACH PARENTS AND CAREGIVERS

Teach/ remind parents and caregivers to:

Try calming a crying baby by rocking gently, offering a pacifier, singing or talking softly, taking a walk with a stroller, or going for a drive in the car.

Seek support by calling a relative, friend, neighbor, or parent helpline for support.

Contact the physician; if the baby will not stop crying, check for signs of illness and call the physician if suspect the child is sick.

Understand that infant crying is normal and is often worse in the first few months of life, but it will get better as the infant /child grows.

Calm down; if getting upset or losing control, focus on calming down. It is recommended to put the baby in a safe place and walk away to calm down, but check on the baby every five to ten minutes.

Never leave the baby with an individual who has a history of violence.

Never leave the baby with an individual who is easily agitated or has a temper.

FOR INDIVIDUALS WHO ARE FRIENDS, FAMILY MEMBER, OR OBSERVER OF A PARENT OR CAREGIVER:

Be aware of new parents in your family and within the community who may need help / support.

Let the parent know that dealing with a crying baby can be very frustrating, especially when they are tired or stressed, but infant crying is normal and it will get better soon.

Provide support by offering to give a parent or caregiver a helping hand or a break when needed.

Encourage parents and caregivers to take a calming break if needed while the baby is safe in the crib.

Be supportive of work policies such as paid family leave, that will make it easier for working parent to stay with their baby during the period of increased infant crying, which is between 4-20 weeks of age.

Be sensitive and supportive in situations when parents are trying to calm a crying baby.

ESTABLISHING DIAGNOSIS

Various physicians have contributed to the scientific data that support Abusive Head Trauma as an established medical diagnosis.

Physicians from fields such as:

- Pediatrics,
- neurology,
- neurosurgery,
- ophthalmology,
- critical care medicine,
- radiology,
- neuroradiology,
- physiatry - (*physiatrists* treat a wide variety of medical conditions which affects the brain, spinal cord, nerves, joints, bones, ligaments, muscles, and tendons).

The clinical diagnosis of Abusive Head Trauma (AHT) has also been confirmed by pathologists, forensic pathologists, and neuropathologists through postmortem research and autopsies.

As mentioned before some of the injuries seen in infants and toddlers with Abusive Head Trauma may include:

- Blunt impact to the head
- Retinal hemorrhages - bleeding on the back surface of the eyes.
- subdural hemorrhages- bleeding over the surface of the brain
- Brain swelling
- Injuries to the white matter of the brain
- Other evidence of physical abuse, such as abdominal injuries, bruises, and recent fractures or healing fractures /broken bones.

CONDUCTING THOROUGH EVALUATIONS

Physicians - child abuse pediatricians and other physicians are trained to conduct a thorough assessment/ evaluation for child abuse, accidental injuries, and also other possible causes of the findings that is seen in each infant/ child.

Hospitals throughout the country treat hundreds of babies /infants and young children who sustain life threatening abusive head trauma. Sometimes the victims of abusive head trauma also present with additional injuries.

The United States government estimates that about 30 children, younger than 1year of age per 100,000, are injured from abusive head trauma (AHT), resulting in at least 1200 seriously injured infants and at least 80 deaths each year.

It is reported that the most common incident leading to abusive head injury is “infant crying”.

Published reports of some cases of abusive head trauma (AHT) detailed that the adult who was caring for the infant admitted to harming the infant. Some parents have confessed that they have shaken the infant on more than one occasion, which lead to the injuries that physicians identify in cases of AHT. These reports confirm the published clinical findings.

The Centers For Disease Control and Prevention (CDC) reported that serious traumatic brain injury in young children is largely the result of abuse.

Applied accurately and consistently, the recently validated, 4-variable clinical prediction rule (CPR) could theoretically improve the accuracy of AHT screening in PICU settings (NIH.gov 2016).

There are states that offer programs that are developed to remind parents/ new parents of various techniques to quiet their baby/infant, reduce their own stresses, and avoid hurting their baby/ infant.

FLORIDA STATUTES

According to Florida Statutes chapter 827:

827.03 Abuse, aggravated abuse, and neglect of a child; penalties;

(1) DEFINITIONS.—As used in this section, the term:

(a) "Aggravated child abuse" occurs when a person:

1. Commits aggravated battery on a child;

2. Willfully tortures, maliciously punishes, or willfully and unlawfully cages a child; or

3. Knowingly or willfully abuses a child and in so doing causes great bodily harm, permanent disability, or permanent disfigurement to the child.

(b) "Child abuse" means:

1. Intentional infliction of physical or mental injury upon a child;

2. An intentional act that could reasonably be expected to result in physical or mental injury to a child; or

3. Active encouragement of any person to commit an act that results or could reasonably be expected to result in physical or mental injury to a child.

(c) "Maliciously" means wrongfully, intentionally, and without legal justification or excuse. Maliciousness may be established by circumstances from which one could conclude that a reasonable parent would not have engaged in the damaging acts toward the child for any valid reason and that the primary purpose of the acts was to cause the victim unjustifiable pain or injury.

(d) "Mental injury" means injury to the intellectual or psychological capacity of a child as evidenced by a discernible and substantial impairment in the ability of the child to function within the normal range of performance and behavior as supported by expert testimony.

(e) "Neglect of a child" means:

1. A caregiver's failure or omission to provide a child with the care, supervision, and services necessary to maintain the child's physical and mental health, including, but not limited to, food, nutrition, clothing, shelter, supervision, medicine, and medical services that a prudent person would consider essential for the well-being of the child; or

2. A caregiver's failure to make a reasonable effort to protect a child from abuse, neglect, or exploitation by another person.

Except as otherwise provided in this section, neglect of a child may be based on repeated conduct or on a single incident or omission that results in, or could reasonably be expected to result in, serious physical or mental injury, or a substantial risk of death, to a child.

(2) OFFENSES

(a) A person who commits aggravated child abuse commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) A person who willfully or by culpable negligence neglects a child and in so doing causes great bodily harm, permanent disability, or permanent disfigurement to the child commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) A person who knowingly or willfully abuses a child without causing great bodily harm, permanent disability, or permanent disfigurement to the child commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(d) A person who willfully or by culpable negligence neglects a child without causing great bodily harm, permanent disability, or permanent disfigurement to the child commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(3) EXPERT TESTIMONY;

(a) Except as provided in paragraph (b), a physician may not provide expert testimony in a criminal child abuse case unless the physician is a physician licensed under chapter 458 or chapter 459 or has obtained certification as an expert witness pursuant to s. 458.3175 or s. 459.0066.

(b) A physician may not provide expert testimony in a criminal child abuse case regarding mental injury unless the physician is a physician licensed under chapter 458 or chapter 459 who has completed an accredited residency in psychiatry or has obtained certification as an expert witness pursuant to s. 458.3175 or s. 459.0066.

(c) A psychologist may not give expert testimony in a criminal child abuse case regarding mental injury unless the psychologist is licensed under chapter 490.

(d) The expert testimony requirements of this subsection apply only to criminal child abuse cases and not to family court or dependency court cases.

CLICK ON LINKS:

FLORIDA

FLORIDA DEPT OF CHILDREN & FAMILIES

ALABAMA

CHILD ABUSE/ NEGLECT REPORTING

GEORGIA

GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES

Child Protective Services staff investigates reports of **child abuse or neglect** and provides services to protect the child and strengthen the family… follow link above for contact and additional information.

DISTRICT OF COLUMBIA

CHILD AND FAMILY SERVICES

OHIO

OFFICE OF FAMILY AND CHILDREN

SOUTH CAROLINA

SOUTH CAROLINA LEGISLATURE

NEW YORK

NEW YORK – OFFICE OF CHILDREN AND FAMILY SERVICES

STATE OF KENTUCKY

According to Kentucky (KRS 600.020):

DEFINITIONS OF CHILD ABUSE, NEGLECT AND DEPENDENCY states:

(1) Abused or neglected child means a child whose health or welfare is harmed or threatened with harm when his parent, guardian, or other person exercising custodial control or supervision of the child:

(a) Inflicts or allows to be inflicted upon the child physical or emotional injury as defined in this section by other than accidental means;

(b) Creates or allows to be created a risk of physical or emotional injury as defined in this section to the child by other than accidental means;

(c) Engages in a pattern of conduct that renders the parent incapable of caring for the immediate and ongoing needs of the child including, but not limited to, parental incapacity due to alcohol and other drug abuse as defined in KRS 222.005(12);

(d) Continuously or repeatedly fails or refuses to provide essential parental care and protection for the child, considering the age of the child;

(e) Commits or allows to be committed an act of sexual abuse, sexual exploitation, or prostitution upon the child;

(f) Creates or allows to be created a risk that an act of sexual abuse, sexual exploitation, or prostitution will be committed upon a child;

(g) Abandons or exploits the child;

(h) Does not provide the child with adequate care, supervision, food, clothing, shelter, education or medical care necessary for the child's well-being. A parent or other person exercising custodial control or supervision of the child legitimately practicing the person's religious beliefs shall not be considered a negligent parent solely because of failure to provide specified medical treatment for a child for that reason alone. This exception shall not preclude a court from ordering necessary medical services for a child; or

(i) Fails to make sufficient progress toward identified goals as set forth in the court approved case plan to allow for the safe return of the child to the parent that results in the child remaining committed to the Cabinet and remaining in foster care for fifteen (15) of the most recent twenty-two (22) months; KRS 600.020(19) states: "Dependent child" means any child, other than an abused or neglected child, who is under improper care, custody, control, or guardianship that is not due to an intentional act of the parent, guardian, or person exercising custodial control or supervision of the child."

DEPENDENCY A Dependent Child is one who is not receiving proper care or supervision due to no fault of the parent. EXAMPLE: The parent is physically or mentally ill or injured

KENTUCKY LAW

There are many factors involved in defining child abuse and neglect. Cultural and ethnic backgrounds, attitudes concerning parenting and professional training all contribute to

an individual's definition. In seeking commonly acceptable definitions, it is helpful to distinguish between abuse and neglect.

In simplistic terms, ABUSE IS AN ACT OF COMMISSION, NEGLECT IS AN ACT OF OMISSION.

Kentucky law contains a definition of an abused or neglected child, which must be utilized in determining whether a situation is appropriate for investigation and services by the child protection program.

It is important to note that, for the situation to be appropriate for the Department for Community Based Services to investigate, the person who is the perpetrator of abuse or neglect must be the parent or guardian or have some type of supervisory responsibility for the child. This can include a babysitter, school teacher or day care center personnel, for example. In order to intervene in the lives of families there must be a legal basis for such intervention.

KENTUCKY - WHEN TO REPORT

When you have reason to believe a child is being abused, neglected or is dependent, call the child protection hotline at 1-877-597-2331 or your county Department for Community Based Services.

If in doubt, call and talk over what has come to your attention, so that help will be given to sort things out, such as whether a specific incident must be reported and to whom. When you feel that a child is in imminent danger or is in need of immediate protection, call 911 or your local police department. For example, a very young child or handicapped child who is left alone with no adult supervision needs immediate help.

Police officers can remove a minor from a threatening environment in order to protect the child if the child is in danger of imminent death or serious physical injury or is being sexually abused and the custodian is unable / unwilling to protect the child.
KRS 620.040(5)(c).

KENTUCKY- WHEN NOT TO REPORT

The state of Kentucky declares that:

Concerned citizens need to know they have a duty to report suspected child abuse. The Department for Community Based Services has the authority and the obligation to assure that reports meet the statutory definition of abuse, neglect, or dependency before a formal child protection investigation is set in motion.

In those cases where the referral is not clearly one of abuse, neglect, or dependency, but indicates service needs, the Department attempts to be responsive and find appropriate services. Some criteria for refusing reports are:

1. A specific act of abuse, neglect or dependency is not alleged, such as a generalized concern for the welfare of the child that does not state specific allegations reflecting child abuse or neglect. Examples are:

(a) A child who is improperly dressed, but the clothing deficiency does not result in harm to the child;

(b) A child who is provided nutritious food irregularly or insufficiently, but the health of the child is not impaired;

(c) Hygiene, that although not optimal, does not adversely affect the well-being of the child;

(d) Life-style issues, such as single parent who has several boy/girl friends with no allegations of abuse or neglect to the child;

(e) A small child who is ambulatory and who has minor marks in routine areas such as the knees and the reporter has no reason to believe the injuries were caused by abuse or neglect;

(f) Corporal punishment appropriate to the age of the child, without injuries, marks, bruises, or substantial risk of harm; or

(g) Reports that have insufficient information to locate the child.

KENTUCKY - WHERE TO REPORT

Reports of suspected child abuse or neglect may be made to a local police department, prosecutors or the Department for Community Based Services. To report child abuse and neglect committed by a parent, guardian, or person exercising custodial control or supervision of a child, contact the Department for Community Based Services at the toll-free child abuse hotline: (877) 597-2331. Calls will also be taken at the local county office.

RESOURCE LINKAGE NETWORK

Sometimes a concerned individual such as you will contact a local Protection and Permanency office with genuine concerns about a child's situation, only to be told that the report does not meet the agency's criteria for abuse, neglect or dependency. When it does not meet criteria the SSW can refer the family or the caller to needed resources. Reports of abuse or neglect committed by someone other than the parent, guardian or person exercising custodial control or supervision (such as a friend, neighbor, stranger, etc.) should be made to your local police department or prosecutors. When the Department for Community Based Services receives this type of report, it will be referred to the local police department.

KENTUCKY - WHO MUST REPORT

The law states that it is the duty of everyone who has reasonable cause to believe that a child is dependent, abused or neglected to report this information.

KRS 620.030 states:

(1) Any person who knows or has reasonable cause to believe that a child is dependent, neglected or abused shall immediately cause an oral or written report to be made to a local law enforcement agency or the Kentucky State Police; the Cabinet or its designated representative; the commonwealth’s attorney or the county attorney; by telephone or otherwise… In addition, the following persons may be required to submit a more detailed, written report:

(2) Any person, including but not limited to a physician, osteopathic physician, nurse, teacher, school personnel, social worker, coroner, medical examiner, child-caring personnel, resident, intern, chiropractor, dentist, optometrist, emergency medical

technician, paramedic, health professional, mental health professional, peace officer or any organization or agency for any of the above, who knows or has reasonable cause to believe that a child is dependent, neglected or abused, regardless of whether the person believed to have caused the dependency, neglect or abuse is a parent, guardian, person exercising custodial control or supervision or another person who has attended such child as a part of his professional duties…

KRS 620.030(1) also states: …Any supervisor who receives from an employee a report...shall promptly make a report to the proper authorities for investigation…

PRIVILEGED COMMUNICATION

KRS 620.050(2) further states:

Neither the husband-wife nor any professional-client or patient privilege, except the attorney-client and clergy-penitent privilege, shall be a ground for refusing to report under this section or for excluding evidence regarding a dependent, neglected or abused child or the cause thereof, in any judicial proceedings resulting from a report pursuant to this section.

This subsection shall also apply in any criminal proceedings in district or circuit court regarding a dependent, neglected or abused child. In other words, only attorneys who gather information from their clients and clergymen who in their capacity as a spiritual advisor who gather information privately from a penitent are exempt from the mandate to make a report based on such information.

IMMUNITY

Both civil and criminal immunity from prosecution are given to any person making a report or assisting legal authorities or the child protection program in making an assessment, as long as that person is acting in good faith.

KRS 620.050(1) states:

Anyone acting upon reasonable cause in the making of a report or acting under KRS 620.030 to KRS 620.050 in good faith shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed. Any such participant shall have

the same immunity with respect to participation in any judicial proceeding or resulting from such report or action. The law states that the failure to report or falsely reporting child abuse or neglect can result in criminal charges.

PENALTY FOR FAILURE TO REPORT

KRS 620.990(1) states: Any person intentionally violating the provisions of this chapter shall be guilty of a Class B misdemeanor. A class B misdemeanor carries a penalty of up to 90 days in jail and/or a fine of up to $250.

WHY REPORT TO THE DEPARTMENT FOR COMMUNITY BASED SERVICES

By legal mandate, child protection has a specialized role in working with children and their families. Briefly, the child protection program's responsibilities are to:

1. Respond promptly to reports of alleged neglect, abuse or exploitation of children to determine the validity of the report;

2. Assess the damage to children resulting from neglect, abuse or dependency;

3. Evaluate the risk of further harm to the child while in the home and whether the child should remain in the home while rehabilitative services are provided;

4. Determine and identify the family problem(s) which contributed to or resulted in neglect or abuse;

5. Evaluate the potential for treatment to correct conditions and rehabilitate the family;

6. Plan a course of treatment calculated to stabilize and rehabilitate the family through services of the Department for Community Based Services and the use of other appropriate community resources to meet special needs of the child(ren) and parents;

7. Initiate the treatment plan and stimulate involvement of services from community resources to meet identified special needs; and

8. Invoke the authority of the Juvenile Code in situations where treatment potential is minimal and where there is risk if the child remains at home. Fortunately, once help is offered, most families cooperate in a treatment plan. They receive help with parenting problems, health and financial problems, domestic violence, chemical dependency and other stressful situations that affect their family life.

WHAT THE DEPARTMENT FOR COMMUNITY BASED SERVICES NEEDS TO KNOW

When you call, we will need information that will allow us to identify the family, evaluate the problem and respond quickly and appropriately.

Will need to know what happened to the child and when.

How do you view this situation and what firsthand knowledge do you have?

Where is the child, and are you concerned about the child's safety now?

Will need the names and addresses of the parents or caretakers, if you have been involved with the family, or if you have made attempts to work with them on the problem. It is helpful if you can tell us how the parents responded to any attempt to help.

Although the answers to these questions are helpful, all of the questions do not have to be answered before making a report.

This is the essential information that will be needed from you:

1. The Child's Identity,

2. Any person believed to be responsible for the abuse or neglect to the child if the person is known

3. The nature and extent of the abuse or neglect,

4. The name and address of the reporter, if he or she so chooses

5. Where the child can be found.

WHAT TO EXPECT AFTER MAKING A REPORT

Due to the nature of reports, the first step taken by the Department for Community Based Services is to determine whether the referral meets the criteria for abuse, neglect, or dependency.

An investigation is conducted as soon as possible on all cases, but in cases where the child may be in imminent danger, a worker will investigate within the hour. Most cases will be initiated within 24-48 hours, depending upon the level of risk to the child. On abuse and neglect reports, the police may also investigate to see whether a crime is being committed or whether the children need to be removed for their safety.

KRS 431.600 requires that all child sexual abuse investigations be conducted jointly by the Department for Community Based Services and law enforcement. The establishment of local multi-disciplinary teams composed of professionals involved in such investigations, including DCBS, law enforcement, prosecutors, mental health professionals, and doctors who conduct child sexual abuse exams, is encouraged to provide a community response to ensuring the protection of the child while coordinating the delivery of service to the family.

If the family must be separated for the child's protection, it is our goal to reunite the family members under better circumstances. When it is possible, we have the children stay with relatives; this helps them maintain their family identity and makes the eventual transition back to their own home easier.

While the first priority is to protect children from abuse, neglect, or dependency, it is not the only goal. We want to help strengthen their family life by providing planned, goal oriented services, which will increase parental capacity for adequate child care. Services are developed both to help parents alleviate problems which may have been causing maltreatment of their children and to acquire better parenting knowledge and skills.

WHO CAN REMOVE CHILDREN FROM THEIR HOMES

An emergency custody order (ECO) must be obtained from the Court any time a child is removed from his or her home. An ECO may be requested in the following situations as defined by statue:

(1) The court for the county where the child is present may issue an ex parte emergency custody order when it appears to the court that removal is in the best interest of the child and that there are reasonable grounds to believe, as supported by affidavit or by recorded sworn testimony, that one (1) or more of the following conditions exist and that the parents or other person exercising custodial control or supervision are unable or unwilling to protect the child;

(a) The child is in danger of imminent death or serious physical injury or is being sexually abused;

(b) The parent has repeatedly inflicted or allowed to be inflicted by other than accidental means physical injury or emotional injury. This condition shall not include reasonable and ordinary discipline recognized in the community where the child lives, as long as reasonable and ordinary discipline does not result in abuse or neglect as defined in KRS 600.020(1); or

(c) The child is in immediate danger due to the parent's failure or refusal to provide for the safety and needs of the child.

KRS 620.060(1). KRS 620.040(5)(c) states:

Any appropriate law enforcement officer may take a child into protective custody and may hold that child in protective custody without the consent of the parent or other person exercising custodial control or supervision, if there exist reasonable grounds for the officer to believe that the child is in danger of imminent death or serious physical injury or is being sexually abused and that the parents or other person exercising custodial control or supervision are unable or unwilling to protect the child. The officer or the person to whom the officer entrusts the child shall, within twelve (12) hours of taking the child into such protective custody, request the court to issue an emergency custody order.

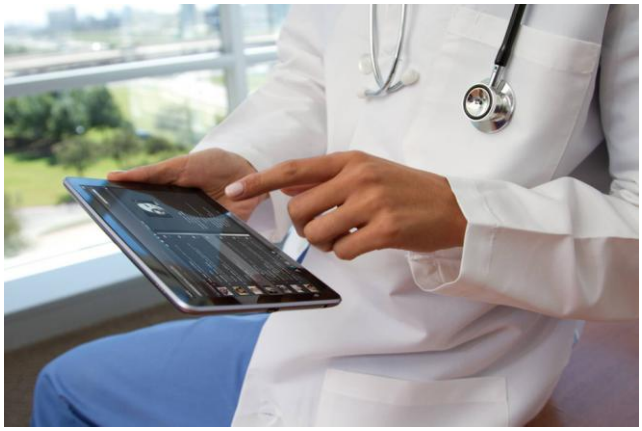
72-HOUR HOLD BY PHYSICIANS AND HOSPITAL ADMINISTRATORS

Although medical personnel may not take children into protective custody, they do have the right to hold a child whom they feel is in imminent danger.

KRS 620.040(5)(b) states: If a child who is in the hospital or under the immediate care of a physician appears to be in imminent danger if he is returned to the persons having custody of him, the physician or hospital administrator may hold a child without court order provided that a request is made to the court for an emergency custody order at the earliest practicable time, not to exceed seventy-two (72) hours.

INFORMATION ABOUT THE CASE

KENTUCKY State law prohibits the Cabinet for Health and Family Services from disclosing any confidential information about a case unless you are a person with a legitimate interest in receiving the information (as specified in KRS 620.050.)



CONFIDENTIALITY

The name of the person making a report is confidential with the exceptions outlined in KRS 620.050(11). The report of suspected child abuse, neglect, or dependency and all information obtained by the Cabinet or its delegated representative, as a result of an investigation made pursuant to this chapter, shall not be divulged to anyone except:

(a) Persons suspected of causing dependency, neglect or abuse;

(b) The custodial parent or legal guardian of the child alleged to be dependent, neglected or abused;

(c) Persons within the Cabinet with a legitimate interest or responsibility related to the case;

(d) Other medical, psychological, educational or social service agencies, child care administrators, corrections personnel or law enforcement agencies, including the county

attorney's office, the coroner, and the local child fatality response team, that have a legitimate interest in the case;

(e) A non-custodial parent when the dependency, neglect or abuse is substantiated;

(f) Members of multidisciplinary teams as defined by KRS 620.020 and which operate pursuant to KRS 431.600;

(g) Employees or designated agents of a children's advocacy center; or

(h) Those persons so authorized by court order. KRS 620.050(7) states: Nothing … shall prohibit a parent or guardian from accessing records for his or her child providing that the parent or guardian is not currently under investigation by a law enforcement agency or the cabinet relating to the abuse of a child.

TAKE EXAM

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