



Office for Children and Families

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# CHILD ABUSE AND NEGLECT

A reference for medical professionals  
Second Edition

## FACTS ABOUT CHILD ABUSE AND NEGLECT

- Child abuse and neglect cut across all class, cultural, and educational groups.
- Child abuse and neglect may be a cyclical or generational phenomenon.
- Child abuse and neglect are symptoms of family dysfunction or crisis.

## AN OPEN LETTER TO MEDICAL AND HEALTH PROFESSIONALS

As a member of the health profession, you may be the first professional to come into contact with a family where abuse or neglect is occurring. In many cases, the medical professional may be the only person who is in a position or is qualified to recognize and diagnose suspected child abuse and neglect. Under Ohio law, you are mandated to report any suspicion of abuse or neglect to your local Children Services Agency or law enforcement agency. The moral commitment you have made to your chosen profession also obligates your action. In order to begin the intervention necessary to protect the child and help the family, the medical and health professional must be knowledgeable in recognizing cases of child abuse and neglect and the proper methods of handling evaluation and referral. This booklet has been developed to address the most frequent child abuse and neglect issues which confront the medical and health professional.

We, in the Ohio Department of Job and Family Services, ask for your help in protecting Ohio's children through a close and cooperative working relationship among the medical, health, and children services professions. We urge you to contact other leaders in your community to promote professional education on the topic of child abuse and neglect.

This publication was funded by the Children's Justice Act grant funds, awarded to Ohio by the U.S. Department of Health and Human Services.

An online copy can be downloaded from the Ohio Department of Job and Family Services

<http://jfs.ohio.gov/>

or from Cincinnati Children's Hospital Web site

[www.cincinnatichildrens.org/Mayerson](http://www.cincinnatichildrens.org/Mayerson)

Editors: Shapiro, Robert Allan, MD and Makoroff, Kathi Lynn, MD  
Mayerson Center for Safe and Healthy Children, Cincinnati Children's Hospital Medical Center

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**General  
Information about  
Child Abuse and  
Neglect**

**1**

# HOW MUCH DO YOU KNOW ABOUT CHILD ABUSE AND NEGLECT?

1. Child abuse and neglect occur rarely.

True ☐ False ☒

2. Child abuse and neglect occur at about the same frequency.

True ☐ False ☒

3. Abused or neglected children may become abusive or neglectful parents.

True ☐ False ☒

4. Spanking and other types of physical discipline are wrong and considered to be child abuse.

True ☐ False ☒

5. The difference between abuse and neglect is that abuse represents an action against a child while neglect represents a lack of action for the child.

True ☐ False ☒

6. Abuse may be directed toward only one child in the family.

True ☐ False ☒

7. Neglect is most apt to involve children from infancy to six years of age.

True ☐ False ☒

8. Most abusive and neglectful parents suffer from mental illness.

True ☐ False ☒

9. Bruises on the elbows, knees, shins, or forehead are likely to be accidental in a preschooler.

True ☐ False ☒

10. Abused children usually will discuss the abuse in an effort to stop it.

True ☐ False ☒

11. Early reporting is encouraged so that the child may be removed from the home of the abusive parent.

True ☐ False ☒

12. You must have evidence of abuse or neglect before you report it.

True ☐ False ☒

13. If you report abuse or neglect, and your suspicions are unfounded, you are liable for civil or criminal suit.

True ☐ False ☒

14. An anonymous report of abuse and neglect will not be investigated.

True ☐ False ☒

15. The identity of the person who reports child abuse or neglect is protected under Ohio law.

True ☐ False ☒

16. Children frequently will fantasize that they have been sexually abused to “get even” with an adult.

True ☐ False ☒

17. Medical, health-related, mental health and legal professionals are not legally required to report child abuse and neglect because of their responsibility to keep client confidentiality.

True ☐ False ☐

18. Abused and neglected children almost always are from low-income families.

True ☐ False ☒

19. Sexual abuse usually occurs between a child and a stranger.

True ☐ False ☒

20. A child may be abused without anyone ever being able to know.

True ☐ False ☒

21. A child never will enjoy sexual touch.

True ☐ False ☒

22. By teaching a child about sexual assault, you may frighten the child or cause the child to be sexually active.

True ☐ False ☒

23. If a family's income is over a certain level, the family will have to pay for services from the public children service agency.

True ☐ False ☒

24. If parents are having trouble coping with their children, they can contact the public children services agency for help.

True ☐ False ☒

25. A child under 12 years of age should never be left at home alone.

True ☐ False ☒



## HOW MUCH DID YOU KNOW ABOUT CHILD ABUSE AND NEGLECT?

### 1. Child abuse and neglect occur rarely

FALSE

In Ohio, 51,000 children were identified as victims of maltreatment in the year 2000\*. In 1999 almost 3 million reports of suspected abuse or neglect were made to public service agencies nationwide. This amounts to 46 reports per 1000 children. The number of reports in Ohio has declined slightly since 1996. Almost 1/3 of these reports substantiated that abuse or neglect had occurred.\*\* It is estimated that 1,100 children died nationwide in 1999 as a result of child abuse or neglect, 3 each day.\*\* Ohio reported 87 child abuse and neglect related fatalities in 1999.\*\*\* Many cases of child abuse and neglect still go unrecognized and unreported.

- \* Ohio Family and Children Services Information System (FACSIS)
- \*\* National Child Abuse and Neglect Reporting System
- \*\*\* Prevent Child Abuse America 2001 report

### 2. Child abuse and neglect occur at about the same frequency.

FALSE

Neglect occurs at a higher incidence rate than abuse. Some professionals feel that, because abuse is more easily recognized and generally perceived by the public as more serious than neglect, a larger percentage of abuse cases are reported to public children services agencies. A demographic breakdown of reports to the Ohio Central Registry of Child Protection shows a relatively equal number of abuse and neglect reports. Abuse, including various forms of physical and sexual maltreatment, accounted for 42% of the total figure; neglect accounted for 53%; and 5% of the reports alleged psychological or emotional abuse.

3. Abused or neglected children may become abusive or neglectful parents.

TRUE

A term often used when child maltreatment is discussed is “the cycle of child abuse and neglect.” This describes the frequency of occurrence of abuse and neglect in successive generations of families. Very few parents have had formal preparation for the role of being a parent. There is, instead, a tendency to model parenting and behaviors after those learned as a child. For example, a child who has been brought up by severe disciplinary measures will be inclined to use these same techniques upon becoming a parent. When praise, love, and nurturing are not received as a child, they cannot easily be given as an adult. This does not mean, however, that all abused or neglected children will grow up to be abusive or neglectful parents. Intervention, education, and child’s individuality are impacting factors.

4. Spanking and other types of physical discipline are wrong and considered to be child abuse.

FALSE

It is difficult to define right and wrong parenting practices. You must be sensitive to the fact that many families employ practices to which you are unaccustomed. This may be due to cultural, financial, religious, or any number of reasons. This difference alone does not make a situation abusive or neglectful. The intent of Ohio law is not to ensure that all families are alike, it is to ensure that children are not in an environment which places them in danger. The key to recognizing if a parenting practice is abusive or neglectful is not whether it fits within your idea of proper parenting, but whether it places a child’s physical or emotional well-being at risk. Every parent may at some point make a bad judgment in child-rearing practices. When a potentially harmful condition or behavior is of long duration or beginning to form a pattern, help may be needed.

5. The difference between abuse and neglect is that abuse represents an action against a child while neglect represents a lack of action for the child.

TRUE

Abuse may be thought of as an act of commission and neglect as an act of omission. In abuse, a physical or mental injury is inflicted upon a child. In neglect, there is a failure to meet the minimum needs of the child, such as the need for adequate food, supervision, guidance, education, clothing, or medical care.

6. Abuse may be directed toward only one child in the family.

TRUE

Many times, one child in a family will be seen as “special” by the parents. The child may require extra care because of a physical or mental handicap or may be labeled as different or difficult for little or no apparent reason. In some abusive situations, this child may be singled out from the remaining children to be the target of abuse. A neglectful situation, on the other hand, tends to involve all children in a family.

7. Neglect is most apt to involve children from infancy to six years of age.

TRUE

Children under six are at a higher risk of abuse than children of any other age group. This may be the result of the amount of continual care children in this age group require, developmental abilities to reason and understand, unrealistic behavioral and developmental expectations which frequently are placed upon children of this age, and a physical inability for self-protection. Both neglect and abuse, however, can and do occur at any age.

8. Most abusive and neglectful parents suffer from mental illness.

FALSE

It is estimated that only 10% of abusive or neglectful parents suffer from a serious mental disorder; 90% of these parents can be successfully treated if professional intervention occurs. The reasons why parents abuse or neglect their children are as varied as the individuals themselves. Certain factors, however, such as lack of parenting knowledge, excessive stress within the home, and isolation from the support of family and friends, are known to contribute to the occurrence of abuse or neglect.

9. Bruises on the elbows, knees, shins, or forehead are likely to be accidental in preschooler.

TRUE

Many injuries such as these are the result of the normal bumps and falls commonly experienced by children of this age. The presence of bruises or cuts on a child does not necessarily mean that a child has been abused. Injuries should be noted in light of the child’s ability to cause such injury. The older a child is, the greater the ability to perform tasks that might result in injury. Bruises, which occur on the back, thighs, buttocks, face, or back of the legs are less likely to be accidental. Any injury on an infant is suspect.

10. Abused children usually will discuss the abuse in an effort to stop it.

FALSE

To a child, the fear of the unknown may be much more frightening than the abuse itself. Children often will try to hide their injuries in an attempt to protect their parent or caretaker. The child may feel that the punishment received was deserved or that the parent will be punished and removed from the home if the abuse is discovered. In the same way, other family members may try to protect the abusive parent or pretend that the abuse is not occurring. The occurrence of abuse within the home does not mean that strong bonds do not exist between family members. Fear of severe punishment or breakup of the family unit may prevent the reporting of abuse. Sexual abuse often is accompanied by threats of violence or retaliation if the abuse were to be reported. The child is made to feel responsible for the abuse and any action that may take place as a result of reporting the abuse. Many children simply do not believe that anyone will listen to them if they tell.

11. Early reporting is encouraged so that the child may be removed from the home of the abusive parent.

FALSE

Early reporting to the children services agency is encouraged to prevent injury or harm to a child. If abuse or neglect is occurring, the children services agency will work with the family to alleviate or correct those factors which contribute to its occurrence. Ohio's child abuse and neglect laws are not intended to punish but to help the family. Primary emphasis is placed upon preserving the family unit intact whenever possible through the provision of supportive services. Children will be removed from the home only when sufficient protection cannot be provided to guarantee their continued safety within the home environment. When deciding whether to report suspected abuse or neglect, you should consider that, regardless of the circumstances, the abuse or neglect will not stop without professional intervention. Not to report is to allow the abuse or neglect to continue.

12. You must have evidence of abuse or neglect before you report it.

FALSE

Ohio law states that a report should be made if you have "reason to believe" that abuse or neglect is occurring – this means if you suspect abuse or neglect for any reason. Physical proof or other validation is not required. It is not your responsibility to determine if abuse or neglect is in fact occurring or any of the circumstances surrounding its occurrence. Making this determination is the legally mandated function of the public children services agency. To assist the children services worker in this task,

you will be asked for information concerning the child, the perpetrator, and the abuse or neglect. Certain information, such as the age of the child or identity of the abuser, may be unknown to you. Although this information is helpful to the children services agency, it is not necessary for making a report.

13. If you report abuse or neglect, and your suspicions are unfounded, you are liable for civil or criminal suit.

FALSE

Although no statute can forbid the filing of civil or criminal charges, Ohio law protects the reporter of suspected child abuse or neglect from any decision or award which might be sought through the filing of such a claim. Under Ohio statute, any person participating in making a report of suspected child abuse or neglect is immune from civil or criminal liability that might otherwise be incurred as a result of such action.

14. An anonymous report of abuse and neglect will not be investigated.

FALSE

The public children services agency is required by law to investigate every report of suspected child abuse and neglect which it receives. Although anonymous reports are permitted, they are not encouraged. People who report are asked to give their names so that they may be contacted at a later date if additional information is needed. The reporter's name will not be used or divulged during the investigation.

15. The identity of the person who reports child abuse or neglect is protected under Ohio law.

TRUE

Every report of suspected abuse or neglect is confidential. Administrative rules, which govern the receipt of child abuse and neglect reports, specifically prohibit the children services worker from identifying the reporter in any way. It should be realized, however, that although steps will be taken to protect the identity of the person who reports, the nature of the complaint or the circumstances described may allow a family to attribute the report to a specific source. Still, when evaluating whether to make a report, the benefits to the family and child far outweigh this consideration. A report of suspected child abuse or neglect is not an attempt to harm or punish a family, but an attempt to help. Your report may be the only chance the child has for protection and the family has to obtain outside support.

16. Children frequently will fantasize that they have been sexually abused to “get even” with an adult.

FALSE

A rule of thumb, which always should be used is that when a child tells you that he has been sexually touched or used in any way, *believe it*. Rarely is it a lie or a fantasy. A young child will not have a broad enough frame of reference to draw upon to make up such a story. Even if, in an older child, the story is that rare result of anger or fantasy, the fact that the child is exhibiting such extreme behavior is a signal that professional intervention is needed.

17. Medical, health-related, mental health and legal professionals are not legally required to report child abuse and neglect because of their responsibility to keep client confidentiality.

FALSE

The responsibility to report child abuse and neglect is a moral duty inherent to the helping disciplines, such as law, medicine, mental health, education, religion, and social work. The ethical commitment, which these professionals have accepted through virtue of their positions, is recognized under Ohio law through the stipulation of mandated reporting. Ohio law does include exemption under specific circumstances for attorneys and doctors to preserve the attorney-client and physician-patient relationship.

18. Abused and neglected children almost always are from low-income families.

FALSE

Maltreated children can be found in all income groups. According to the National Study of the Incidence and Severity of Child Abuse and Neglect, children from low-income families are, however, more likely to suffer maltreatment than are children from high-income families. This finding would tend to lend weight to the hypothesis that various environmental and family stresses associated with low income contribute to child abuse and neglect. The most persistent characteristic of child abuse and neglect is its universality. No geographic, ethnic, or economic setting is free of child abuse and neglect. In fact, the National Study of the Incidence and Severity of Child Abuse and Neglect found the incidence rates to be similar for urban, suburban, and rural communities.

19. Sexual abuse usually occurs between a child and a stranger.

FALSE

It is estimated that in 80% of the cases of sexual abuse, the perpetrator is an adult known to the child. Only 20% of the incidents involve a stranger. Sexual abuse usually does not occur as an isolated incident, but is a long-term situation, which develops gradually. Sexual abuse is not always accompanied by violence and physical force; it may be the result of subtle forms of coercion, such as the use of adult-child authority or parent-child bonds. Young children do not have the developmental or emotional capability to choose to engage in sexual activity with an adult. All sexual abuse, regardless of the form of coercion employed, is the result of force.

20. A child may be abused without anyone ever being able to know.

TRUE

Although some forms of abuse and neglect are more difficult to detect than others, there are usually signs or indicators, which singly or together suggest that a child may be in need of help. The key is learning to recognize and be alert to these indicators. In many instances, the indicators will be environmental or behavioral, not physical.

21. A child never will enjoy sexual touch.

FALSE

Many people find it difficult to comprehend a child feeling any good from such a bad situation and can, as a result, misdirect the blame for its occurrence to the child. Similarly, the child may feel tremendous guilt at having enjoyed the experience and perceive himself as dirty or bad. It is important to recognize the difference between sexuality and sex. Sexuality is an inherent characteristic of the human body, which is present at birth. It is the quality, which lets us develop relationships and care for one another. The human body is programmed to enjoy sexual touch. It is a normal reaction for a child to like being kissed and caressed, especially by a close or trusted adult. Initially, having been singled out for extra attention, the child may feel special. One of the most psychologically damaging aspects of interfamilial child sexual abuse is that it takes advantage of and betrays the trust and emotional bonds which exist between family members.

22. By teaching a child about sexual assault, you may frighten the child or cause the child to be sexually active.

FALSE

Knowledge is the most effective prevention tool a child may have in his possession. Just as we teach our children how to cross a street or respond in emergencies, we should teach our children to protect themselves from unwanted touch.

23. If a family's income is over a certain level, the family will have to pay for services from the public children service agency.

FALSE

The services of the public children services agency are free of charge without regard to income.

24. If parents are having trouble coping with their children, they can contact the public children services agency for help.

TRUE

Being a parent is difficult. At times, it is so difficult that the parent becomes frustrated, loses control, and overreacts. This is the most common cause of child abuse. A parent is not a bad parent because he feels he no longer can stand the demands made upon him. But, he does need help. Public children services agency staff are specially trained to help families under stress. They cannot make the problems suddenly disappear, but they can help.

25. A child under 12 years of age should never be left at home alone.

FALSE

"When is it all right for a child to stay alone?" is the most frequently asked and the most difficult question about childcare. Like most questions concerning families, there is no one response. When determining the appropriateness of a child's being left alone, there are many factors to consider. A primary factor is age. Other factors include the time of day, the child's maturity, the length of time the child is left alone, the child's proximity and accessibility to trusted adults, and the child's knowledge of safety techniques. Again, the underlying factor is whether the situation places the child at risk of harm. If you are unsure, err on the side of safety and notify your local public children services agency.



## SOME MYTHS ABOUT SEXUAL ABUSE

### MYTH

To protect your children from sexual abuse, you should teach them to beware of the “dirty old man” and stranger in the park.

### FACT:

This is a good idea. Certainly all children should be taught the dangers of the unknown. In most instances of sexual abuse, however, the abuser is someone the child knows and trusts. The abuser may be a member of the family, a relative, a babysitter, or a neighbor. 50% of the children who are sexually abused are perpetrated by a parent and another 18% are abused by a relative other than the parent. Only 3 % are sexually abused by a substitute care provider.

### MYTH

Sexual abuse of children usually occurs between adult men who exploit young girls, and adult women who exploit young boys.

### FACT:

The majority of cases that are referred to child protection agencies involve adult or teenage men and underage girls. When boys are abused or exploited, they usually are the victims of adult males. This is not to say that other types of abuse do not occur, merely that they are not reported at the same rate. Among the reported victims of sexual abuse, girls outnumber boys four to one. Some researchers hold the opinion that sibling incest is by far the most widespread form of incest. The comparatively lower rate of reported mother-son incest may be the result of lower incidence of accompanying physical injury, a societal perception of its being less harmful, or a general disbelief in its existence.

MYTH

The child sexual abuser relies on physical violence.

FACT:

The child sexual abuser rarely uses physical violence and usually will avoid its use as injury may lead to discovery. The sexual abuser is more likely to use his power and authority as an adult (or older child) to coerce the child victim through bribes, threats, and the child's fear of the unknown. Children are taught to obey without question or resistance. The abuser's most powerful weapons are authority and secrecy.

MYTH

You usually can spot a child sexual abuser.

FACT:

Unless you are clinically trained and given the opportunity for diagnostic assessment, it is unlikely that you could identify a child sexual abuser. He or she usually does not suffer from pathological mental illness. He or she is likely to engage in ordinary work or social activities, and he appears normal. It is difficult to "avoid" a child sexual abuser. Even the most cautious and vigilant of parents cannot, nor would they want to, keep a 24-hour watch on their child. Besides, the adult who is prone to sexually abuse children often chooses work or activities, which bring him into contact with children. The best defense against sexual abuse is education. The second is communication. Parents are primary teachers of children and are responsible for showing them how to survive and how to cope with life. The first thing parents can do to protect their children is to teach them to protect themselves, to communicate their fears, and to talk about their daily activities.

MYTH

The sexual abuser can be the victim of the seductive or sexually promiscuous child.

FACT:

The child is always the victim. A seductive or promiscuous child often is the result, but never the cause, of sexual abuse. One characteristic common to sexual abusers is a capacity for rationalizing their actions, mentally justifying an illegal, unacceptable, and inappropriate behavior as necessary and alright. Perpetrating the myth of the seductive or sexually promiscuous child is one way of doing this. Through this type of reasoning, the abuser shifts the blame for his actions onto someone else. In the same manner, incestuous parents often justify their own sexual behavior as a way of teaching the child or keeping him off the street. These justifications ignore the abuser's responsibility as

an adult, the child's vulnerability and dependency on the adult, and the long-term harm to the child.

#### MYTH

Sexual contact with children is the only kind of sexual gratification abusers find satisfying.

#### FACT:

There are varying theories on the reasons why adults sexually molest children. These differences probably reflect the wide spectrum of personality types, the complexity of the problem, and the difference in types of sexual abuse which occur – from the sadistic “stranger” rape to the long-term relationship of incest. One theory sees child sexual abuse not as a sexual offense committed for sexual gratification, but as an act of power. The child sexual abuser is characterized, for any number of reasons, by an inability to have successful adult relationships. To gain control, he seeks personal fulfillment through a child. The abuser believes it is his right to use the bodies of children and that his needs come first, over the needs of those who are weak and vulnerable.

Some clinicians disagree with this approach and feel it is important to acknowledge the sexuality of child sexual abuse. They believe to ignore the sexual aspect in treatment and prevention is to avoid the central issue. Sexual abuse of children, regardless of the form it takes, is a sexual act, which results in sexual gratification for the perpetrator. There is a recognized clinical condition, pedophilia, which describes a persistent and long-term sexual interest in children. Pedophiles differ in typology and primary sexual orientation. The pedophile may confine his sexual contact to children or have co-existing sexual relationships with adults of the same age group.

An examination of the wide difference in opinion regarding the causes of child sexual abuse is important for two reasons. First, the inability to identify the right or wrong approach brings attention to the human factor involved in child sexual abuse. Each case and each incident is unique, characterized by the individuals involved. There is no one cause or reason for child sexual abuse. Second, there are no easy solutions to difficult problems. We don't have all the answers, and there still is much work to do for children, their families, and people who sexually abuse.

#### MYTH

The lower the family income and social status, the higher the likelihood of sexual abuse.

FACT:

Socioeconomic status is of no help in identifying sexual abuse. Sexual abuse appears to occur at all levels of income and education. Most of the families present an appearance of respectability. The vast majority of sexually abusive fathers are employed, function well in the community, and are respected by their peers.

MYTH

In the majority of cases, sexually abused children want to leave their homes permanently.

FACT:

On the contrary, most children do not want their families disrupted; they simply want the abuse to stop.

MYTH

Once incest is brought to the attention of the authorities, the family admits the problem and seeks help.

FACT:

The denial system of the family usually is very strong. Generally, family members will assert that nothing has happened or, if confronted with undeniable circumstances, claim "it will never happen again." In this circumstance, treatment is very difficult. If the victim returns home without intensive intervention in the family system, the old patterns of sexual abuse will continue.

MYTH

The sexual abuser will abuse a child once, and then find another victim.

FACT:

If the sexual abuser is a stranger, this usually is true. This type of perpetrator will abuse many children a single time, generally stopping only if caught. The "stranger abuser" usually is a pedophile, and limits his victims to distinct target groups. His victims are determined by age, sex, and physical attributes of his preference range. When the sexual abuser is known to the child, however, the methods of seduction usually are very different. The abuse frequently will be of long duration, escalating in frequency and intimacy over time. The "known abuser" builds upon his relationship with the child, using the child's innocence and trust as his main weapons.

# CHILD ABUSE AND NEGLECT

## DEFINITIONS

Some cases of child abuse and neglect are easily recognized: an infant left alone in a hot car; a one-year old with multiple unexplained fractures; or a child who repeatedly is locked out of the house for long periods of time. However, these cases represent only a fraction of the many children who are in need of professional help.

What about the more subtle forms of abuse or neglect: verbal abuse; poor supervision; or overly strict discipline? The key to recognizing the various forms of child maltreatment is a basic understanding of the meaning of the term *child abuse and neglect*. There are numerous factors involved in defining child abuse and neglect: cultural and ethnic backgrounds; attitudes concerning parenting; professional training and affiliation. In seeking commonly acceptable meanings, it is helpful to begin by distinguishing between abuse and neglect.

**ABUSE** Abuse represents an action against a child. It is an act of commission. Generally, abuse is categorized as follows:

**Physical abuse** The non-accidental injury of a child.

**Sexual Abuse** Any act of a sexual nature upon or with a child. The act may be for the sexual gratification of the perpetrator or a third party. This would, therefore, include not only anyone who actively participated in the sexual activity, but anyone who allowed or encouraged it

**Emotional Abuse** Chronic attitude or acts, which interfere with the psychological and social development of a child. Emotional abuse is consistent and chronic behavior. It usually is related to a constellation of interactions and is cumulative.

When an incident of abuse occurs, an acute crisis is often the trigger. A crisis generally will be the precipitating factor that sets the abuser in motion. The crisis may come in any form or level of apparent severity; for example, the crisis may be the loss of a job, divorce, illness, death in the family; a child's wet pants, consistent crying, or a broken dish. What is significant is not what the crisis is, but that it creates a situation beyond the abuser's ability to cope in a non-abusive manner.

**NEGLECT** Neglect is failure to act on behalf of a child. It is an act of omission. Neglect may be thought of as child-rearing practices, which are essentially inadequate or dangerous. It may not produce visible signs, and it usually occurs over a period of time. Neglect generally is physical or emotional.

**Physical Neglect** Failure to meet the requirements basic to a child's physical development, such as supervision, clothing, medical attention, nutrition, and support. For purposes of reporting, some agencies will further break this category into more specific acts of omission, such as medical neglect, lack of proper supervision, or educational neglect.

**Emotional Neglect** Failure to provide the support or affection necessary to a child's psychological and social development. Failure on the part of the parent to provide the praise, nurturance, love, or security essential to the child's development of a sound and healthy personality may constitute emotional neglect. Intervention in cases of emotional neglect can be very difficult.

The statutory definitions used in child protection are found in the following sections of the Ohio Revised Code.

2151.03	Neglected Child
2151.031	Abused Child
2151.04	Dependent Child
2151.05	Child Without Proper Parental Care
2919.22	Child Endangering

The Ohio Revised Code can be found at:  
<http://onlinedocs.andersonpublishing.com/revisedcode/>

**Identifying  
Child Abuse and  
Neglect**

2

# IDENTIFYING ABUSE

## OVERVIEW

- Each case of child abuse and neglect is individual.
- The child is always the victim.
- Although Ohio law permits corporal punishment in the home, school, and institution, excessive physical discipline is abuse. It is difficult to define “excessive,” but there are guidelines you can use. Physical discipline probably is excessive if:
  - ▶ It results in physical injury, including bruises
  - ▶ The injuries are in particularly sensitive locations (eyes, genitals)
  - ▶ It is inconsistent, arbitrary punishment designed not to educate, but to instill fear
  - ▶ The caretaker loses control during discipline
  - ▶ It is inappropriate to the age of the child
  - ▶ It is the result of unreasonable expectations or demands on the child by the caretaker
- A perpetrator of child abuse or neglect can be any person who has care, custody, or control of the child at the relevant time. This could include parent, stepparent, teacher, babysitter or day care staff person, relative, institution staff person, bus driver, playground attendant, caretaker, parent’s boy/girlfriend, or anyone with whom the child has contact. There also are instances when the parent or regular caretaker can be held responsible for abuse or neglect perpetrated by another; for example, when a parent allows the spouse to physically abuse their child, or when a child is left in inappropriate care and subsequently suffers abuse or neglect.
- There are no simple answers. Abuse or neglect rarely occurs in clear, simple, and specific terms. Abuse or neglect usually results from complex combinations of a range of human and situational factors.



## WHAT WE KNOW ABOUT IDENTIFYING THE ABUSER

Many of us have felt at times that life is more than we can handle. What stops us from giving up or lashing out are skills and mechanisms we have learned to control or divert our anger, accept and assume adult responsibility, recognize, realistic boundaries of acceptable behavior and expectation, and seek and accept help and support. When adults are faced with a situation which requires the use of coping skills that have not been developed, child abuse or neglect often results.

Although this explanation is oversimplified, it does help us understand how abuse and neglect can occur. It also explains the term “cycle of child abuse and neglect.” Children learn from their parents. A child who has been raised in a home where violence is an accepted response to frustration will, as an adult, tend to react violently. The skills necessary for controlling anger or frustration are never learned. What is learned is violence.

In the same way, a parent who lacks self-esteem or maturity cannot instill these characteristics within his child. Without significant outside influences, the child is likely to become an adult who perceives himself and life in the same manner as his parent does. This is the cycle of child abuse and neglect: adults tend to repeat the actions and attitudes which they learn as children.

Adults who abuse or neglect children usually will share several of the following general characteristics.

ISOLATION	Adults who abuse or neglect children often do not have the support they need. They are isolated physically and emotionally from family, friends, neighbors, and organized groups. They may discourage social contact, and rarely will participate in school or community activities.
POOR SELF-CONCEPT	Many of these adults perceive themselves as bad, worthless, or unlovable. Children of parents with a poor self-concept often are regarded by their parents as deserving of abuse or neglect, because they see their children as reflections of themselves. They view abuse and neglect as behavior that is expected of them.
IMMATURITY	This characteristic may be reflected in many ways: impulsive behavior; using the child to meet the adult's own emotional or physical needs; a constant craving for change and excitement.
LACK OF PARENTING KNOWLEDGE	Many times, abuse or neglect results because the adult does not understand the child's developmental needs. Abusive parents often are strict disciplinarians who are frustrated from unmet expectations. These parents tend to place unrealistic demands upon their children, and view their child's inability to perform as willful, deliberate disobedience.
SUBSTANCE ABUSE	It has not been clearly established whether substance abuse is a causative or a resulting factor. However, studies consistently have shown a correlation between the misuse of drugs or alcohol and the occurrence of abuse and neglect.
LACK OF INTERPERSONAL SKILLS	The abusive or neglectful adult often has not learned to interact with people, socialize, or work with others.
UNMET EMOTIONAL NEEDS	Often, the abusive or neglectful parent has unmet basic emotional needs—warmth, support, love. Unable then, to provide the child with these feelings, they will instead seek fulfillment from the child.

In the family where physical abuse occurs, the abusive adult may...

- have unrealistically high standards and expectations for himself/his children
- be rigid or compulsive
- be hostile and aggressive
- be impulsive with poor emotional control
- be authoritative and demanding
- fear or resent authority
- lack control or fear losing control
- be cruel or sadistic
- be irrational
- be incapable of child rearing
- trust no one
- believe in the necessity of harsh physical discipline
- accept violence as a viable means of problem resolution
- have an undue fear of spoiling the child
- consistently react to the child with impatience or annoyance
- be overcritical of the child and seldom discuss the child in positive terms.
- lack understanding of the child's physical and emotional needs
- lack understanding of the child's developmental capabilities
- perceive himself as alone, without friends or support
- view seeking or accepting help as a weakness
- be under pressure
- have an emotionally dependent spouse
- be engaged in a dominant-passive marital relationship
- have marital problems
- have been physically abused himself

In the family where sexual abuse occurs, the abusive adult may...

- be overly protective of the child
- refuse to allow the child to participate in social activities
- be jealous of the child's friends or activities
- accuse the child of promiscuity
- distrust the child
- have marital problems
- need to be in control or fear losing control
- be domineering, rigid, or authoritative
- favor a "special" child in the family
- have been sexually abused himself

In the family where emotional maltreatment occurs, the maltreating adult may...

- act irrationally or appear to be out of touch with reality
- be deeply depressed
- exhibit extreme mood swings
- constantly belittle the child or describe the child in terms such as "bad," "different," or "stupid"
- be cruel or sadistic
- be ambivalent towards the child
- expect behavior that is inappropriate for the child's age or developmental capabilities
- constantly shame the child
- threaten the child with the withdrawal of love, food, shelter, or clothing
- threaten the child's health or safety
- reject the child or discriminate among children in the family
- be involved in criminal activities
- use bizarre or extreme methods of punishment
- avoid contact with the child, seldom touching, holding, or caressing him
- avoid looking or smiling at the child
- be overly strict or rigid
- torture the child
- physically abuse or neglect the child
- have been abused or neglected himself

In the family where neglect occurs, the neglecting adult may...

- be apathetic
- have a constant craving for excitement and change
- express dissatisfaction with his life
- express desire to be free of the demands of the child
- lack interest in the child's activities
- have a low acceptance of the child's dependency needs
- be generally unskilled as a parent
- have little planning or organizational skills
- frequently appear unkempt
- perceive the child as a burden or bother
- be occupied more with his problems than he is with the child's
- be overcritical of the child and seldom discuss him in positive terms
- have unrealistic expectations of the child, expecting or demanding behavior beyond the child's ability
- seldom touch or look at the child
- ignore the child's crying or react with impatience
- keep the child confined, perhaps in a crib or playpen, for long periods of time
- be hard to locate
- lack understanding of the child's physical or emotional needs
- be sad or moody
- fit the clinical description "passive and dependent"
- lack understanding of the child's developmental capabilities
- fail to keep appointments and return telephone calls
- have been neglected himself

## ADOLESCENT OFFENDERS

Adolescent offenders account for an estimated one-third of the sexual offenses against young children. The majority of these offenses occur either in their own home involving a younger sibling or in the role as baby sitter for other young children. These offenders reflect many of the same characteristics as an adult offender and are often "loners" with minimal peer relationships.

## WHAT WE KNOW ABOUT IDENTIFYING VICTIMS OF ABUSE

Abuse and neglect can be difficult to detect. There may be signs and indications, which, singly or together, suggest that a child might be in need of help.

Physical Indicators	These signs are often the easiest to detect and diagnose. Aspects of the child's appearance and the presence of bodily injury are physical indicators.
Behavioral Indicators	Often, children will send messages through their behavior, which suggest the occurrence of abuse or neglect. These clues may be in the form of "acting out" behaviors or behaviors which reflect the child's attempt to cope with or hide the abuse or neglect. Behavioral indicators are more difficult to detect and interpret than physical indicators.

There is no blueprint for identifying an abused or neglected child. While some of these behavioral or physical indicators may occur in a child who has not been abused, be especially alert to repetition or the presence of multiple indicators.

Immediately report any suspicion of child abuse or neglect to your local public children services agency. The child's safety and the serious ramifications of alleged child abuse and neglect make it critical that the determination of abuse be made by a collaboration of experienced and trained professionals.

CHILD MALTREATMENT FALLS IN ONE OR MORE OF FOUR  
GENERAL CATEGORIES:

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Physical Abuse

Sexual Abuse

Emotional Maltreatment

Neglect

## CLUES TO RECOGNIZING PHYSICAL ABUSE

### Physical Indicators

#### UNEXPLAINED, CHRONIC, OR REPEATED BRUISING

Be especially alert to bruises:

- on the face, throat, upper arms, buttocks, thighs, or lower back
- in unusual patterns or shapes which suggest the use of an instrument (loop, lash, linear, circular, or rectangular marks)
- on an infant (especially if not cruising or walking)
- in the shape of bite or pinch marks
- in clusters

#### UNEXPLAINED BURNS

Be especially alert to:

- cigarette burns. This type of burn is circular, and often found on the child's palms, soles of feet, genitalia, or abdomen.
- immersion burns. These burns characteristically will produce sharp lines of demarcation and appear on the buttocks, genital area, or extremities. On the hands and feet, burn can produce a "glove" or "stocking" pattern; on the buttocks, immersion burns often will be "doughnut shaped."
- rope burns
- burns in the shape of common household utensils or appliances

#### UNEXPLAINED SKELETAL INJURIES

Skeletal injuries resulting from physical abuse often include:

- injury to the bones around the joints ("metaphyseal fractures")
- rib fractures, vertebral fractures
- any skeletal injury in an infant or child without a plausible explanation

#### OTHER UNEXPLAINED OR REPEATED INJURIES

Injuries resulting from physical abuse often include:

- lacerations, abrasions, welts, scars, human bite or pinch marks
- missing, chipped, or loosened teeth, tearing of the gum tissue, lips, tongue, and skin surrounding the mouth
- loss of hair/bald patches
- broken eardrum
- retinal hemorrhage
- abdominal injuries

## CLUES TO RECOGNIZING PHYSICAL ABUSE

### Behavioral Indicators

- behavioral extremes (withdrawal, aggression, regression)
- inappropriate or excessive fear of parent or caretaker
- unusual shyness, wariness of physical contact
- antisocial behavior, such as substance abuse, truancy, running away
- reluctance to return home
- belief that punishment is deserved
- suggestion that other children should be punished in a harsh manner
- victim's disclosure of abuse
- depression, excessive crying
- unbelievable or inconsistent explanation for injuries
- attempt to hide injuries



### CLUES TO RECOGNIZING SEXUAL ABUSE

#### Physical Indicators

- somatic complaints, including pain and irritation of the genitals
- sexually transmitted disease
- pregnancy
- bruises or bleeding from external genitalia, vagina, or anal region
- genital discharge
- torn, stained, or bloody underclothes
- frequent, unexplained sore throats, yeast or urinary infections
- bed wetting

### CLUES TO RECOGNIZING SEXUAL ABUSE

#### Behavioral Indicators

- the victim's disclosure of the sexual abuse
- poor peer relationships, inability to relate to children of same age
- regressive behaviors, such as thumb sucking, bedwetting, fear of the dark, or reattachment to a favorite toy
- sudden changes in behavior
- promiscuity or seductive behavior
- aggression or delinquency
- truancy or chronic running away
- prostitution
- substance abuse
- difficulty in walking or sitting
- reluctance to participate in recreational activity
- preoccupation with sexual organs (the child's own or other's)
- recurrent nightmares, disturbed sleep patterns, or fear of the dark
- unusual and age-inappropriate interest in sexual matters.
- age-inappropriate ways of expressing affection
- avoidance of undressing or wearing extra layers of clothes
- sudden avoidance of certain familiar adults or places
- sudden decline in school performance
- self-injury

## CLUES TO RECOGNIZING EMOTIONAL MALTREATMENT

### Physical Indicators

- eating disorders, including obesity or anorexia
- speech disorders, such as stuttering or stammering
- developmental delays in the acquisition of speech or motor skills
- weight or height level substantially below the norm
- flat or bald spots on an infant's head
- frequent vomiting
- nervous disorders, such as hives, rashes, facial tics, or stomach aches
- bedwetting or loss of bowel control (after child has been trained)

## CLUES TO RECOGNIZING EMOTIONAL MALTREATMENT

### Behavioral Indicators

- poor relations with peers
- withdrawal or self-isolation
- cruel behavior, seeming to get pleasure from hurting children, adults, or animals; seeming to get pleasure from being mistreated
- age-inappropriate behavior
- lack of self-confidence
- unusual fears for child's age
- being constantly withdrawn and sad

Emotional abuse is maltreatment which can involve words, actions and/or indifference. Abusers ignore, belittle, dominate and criticize the victim. There may be overlap with physical abuse. The exposure of children to repeated episodes of domestic violence may constitute emotional abuse.

### CLUES TO RECOGNIZING NEGLECT

#### Physical Indicators

- poor hygiene
- unsuitable clothing; missing key articles of clothing such as underwear, socks, shoes, or coat; or overdressed in hot weather
- untreated illness or injury
- excessive sunburn, colds, insect bites, or other conditions which would indicate prolonged exposure to the elements
- height and weight significantly below age level
- lack of immunizations

### CLUES TO RECOGNIZING NEGLECT

#### Behavioral Indicators

- unusual school attendance, such as frequent or chronic absence, lateness, coming to school early or leaving late
- chronic hunger, tiredness, or lethargy
- begging or collecting leftovers
- assuming adult responsibilities
- reporting no caretaker in home

Child neglect is difficult to define. Indicators of neglect must be considered in light of the parent's cultural background and financial ability to provide. Poverty is not neglect. Because many situations of neglect require judgment calls, you must be careful not to use personal values as the decision-making standard. Instead, ask yourself if the child is:

- adequately supervised?
- receiving necessary medical and dental care?
- having his nutritional needs met?
- receiving necessary developmental and educational stimulation?

In addition there should be no obvious health or safety risks in home.

## DISTINGUISHING ABUSIVE INJURIES FROM ACCIDENTS

The very nature of childhood invites accidents. Children are curious and fearless. They run, climb, jump, and explore. A child's motor skills usually outpace his cognitive skills, allowing him to approach danger without recognizing it. It can be difficult to distinguish accidental injuries from abusive non-accidental injuries.

### HOW TO DISTINGUISH ABUSIVE INJURIES FROM ACCIDENTAL INJURIES

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Where is the injury?

Certain locations on the body are more likely to sustain accidental injury: knees, elbows, shins, and the forehead; all are parts of the body which can be injured during an accidental fall or bump. Protected or non-protuberant parts of the body, such as the back, thighs, genital area, buttocks, back of the legs, or face, are less likely to accidentally come into contact with objects which could cause injury. For example, bruised knees and shins on a toddler are likely to be the result of normal age-related activity; bruises on the lower back are more likely to have been inflicted non-accidentally.

How many injuries does the child have?

The greater the number of injuries, the greater the cause for concern. Unless involved in a serious accident, a child is not likely to sustain a number of different injuries accidentally. Injuries in different stages of healing can suggest a pattern of recurrent abusive episodes.

Are there several injuries occurring at one time or over a period of time?

What is the size and shape of the injury?

Many non-accidental injuries are inflicted with familiar objects: a stick, a board, a belt, a hairbrush. The marks which result usually bear strong resemblance to the object which was used. For example, welts caused by beating a child with an electrical cord might be loop shaped; a belt might cause bruises in the shape of the buckle. Accidental marks resulting from bumps and falls usually have no defined shape.

Does the description of how the injury happened seem likely?

If an injury is accidental, there should be a reasonable explanation of how it happened which is consistent with its severity, type, and location. When the description of how the injury occurred and the appearance of the injury do not seem related, there is cause for concern. For example, a fall off a chair onto a rug should not produce bruises all over the body.

Is the injury consistent with the child's developmental capabilities?

As a child grows and gains new skills, he increases his ability to engage in activities, which can cause injury. A toddler trying to run is likely to suffer bruised knees and a bump on the head before the skill is perfected. He is less likely to suffer a broken arm than is an eight-year-old who has discovered the joy of climbing trees. A two-week-old infant does not have the movement capability to self-inflict a bruise.

Accidents do happen.

Parents are not perfect. Injuries occur which may have been avoided. Still, accidents of this nature should not happen repeatedly.

Reporting  
Child Abuse and  
Neglect

3

# WHO IS RESPONSIBLE TO REPORT ABUSE OR NEGLECT?

Anyone who has reason to believe a child is being abused or neglected should make the report! We *all* have a responsibility to report a child we suspect may be in danger. Ohio law encourages you to act on behalf of a child in need of protection, and to report your suspicions to the appropriate authorities.

Certain professionals, identified in Section 2151.421 of the Ohio Revised Code, are mandated to report a child they suspect may be abused or neglected. The code can be read online at <http://onlinedocs.andersonpublishing.com/>. Reporting is required if, while acting in a professional or official capacity, a mandated reporter suspects that a child under 18 years of age, or a mentally retarded, developmentally disabled or physically impaired child under 21 years of age, has suffered or faces a threat of physical or mental abuse or neglect. If they fail to report, they could be found guilty of a misdemeanor of the fourth degree and liable for civil damages. Those required to report suspected child abuse and neglect include:

- |                                      |   |
|--------------------------------------|---|
| ■ attorneys                          | ■ physicians, including hospital<br>interns and residents |
| ■ audiologists                       | ■ podiatrists   |
| ■ child care workers                 | ■ psychologists   |
| ■ children services agency personnel | ■ school authorities                                      |
| ■ clergy                             | ■ school employees  |
| ■ coroners                           | ■ school psychologists (licensed)                         |
| ■ day care personnel                 | ■ school teachers   |
| ■ dentists                           | ■ social workers  |
| ■ nurses                             | ■ speech pathologists                                     |

Ohio law provides certain exemption for the attorney and physician to protect the confidentiality of his relationship with his client or patient. An attorney or physician is not mandated to report suspected child abuse or neglect if his suspicions are the result of a communication made to him in the attorney-client or physician-patient relationship unless: 1) the client/patient is a child under 18 years of age or a physically or mentally handicapped child under 21 years of age; 2) the attorney or physician knows or suspects as a result of the communication or observation made during the communication that the client/patient has been abused or neglected; and 3) the relationship does not arise out of the client/patient's attempt to have an abortion without notification of her parents.

## HOW DO I DETERMINE IF A REPORT IS NECESSARY?

You should report any child under 18 years of age or any physically or mentally handicapped child under 21 years of age, who you have reason to believe has suffered any wound, injury, disability, or condition of such a nature as to indicate abuse or neglect. It is important to note that you need only suspect – have reason to believe – that abuse or neglect is occurring; physical proof or other forms of validation are not required. It is the responsibility of the children services agency, through its investigation to determine if abuse or neglect is in fact occurring.

## WHAT SPECIFIC INFORMATION SHOULD I REPORT?

- The name and address of the child you suspect is being abused or neglected.
- The age of the child.
- The name and address of the parent or caretaker of the child.
- The name of the person you suspect is abusing or neglecting the child.
- The reason you suspect the child is being abused or neglected.
- Any other information which may be helpful to the investigation.
- Your name, if you want to give it. You may report anonymously if you choose, but you are encouraged to give your name. This makes it possible for the children's protective services worker to get in touch with you later if additional or clarifying information is needed.
- If you are a mandated reporter, you may be required by the children services agency to follow up your verbal report in writing. This request generally is made if your report is based on specific diagnostic information or if an agreement exists between your agency of employment and the children services agency.

It is helpful if you provide as much of this information as you can. You should not hesitate to report if you do not have all the information. Any uncertainty you have regarding whether to report should be resolved in favor of the child's protection.



## WILL MY REPORT BE CONFIDENTIAL? CAN THE CHILD'S PARENTS FILE CHARGES AGAINST ME?

A report of suspected child abuse and neglect is confidential. Your identity will not be released or affirmed to anyone without your written consent, except under direct order of the court. You also are protected from civil or criminal liability. Although no statute can forbid the filing of civil or criminal charges, Section 2151.421 of the Ohio Revised Code protects the reporter from decision or award, which might be sought through the filing of such claims.

## HOW WILL MY REPORT BENEFIT THE CHILD?

First and foremost, you should report to protect the child. The intent of the law is not to hurt or to punish; it is to get help to children and families in need. We all have a stake in the protection of Ohio's children. Studies have linked child abuse and neglect to a wide range of criminal and social misbehaviors. Why? Violence breeds violence. The only method of response the victim of child abuse may know is physical force or aggression. The lessons necessary for development of interpersonal skills may have never been taught in the abusive or neglectful environment. The emotional damage, which may result from child abuse or neglect often is vented through self-destructive expressions, such as rape, murder, and continuation of child abuse and neglect.

## HOW SHOULD I RESPOND TO THE CHILD WHO DISCLOSES ABUSE OR NEGLECT?

Many child victims have difficulty disclosing the abuse. They may have been told not to tell or they might be afraid of what will happen if they disclose. Abuse victims may be ashamed of what people will think if the truth is discovered or think that they will not be believed. If a child discloses abuse to you, he/she is confiding and placing their trust in your hands.

There may be a time when a child or adolescent tells you, openly or indirectly, about abuse or neglect in his family. Recognize the strength which this child has demonstrated by sharing his secret and honor the trust he has shown by choosing you as his confidant. Although it may be a difficult subject for you to discuss, it is important that you handle the disclosure with sensitivity. In part, this can be accomplished by following some general guidelines:

Listen to what is being told to you	Do not project or assume anything. Do not push the child to share more than he is willing. The child needs warmth and acceptance, not curiosity or interrogation. It is not necessary at this time that he reveal specific or intimate details.
Reassure him that he has done the right thing by telling you	Acknowledge the difficulty of his decision and the personal strength he has shown in making his choice. Make it clear that the abuse or neglect is not his fault, that he is not bad or to blame.
Keep your own feelings under control	Be calm and nonjudgmental. Do not express emotions such as shock, embarrassment, anger, or disgust. Do not criticize or belittle the child's family.
Do not promise not to tell	Know your limits. This is not a situation you can handle by yourself.
Tell the truth	Don't make promises you can't keep, particularly relating to secrecy, court involvement, placement, and caseworker decisions. After abuse or neglect has been disclosed, there may be actions taken over which neither you nor the child has control.

Be specific	Let the child know exactly what is going to happen. Tell the child you are going to report the abuse or neglect to the children services agency. If you are a mandated professional, let him know you are required by law to report. Tell the child exactly what will happen when the report is made. Be honest; it does not protect him to hide anything. For example, if the child discloses sexual abuse, be candid that the child or the abusing adult/parent may be removed from the home. You can help by preparing the child for what lies ahead.
Assess the child's immediate safety	Is it safe for the child to return home? Is he in immediate physical danger? Is it a crisis? Is there in-home protection?
Be supportive	Remember why the child came to you. He needs your help, support, and guidance. Be there for him; let him know that telling about the abuse or neglect was the right thing to do. It is the only way to make it stop.
Try to help the child regain control	The child is about to be involved in a process in which the primary intent will be to determine his best interest. At times, this may seem to sweep him up in a series of events that are beyond his control. Although alternatives may be limited, it can help to let the child make decisions whenever possible. For example, let the child choose whether to accompany you when the report is made, who else to talk to. Although many of the decisions may seem trivial, they will allow the child some sense of self-determination.

# WHO DO I CONTACT TO REPORT SUSPECTED ABUSE OR NEGLECT?

A report may be made by telephone, in person, or in writing to the children services agency in the county in which the child lives or was abused, or to the law enforcement agency. The addresses and phone numbers of Ohio Public Children Service Agencies (PCSA) are listed below. The listing is also available online at

<http://jfs.ohio.gov/county/cntydir.stm>

## OHIO COUNTY PUBLIC CHILDREN SERVICE AGENCIES

### **Adams County PCSA**

300 North Wilson Drive  
West Union, Ohio 45693-1157  
PCSA Phone: (937) 544-2511  
PCSA Fax: (937) 544-9724  
PCSA After-hours Phone: (937) 544-2511  
TTY/TDD: None  
Hours of operation: 8:30-4:30, M-F

### **Allen County PCSA**

330 North Elizabeth Street  
Lima, Ohio 45801-4305  
PCSA Phone: (419) 227-8590  
PCSA Fax: (419) 229-2296  
PCSA After-hours Phone: (419) 221-5680  
TTY/TDD: None  
Hours of operation: 8:30-5, M-F

### **Ashland County PCSA**

15 West Fourth Street  
Ashland, Ohio 44805-2137  
PCSA Phone: (419) 289-5000  
PCSA Fax: (419) 282-5010  
PCSA After-hours Phone: (419) 289-2276  
TTY/TDD: (419) 282-5002  
Hours of operation: 8-4:00, M,W,Th,F; 8-6:30, T

### **Ashtabula County PCSA**

3914 C Court  
P.O. Box 1175  
Ashtabula, Ohio 44005-1175  
PCSA Phone: (440) 998-1811  
PCSA Fax: (440) 992-6828  
PCSA After-hours Phone: 1-888-998-1811  
TTY/TDD: (440) 998-1811  
Hours of operation: 8-5, M-F  
E-mail Address: [csforkid@interlaced.net](mailto:csforkid@interlaced.net)

### **Athens County PCSA**

18 Stonybrook Drive  
P.O. Box 1046  
Athens, Ohio 45701-1046  
PCSA Phone: (740) 592-3061  
PCSA Fax: (740) 593-3880  
PCSA After-hours: (877) 477-0772  
TTY/TDD: None listed  
Hours of operation: 8-4:30, M-F  
World Wide Web:  
<http://www.athenschilchildrenservices.com>

**Auglaize County PCSA**

12 North Wood Street  
P.O. Box 368  
Wapakoneta, Ohio 45895-0368  
PCSA Phone: (419) 739-6505  
PCSA Fax: (419) 739-6506  
PCSA After-hours: (419) 738-2147  
TTY/TDD: None listed  
Hours of operation: 7-4:30, M-F

**Belmont County DJFS**

310 Fox Shannon Place  
St. Clairsville, Ohio 43950-9765  
PCSA Phone: 740 695-KIDS  
PCSA Fax: 740 695-5251  
PCSA After-hours: 740 695-1074  
TTY/TDD: None listed  
Hours of operation: 8-4:30, M-F

**Brown County PCSA**

775 Mt. Orab Pike  
Georgetown, Ohio 45121  
PCSA Phone: (937) 378-6104  
PCSA Fax: (937) 378-4753  
PCSA After-hours Phone: (937) 378-4435  
TTY/TDD: None  
Hours of operation: 7-12 and 12:45-5:45, M-F

**Butler County PCSA**

300 North Fair Avenue  
Hamilton, Ohio 45011-4249  
PCSA Phone: (513) 887-4055  
PCSA Fax: (513) 887-4260  
PCSA After-hours Phone: (513) 868-0888  
TTY/TDD: (513) 887-4322  
Hours of operation: 7:30-5, M-F  
World Wide Web Site: [www.bccsb.org/](http://www.bccsb.org/)

**Carroll County PCSA**

95 East Main Street  
P.O. Box 219  
Carrollton, Ohio 44615  
PCSA Phone: (330) 627-7313  
PCSA Fax: (330) 627-4969  
PCSA After-hours Phone: (330) 627-2141  
TTY/TDD: None listed  
Hours of operation: 7:45-4:30, M-F  
E-mail Address: [offenk@odifs.state.oh.us](mailto:offenk@odifs.state.oh.us)

**Champaign County PCSA**

1512 South US Highway 68, Suite N100  
Urbana, Ohio 43078-0353  
PCSA Phone: (937) 484-1500  
PCSA Fax: (937) 484-1506  
PCSA After-hours Phone: (937) 652-1311(Sheriff)  
TTY/TDD: (937) 484-1560  
Hours of operation: 8-4:30, M, W--F; 7:30-6 T  
World Wide Web:  
<http://www.co.champaign.oh.us/difs>

**Clark County PCSA**

1345 Lagonda Avenue, PO Box 976A  
Springfield, Ohio 45501-1037  
PCSA Phone: (937) 327-1700  
PCSA Fax: (937) 327-1910  
PCSA After-hours Phone: (937) 324-8687  
TTY/TDD: (937) 327-1873  
Hours of operation: 7-5,M,F; 7-5:30,T,Th; 7-6 W  
World Wide Web: <http://clarkdjfs.org>  
Email Address: [inquiry@clarkdjfs.org](mailto:inquiry@clarkdjfs.org)

**Clermont County PCSA**

2400 Clermont Center Drive, Suite 106  
Batavia, Ohio 45103  
PCSA Phone: (513) 732-7111  
PCSA Fax: (513) 732-7216  
PCSA After-hours Phone: (513) 732-7173  
TTY/TDD: None listed  
Hours of operation: 8-4:30, M-F

**Clinton County PCSA**

1025 S. South St., Suite 300  
Wilmington, Oh 45177  
PCSA Phone: (937) 382-5935  
PCSA Fax: (937) 382-1165  
PCSA After-hours Phone: (937) 382-2449  
TTY/TDD: None  
Hours of operation: 8-4:30, M-F

**Columbiana County PCSA**

110 Nelson Avenue  
Lisbon, Ohio 44432  
PCSA Phone: (330) 424-1471  
PCSA Fax: (330) 424-1455  
PCSA After-hours Phone: (330) 424-7767  
TTY/TDD: (330) 424-7767  
Hours of operation: 8-4:30, M-F

**Coshocton County PCSA**

725 Pine St.  
Coshocton, OH 43812  
PCSA Phone: (740) 622-1020  
PCSA Fax: (740) 622-5591  
PCSA After-hours Phone: (740) 622-2411 Sheriff  
TTY/TDD: None listed  
Hours of operation: 7:00-4, M-F

**Crawford County PCSA**

865 Harding Way West  
Galion, Ohio 44833-1685  
PCSA Phone: (419) 468-3255  
PCSA Fax: (419) 468-6771  
PCSA After-hours Phone: (877) 997-4344 (Pager)  
TTY/TDD: None listed  
Hours of operation: 7:30-4:30, M-F

**Cuyahoga County PCSA**

3955 Euclid Avenue  
Cleveland, Ohio 44115-2583  
PCSA Phone: (216) 432-3390  
PCSA Fax: (216) 432-3379  
PCSA After-hours: (216) 696-KIDS (5437)  
TTY/TDD: None listed  
Hours of operation: 8:30-4:30, M-F

**Darke County PCSA**

631 Wagner Ave.  
Greenville, Ohio 45331  
PCSA Phone: (937) 548-3840  
PCSA Fax: (937) 548-8723  
PCSA After-hours Phone: (937) 548-2020  
TTY/TDD: (937) 548-4132  
Hours of operation: 8-5, M-F  
E-mail Address: [ratlig@odjfs.state.oh.us](mailto:ratlig@odjfs.state.oh.us)

**Defiance County PCSA**

06879 Evansport Road  
P. O. Box 639  
Defiance, Ohio 43512-0639  
PCSA Phone: (419) 782-3881  
PCSA Fax: (419) 784-3249  
PCSA After-hours Phone: (419) 784-1155  
TTY/TDD: None  
Hours of operation: 8-4:30, M-F  
E-mail Address: [dcdhs@inos.com](mailto:dcdhs@inos.com)

**Delaware County PCSA**

140 North Sandusky Street  
Delaware, Ohio 43015-1789  
PCSA Phone: (740) 833-2300  
PCSA Fax: (740) 833-2299  
PCSA After-hours Phone: (740) 833-2300  
TTY/TDD: (740) 368-1988  
Hours of operation: 8-4:45, M-F

**Erie County PCSA**

221 West Parish Street  
Sandusky, Ohio 44870-4886  
PCSA Phone: (419) 624-6401  
PCSA Fax: (419) 626-5854  
PCSA After-hours: (419) 625-7951 (Sheriff)  
TTY/TDD: (419) 626-6781  
Hours of operation: 8-5, M-F  
E-mail Address: [englej@odjfs.state.oh.us](mailto:englej@odjfs.state.oh.us)

**Fairfield County PCSA**

239 West Main Street  
Lancaster, Ohio 43130  
PCSA Phone: (740) 653-4060  
PCSA Fax: (740) 687-7070  
PCSA After-hours Phone: (740) 653-5223 Sheriff  
TTY/TDD: (740) 681-7211  
Hours of operation: 8:00am-5:00pm, M-F  
E-mail Address: [web@fcjfs.org](mailto:web@fcjfs.org) World Wide  
Web Site: [www.fcjfs.org](http://www.fcjfs.org)

**Fayette County PCSA**

133 S. Main Street  
P.O. Box 220  
Washington Court House, Ohio 43160  
PCSA Phone: (740) 335-0350  
PCSA Fax: (740) 333-3581  
PCSA After-hrs Phone: (740) 335-6170  
TTY/TDD: None listed  
Hours of operation: 7:30-4:30, M-F

**Franklin County PCSA**

855 West Mound Street  
Columbus, Ohio 43223  
PCSA Phone: (614) 275-2571  
PCSA Fax: (614) 229-7208  
PCSA After-hours Phone: (614) 229-7000  
TTY/TDD: (614) 278-5925  
Hours of operation: 8-5, M-F  
E-mail Address: [jsaros@fccs.co.franklin.oh.us](mailto:jsaros@fccs.co.franklin.oh.us)  
World Wide Web Site:  
[http://www.co.franklin.oh.us/Children\\_Services](http://www.co.franklin.oh.us/Children_Services)

**Fulton County PCSA**

604 South Shoop Avenue Suite 200  
 Wauseon, Ohio 43567  
 Phone: (419) 337-0010  
 Fax: (419) 335-0337  
 PCSA After-hours Phone: (419) 335-4010  
 TTY/TDD: (419) 337-7630  
 Hours of operation: 8-4:30, M-F  
 E-mail Address: [caldwk01@odjfs.state.oh.us](mailto:caldwk01@odjfs.state.oh.us)

**Gallia County PCSA**

83 Shawnee Lane  
 Gallipolis, Ohio 45631-8595  
 PCSA Phone: (740) 446-4963  
 PCSA Fax: (740) 446-2063  
 PCSA After-hours Phone: (740) 446-1221  
 (Sheriff)  
 TTY/TDD: None listed  
 Hours of operation: 8-4:30, M-F  
 E-mail Address: [shradc@odjfs.state.oh.us](mailto:shradc@odjfs.state.oh.us)

**Geauga County PCSA**

12480 Ravenwood Drive  
 P.O. Box 309  
 Chardon, Ohio 44024-9009  
 PCSA Phone: (440) 285-9141  
 PCSA Fax: (440) 286-6654  
 PCSA After-hours Phone: (440) 285-5665  
 TTY/DD: (440) 285-9141  
 Hours of operation: 8-4:30, M-F  
 World Wide Web Site:  
<http://website:www.geaugajfs.org>

**Greene County PCSA**

601 Ledbetter Road  
 Xenia, Ohio 45385-5336  
 PCSA Phone: (937) 562-6600  
 PCSA Fax: (937) 562-6650  
 PCSA After-hours Phone: (937) 372-4357  
 TTY/TDD: None  
 Hours of operation: 8-5, M-F

**Guernsey County PCSA**

274 Highland Avenue  
 Cambridge, Ohio 43725-2528  
 PCSA Phone: (740) 439-5555  
 PCSA Fax: (740) 439-5521  
 PCSA After-hours Phone: (740) 439-5555  
 TTY/TDD: None listed  
 Hours of operation: 8:30-4:30, M-F

**Hamilton County PCSA**

222 East Central Parkway  
 Cincinnati, Ohio 45202-1225  
 PCSA Phone: (513) 946-1000  
 PCSA Fax: (513) 946-2248  
 PCSA After-hours Phone: (513) 241-KIDS (5437)  
 TTY/TDD: (513) 946-1295  
 Hours of operation: 8-4:00, M-F  
 World Wide Web Site: <http://www.hamilton-co.org/dhs/>

**Hancock County PCSA**

7814 County Road 140  
 P.O. Box 270  
 Findlay, Ohio 45840  
 PCSA Phone: (419) 424-7022  
 PCSA Fax: (419) 422-1081  
 PCSA After-hours Phone: (419) 424-7022  
 TTY/TDD: None listed  
 Hours of operation: 8-4:30, M,W-F; 8-5:30, Tues.  
 E-mail Address: [thomas01@odjfs.state.oh.us](mailto:thomas01@odjfs.state.oh.us)

**Hardin County PCSA**

175 West Franklin Street, Suite 150  
 Kenton, Ohio 43326-1972  
 PCSA Phone: (419) 675-1130  
 PCSA Fax: (419) 674-2340  
 PCSA After-hours Phone: (800) 442-7346  
 TTY/TDD: (419) 675-3630  
 Hours of operation: 8:30am-4:30pm, M,T,Th;  
 8:30am-6:30pm, W; 8:30am-2:30pm, F

**Harrison County PCSA**

520 North Main Street  
 P.O. Box 239  
 Cadiz, Ohio 43907-0239  
 PCSA Phone: (740) 942-3015  
 PCSA Fax: (740) 942-2370  
 PCSA After-hours Phone: (740) 942-2179  
 TTY/TDD: None  
 Hours of operation: 8-4:30, M-F

**Henry County PCSA**

104 East Washington Street -- Hahn Center  
 P.O. Box 527  
 Napoleon, Ohio 43545-0527  
 PCSA Phone: (419) 592-0946  
 PCSA Fax: (419) 592-4942  
 PCSA After-hours Phone: (419) 592-8010  
 TTY/TDD: (419) 592-5748  
 Hours of operation: 8-5,T,Th; 8-4:30,M,W,F

**Highland County PCSA**

117 East Main Street  
Hillsboro, Ohio 45133-1468  
PCSA Phone: (937) 393-3111  
PCSA Fax: (937) 393-3299  
PCSA After-hours Phone: (937) 393-8010  
TTY/TDD: None  
Hours of operation: 7:30-5:30, M-F  
E-mail Address: [robbyid@odjfs.state.oh.us](mailto:robbyid@odjfs.state.oh.us)

**Hocking County PCSA**

25 East Second Street  
Logan, Ohio 43138-1243  
PCSA Phone: (740) 385-4168  
PCSA Fax: (740) 385-2479  
PCSA After-hours Phone: (740) 380-8239  
TTY/TDD: None listed  
Hours of operation: 8:30-4:30, M-F

**Holmes County PCSA**

85 North Grant Street  
P.O. Box 72  
Millersburg, Ohio 44654-0072  
PCSA Phone: (330) 674-1111  
PCSA Fax: (330) 674-0770  
PCSA After-hours Phone: (330) 674-KIDS(5437)  
TTY/TDD: (330) 674-0966  
Hours of operation: 7:30-4:30, M-F

**Huron County PCSA**

185 Shady Lane Drive  
Norwalk, Ohio 44857-2373  
PCSA Phone: (419) 668-8126  
PCSA Fax: (419) 668-4738  
PCSA After-hours Phone: (419) 668-5281  
TTY/TDD: (419) 668-8126  
Hours of operation: 8-4:30, M,W-F; 8-5:30, T  
E-mail Address: [jobs@accnorwalk.com](mailto:jobs@accnorwalk.com)

**Jackson County PCSA**

25 East South Street  
Jackson, Ohio 45640  
PCSA Phone: (740) 286-4181  
PCSA Fax: (740) 286-4775  
PCSA After-hours Phone: 1-800-252-5554  
TTY/TDD: (740) 286-5246  
Hours of operation: 8-4:30, M,T,Th,F; 7:30-5:30, W

**Jefferson County PCSA**

240 John Scott Memorial Highway  
Steubenville, Ohio 43952-3090  
PCSA Phone: (740) 264-5515  
PCSA Fax: (740) 264-2860  
PCSA After-hours Phone: (740) 264-5515  
TTY/TDD: (888) 215-2272  
Hours of operation: 8-4:30, M-F

**Knox County PCSA**

117 East High Street, Fourth Floor  
Mount Vernon, Ohio 43050-3400  
PCSA Phone: (740) 397-7177  
PCSA Fax: (740) 392-1249  
PCSA After-hours Phone: (740) 392-KIDS(5437)  
TTY/TDD: None  
Hours of operation: 7:30-4:30, M,W-F; 7:30-6:00, W

**Lake County PCSA**

177 Main Street  
Painesville, Ohio 44077-9967  
PCSA Phone: (440) 350-4000  
PCSA Fax: (440) 350-4399  
PCSA After-hours Phone: (440) 350-4000  
TTY/TDD: (440) 350-3321  
Hours of operation: 8-4:30, M,T,Th,F; 7:30-6, W

**Lawrence County PCSA**

1100 South Seventh Street  
P.O. Box 539  
Ironton, Ohio 45638-0539  
PCSA Phone: (740) 532-3324  
PCSA Fax: (740) 532-9490  
PCSA After-hours Phone: (740) 532-1176  
TTY/TDD: (740) 532-3080  
Hours of operation: 7:30-4:30, M-F

**Licking County PCSA**

74 South Second Street  
P.O. Box 5030  
Newark, Ohio 43058-5030  
PCSA Phone: (740) 349-6225  
PCSA Fax: (740) 349-6230  
PCSA After-hours Phone: (740) 349-6400 Sheriff  
TTY/TDD: Available on request  
Hours of operation: 7-5, M-F  
E-mail Address: [lcdhs@msmisp.com](mailto:lcdhs@msmisp.com)  
World Wide Web Site:  
<http://www.msmisp.com/lcdhs>



**Logan County PCSA**

1855 State Route 47 West  
 Bellefontaine, Ohio 43311-9329  
 PCSA Phone: (937) 599-7290  
 PCSA Fax: (937) 599-7296  
 PCSA After-hours Phone: (937) 592-5731  
 TTY/TDD: None  
 Hours of operation: 8:00-4:30, M-F

**Lorain County PCSA**

226 Middle Avenue  
 Elyria, Ohio 44035-5644  
 PCSA Phone: (440) 329-5340  
 PCSA Fax: (440) 329-5378  
 PCSA After-hours Phone: (440) 329-2121  
 TTY/TDD: (440) 329-5344  
 Hours of operation: 8-4:30, M-F  
 World Wide Web:  
<http://www.childrens-services.org>

**Lucas County PCSA**

705 Adams Street  
 Toledo, Ohio 43624-1602  
 PCSA Phone: (419) 213-3200  
 PCSA Fax: (419) 327-3291  
 PCSA After-hours Phone: (419) 213-3200  
 TTY/TDD: (419) 327-3559  
 Hours of operation: 8:30-4:30, M-F

**Madison County PCSA**

200 Midway Street  
 London, Ohio 43140-1356  
 PCSA Phone: (740) 852-4770  
 PCSA Fax: (740) 852-4756  
 PCSA After-hours Phone: (740) 852-4770  
 TTY/TDD: (740) 852-4770, 1-800-852-0243  
 Hours of operation: 8-4, M-F

**Mahoning County PCSA**

2801 Market Street, Room 206  
 Youngstown, Ohio 44507-1671  
 PCSA Phone: (330) 783-0411  
 PCSA Fax: (330) 783-3373  
 PCSA After-hours Phone: (330) 783-0411  
 TTY/TDD: (330) 783-0411  
 Hours of operation: 8:30-4:30, M-F  
 E-mail Address: [steward@odjfs.state.oh.us](mailto:steward@odjfs.state.oh.us)  
 World Wide Web: [www.mahoningkids.com](http://www.mahoningkids.com)

**Marion County PCSA**

1680 Marion-Waldo Road  
 Marion, Ohio 43302-7426  
 PCSA Phone: (740) 389-2317  
 PCSA Fax: (740) 386-2032  
 PCSA After-hours Phone: (740) 382-8244  
 TTY/TDD: None listed  
 Hours of operation: 8-4:30, M-F

**Medina County PCSA**

232 Northland Dr.  
 Medina, Ohio 44256  
 PCSA Phone: (330) 722-9283  
 PCSA Fax: (330) 722-9352  
 PCSA After-hours Phone: (330) 725-6631  
 TTY/TDD: None  
 Hours of operation: 8-4:30, M-F  
 E-mail Address: [medina@mdjfs.org](mailto:medina@mdjfs.org)  
 World Wide Web: <http://www.mcjfs.org>

**Meigs County PCSA**

175 Race Street  
 P.O. Box 191  
 Middleport, Ohio 45760-0191  
 PCSA Phone: (740) 992-2117  
 PCSA Fax: (740) 992-5688  
 PCSA After-hours Phone: (740) 992-3658  
 TTY/TDD: (740) 992-2117  
 Hours of operation: 8-4:30, M-F  
 World Wide Web: <http://www.meigsdjfs.net>

**Mercer County PCSA**

220 W. Livingston St. Suite 10  
 Celina, Ohio 45822-1797  
 PCSA Phone: (419) 586-5106  
 PCSA Fax: (419) 586-5643  
 PCSA After-hours Phone: (419) 586-7724  
 TTY/TDD: None listed  
 Hours of operation: 8-4:30, M-F  
 E-mail Address: [cromwk@odjfs.state.oh.us](mailto:cromwk@odjfs.state.oh.us)

**Miami County PCSA**

1695 Troy-Sidney Road  
 Troy, Ohio 45373-9743  
 PCSA Phone: (937) 335-4103  
 PCSA Fax: (937) 339-7533  
 PCSA After-hours Phone: (937) 339-6400 Sheriff  
 TTY/TDD: None  
 Hours of operation: 8-5, M-F

**Monroe County PCSA**

100 Home Avenue  
Woodsfield, Ohio 43793-0638  
PCSA Phone: (740) 472-1602  
PCSA Fax: (740) 472-5666  
PCSA After-hours Phone: (740) 472-1612-Sheriff  
TTY/TDD: None  
Hours of operation: Mon 8-6:30; Tues-Fri 8-4:30

**Montgomery County PCSA**

3304 North Main St.  
Dayton, Ohio 45405  
PCSA Phone: (937) 224-5437  
PCSA Fax: (937) 276-6601  
PCSA After-hours Phone: (937) 276-1643  
TTY/TDD: None listed  
Hours of operation: 8:30-5, M-F  
E-mail Address: [anns@montcsb.mhs.compuserve.com](mailto:anns@montcsb.mhs.compuserve.com)  
World Wide Web: <http://www.montcsb.org>

**Morgan County PCSA**

155 E. Main St., Rm. 009  
McConnelville, Ohio 43756  
PCSA Phone: (740) 962-3838  
PCSA Fax: (740) 962-5344  
PCSA After-hours Phone: (740) 962-3333  
TTY/TDD: (740) 962-2754  
Hours of operation: 7-6 M, 7-3:30 Tu-F

**Morrow County PCSA**

619 West Marion Road  
Mount Gilead, Ohio 43338-1280  
PCSA Phone: (419) 947-5444  
PCSA Fax: (419) 947-1076  
PCSA After-hours Phone: (419) 946-6991 Sheriff  
TTY/TDD: (740) 962-2754  
Hours of operation: 8-4:30, M-F  
E-mail Address: [waked@odjfs.state.oh.us](mailto:waked@odjfs.state.oh.us)

**Muskingum County PCSA**

205 North Seventh Street  
P.O. Box 157  
Zanesville, Ohio 43702-0157  
PCSA Phone: (740) 455-6710  
PCSA Fax: (740) 455-6719  
PCSA After-hours Phone: (740) 849-2344  
TTY/TDD: None  
Hours of operation: 8-4:30, M-F  
E-mail Address: [mccs@ee.net](mailto:mccs@ee.net)

**Noble County PCSA**

18065 SR 78  
P.O. Box 250  
Caldwell, Ohio 43724-0250  
PCSA Phone: (740) 732-2392  
PCSA Fax: (740) 732-4108  
PCSA After-hours Phone: (740) 732-5631(Sheriff)  
TTY/TDD: (740) 732-1412  
Hours of operation: 8-7 M, 8-4:30, T-F  
E-mail Address: [boydd01@odjfs.state.oh.us](mailto:boydd01@odjfs.state.oh.us)

**Ottawa County PCSA**

8043 West State Route 163, Suite 200  
Oak Harbor, Ohio 43449  
PCSA Phone: (419) 898-3688  
PCSA Fax: (419) 898-2048  
PCSA After-hours Phone: (419) 734-4404 Sheriff  
TTY/TDD: (419) 898-3688  
Hours of operation: 8-4:30, M-F  
E-mail Address: [robend@odjfs.state.oh.us](mailto:robend@odjfs.state.oh.us)

**Paulding County PCSA**

303 West Harrison Street  
Paulding, Ohio 45879-1497  
PCSA Phone: (419) 399-3756  
PCSA Fax: (419) 399-4674  
PCSA After-hours Phone: (419) 399-3791 Sheriff  
TTY/TDD: None  
Hours of operation: 8-4:30, M,W,Th,F; 8-6, T  
E-mail Address: [grosss@odjfs.state.oh.us](mailto:grosss@odjfs.state.oh.us)

**Perry County PCSA**

526 Mill Street  
New Lexington, Ohio 43764-1478  
PCSA Phone: (740) 342-3836  
PCSA Fax: (740) 342-5531  
PCSA After-hours Phone: (740) 342-3836  
TTY/TDD: Available at (740) 342-3836  
Hours of operation: 8:30-4:30, M-F

**Pickaway County PCSA**

110 Island Road  
P.O. Box 439  
Circleville, Ohio 43113-0439  
PCSA Phone: (740) 474-7588  
PCSA Fax: (740) 477-1023  
PCSA After-hours Phone: (740) 474-7588  
TTY/TDD: Available at (740) 474-7588/3105  
Hours of operation: 8-4:30, M-F  
E-mail Address: [info@pickawayjfs.org](mailto:info@pickawayjfs.org)  
World Wide Web: <http://pickawayjfs.org>

**Pike County PCSA**

525 Walnut Street  
Waverly, Ohio 45690-1161  
PCSA Phone: (740) 947-5080  
PCSA Fax: (740) 947-8413  
PCSA After-hours Phone: (740) 290-4941  
TTY/TDD: None listed  
Hours of operation: 8-4:30, M-F  
E-mail Address: [amlinp@odjfs.state.oh.us](mailto:amlinp@odjfs.state.oh.us)

**Portage County PCSA**

449 South Meridian Street, Second Floor  
Ravenna, Ohio 44266-1208  
PCSA Phone: (330) 298-1102  
PCSA Fax: (330) 298-1107  
PCSA After-hours: (330) 296-2273  
TTY/TDD: None listed  
Hours of operation: 8-4:30, M-F

**Preble County PCSA**

1500 Park Avenue  
Eaton, Ohio 45320  
PCSA Phone: (937) 456-1135  
PCSA Fax: (937) 456-6086  
PCSA After-hours Phone: (937) 456-1135  
TTY/TDD: None  
Hours of operation: 7:30-4:30, M-F  
E-mail Address: [SHUTES@odjfs.state.oh.us](mailto:SHUTES@odjfs.state.oh.us)

**Putnam County PCSA**

1225 East Third Street  
Ottawa, Ohio 45875-2062  
PCSA Phone: (419) 523-4580  
PCSA Fax: (419) 523-6130  
PCSA After-hours Phone: (419) 532-3208  
TTY/TDD: None  
Hours of operation: 8-4:30, M-F

**Richland County PCSA**

731 Scholl Road  
Mansfield, Ohio 44907-1571  
PCSA Phone: (419) 774-4100  
PCSA Fax: (419) 774-4103  
PCSA After-hours Phone: (419) 774-4357  
TTY/TDD: Available at (419) 774-4156  
Hours of operation: 8-4:30, M-F  
E-mail Address:  
[info@richlandcountychildrenservices.org](mailto:info@richlandcountychildrenservices.org)

**Ross County PCSA**

381 Western Avenue- Suite B  
P.O. Box 469  
Chillicothe, Ohio 45601  
PCSA Phone: (740) 773-2651  
PCSA Fax: (740) 772-7552  
PCSA After-hours Phone: (740) 773-2651  
TTY/TDD: 1-800-750-0750  
Hours of operation: 7:30-5:00, M-F; 7:30-7, Th

**Sandusky County PCSA**

2511 Countryside Drive  
Fremont, Ohio 43420-9987  
PCSA Phone: (419) 334-8708  
PCSA Fax: (419) 355-5329  
PCSA After-hours Phone: (419) 334-8708  
TTY/TDD: (419) 334-8231  
Hours of operation: 8-4:30, M-F

**Scioto County PCSA**

3940 Gallia Street  
New Boston, Ohio 45662  
PCSA Phone: (740) 456-4164  
PCSA Fax: (740) 456-6728  
PCSA After-hours Phone: (740) 456-4164  
TTY/TDD: (740) 456-4164  
Hours of operation: 8-4:30, M-F

**Seneca County PCSA**

3362 South Township Road 151  
Tiffin, Ohio 44883-9499  
PCSA Phone: (419) 447-5011  
PCSA Fax: (419) 447-5275  
PCSA After-hours Phone: (419) 447-3456  
TTY/TDD: (419) 448-7036  
Hours of operation: 8-4:30, M-F

**Shelby County PCSA**

227 South Ohio Ave.  
Sidney, Ohio 45365  
PCSA Phone: (937) 498-4981  
PCSA Fax: (937) 498-1492  
PCSA After-hours Phone: (937) 498-1111(Sheriff)  
TTY/TDD: None listed  
Hours of operation: 7:30-4:30, M-F  
E-mail Address: [beyt01@odjfs.state.oh.us](mailto:beyt01@odjfs.state.oh.us)

**Stark County PCSA**

220 East Tuscarawas Street  
Canton, Ohio 44702-1293  
PCSA Phone: (330) 451-8846  
PCSA Fax: (330) 451-8706  
PCSA After-hours: (330) 455-5437;  
1-800-233-5437  
TTY/TDD: (330) 451-8879  
Hours of operation: 8-4:45, M-F  
World Wide Web:  
<http://www.djfs.co.stark.oh.us>

**Summit County PCSA**

264 South Arlington Street  
Akron, Ohio 44306-1399  
PCSA Phone: (330) 379-9094  
PCSA Fax: (330) 379-1981  
PCSA After-hours Phone: (330) 379-1880  
TTY/TDD: (330) 379-2036  
Hours of operation: 8-4:30, M-F  
E-mail Address: [chumble@summitkids.org](mailto:chumble@summitkids.org)  
World Wide Web: <http://www.summitkids.org>

**Trumbull County PCSA**

2282 Reeves Road Northeast  
Warren, Ohio 44483-4354  
PCSA Phone: (330) 372-2010  
PCSA Fax: (330) 372-3446  
PCSA After-hours Phone: (330) 372-2010  
TTY/TDD: Available at (330) 372-2010  
Hours of operation: 8:30-4:30, M-F  
E-mail Address: [trumb-csb@neonet.net](mailto:trumb-csb@neonet.net)

**Tuscarawas County PCSA**

389 16th Street, SW  
New Philadelphia, Ohio 44663-6401  
PCSA Phone: (330) 339-7791  
PCSA Fax: (330) 339-6388  
PCSA After-hours Phone: (330) 339-2000  
TTY/TDD: (800) 431-2347  
Hours of operation: 8-4:45, M-F  
E-mail Address:  
[tusc\\_cdjfs\\_email@odjfs.state.oh.us](mailto:tusc_cdjfs_email@odjfs.state.oh.us)  
World Wide Web: <http://web.tusco.net/tcifs/>

**Union County PCSA**

940 London Avenue, Suite 1800  
Marysville, Ohio 43040-0389  
PCSA Phone: (937) 644-1010  
PCSA Fax: (937) 644-8700  
PCSA After-hours Phone: (937) 644-4130 Sheriff  
TTY/TDD: Available at (800) 248-2347  
Hours of operation: 7:30-5, M-F

**Van Wert County PCSA**

114 East Main Street  
P.O. Box 595  
Van Wert, Ohio 45891-0595  
PCSA Phone: (419) 238-5430  
PCSA Fax: (419) 238-6045  
PCSA After-hours Phone: (419) 238-3866(Sheriff)  
TTY/TDD: (419) 238-5498  
Hours of operation: 8:00-4:30, M-F

**Vinton County DJFS**

30975 Industry Park Drive  
McArthur, Ohio 45651  
PCSA Phone: (740) 596-2584  
PCSA Fax: (740) 596-1802  
PCSA After-hours Phone: (740) 596-5242  
TTY/TDD: None listed  
Hours of operation: 8-4:30, M-F

**Warren County PCSA**

416 South East Street  
Lebanon, Ohio 45036-0620  
PCSA Phone: (513) 695-1546  
PCSA Fax: (513) 695-2957  
PCSA After-hours Phone: (513) 695-1600  
TTY/TDD: None  
Hours of operation: 8-5, M-F

**Washington County PCSA**

204 Davis Avenue  
Marietta, Ohio 45750-0360  
PCSA Phone: (740) 373-3485  
PCSA Fax: (740) 373-1856  
PCSA After-hours Phone: (740) 373-3485  
TTY/TDD: None  
Hours of operation: 8-5, M-F  
World Wide Web:  
<http://co.washington.oh.us/asp/childrenservices/ss-child>

**Wayne County PCSA**

2534 Burbank Road  
Wooster, Ohio 44691-1600  
PCSA Phone: (330) 345-5340  
PCSA Fax: (330) 345-7082  
PCSA After-hours Phone: (330) 345-5340  
TTY/TDD: None listed  
Hours of operation: 8-5, M-F

**Williams County PCSA**

117 West Butler Street  
Bryan, Ohio 43506-1650  
PCSA Phone: (419) 636-6725  
PCSA Fax: (419) 636-8843  
PCSA After-hours Phone: (419) 636-3151-Sheriff  
TTY/TDD: None  
Hours of operation: 8-5, M-F

**Wood County PCSA**

1928 East Gypsy Lane Road  
P.O. Box 679  
Bowling Green, Ohio 43402  
PCSA Phone: (419) 352-7566  
PCSA Fax: (419) 352-5951  
PCSA After-hours Phone: (419) 354-9001  
TTY/TDD: None  
Hours of operation: 8-4:30, M, W, R, F; 8-6 T

**Wyandot County PCSA**

120 East Johnson Street  
Upper Sandusky, Ohio 43351  
PCSA Phone: (419) 294-4677  
PCSA Fax: (419) 294-5874  
PCSA After-hours Phone: (419) 294-2362  
TTY/TDD: None listed  
Hours of operation: 8-4:30, M-F  
E-mail Address:  
[BENNEW@ODJFS.STATE.OH.US](mailto:BENNEW@ODJFS.STATE.OH.US)

# WHAT DOES THE CHILDREN'S SERVICES AGENCY DO WHEN SUSPECTED CHILD ABUSE OR NEGLECT IS REPORTED?

**Public children services agency (PCSA) begins investigation.** When a report of suspected child abuse or neglect is received either directly by PCSA or by referral from a law enforcement agency, PCSA determines if the circumstances as described pose an immediate threat of harm to the child's health and well being (such as alleged abandonment or severe physical abuse of the child, or alleged mental instability of the child's parents or custodians). In these instances, PCSA provides immediate emergency intervention. If a report is determined not to be an emergency, PCSA begins an investigation within 24 hours to determine the validity of the allegation. The investigation includes a visit to the child's home to interview the parents/custodians and the child. Contact may also be made with community professionals who may be able to provide additional information or services: school personnel, hospital and family physicians, public health nurses, mental health counselors.

Through interview, observation, and collateral contacts, **PCSA makes one of three determinations regarding the report:**

**Report unsubstantiated:**

Investigation determined no evidence of child abuse or neglect.

**Report indicated:** Investigation determined circumstantial, or other isolated indicators of child abuse or neglect lacking confirmation or a determination by the caseworker that the child has been abused or neglected based upon the completion of an assessment/investigation.

**Report substantiated.** There is an admission of child abuse or neglect by the person responsible; an adjudication of child abuse or neglect; or other forms of confirmation deemed valid by the PCSA.

**No court involvement required: In-home services provided. Child remains in home.** Most cases of abuse or neglect do not require court involvement. Most families do not neglect or injure a child with willful intent, and will accept help in correcting the circumstances which caused the occurrence. While the primary goal of the PCSA is the safety, well being and permanency of the child, it is important to remember that the trauma caused by removing a child from his home may often be as damaging as the act of neglect or abuse

itself. For this reason, the child will not be removed from the home if there is no serious threat to his health and well being. Services will be provided to the family and child as a unit.

**Court involvement required:** If the family refuses services or if it is potentially harmful for the child to remain in the home, court involvement will be initiated. PCSA and the law enforcement agency consult with and make recommendations to the county prosecutor. In cases of severe abuse or neglect, the county prosecutor will determine if filing charges against the alleged perpetrator is appropriate.

**Court orders services for family: Child remains in home.** The court may place the family under protective services supervision. The court permits the child to remain in the home with the stipulation that the family participate in appropriate community services, such as parenting education classes, mental health counseling, homemaker services.

**Court orders placement of child.** The court may determine it is potentially harmful to the child's health and well being to remain in the home. The court will order removal of the child from the home. In most cases, temporary custody of the child will be given to the PCSA, and placement will be made in a substitute care setting.

**Court orders child placed in temporary substitute care setting. Child and family provided services.** The court orders the child placed in a substitute care setting. PCSA chooses the setting most appropriate to the child's age and personal needs, such as the home of a relative, a foster home, or a group home. The purpose of this type of placement is to remove the child from threat of danger while allowing the parents/custodians the opportunity to correct the circumstances which contributed to or caused the abuse or neglect.

**Court orders termination of parental rights.** If the court determines that the child's parents/custodians cannot or will not provide the care necessary to ensure the child's healthy physical and emotional development, parental rights will be terminated and the child freed for placement in a permanent adoptive home. Parental rights are terminated only when it is clearly demonstrated that the parents/custodians are unable or unwilling to meet or adapt to minimum standards of care.

**PCSA matches community resources to needs of family.** PCSA helps the family recognize and overcome the factors which contributed to or caused the abuse or neglect. Together they identify and set goals aimed to create a home environment suitable for the child. In cases where the risk of future harm is assessed to be moderate or high, the PCSA provides support and guidance to the family in order to reduce or eliminate those dynamics that are impacting the safe care of the child. Many communities have multi-disciplinary teams to assist in the selection of comprehensive and effective services. PCSA workers, physicians, nurses, educators, mental health workers, and law enforcement personnel combine their expertise to provide a broad-based range of skills for treatment planning.

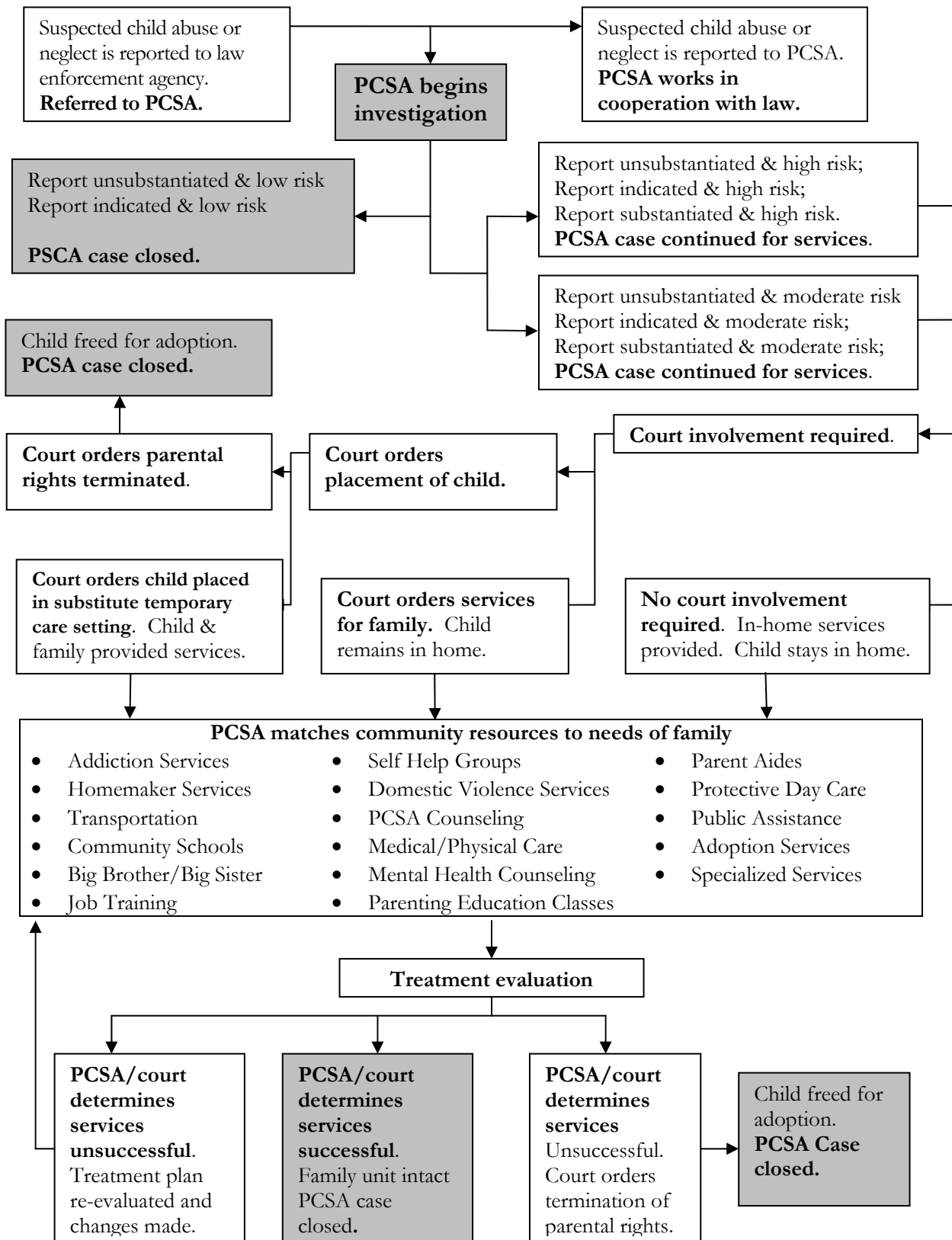
**Treatment evaluation:** Every child has the basic human right to a permanent and stable home. Early in the treatment planning, the family and the PCSA worker set time-limited guidelines for the achievement of agreed-upon goals. To avoid having the child in limbo for an indefinite time, the PCSA worker and the family periodically evaluate the family's progress.

**PCSA/court determines services successful. Family unit intact:** Through the provision of appropriate supportive services, most families are able to prevent the recurrence of abuse or neglect. An estimated 90% of people involved in abuse or neglect can be treated successfully.

**PCSA/court determines services unsuccessful.** Treatment plan is reevaluated and changes made. A family may suffer a setback during the time services are provided. An unexpected crisis, unrealistic goals, or inappropriate service selection may prevent the family from achieving set objectives within the agreed-upon time frame. When this occurs, the family and the PCSA worker reevaluate the treatment plan to determine appropriate changes to be made.

**PCSA/court determines services unsuccessful.** Court orders termination of parental rights. If it becomes apparent during the treatment program that the parents/custodians are unwilling or unable to accomplish the goals necessary to meet minimum standards of care for the child, PCSA requests the court to terminate parental rights and free the child for a permanent adoptive placement.





For Medical and  
Health  
Professionals

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# APPROACHING THE PROBLEM

Determining whether an injury in a child is due to child abuse can be difficult. Child abuse and neglect will frequently present itself as a series of unexplained injuries or conditions. The challenge to the health professional is to accurately identify those injuries or conditions, which are non-accidental and to quickly identify the proper treatment and intervention.

For many health professionals confronted with the suspicion of child abuse or neglect, the choice of proper action steps can be difficult. However, child abuse and neglect should be thought of as any other pediatric illness. The medical professional's responsibility to the patient is the same, and the diagnostic evaluation must be approached in the same logical manner.

## SUSPECTED CHILD ABUSE AND NEGLECT EVALUATION PLAN

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1. Interview child, if age appropriate.
2. Interview parents and take a medical history.
3. Perform a complete physical examination.
4. Evaluate presenting symptoms for indicators of child abuse or neglect.
5. Determine types of additional medical, social, and psychological information necessary to consider alternative diagnoses.
6. Determine emergency medical and protective actions to be taken for the child.
7. Refer suspicions to local children services or law enforcement agency.
8. Determine need for hospitalization for treatment, observation, or protection.
9. Identify additional diagnostic information to be gathered; list specific persons and agencies to be contacted and utilized as resource.
10. Schedule physical examinations for other children in the home. Any other child residing in the home with the suspected victim should also be physically examined with 24 hours, and protective actions considered as well.

# INTERVIEWING THE CHILD

The first step to a successful interview is establishing its purpose. When preparing to interview a suspected child victim, the health professional must remember that the purpose of the medical interview is to gather sufficient information to make a diagnosis and determine a course of treatment, not to validate abuse or neglect or identify the perpetrator. This is the responsibility of the public children services or law enforcement agency. Still, your roles, although distinctly separate, are interdependent. The information you gather through the medical assessment will:

- Form the basis for any civil action, which is taken to protect the child.
- Be a critical factor in deciding the need to initiate criminal charges.
- Guide the immediate action to be taken by children services personnel.
- Provide important support to social service and children service personnel in determining the most effective method of helping the family and ameliorating the causes of abuse or neglect.

When eliciting information from the child, keep in mind he is not a miniature adult. His emotional needs and cognitive and verbal capabilities are different from those of an adult. Your interview approach must reflect these differences.

- Make sure the child is comfortable. Identify the probable mood of the child from nonverbal and behavioral expression. Adjust your manner accordingly to convey reassurance and caring.
- Don't be rushed. Allow yourself and the child plenty of time. Do not check your watch, show impatience, or indicate that there is any matter more pressing than the child before you.
- Slow the tempo of your normal interview. Children are slower in responding to questions, and may be fearful of answering. Avoid rapid or abrupt questions.
- Use simple, age-appropriate vocabulary. Do not use compound sentences requiring multiple responses or abstract terms.
- If you suspect abuse or neglect has been perpetrated by the parents, and the child is secure in separation, speak with the child alone. Send parents and other family members into another room to wait. Items of fact, such as name, age, and address, may be obtained from the parents separately.
- Tell the child your name, why you are there, and that you are a doctor (nurse, social worker). Make sure that the child understands in simple terms what you do.
- Begin with open-ended questions and ask as many open-ended questions as possible. Use specific questions for clarification only.
- Write down the child's exact words in quotations, if necessary.
- Have a non-judgmental demeanor.
- Your interest is the child's physical and mental health. Confine your questions to this area. When pursuing the cause of injuries, allow for the child's developmental limitations when responding to "who, what, why, where, and when" questions.
- Be aware that the child may become uneasy or fearful. He may fear rejection, punishment, or removal from home.
- Do not force or demand answers or details.
- Do not criticize the child, either directly or by implication.

- Do not attack, criticize, or judge the parent.
- Make no attempt to become intimate or overly friendly by the use of childish talk or condescending mannerisms, such as tweaking the cheek or patting the head.
- Don't make promises you cannot keep: i.e. secrecy, court involvement, or separation of family members.

## INTERVIEWING THE PARENT(S)

Interviewing the parents you suspect of abusing or neglecting their child can be difficult, frustrating, and anxiety-provoking. These reactions can be accentuated by your uncertainty about the purpose of the interview, confusion regarding your role with the parents, or concerns regarding the parents' right to privacy. Fundamental principles of interviewing can be applied to the medical interview to help clarify your role and the interview process.

It is important to remember that, as a medical professional, your role is to diagnose and treat, not accuse, convict, or punish. It is likely that, at some point, treatment will require the commitment and voluntary participation of the suspected victim's parents, regardless of who committed the abuse or neglect. Honesty and the respect due any human being are essential not only to elicit communication from the parents, but also to form the foundation for these later efforts. Take care not to criticize, dominate, ridicule, berate, accuse, set limits of acceptable behavior, or impart your own standards.

Prepare for the interview.

- Establish the purpose of the interview. Clarifying the purpose for yourself will enable you to conduct a direct and straightforward interview.
- Define your objectives for the interview, such as: a) determining the cause of the child's injuries, b) identifying problems and needs as a basis for treatment planning and c) establishing rapport for ongoing relationships with the family.
- Decide on the specific information you want to elicit, such as the child's medical history, social history and environmental context in which the family lives, family dynamics and a history of the injury.

During the interview...

- Use language that is easily understood by the parents and which makes them comfortable.
- Avoid ambiguities in your questions; make sure the parents know what is being asked.
- Avoid accusatory questions or statements. The purpose of the medical interview is to gather data and establish rapport - not to establish the identity of the perpetrator.
- Encourage the parents to maintain expectations of what you can or cannot do for them or what will happen to them as a result of the interview. Setting clear expectations will avoid undue frustration, fear, or feelings of betrayal and can help build an ongoing relationship with the family.
- Allow the caretakers to tell you what happened in their own words; do not solely rely on the history that is recorded in the medical records.
- Clarify your role. Parents may be confused, skeptical, or hostile. It is crucial to be explicit from the outset about what your role is as a medical or health professional. Especially important is defining your position in relation to the criminal justice system, so that parents know what action you can and cannot take with respect to legal intervention. Inform the parent of your role as the interviewer, the purpose of the interview, and the laws which govern the mandatory reporting of suspected child abuse and neglect.
- Listen carefully to what the parents say. In any interview there exists unstated communication. In some cases, information or feelings are implied in what the client says; in others, nonverbal behavior offers clues to how a respondent is feeling or types of information that may not be stated outright. When dealing with professionals, parents frequently feel a need to protect themselves. They may omit or falsify information, or present facts that they feel will be more acceptable to the interviewer. The task of the interviewer is to be aware of clues that omission or falsification may be occurring, while remaining sensitive to the needs or fears of abusive or neglectful parents that may, in fact, precipitate the omission or fabrication.
- **Ask non-accusatory, open-ended questions.** Phrase questions in a way that is open-ended, allowing parents to respond in a manner comfortable for them, rather than feeling trapped by accusatory or offensive kinds of questions. Ask "Tell me again how your child's hand was burned." Don't ask "Was this burn on your child's hand inflicted by either you or your wife?"

When ending the interview...

- Be clear about what will happen to the family as a result of the interview: whether they will be contacted again by you or another professional, and what they can expect from the next contact. Answer any questions the parents may have about the process, about you, their child, or anything else. Make sure all questions have been answered and that the parents' expectations are appropriate before the interview is concluded.

# MEDICAL INDICATORS OF CHILD ABUSE AND NEGLECT

Certain injuries and/or conditions may be associated with child abuse and neglect. These indicators should be considered in light of the explanation provided, the child's/family's medical history, and the child's developmental abilities. Presence of any of these injuries or conditions may indicate a need for immediate referral to children's protective services agency and additional protective action. Child abuse should be considered during the evaluation of any injury. The physician should routinely ask: Is his injury consistent with the history given and the child's developmental capabilities?

## BRUISES/SOFT TISSUE INJURY

Injuries frequently caused by child abuse

- Symmetrical bruises
- Clustered bruises
- Bruises on buttocks or lower back
- Facial bruises (especially on an infant)
- Bruises on inner thigh or genital area
- Bruises of external ear or behind ear
- Lacerated frenula of lips or tongue
- Pharyngeal injuries, tears, or diverticulae
- Neck marks (choke or tie)
- Human adult bite marks
- Subgaleal hemorrhages
- Circumferential bruises
- Bruises at corners of the mouth
- Geometric bruises/scars which suggest the pattern of an instrument, such as:
  - ▶ Loop marks
  - ▶ Strap or belt marks
  - ▶ Lash marks
  - ▶ Linear marks
  - ▶ Rectangular marks
  - ▶ Hand marks
- Grab, squeeze, or pinch marks
- Bald patches interspersed with normal hair growth
- Abrasions/lacerations

Conditions often confused with abusive injuries

- Mongolian spots
- Bleeding disorders
- Petechiae
- Playmate & self-inflicted biting/trauma
- Cao Gio (coin rubbing) or cupping
- Phytophotodermatitis
- Allergic periorbital discoloration
- Henoch-Schoenlein Purpura (HSP)
- Hemangiomas
- Ehlers-Danlos Syndrome
- Spider bites
- Impetigo

## BURNS

Injuries frequently caused by child abuse

- Cigarette burns (circular; often found on palms, face, soles, abdomen)
- Immersion burns – characteristically produce sharp lines of demarcation, appear on buttocks, perineum, genitalia, or extremities – “glove” or “stocking” distribution with sparing areas of flexion
- Rope burns
- Chemical burn
- Contact burns
- Burns in configuration of common household utensil or appliance (iron, curling iron, hairdryer, stun gun)

Conditions often confused with abusive injuries

- Bullous impetigo
- Scalded skin syndrome
- Accidental burn
- Insect bites
- Moxibustion
- Dermatitis on buttocks

## ABDOMINAL/TRUNCAL INJURIES

Injuries frequently caused by child abuse

- Chylous ascites from injured lymphatic system
- Laceration of liver or spleen
- Renal injury
- Pancreatic laceration with subsequent pancreatitis and pseudocyst formation
- Fractured ribs
- Spinal cord injury
- Rupture of small or large intestine
- Hematoma of the duodenum or jejunum
- Rupture of the inferior vena cava
- Lung contusion, pneumothorax, hemothorax

Note: Bruises on trunk may be absent from infants and small children who suffer severe internal injury such as a rupture of a hollow viscus or hematoma of the liver or bowel.



## HEAD INJURY

Injuries frequently caused by child abuse

- Retinal hemorrhage
- Hemorrhages or bruises on the pinna of the ear from a slap or pinch
- Subdural & subarachnoid hematoma
- Skull fracture
- Detached retina
- Bleeding around spinal cord
- Bruising of the face or head

Note: Often an infant or child with abusive head injury will have no external bruising. Abusive head injury can be associated with fractures, such as rib & metaphyseal fractures.

Conditions confused with abusive injuries

- Accidental head injury
- Bleeding disorders (very rarely associated with bleeding into the head)
- Glutaric aciduria type I. Has associated subdural hematomas and characteristic neurological findings such as loss of developmental milestones, specific head CT findings & seizures.

## EYE INJURIES

Injuries frequently caused by child abuse

- Traumatic cataract
- Dislocated lens
- Retinal hemorrhage
- Detached retina

Conditions confused with abusive injuries

- Periorbital ecchymosis from forehead bruising
- Allergic periorbital discoloration

## SKELETAL INJURIES

Fractures with a high specificity for child abuse

- Metaphyseal fractures
- Rib fractures - especially posterior
- Sternum fractures
- Scapular fractures
- Spinous process fractures

Fractures with a moderate specificity for child abuse

- Epiphyseal separation
- Complex skull fractures
- Vertebral body fractures

Common fractures but with a low specificity for child abuse

- Periosteal reaction or elevation
- Long bone shaft fracture
- Linear skull fractures
- Clavicular fractures

Conditions confused with abusive skeletal injury

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>■ Accidental trauma</li> <li>■ Normal variants</li> <li>■ Physiologic periosteal new bone</li> <li>■ Skeletal dysplasia               <ul style="list-style-type: none"> <li>▶ Osteogenesis imperfecta</li> </ul> </li> <li>■ Obstetric trauma</li> <li>■ Infection               <ul style="list-style-type: none"> <li>▶ Congenital syphilis</li> <li>▶ Osteomyelitis</li> </ul> </li> <li>■ Nutritional/Metabolic disorders               <ul style="list-style-type: none"> <li>▶ Rickets</li> <li>▶ Scurvy</li> <li>▶ Secondary hyperparathyroidism</li> <li>▶ Menkes' syndrome</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>■ Drug toxicity               <ul style="list-style-type: none"> <li>▶ Prostaglandin E</li> <li>▶ Hypervitaminosis A</li> <li>▶ Methotrexate</li> </ul> </li> <li>■ Prematurity</li> <li>■ Neuromuscular defect               <ul style="list-style-type: none"> <li>▶ Myelodysplasia</li> <li>▶ Cerebral palsy</li> <li>▶ Congenital insensitivity to pain</li> </ul> </li> <li>■ Neoplasm               <ul style="list-style-type: none"> <li>▶ Leukemia</li> <li>▶ Histiocytosis X</li> <li>▶ Metastatic neuroblastoma</li> </ul> </li> <li>■ Infantile cortical hyperostosis (Caffey disease)</li> </ul> |
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Ref 1: Kleinman PK. Skeletal trauma: general considerations. In Kleinman PK, ed. Diagnostic imaging of child abuse. St. Louis: Mosby, 1998; 8-25.

Ref 2: Cooperman DR, Merten DF. Skeletal manifestations of child abuse. In Reece RM, Ludwig S, eds. Child Abuse: Medical Diagnosis and Management. Philadelphia: Lippincott Williams & Wilkins, 2001; 123-156.

## SEXUAL ABUSE

Findings that are clear evidence of sexual abuse  
these findings have no explanation other than trauma.

- Lacerated hymen
- Bruising of the hymen
- Healed hymenal transection-torn through to base
- Absence of hymenal tissue in inferior half of rim
- Presence of semen
- Bruised or swollen scrotum or penis
- Anal lacerations
- Pregnancy
- Certain sexually transmitted infections (see table below)

Findings concerning for sexual abuse  
these findings are seen more commonly in sexually abused children compared to non-abused children but they are not diagnostic of sexual abuse.

- Lacerated, friable, or scarred fourchette
- Abrasion, bruise or laceration to labia
- Injury to the perineum
- Hymenal cleft in the inferior half of the hymenal rim which is persistent in all examination positions
- Certain sexually transmitted infections (see table below)

Non-specific findings  
these findings may be due to sexual abuse, but may also be due to other causes.

- Vaginitis
- Vulvitis
- Discharge
- Recurrent urinary tract infections
- Pain or itching in genital area
- Dysuria
- Hematuria
- Enuresis
- Encopresis
- Genital erythema

Conditions often confused with sexual abuse

- “Straddle injury”
- Pinworm infestation
- Poor genital hygiene
- Soap sensitivity
- Foreign body
- Urethral prolapse
- Urethral polyp
- Labial adhesions
- Infections (candidal, streptococcal)
- Lichen sclerosis
- Dye from clothing
- Premature menses

## Likelihood of sexual transmission of specific sexually transmitted diseases

Sexually Transmitted Disease	Likelihood of sexual transmission
Gonorrhea*	Very high
Chlamydia*	Very high
Syphilis*	Very high
HPV*	Possible
Trichomonas	High
HSV	Possible
HIV*+	Very high
Bacterial Vaginosis	Low
Hepatitis B	Possible

HIV = Human Immunodeficiency Virus

HPV = Human Papilloma Virus

HSV = Herpes Simplex Virus

\* = exclude perinatal transmission

+ = if not transfusion acquired

## NEGLECT

There are different types of neglect which reflect the different basic needs of children that are not adequately met. This focus is on the types that are likely to be encountered by health care providers.

- Poor skin hygiene
- Lack of medical attention for infections or injuries
- Failure or delay in seeking health care
- Chronically inadequate dental care
- Lack of necessary immunizations
- Hunger, failure to thrive
- Educational needs not being met
- inadequate supervision or abandonment

It is important to limit the definition of neglect to those practices which may jeopardize a child's health and safety. Other contributing social, religious and medical factors which must be considered include:

- Poverty, inadequate parenting knowledge, lack of transportation
- Folk medicine practices
- Religious practices, beliefs
- Medical causes of failure to thrive; constitutional short stature

# WHEN TO ADMIT THE CHILD TO THE HOSPITAL

Refer to the AAP policy statement “**Medical Necessity for the Hospitalization of the Abused and Neglected Child**” found in Section 5 of this book.

## MAKING THE REPORT

The decision to report suspected child abuse or neglect can be intimidating to the health professional. You may feel confusion over what seems to be a conflict of professional ethics regarding the parents’ right to confidentiality and the patient’s right to treatment. It is important to recognize that the child – not the parent – is your patient. Your professional obligation is to the child’s well being. Failing to report suspected child abuse or neglect places the child at a high risk of re-injury. History tells us that child abuse or neglect rarely stops without professional help; there is instead a tendency for escalation over time.

Section 2151.421 of the Ohio Revised Code requires physicians and other professionals who come into contact with children to report suspected abuse or neglect to the proper authorities. Any mandated reporter, such as a physician (including a hospital intern or resident), dentist, podiatrist, nurse, health care worker or social worker, who has reason to believe that a child has been abused or neglected must report the suspected abuse or neglect to the children services or law enforcement agency in the county in which the child lives or the abuse or neglect occurred. Anyone or any hospital or agency, participating in the report of suspected abuse or neglect, or any judicial proceeding resulting from a report, is immune from any civil or criminal liability that otherwise might result from such action.

Some health professionals are concerned that a report will alienate the family and impede treatment of the child. The need for intervention far outweighs this consideration; however, there are actions which the health professional can take to minimize conflict. When making a report of suspected child abuse or neglect:

- Maintain honest and open communication with the family. Your actions now will form your future relationship.
- Tell the parents of your intent to make a report. You have the responsibility to conduct yourself in a truthful and professional manner. Parents should be informed of your concern for the child and your legal obligation to report injuries of this nature. Secretive or misleading behavior is unethical and counterproductive to the child's well being.
- Be supportive of the parents. Acknowledge the parents' concern for their child's well being and their desire for complete diagnosis and appropriate treatment.
- Do not confront or accuse. It is sufficient to state that you are worried about the child's condition and concerned that someone might have harmed him.
- Stress your shared desire to seek the best treatment for the child.
- Review your medical findings with the parents. It is the parents' right to be informed. Explaining the generalities of the medical report, as you would with any other presenting condition, reinforces your understanding of the situation and professional standing.
- Be patient and non-argumentative. Recognize that the parents are in a period of crisis. If the parents remain confrontational or hostile, you can advise them of their right to obtain legal counsel and restate your legal obligation to report.

## "Baby Doe"

J. PHILLIP JONES, D.O., WILLIAM H. CARLSON, D.O.,  
D. THOMAS CLARK, D.O.

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On April 9, 1982, in Bloomington, Indiana, "Baby Doe" was born with Down Syndrome (Trisomy 21) complicated by esophageal atresia and tracheo-esophageal fistula. The latter congenital defect is treated in most, if not all, children's hospitals throughout the nation by teams of skillful physicians, in this case, Baby Doe's obstetrician and pediatrician were on opposite sides of a spirited debate. The obstetrician felt that the baby should not receive further treatment, while the baby's pediatrician opted for treating the condition. After consideration, the baby's parents decided to forego any treatment. Since the baby was unable to take oral sustenance, the parents elected not to have I.V. fluids instituted. Subsequently, the juvenile court decided, after meeting with the baby's pediatrician, obstetrician, and parents, that the baby should not receive protection from the courts and sustained the parents' decision to forego treatment. The decision was appealed to the Indiana Supreme Court which upheld the parents' decision as Baby Doe died of dehydration, pneumonia, and seizures.

The epic case culminated in the Baby Doe regulations with which we have become quite familiar. The final regulations went into effect on May 15, 1985. These regulations were based initially upon the federal law, section 504 of the Rehabilitation Act of 1973, which applies to programs or activities receiving federal financial assistance. This law prohibits discrimination based upon handicap. "Under this law, nourishment and medically beneficial treatment (as determined with respect for reasonable medical judgments) should not be withheld from handicapped infants solely on the basis of their present or anticipate mental or physical impairment."<sup>1</sup>

Because of the debate between the American Academy of Pediatrics, American Medical Association and the federal government, including the federal court, the regulations were changed, taking final form on April 15, 1985, near the third anniversary of Baby Doe's birth. The final regulations explicitly extend the meaning of the term "medical neglect" to include "the withholding of medically indicated treatment from a disabled infant with a life-threatening condition," and give further definition as to what that means. The rule designates the children services agency of each state to be responsible to see that no infant is the victim of "medical neglect."<sup>2</sup>

What is the exact definition of withholding medically indicated treatment? It is "the failure to respond to the infant's life-threatening conditions by providing treatment (including appropriate nutrition, hydration, and medication (which, in the treating physician's (or physicians') reasonable

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<sup>1</sup> Murray, T.H., The Final, Anticlimactic Rule on "Baby Doe," Hastings Center Report 1985, pp. 5-9.

<sup>2</sup> Ibid.

medical judgment will be most likely to be effective in ameliorating or correcting all such conditions....”<sup>3</sup>

There are three exceptions where withholding of treatment “other than appropriate nutrition, hydration, or medication” is not “medical neglect.” They are:

1. The infant is chronically and irreversibly comatose;
2. The provision of such treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant’s life-threatening conditions, or otherwise be futile in terms of the survival of the infant; or
3. The provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment under such circumstances would be inhumane.<sup>4</sup>

The following links are policy statements from the American Academy of Pediatrics regarding initiation and withdrawal of treatment for critically ill and high-risk newborn infants. The policy statements are also reproduced in Section 5 of this book.

Ethics and the Care of Critically Ill Infants and Children  
<http://www.aap.org/policy/01460.html>

The Initiation or Withdrawal of Treatment for High-Risk Newborns  
<http://www.aap.org/policy/00921.html>

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<sup>3</sup> Ibid

<sup>4</sup> Ibid.



## WARNING SIGNALS: CAN WE RECOGNIZE A POTENTIALLY ABUSIVE PARENT BEFORE A BABY IS BORN?

There are factors of risk and expressions of behavior, which are known to correlate with the occurrence of child abuse or neglect. Certain characteristics may be particularly noticeable before the birth of a child.

The characteristics described here are warning signals only. Their presence does not mean that abuse or neglect will occur, but it can signal that the parent could benefit from outside support or intervention during the difficult time following birth of the baby. A single characteristic or even a few characteristics displayed for a short time may be the result of the normal anxiety a new mother or father experiences; however, if many of the characteristics are present and continue, you should work with the parents to identify and address the underlying problems.

- The mother denies the pregnancy, refuses to talk about it, has made no plans whatsoever.
- The mother is not willing to gain weight during the pregnancy.
- The mother is alone and frightened, especially of the prospect of the delivery.
- The mother lacks support from the baby's father or her family.
- The parent is overly concerned with what the sex of the baby will be.
- The parent is overly concerned with how the baby will perform, whether it will meet up to standards.
- The parent feels that the child is going to be one too many children.
- One or both parents wanted an abortion but did not go through with it or waited until it was too late.
- The mother considered giving up the child, but changed her mind.
- The parent is isolated, does not have relatives or friends around.
- After delivery of the baby, the parent shows no active interest in it, doesn't want to touch or hold it, seems hostile toward it, and is disappointed over the baby's sex.
- After the baby comes home, the parent is very bothered about the baby's crying; sees the baby as too demanding, yet frequently ignores the baby's needs, not comforting it when it cries; finds changing diapers distasteful.
- The parent doesn't have fun with the baby, doesn't talk to the baby, says mostly negative things about it.
- One parent resents the time the other spends with the baby and is jealous of any affection shown toward the baby.
- The parent expresses unrealistic expectations regarding the baby's behaviors or achievements.
- The parents have firm concepts of traditional roles, and do not view the care of the baby as a shared responsibility.
- Either parent abuses drugs or alcohol.
- There is a history of domestic violence.
- Either parent was a victim of abuse or neglect as a child.
- Either parent suffers from an untreated mental illness.

## MUNCHAUSEN SYNDROME BY PROXY

In this condition, the child is the subject of acute illness, which has been falsified by an adult, usually a female. Symptoms may be induced by medication or poisoning and supported by a long and detailed, although invalid, medical history. The syndrome is characterized by the combined presence of the following factors:

- An illness which is faked and/or produced by a parent or someone who is in loco parentis
- A presentation, usually on a persistent basis, of the child for medical assessment and care, often resulting in multiple medical procedures
- A denial of knowledge as to the etiology of the illness
- An abatement of symptoms when separation between the child and adult occurs
- A long history of multiple, medical consultations
- An increase in symptoms after contact with the presenting adult, even when the child is in the hospital
- The presence of a rare or never-before-described disease
- An illness that follows an atypical course
- Lack of response to traditional treatment or therapy
- Referral to a major medical center because of difficulties in diagnosis
- Unexplainable, persistent, or recurrent illness
- Failure to display described symptoms (seizures, vomiting) in hospital setting

The clinical presentations of Munchausen Syndrome by Proxy include:

- Vomiting with or without blood
- Diarrhea with or without blood
- Seizures
- Apnea
- Abdominal pain
- Bleeding
- Rash
- Fever
- Infections
- Feeding problems
- Unconsciousness / Altered mental status
- Bloody urine
- Muscular weakness
- Neurological problems
- Abnormal laboratory values

Maternal behaviors in Munchausen Syndrome by Proxy include:

Mothers are perpetrators most of the time. The mother generally appears well educated, and may be perceived as an “ideal” parent. Fathers are usually absent or not available. The personality characteristics of the perpetrator are poorly understood, although depression and personality disorders have been noted. Other behaviors may include:

- Calmness about the child’s condition
- Lack of spousal involvement
- A history of Munchausen Syndrome
- A medical history similar to the child’s
- A strong family history of dramatic illnesses
- Unusual knowledge of medical terms and procedures

- An insistence that she is the only one for whom the child will eat, take medicine, sleep, etc.
- “Doctor Shopping”
- Extreme cooperation: welcomes medical procedures
- An “overprotective” attitude with the child
- Reluctance to leave hospital

#### Protocol for evaluating suspected Munchausen Syndrome by Proxy

- Involve the hospital social service staff as early as possible.
- Seek professional consultation of physicians familiar with the syndrome.
- Review the past medical history of the child including all medical records; obtain external verification for as much as possible provided in the history.
- Verify symptoms when possible: obtain fluid for toxicological analysis, laboratory analysis; have hospital personnel perform all procedures.
- Patient and other lab specimens should be handled carefully to maintain the chain of evidence.
- Obtain a complete, in-depth family and medical history.
- Arrange a meeting of all involved professionals and maintain regular communication in the form of care conferences.
- Surveillance of the child during hospitalization can be arranged when needed through the use of a sitter. Covert surveillance is possible but difficult due to staffing, privacy issues, technology and space.
- Involve the children services agency as soon as evidence is sufficient to support a diagnosis of Munchausen Syndrome by Proxy.
- The diagnosis should be discussed with the perpetrator. Psychiatric care should be offered to both caretaker and child. Anticipate suicidal behavior or escalation of deception by perpetrator.
- If a decision is made to remove the child from perpetrator’s care, this serves both protective and diagnostic functions.

**Selected Policy  
Statements from the  
American Academy  
of Pediatrics**

5



## Assessment of Maltreatment of Children With Disabilities

### AMERICAN ACADEMY OF PEDIATRICS

Committee on Child Abuse and Neglect and Committee on Children With Disabilities

**ABSTRACT.** Widespread efforts are continuously being made to increase awareness and provide education to pediatricians regarding risk factors of child abuse and neglect. The purpose of this statement is to ensure that children with disabilities are recognized as a population that is also at risk for maltreatment. The need for early recognition and intervention of child abuse and neglect in this population, as well as the ways that a medical home can facilitate the prevention and early detection of child maltreatment, should be acknowledged.

**ABBREVIATIONS.** CPS, child protective services; IFSP, Individual Family Service Plan; IEP, Individual Education Plan.

### BACKGROUND

The maltreatment of children, including those with disabilities, is a critical public health issue that must be addressed. The Third National Incidence Study of Child Abuse and Neglect showed that the estimated number of abused and neglected children more than doubled between 1986 and 1993.<sup>1</sup> According to a report from the National Child Abuse and Neglect Data System, child protective services (CPS) agencies investigated nearly 2 million reports of alleged maltreatment of an estimated 3 million children in 1995.<sup>2</sup> More than 1 million children were identified as victims of abuse and neglect during that year.

The numbers of children surviving disabling medical conditions as a result of technologic advances and children being recognized and identified as having disabilities are increasing.<sup>3</sup> The rates of child maltreatment have been found to be high with both the child population in general as well as with children who are blind, deaf, chronically ill, developmentally delayed, behaviorally or emotionally disordered, and multiply disabled.<sup>4</sup> Furthermore, child maltreatment may result in the development of disabilities, which in turn can precipitate further abuse.<sup>5</sup> Previous studies have been unable to accurately document the extent or rate of abuse among children with disabilities or determine if disabilities were present before the abuse or were the direct result of maltreatment.<sup>6</sup> Little research on child abuse has focused specifically on children with disabilities.<sup>7</sup>

### INCIDENCE

The Child Abuse and Prevention, Adoption, and Family Services Act of 1988<sup>8</sup> mandated the study of the incidence of child maltreatment among children with disabilities. This research was funded by the

National Center on Child Abuse and Neglect and conducted by the Center for Abused Children With Disabilities at the Boys Town National Research Center.<sup>4</sup> A study by Westat Inc determined the incidence of abuse among children with disabilities and the relationship between child abuse and disabilities.<sup>7</sup> Data were collected from 35 CPS agencies across the country, and results indicated that 14.1% of children whose maltreatment was substantiated by CPS workers had 1 or more disabilities. Disabilities were found to be twice as prevalent among maltreated children in hospitals as among hospital controls, which is consistent with the hypothesis that disabilities increase the risk for maltreatment. However, the data are also consistent with the hypothesis that maltreatment contributes to disabilities.<sup>9</sup>

According to the Boys Town National Research Hospital, children with disabilities were found to be at greater risk of becoming victims of abuse and neglect than children without disabilities. The study showed that children with disabilities are 1.8 times more likely to be neglected, 1.6 times more likely to be physically abused, and 2.2 times more likely to be sexually abused than children without disabilities.<sup>4</sup> The study by Westat Inc determined that, overall, the estimated incidence of maltreatment among children with disabilities was 1.7 times greater than the estimated incidence in children without disabilities.<sup>9</sup> One study found the overall incidence of child maltreatment to be 39% in 150 children with multiple disabilities admitted to a psychiatric hospital. Of those children, 60% had been physically abused, 45% had been neglected, and 36% had been sexually abused.<sup>10</sup>

### **CURRENT RESEARCH LIMITATIONS**

A major problem cited by literature is the definition of "disabilities."<sup>6</sup> There is currently no universal definition of what constitutes a disability. The Americans With Disabilities Act<sup>11</sup> defines "disability" as a physical or mental impairment that substantially limits 1 or more of the major life activities of an individual. This definition includes all types of disabilities, including physical disabilities, cognitive or learning disabilities, motor and sensory dysfunctions, mental illness, or any other kind of physical, mental, or emotional impairment.<sup>12</sup> The term "developmental disability" applies to children who have significant developmental delays, congenital abnormalities, or acquired conditions that may result in disability if adequate resources and services are not provided.<sup>13</sup> The term "children with special health care needs" is less limiting than some other terms.

Legal definitions do not always match clinical data. Child development evaluations do not always allow an immediate and precise diagnosis of disability, and some studies rely on evaluations by untrained observers. Therefore, research efforts are hindered by different definitions of terms (eg, disabilities and maltreatment), noncomparable methods, various study sample sizes, and lack of uniform data collection. Furthermore, changes in reporting laws and societal attitudes can occur during a study period.<sup>14</sup>

Another problem that has been cited in the literature is the lack of recognition and documentation of disabilities by CPS workers and their lack of training on evaluating children with disabilities.<sup>6</sup> In the study by Westat Inc, analyses were based on CPS workers' opinions rather than data empirically derived from physicians or other professionals trained to diagnose disabilities.<sup>7</sup> Bonner et al demonstrated that since 1982, correct and consistent use of the CPS system of collecting information regarding disabilities in maltreated children had decreased, suggesting that disabilities were unlikely to be identified as children enter the CPS system.<sup>6</sup> A survey of 51 state CPS agencies found that in 86% of states, CPS workers used a standardized form to record child maltreatment cases, but in only 59% of those states did the workers record information regarding preexisting disabilities on the form.<sup>15</sup>

The Westat study was limited to intrafamilial cases.<sup>7</sup> Because it is well known that individuals other than family members can commit harm to children, statistics limited to intrafamilial cases would be likely to underestimate the overall incidence of maltreatment among children with disabilities.

### **CAUSAL FACTORS**

In general, the causes of abuse and neglect of children with disabilities are the same as those for all children; however, several elements may increase the risk of abuse for children with disabilities. Children with chronic illnesses or disabilities often place higher emotional, physical, economic, and social demands on their families.<sup>14</sup> For example, a physical disability that causes difficulty in ambulation can place a child at risk for accidental falls. Therefore, close supervision would be needed. Parents with limited social and community support may be at especially high risk for maltreating children with disabilities, because they may feel more overwhelmed and unable to cope with the care and supervision responsibilities that are required.<sup>12</sup> Lack of respite or breaks in child care responsibilities can contribute to an increased risk of abuse and neglect.

The requirement of special health and educational needs can result in failure of the child to receive needed medications, adequate medical care, and appropriate educational placements, resulting in child neglect.<sup>12</sup> Numerous problems have been cited with the provision of care for foster children with disabilities. Foster parents are sometimes not told about a child's medical and emotional problems and are, therefore, not sufficiently educated or prepared to deal with the specific condition. Other problems for foster children with disabilities include lack of permanent placement, lack of a medical home, lack of financial support, and failure to select appropriate foster parents.<sup>5</sup>

Parents or caregivers may feel increased stress because children with disabilities may not respond to traditional means of reinforcement, and children's behavioral characteristics (ie, aggressiveness, noncompliance, and communication problems, which may appear to be temper tantrums) may become frustrating.<sup>4</sup> A behaviorally challenging child may further increase the likelihood of physical abuse.<sup>12</sup> Parents of children with communication problems may resort to physical discipline because of frustration over what they perceive as intentional failure to respond to verbal guidance. It has been noted, however, that families who report higher stress levels may actually have greater insight into problems associated with caring for a disabled child, whereas parents with a history of neglect of a child may not experience the level of stress that a more involved parent may experience.<sup>16</sup>

In regard to sexual abuse, infrequent contact of a child with disabilities with others may facilitate molestation, because there is decreased opportunity for the child to develop a trusting relationship with an individual to whom he or she may disclose the abuse.<sup>12</sup> Also, children who have increased dependency on caregivers for their physical needs may be accustomed to having their bodies touched by adults on a regular basis. Children with disabilities who require multiple caregivers or providers may have contact with numerous individuals, thereby increasing the opportunity for abuse. However, an advantage to having a large number of caregivers is that not only may someone detect the injuries or signs of abuse, but also the amount of stress placed on the primary caregiver is decreased.

Children with disabilities often have limited access to critical information pertaining to personal safety and sexual abuse prevention. Parents may object to their child being provided with education on human sexuality. Children with disabilities may also be conditioned to comply with authority, which could result in them failing to recognize abusive behaviors as maltreatment.<sup>4</sup> Children with disabilities are often perceived as easy targets, because their intellectual limitations may prevent them from being able to discern the experience as abuse. Impaired communication abilities may prevent them from disclosing abuse. Because some forms of therapy may be painful (eg, injections or manipulation as part of physical therapy), the child may not be able to differentiate appropriate pain from inappropriate pain.

## **PEDIATRICIAN'S ROLE**

Pediatricians should be aware that the presence of disabilities in a child could be a risk factor for victimization and that disabilities can also be the result of child maltreatment. The pediatrician should work with families, other health care providers, and other community resources to ensure the safety of all children.

### **Identification and Reporting**

Pediatricians should always be alert to signs or symptoms that are suggestive of abuse, no less in children with disabilities than in others. However, recognizing the signs and symptoms of maltreatment among children with disabilities may be difficult, because children may not be able to verbalize that they were abused or they may not understand that what took place was wrong.<sup>12</sup> Children with motor and balance disabilities may experience increased injuries from accidents. However, children with neurosensory disabilities may be predisposed to fractures, and in the absence of pain, there may be a delay in seeking medical attention. Pediatricians and other professionals who work with children must be aware of injury patterns from inflicted versus noninflicted trauma. Signs and symptoms of maltreatment in children with disabilities are commonly ignored, misinterpreted, or misunderstood. Furthermore, many institutions may have a disincentive to recognize or report child maltreatment because of fear of negative publicity or loss of funding or licensure.

If abuse or neglect is suspected after a careful assessment, a report must be made to the appropriate CPS agency. Every child suspected of being abused or neglected should have a thorough evaluation by an experienced professional trained in the field of child abuse and neglect.<sup>17</sup> The evaluation process should consist of a structured interview with the child, if possible, and a comprehensive physical examination, including appropriate laboratory and radiologic studies.

### **Treatment**

Appropriate medical treatment for injuries, infections, or other conditions should be provided. Each case of abuse or neglect that is clinically confirmed or strongly suspected should include a multidisciplinary treatment plan, which includes a mental health therapy component appropriate for the child's cognitive and developmental level and counseling for the family. This treatment plan should be integrated with other intervention plans that may have already been developed for the child. Federal legislation requires that each child identified as having a disability should have a written plan of service (an Individual Family Service Plan [IFSP] for children from birth through 2 years of age or an Individual Education Plan [IEP] for children 3 through 21 years of age).<sup>17</sup> A recommendation may be the simple provision of protective gear for the head or other anatomic regions to minimize the consequences of accidental falls or impacts. Removal of the child from the home or therapeutic foster care placement should be at the discretion of the CPS agency after a thorough investigation.

### **Education**

One study found that only 7 states require training in disabilities for child welfare workers and that training averages 4 hours.<sup>17</sup> In-service training for CPS workers, law enforcement professionals, health care providers, child care professionals, early childhood educators, teachers, and judges should be provided; and protocols should be developed for the identification, reporting, and referral of all cases of suspected child maltreatment in all institutional settings. In addition, risk factors for maltreatment of children with disabilities should be emphasized. Health care providers should be trained to monitor children with disabilities for signs of abuse and neglect and screen suspected victims of child maltreatment for disabilities.<sup>13</sup>

### **Prevention**

Support and assistance with parenting skills are often needed by families with children with special health care needs. Medical and nonmedical needs of the child and family should be addressed at each health supervision visit. Child and family strengths should be recognized and fostered at each encounter. Family stressors should be addressed, and referrals for appropriate services should be made. The availability of parent support groups, respite care, and home health services, when appropriate, should be explored. Pediatricians should educate parents of children with disabilities about respite waiver subsidies and how to qualify for such funds as well as the need to get on a waiting list as early as possible.



Children with disabilities need a medical home consisting of a health care provider readily accessible to the family to answer questions, help coordinate care, and discuss concerns.<sup>19</sup> Developmental and behavioral pediatricians who are trained and experienced in the diagnosis and evaluation of children with disabilities can also serve as excellent resources. Families should be encouraged to work with a variety of disciplines and pursue resources and services that they need. Child abuse prevention, including indicators of abuse, should be discussed with parents and caregivers.<sup>16</sup>

### **Advocacy**

The physician must act as his or her patient's advocate by assuming oversight and ultimate responsibility for the overall care that is provided by the various agencies and resources, which can be done by coordinating efforts and ensuring that recommendations are conducted.<sup>19</sup> By doing so, if child maltreatment is suspected, the need for appropriate referrals can be immediately identified. State, educational, social, foster care, financial, and health care systems often function in isolation from each other, with very little coordination or communication.<sup>4</sup> Community involvement can also encourage the development of needed resources. Foster children with disabilities and their foster parents often suffer from lack of adequate support systems.<sup>6</sup> Communication with schools and other systems with which families with disabled children interact is another avenue to heighten the awareness of the needs of children with special health care needs.

As child advocates, pediatricians are in an ideal position to influence public policy by sharing information and giving educational presentations on child maltreatment and the needs of children with disabilities. They should advocate for state practices or policies that mandate CPS agencies to gather disability information on child maltreatment cases. This could help emphasize the devastating costs of child maltreatment to lawmakers, policymakers, and the public.<sup>6</sup> Pediatricians should also advocate for screening procedures for potential employees in educational, recreational, and residential settings to help ensure the safety of all children in their care.<sup>20</sup>

### **RECOMMENDATIONS**

1. All pediatricians should be capable of recognizing signs and symptoms of child maltreatment in all children and adolescents, including those with disabilities.
2. Because children with disabilities may be at increased risk for maltreatment, pediatricians should be vigilant not only in their assessment for indications of abuse but also in their offerings of emotional and instrumental support.
3. Pediatricians should ensure that any child in whom abuse has been identified is thoroughly evaluated for disabilities.
4. All children with disabilities should have a medical home.
5. Pediatricians should be actively involved with treatment plans developed for children with disabilities.
6. Health supervision visits should be used as a time to assess a family's strengths and need for resources to counterbalance family stressors and parenting demands.
7. Pediatricians should advocate for changes in state and local policies in which system failures seem to occur regarding the identification, treatment, and prevention of maltreatment of children with disabilities.
8. Pediatricians should advocate for better health care coverage by both private insurers and governmental funding.

## CONCLUSION

The American Academy of Pediatrics supports the belief that pediatricians play a significant role in the prevention, identification, and treatment of child abuse and neglect, especially in children with disabilities, who may be at increased risk of maltreatment. Furthermore, children suspected of maltreatment should be evaluated for developmental disabilities. Pediatricians with experience in child abuse evaluations should provide training to other individuals. In addition, CPS workers and others involved in the investigation of child maltreatment should work closely with pediatricians to identify disabilities in children.<sup>12</sup> Every effort should be made to ensure the safety of children through collaboration with families, other health care providers, schools, CPS agencies, and other appropriate resources.

### COMMITTEE ON CHILD ABUSE AND NEGLECT, 2000-2001

Steven W. Kairys, MD, MPH,  
Chairperson  
Randell C. Alexander, MD, PhD  
Robert W. Block, MD  
V. Denise Everett, MD  
Kent P. Hymel, MD  
Carole Jenny, MD, MBA

### LIAISONS

David L. Corwin, MD  
American Academy of Child and  
Adolescent Psychiatry  
Gene Ann Shelley, PhD  
Centers for Disease Control and  
Prevention

### SECTION LIAISON

Robert M. Reece, MD  
Section on Child Abuse and Neglect

### STAFF

Tammy Piazza Hurley

### COMMITTEE ON CHILDREN WITH DISABILITIES, 2000-2001

Adrian D. Sandler, MD, Chairperson  
Dana Brazdziunas, MD  
W. Carl Cooley, MD  
Lilliam González de Pijem, MD  
David Hirsch, MD

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Theodore A. Kastner, MD  
Marian E. Kummer, MD  
Richard D. Quint, MD, MPH  
Elizabeth S. Ruppert, MD

### LIAISONS

William C. Anderson  
Social Security Administration  
Bev Crider  
Family Voices  
Paul Burgan, MD, PhD  
Social Security Administration  
Connie Garner, RN, MSN, EdD  
US Department of Education  
Merle McPherson, MD  
Maternal and Child Health Bureau  
Linda Michaud, MD  
American Academy of Physical  
Medicine and Rehabilitation  
Marshalyn Yeargin-Allsopp, MD  
Centers for Disease Control and  
Prevention

### SECTION LIAISONS

Chris P. Johnson, MEd, MD  
Section on Children With Disabilities  
J. Daniel Cartwright, MD  
Section on School Health

### STAFF

Karen Smith

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The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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## Diagnostic Imaging of Child Abuse (RE9944)

### AMERICAN ACADEMY OF PEDIATRICS

#### Section on Radiology

**ABSTRACT.** The role of imaging in cases of child abuse is to identify the extent of physical injury when abuse occurs, as well as to elucidate all imaging findings that point to alternative diagnoses. Diagnostic imaging of child abuse is based on both advances in imaging technology, as well as a better understanding of the subject based on scientific data obtained during the past 10 years.<sup>1-3</sup> The initial recommendation was published in *Pediatrics* (1991;87:262-264).

**ABBREVIATIONS.** CT, computed tomography; MRI, magnetic resonance imaging.

The concept of child abuse as a medical entity has its origin in the studies of the pediatric radiologist, John Caffey, MD,<sup>4</sup> as well as many other specialists in the field of diagnostic imaging. Kempe<sup>5</sup> relied heavily on the work of Caffey and his protégé, Frederick Silverman, MD,<sup>6</sup> when developing the familiar concept of the "battered child syndrome." When all cases of child abuse and neglect are studied, the incidence of physical evidence documented by diagnostic imaging studies is relatively small. However, imaging studies are often critical in the assessment of infant and young child with evidence of physical injury, and they also may be the first indication of abuse in a child who is seen with an apparent natural illness. When viewed in conjunction with clinical and laboratory studies, imaging findings commonly provide support for allegations of abuse.<sup>7</sup> For severely abused infants, the imaging findings alone may form the basis for a diagnosis of the inflicted injury. The role of imaging in cases of suspected abuse is not only to identify the extent of physical injury when abuse has occurred, but also to elucidate all imaging findings that point to alternative diagnoses.<sup>8,9</sup> As most conventional imaging studies performed in these settings are noninvasive and entail minimal radiation risks,<sup>10</sup> recommendations about imaging should focus on examinations that provide the highest diagnostic yield at acceptable cost.<sup>11</sup>

#### SKELETAL TRAUMA

Although skeletal injuries rarely pose a threat to the life of the abused child, they are often the strongest radiologic indicators of abuse. In fact, in an infant, certain patterns of injury are sufficiently characteristic to permit a firm diagnosis of inflicted injury in the absence of clinical information.<sup>12</sup> This fact mandates that imaging surveys performed to identify skeletal injury be performed with at least the same level of technical excellence routinely used to evaluate accidental injuries. The "body gram" (a study that encompasses the entire infant or young child on 1 or 2 radiographic exposures) or abbreviated skeletal surveys have no role in the imaging of these subtle but highly specific bony abnormalities.

#### THE RADIOGRAPHIC SKELETAL SURVEY

##### Equipment

In general, the radiographic skeletal survey is the method of choice for global skeletal imaging in cases of suspected abuse.<sup>13</sup> Low-dose all-purpose pediatric imaging systems provide insufficient anatomic detail to image the skeleton of the infant and young child. The American College of Radiology has published standards for skeletal survey imaging in cases of suspected abuse. Modern pediatric imaging systems commonly use special film cassettes and intensifying screens to minimize exposure. Although these low-dose systems are adequate for chest and abdominal imaging, they fail to provide the necessary contrast and spatial resolution to image subtle metaphyseal, rib, and other high specificity injuries that are characteristic of abuse. According to the American College of Radiology, imaging systems used for suspected abuse of infants should have a spatial resolution of at least 10 line pairs per millimeter and a speed of no more than 200.<sup>13</sup> These systems should be used without a grid. Beyond infancy, faster general purpose systems are required for thicker body regions (eg, skull, lateral lumbar spine). Digital or filmless radiology is beginning to replace film screen radiography in some centers. Data are limited about the suitability of this technique for the evaluation of inflicted skeletal injury. This technique should be shown to perform comparably to high-detail film screen radiography before it is used routinely for suspected child abuse. In any case, an experienced radiologist must monitor the radiographic examination of the skeleton to ensure that appropriate high-resolution images are obtained.

### **Imaging Protocol**

Once the appropriate imaging system is chosen, a precise protocol for skeletal imaging must be developed to ensure consistent quality. In routine skeletal imaging, an accepted principle is that film must be coned or restricted to the specific anatomic area of interest. It is common practice to encompass larger anatomic regions when skeletal surveys are performed, and this results in areas of underexposure and overexposure, as well as loss of resolution resulting from geometric distortion and other technical factors. The standard skeletal survey imaging protocol that has been developed by the American College of Radiology is given in [Table 1](#).<sup>13</sup> Of special note is the inclusion of lateral views of the spine to assess for vertebral fractures and dislocations and separate views of the hands and feet to identify subtle digital injuries. Anteroposterior and lateral views of the skull are mandatory even when cranial computed tomography (CT) has been performed, because skull fractures coursing in the axial plane may be missed with axial CT. Studies must be monitored by a radiologist for technical adequacy. Skeletal injuries, especially those requiring orthopedic management, necessitate at least 2 radiographic projections. Oblique views of the thorax increase the yield for the detection of rib fractures. Recent evidence suggests that a follow-up skeletal survey approximately 2 weeks after the initial study increases the diagnostic yield,<sup>14</sup> and this procedure should be considered when abuse is strongly suspected. The repeated study may permit more precise determination of the age of individual injuries. Lack of interval change may indicate that the initial radiographic finding is a normal anatomic variant or is related to a bone dysplasia.

### **Radionuclide Bone Scans**

When performed by staff experienced with pediatric nuclear imaging, skeletal scintigraphy may offer an alternative or an adjunct to the radiographic skeletal survey in selected cases, particularly in children older than 1 year. Scintigraphy seems to provide increased sensitivity for detecting rib fractures, subtle shaft fractures, and areas of early periosteal elevation. However, data are limited about the sensitivity of scintigraphy for classic metaphyseal lesions of abuse, particularly when the lesions are bilateral, as well as subtle spinal injuries, features that carry a high specificity for abuse in infants.<sup>15,16</sup> Skeletal scintigraphy usually requires sedation and is generally more expensive than radiographic surveys. Bone scans often are used to supplement radiographic skeletal surveys in the acute care setting, but for the child who is placed in a "safe" environment, a follow-up skeletal survey is an attractive alternative to initial scintigraphy. If radionuclide bone scans are performed as the initial study, all positive areas must be evaluated further with radiography, and because scintigraphy is insensitive for detecting cranial injuries, skull radiography in at least 2 projections must supplement the bone scan.

### **Imaging Guidelines**

The skeletal survey is mandatory in all cases of suspected physical abuse in children younger than 2 years. The screening skeletal survey or bone scan has little value in children older than 5 years. Patients in the 2- to 5-year-old group must be handled individually based on the specific clinical indicators of abuse. 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.

Magnetic resonance imaging (MRI)<sup>17</sup> and sonography may be indicated when epiphyseal separations are suspected based on plain film results. Application of these guidelines to selected cases of neglect and sexual abuse is appropriate when associated physical maltreatment is suspected. Evidence suggests that if 1 infant twin is injured, the other is at risk, and, therefore, a skeletal survey is advisable in such cases.

## HEAD TRAUMA

High-energy forces associated with impact or violent shaking result in a variety of central nervous system injuries that can be detected by modern neuroimaging techniques. The evolution of these injuries, as well as processes developing secondary to the original insult, often are effectively displayed on serial imaging studies.<sup>18</sup>

All infants and children with suspected intracranial injury must undergo cranial CT or MRI, or both. Strategies should be directed toward the detection of all intracranial sequelae of abuse and neglect with a thorough characterization of the extent and age of the abnormalities.<sup>19</sup> In the acute care setting, efforts are directed toward rapid detection of treatable conditions. Subsequent studies are designed to more fully delineate all abnormalities, determine the timing of the injuries, and monitor their evolution.

## CT

The CT without intravenous contrast should be performed as part of the initial evaluation for suspected inflicted head injury. It has a high sensitivity and specificity for diagnosing acute intraparenchymal, subarachnoid, subdural, and epidural hemorrhage. Abnormalities that require emergency surgical intervention generally are well-demonstrated. The CT is readily available and rapidly performed for critically ill patients. The CT is better than MRI for evaluation of acute hemorrhage. Associated skull and facial fractures also can be diagnosed with appropriate bone window setting images.

## SONOGRAPHY

Sonography via the anterior fontanelle in young infants has gained a limited but important role for assessing the short- and long-term consequences of inflicted head injury. Subcortical white matter tears in the frontal and anterior parietal parasagittal regions can be demonstrated with this technique.<sup>20</sup> These lesions are less well-defined by CT, and sonography provides the advantage of a bedside technique. Because sonography reliably differentiates convexity subdural from subarachnoid collections, it is particularly useful for the infant with macrocephaly or any infant with large cerebral convexity collections demonstrated by CT.<sup>21</sup> Because sonography is insensitive for detecting small acute subdural hematomas, particularly within the interhemispheric fissure, and many other acute intracranial injuries, it must be performed in conjunction with CT or MRI, or both.<sup>17,22</sup>

## MRI

The MRI is the best modality to fully assess intracranial injury, including extra-axial collections, intraparenchymal hemorrhages, contusions, shear injuries, and brain swelling, or edema. Imaging should be performed with T<sub>1</sub> and T<sub>2</sub> weighting with proton-density or inversion-recovery sequences to differentiate cerebrospinal fluid collections from other water-containing lesions. Gradient echo sequences should be included to detect hemorrhage or mineralization not demonstrable by other MRI techniques. Although the specific type and order of pulse sequences may vary, imaging must be performed at least in the axial and coronal planes. Because MRI may fail to detect acute subarachnoid or subdural hemorrhage,

its use should be delayed for 5 to 7 days in acutely ill children. Diffusion imaging is a new and valuable technique for the evaluation of stroke and likely will have a role in the assessment of inflicted cerebral injury. Abused infants may not demonstrate neurologic signs and symptoms, despite significant central nervous system injury. The MRI offers the highest sensitivity and specificity for diagnosing subacute and chronic injury and should be considered whenever typical skeletal injuries associated with shaking or impact are identified.<sup>17,23</sup>

## **SPINAL TRAUMA**

Plain radiographs are often sufficient to evaluate vertebral compression and spinous process fractures. Complex fractures may require thin-section CT with multiplanar reformatted images. If a fracture or subluxation may compromise the spinal contents or if clinical findings indicate spinal cord or nerve root injury, MRI should be performed.

## **THORACOABDOMINAL TRAUMA**

Blunt thoracoabdominal injury may occur in victims of child abuse. The evaluation and management of the acute problem is the same as for children with accidental injuries.<sup>24</sup> However, when an infant or child sustains serious injury to the chest or abdomen without a known or observed mechanism, investigation of potential child abuse is warranted. Pancreatitis, duodenal hematomas, bowel perforation, and thoracoabdominal injury associated with rib fracture heighten the suspicion of child abuse. Unsubstantiated stories, such as falling out of bed, sibling stepping on infant, and rolling onto a child sleeping in bed, also should arouse suspicion of child abuse.

Chest, abdominal, and cervical spine radiographs often are obtained in the initial assessment of injured children. If internal chest or abdominal injury is suspected and the patient's condition is stable, a CT scan should be performed. A CT scan will best demonstrate many of the injuries associated with child abuse. The chest should be included if serious chest trauma is suspected.

The use of oral contrast is debatable. Oral contrast in the stomach and small bowel is useful to better define the lesser sac of the peritoneum, pancreas, and duodenum and jejunum. However, oral contrast may place the patient at greater risk of aspirating, especially if the patient is obtunded, sedated, or immobilized. If surgery or general anesthesia is likely, it is better to have an empty stomach.

Intravenous contrast is used routinely. Vascular injuries and injuries to the liver, spleen, pancreas, and kidneys are best demonstrated after administration of intravenous contrast material. Helical or dynamic axial scanning techniques with proper timing of the intravenous contrast bolus are important for accurate diagnosis. The only relative contraindications for intravenous contrast are a strong history of allergy to iodine, severe shock, and renal failure.

Abused children suffer some of the same injuries as children with accidental blunt trauma. In the chest, pulmonary contusion, pneumothorax, pleural effusion, rib fractures, vascular, or tracheobronchial injuries may occur. Abused children have an increased occurrence of pancreatic injuries and duodenal hematomas. Bowel injury should be suspected when there is peritoneal fluid without evidence of solid organ injury and when free intraperitoneal air or contrast is observed. Bone windows should be monitored not only for rib fractures, but also for signs of pelvic or spine fractures.

Peritoneal lavage rarely is used in pediatric practice. If performed before CT, it may decrease the diagnostic usefulness. It sometimes is used when emergency surgery is required to treat a patient whose condition is not stable enough for a CT scan.<sup>24</sup>

The use of ultrasonography in pediatric trauma is controversial. Some institutions have used ultrasonography successfully for a more detailed, comprehensive evaluation of organ injury. However, for seriously injured children and those with suspected child abuse, CT scanning is the preferred initial

diagnostic modality of choice in majority of the institutions. Peritoneal fluid alone, which can be detected well in both with ultrasonography and CT scan, is a poor predictor of major trauma in children. An upper gastrointestinal series sometimes is used to evaluate and follow-up duodenal hematomas.

Nonoperative management of injury to the liver, spleen, kidney, or pancreas is common in most pediatric centers. Follow-up imaging usually is limited but may be useful to help determine recommendations for the level of physical activity ([Table 2](#)).

## CONCLUSION

In summary, thoracoabdominal trauma in abused children should be evaluated and managed similar to accidental trauma. Abuse should be suspected and appropriate investigations initiated when the injury, clinical history, or the findings on the diagnostic imaging studies suggest the possibility of child abuse or nonaccidental injury.

## SECTION ON RADIOLOGY, 1999-2000

Shashikant M. Sane, MD, Chairperson  
 Paul K. Kleinman, MD  
 Ronald A. Cohen, MD  
 Michael A. Di Pietro, MD  
 Joanna J. Seibert, MD  
 Beverly P. Wood, MD  
 Michael J. Zerlin, MD

### EX-OFFICIO

Richard Gravis, MD

### STAFF

Karen Schell

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**TABLE 1.** The Standard Skeletal Survey<sup>13</sup>

Appendicular skeleton Humeri (AP) Forearms (AP) Hands (oblique PA) Femurs (AP) Lower legs (AP) Feet (AP)
Axial skeleton Thorax (AP and lateral) Pelvis (AP; including mid and lower lumbar spine) Lumbar spine (lateral) Cervical spine (lateral) Skull (frontal and lateral)
Technique High resolution High contrast Screen/film speed not to exceed 200 Low kVp (bone technique) Single emulsion or special film-screen combination

AP indicates anteroposterior; PA, posteroanterior; kVp, kilovolt peak.

**TABLE 2.** Imaging Recommendations for Thoracoabdominal Trauma

1. CT of abdomen and/or thorac helical of dynamic axial scanning intravenous contrast, nonionic preferable*, gastrointestinal contrast optional
2. Ultrasonography of abdomen usually as a follow-up examination
3. Upper gastrointestinal series

\* Relative contraindication; strong history of allergy to iodine, severe shock, and renal failure.

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The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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## Distinguishing Sudden Infant Death Syndrome From Child Abuse Fatalities (RE0036)

### AMERICAN ACADEMY OF PEDIATRICS

Committee on Child Abuse and Neglect

**ABSTRACT.** In most cases, when a healthy infant younger than 1 year dies suddenly and unexpectedly, the cause is sudden infant death syndrome (SIDS). SIDS is more common than infanticide. Parents of SIDS victims typically are anxious to provide unlimited information to professionals involved in death investigation or research. They also want and deserve to be approached in a nonaccusatory manner. This statement provides professionals with information and guidelines to avoid distressing or stigmatizing families of SIDS victims while allowing accumulation of appropriate evidence in potential cases of death by infanticide.

**ABBREVIATIONS.** SIDS, sudden infant death syndrome; ALTE, apparent life-threatening events.

Approximately 50 years ago, the medical community began a search to understand and prevent sudden infant death syndrome (SIDS).<sup>1,2</sup> Almost simultaneously, medical professionals were awakened to the realities of child abuse.<sup>3-6</sup> Since then, public and professional awareness of SIDS and fatal child abuse during infancy have increased steadily. Recently, well-validated reports of child abuse and infanticide—perpetrated by suffocation and masqueraded as apparent life-threatening events (ALTE) and/or SIDS—have appeared in the medical literature and in the lay press.<sup>7,8</sup> The differentiation between SIDS and fatal child abuse can be a critical diagnostic decision.<sup>9</sup> Additional funding for research into the causes and prevention of SIDS and child abuse is needed.

#### **SIDS: EPIDEMIOLOGY, PRESENTATION, AND RISK FACTORS**

SIDS, also called crib or cot death, is the sudden death of an infant under 1 year of age that remains unexplained after thorough case investigation, including performance of a complete autopsy, examination of the death scene, and a review of the clinical history.<sup>10</sup> SIDS is the most common cause of death between 1 and 6 months of age. The incidence of SIDS peaks between 2 and 4 months of age. Approximately 90% of SIDS deaths occur before the age of 6 months.<sup>11</sup>

SIDS is suspected when a previously healthy infant, usually younger than 6 months, is found dead in bed, prompting an urgent call for emergency assistance. Often, the baby is fed normally just before being

placed in bed to sleep, no outcry is heard, and the baby is found in the position in which he or she had been placed at bedtime or naptime. In some cases, cardiorespiratory resuscitation initiated at the scene by emergency personnel is continued without apparent beneficial effect en route to the hospital, where the baby is finally declared dead. Evidence of terminal motor activity, such as clenched fists, may be seen. There may be serosanguineous, watery, frothy, or mucoid discharge coming from the nose or mouth. Skin mottling and postmortem lividity in dependent portions of the infant's body are commonly found. Review of the medical history, scene investigation, radiographs, and autopsy are unrevealing.

Despite extensive research, understanding of the etiology of SIDS remains incomplete. The discovery of abnormalities in the arcuate nucleus of the brainstems of some SIDS victims suggests that true SIDS deaths likely reflect delayed development of arousal, cardiorespiratory control, or cardiovascular control.<sup>12,13</sup> When the physiologic stability of such infants becomes compromised during sleep, they may not arouse sufficiently to avoid the noxious insult or condition.<sup>14</sup>

The SIDS rates are 2 to 3 times higher among African American and some American Indian populations. SIDS has been linked etiologically in research studies to prone sleep position, sleeping on a soft surface, maternal smoking during or after pregnancy, overheating, late or no prenatal care, young maternal age, prematurity, low birth weight, and male gender.<sup>15-23</sup> To date, no definitive evidence establishes causality between SIDS and recurrent cyanosis, apnea, ALTE, or immunizations during infancy. When recurrent cyanosis, apnea, or ALTE during infancy are reported, pediatricians should document these events objectively and determine if or not these events have occurred in the presence of more than 1 caregiver.

In recent years, national campaigns aimed at reducing prone sleeping during infancy have dramatically decreased the incidence of SIDS in the United States and in other countries.<sup>14,24-29</sup> Many of these educational campaigns have also emphasized prompt evaluation and treatment for sick infants, appropriate immunizations, breastfeeding, and avoidance of overlying, overheating, overwrapping, gestational or postnatal passive smoke exposure, and soft sleep materials or surfaces.

### **SIDS: A DIAGNOSIS OF EXCLUSION**

The diagnosis of SIDS is exclusionary and requires a postmortem examination, death scene investigation,<sup>30</sup> and review of case records that fail to reveal another cause of death. Infant deaths without postmortem examination should not be attributed to SIDS. Cases that are autopsied and carefully investigated but reveal substantial and reasonable uncertainty regarding the cause or manner of death may be designated as undetermined. Examples of undetermined cases include suspected (but unproven) infant death attributable to infection, metabolic disease, accidental asphyxiation, or child abuse.

A diagnosis of SIDS reflects the clear admission by medical professionals that an infant's death remains completely unexplained. A young infant's death should be ruled as attributable to SIDS when all of the following are true:

- a complete autopsy is done, including cranium and cranial contents, and autopsy findings are compatible with SIDS;
- there is no gross or microscopic evidence of trauma or significant disease process;
- there is no evidence of trauma on skeletal survey<sup>31</sup>;
- other causes of death are adequately ruled out, including meningitis, sepsis, aspiration, pneumonia, myocarditis, abdominal trauma, dehydration, fluid and electrolyte imbalance, significant congenital lesions, inborn metabolic disorders, carbon monoxide asphyxia, drowning, or burns;
- there is no evidence of current alcohol, drug, or toxic exposure; and

- thorough death scene investigation and review of the clinical history are negative.

### **CHILD ABUSE FATALITIES BY SUFFOCATION**

As the occurrence of cases of true SIDS has decreased, the proportion of unexplained infant deaths attributable to fatal child abuse may be increasing.<sup>32</sup> Estimates of the incidence of infanticide among cases designated as SIDS range from <1% to 5%.<sup>7,9,33-35</sup>

Parents of infants with recurrent ALTEs have been observed trying to suffocate and harm their infants.<sup>7,36</sup> In Great Britain, covert video surveillance was used to assess child abuse risk in 39 young children referred for evaluation of recurrent ALTEs.<sup>7</sup> Abuse was revealed in 33 of 39 cases, with documentation of intentional suffocation observed in 30 patients. Among 41 siblings of the 39 infants in the studies, 12 had previously died suddenly and unexpectedly. Although 11 of these deaths had been classified as SIDS, 4 parents later admitted to suffocating 8 of these siblings. Other cases previously thought to be multiple SIDS deaths within a family<sup>37</sup> have been revealed to be cases of multiple homicide by suffocation.<sup>8,32</sup>

It is impossible to distinguish at autopsy between SIDS and accidental or deliberate asphyxiation with a soft object.<sup>38</sup> However, certain circumstances should indicate the possibility of intentional suffocation, including:

- previous recurrent cyanosis, apnea, or ALTE while in the care of the same person;
- age at death older than 6 months;
- previous unexpected or unexplained deaths of 1 or more siblings;
- simultaneous or nearly simultaneous death of twins<sup>39</sup>;
- previous death of infants under the care of the same unrelated person<sup>40</sup>; or
- discovery of blood on the infant's nose or mouth in association with ALTEs.<sup>7</sup>

### **MANAGEMENT OF SUDDEN UNEXPECTED INFANT DEATH**

Most sudden infant deaths occur at home. Parents are shocked, bewildered, and distressed. Parents who are innocent of blame in their child's death often feel responsible nonetheless and imagine ways in which they might have contributed to or prevented the tragedy.<sup>41,42</sup> The appropriate professional response to any child death must be compassionate, empathic, supportive, and nonaccusatory. Inadvertent comments, as well as necessary questioning by medical personnel and investigators, are likely to cause additional stress. It is important for those in contact with parents during this time to be supportive while at the same time conducting a thorough investigation.

Personnel on first-response teams should be trained to make observations at the scene, including position of the infant, marks on the body, body temperature and rigor, type of bed or crib and any defects, amount and position of clothing and bedding, room temperature, type of ventilation and heating, and reaction of the caregivers. Guidelines are available for death scene investigation of sudden, unexplained infant deaths.<sup>30,33</sup> Paramedics and emergency department personnel should be trained to distinguish normal findings, such as postmortem anal dilation and lividity, from trauma attributable to abuse.<sup>42,43</sup>

When a previously healthy infant has died unexpectedly in the absence of external evidence of injury, a preliminary diagnosis of "probable SIDS" can be given. To the family of a true victim of SIDS, this diagnosis conveys the health care provider's initial impression that they could not have prevented their infant's death. Assignment of this preliminary diagnosis should not limit or prevent subsequent thorough case investigation.

Parents should be informed that other causes of death will be excluded only by thorough death scene investigation, postmortem examination, and review of case records. It should be explained to parents that these procedures might enable them and their physician to understand why their infant died and how other children in the family, including children born later, might be affected. Only on completion of a thorough and negative case investigation (including performance of a complete autopsy, examination of the death scene, and review of the clinical history) should a definitive diagnosis of SIDS be assigned as the cause of death.

The family is entitled to an opportunity to see and hold the infant once death has been pronounced. A protocol<sup>44</sup> may help in planning how and when to address the many issues that require attention, including baptism, grief counseling, funeral arrangements and religious support, cessation of breastfeeding, and the reactions of surviving siblings.<sup>41,45</sup> All parents should be provided with information about SIDS<sup>46,47</sup> and the telephone number of the local SIDS support group.<sup>46</sup>

Controversy exists in the medical literature regarding the likelihood of a repetition of SIDS within a sibship.<sup>48-51</sup> When an infant's sudden and unexpected death has been thoroughly evaluated and alternate environmental or accidental causes of death have been carefully excluded, parents should be informed that the risk for SIDS in subsequent children is not likely increased.

In many states, multidisciplinary teams have been established to review child fatalities.<sup>52,53</sup> Ideally, a multidisciplinary death review committee should include a child welfare/child protective services social worker, a law enforcement officer, a public health officer, the medical examiner/coroner, a pediatrician with expertise in child maltreatment, a forensic pathologist, a pediatric pathologist, and the local prosecutor.<sup>53</sup> The proceedings of multidisciplinary death review committees should remain confidential. Sharing data among agencies helps ensure that deaths attributable to child abuse are not missed and that surviving and subsequent siblings are protected. Some child fatality teams routinely review infant deaths attributable to apparent SIDS.

### **THE IMPORTANCE OF AUTOPSY, SCENE INVESTIGATION, AND CASE REVIEW**

The failure to differentiate fatal child abuse from SIDS is costly. In the absence of postmortem examination, death scene investigation, and case review, child maltreatment is missed, familial genetic diseases go unrecognized, public health threats are overlooked, inadequate medical care goes undetected, product safety issues remain unidentified, and progress in understanding the etiology of SIDS and other causes of unexpected infant death is delayed. Inaccurate vital statistics lead to inappropriate allocation of limited health care resources. By thoroughly investigating apparent SIDS deaths, the potential hazards of defective infant furniture, water beds, and beanbag mattresses have been identified and remedied.<sup>54,55</sup>

If appropriate toxicologic tests are not done, the few infant deaths attributable to accidental or deliberate poisoning will be missed.<sup>42,56</sup> Occult cocaine exposure is widespread and potentially lethal. One review found that 17 (40%) of 43 infants who died before 2 days of age without an obvious cause of death at autopsy had toxicologic evidence of cocaine exposure.<sup>57</sup> A second review of 600 infant deaths revealed evidence of cocaine exposure in 16 infants (2.7%) younger than 8 months who died suddenly and unexpectedly.<sup>58</sup> Lethal concentrations of cocaine and many other drugs in infancy are not yet established.

### **POSTMORTEM IMAGING**

Radiographic skeletal surveys performed before autopsy in cases of suspected SIDS may reveal evidence of traumatic skeletal injury or skeletal abnormalities indicative of a naturally occurring illness. Thorough documentation of all sites of suspected skeletal injury may require specimen resection and high-detail specimen radiography. The presence of old and new inflicted traumatic injuries identified on skeletal survey before autopsy may lend focus to the postmortem examination, death scene investigation, and police investigation.<sup>51,59</sup>

## **PATHOLOGY**

The American Academy of Pediatrics endorses universal performance of autopsies on infants who die suddenly and unexpectedly.<sup>60</sup> An international standardized autopsy protocol is available for this purpose.<sup>61</sup> Postmortem findings in cases of fatal child abuse most often reveal cranial injuries, abdominal trauma (eg, liver laceration, hollow viscous perforation, or intramural hematoma), burns, drowning, or exposure as the cause of death.<sup>62-65</sup> Pathologists establish the diagnosis of SIDS by exclusion when they are unable to identify other specific causes for a child's death.<sup>42</sup>

Intrathoracic petechiae are identified in 80% to 85% of SIDS cases but are not pathognomonic. Substantial evidence regarding intrathoracic petechiae in human and experimental studies supports the hypothesis that upper airway obstruction is the final event in SIDS.<sup>66</sup>

Inborn errors of metabolism<sup>67-69</sup> have been implicated to cause a small percentage of sudden unexplained deaths in infants with autopsy findings consistent with SIDS. Although cytomegaloviral inclusion bodies have been identified in some infants who died suddenly and unexpectedly, a definitive causal link between cytomegaloviral infection and SIDS has not been established.<sup>70</sup> Analysis of blood or other body fluids (urine, vitreous humor, cerebrospinal fluid, bile, and stomach contents collected and stored at -80°C) and brain, liver, kidney, heart, muscle, adrenal gland, and/or pancreas tissue may facilitate diagnosis of a fatal inborn error of metabolism. Blood tests for evaluation of many metabolic disorders are now available at low cost.

## **RECOMMENDATIONS**

The Academy makes the following recommendations for evaluation of sudden, unexplained infant deaths:

- accurate history taking by emergency responders and medical personnel at the time of death and made available to the medical examiner or coroner;
- prompt death scene investigation<sup>30,33</sup> where the infant was found lifeless and careful interviews of household members by knowledgeable individuals (potentially including a pediatrician);
- examination of the dead infant at a hospital emergency department by a child maltreatment specialist;
- postmortem examination following established protocol<sup>61</sup> within 24 hours of death, including radiographic skeletal survey, toxicologic, and metabolic screening;
- collection of medical history through interviews of caretakers, interviews of key medical providers, and review of previous medical records;
- maintenance of a supportive approach to parents during the death review process;
- consideration of intentional asphyxiation in cases of unexpected infant death with a history of recurrent cyanosis, apnea, or ALTE witnessed only by a single caretaker or in a family with previous unexplained infant death(s);
- use of accepted diagnostic categories on death certificates as soon as possible after review;
- prompt informing sessions with parents when results indicate SIDS or medical causation of death; and
- locally based infant death review teams<sup>53</sup> to review collected data with participation of the medical examiner or coroner in the review.

**COMMITTEE ON CHILD ABUSE  
AND NEGLECT, 2000-2001**

Steven W. Kairys, MD, MPH,  
Chairperson  
Randell C. Alexander, MD, PhD  
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**LIAISON REPRESENTATIVES**

David L. Corwin, MD  
American Academy of Child and  
Adolescent Psychiatry  
Gene Ann Shelley, PhD

Centers for Disease Control and  
Prevention

**SECTION LIAISON**

Robert M. Reece, MD  
Section on Child Abuse and Neglect

**CONSULTANT IN PEDIATRIC  
PATHOLOGY**

Henry F. Krous, MD  
Children's Hospital of San Diego, CA

**STAFF**

Tammy Piazza Hurley

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The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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## Ethics and the Care of Critically Ill Infants and Children

**AMERICAN ACADEMY OF PEDIATRICS**  
Committee on Bioethics

**ABSTRACT.** The ability to provide life support to ill children who, not long ago, would have died despite medicine's best efforts challenges pediatricians and families to address profound moral questions. Our society has been divided about extending the life of some patients, especially newborns and older infants with severe disabilities. The American Academy of Pediatrics (AAP) supports individualized decision making about life-sustaining medical treatment for all children, regardless of age. These decisions should be jointly made by physicians and parents, unless good reasons require invoking established child protective services to contravene parental authority. At this time, resource allocation (rationing) decisions about which children should receive intensive care resources should be made clear and explicit in public policy, rather than be made at the bedside.

Since the advent of means for supporting newborns with respiratory distress, neonatal and pediatric intensive care has helped tens of thousands of children survive life-threatening illness and the rigors of major surgical intervention. For more than a decade, however, many responsible for the health care of children have debated the appropriateness of applying life-sustaining medical technology (LSMT) to all critically ill children. (The term LSMT here applies to methods of supporting life typically applied in intensive care units, such as the use of ventilators and mechanical or pharmacologic support of circulation. The term critically ill here refers to disorders requiring such LSMT. Both terms defy precise definition.) As a recent AAP policy statement[1] on forgoing LSMT notes, the value of such therapy may be uncertain, especially when first considered. Good medical practice may favor initiation of LSMT until clarification of the clinical situation and relevant ethical values can occur. Much discussion has focused on highly visible "selective nontreatment of handicapped infants"[2] and the responses of the federal government, now known colloquially as the "Baby Doe" rules.[3,4] In the last few years, clinicians and the public also have become increasingly concerned about the high costs, in terms of money, time, and psychosocial consequences, of neonatal and pediatric intensive care.

## NEWBORNS AND INFANTS

Much controversy has surrounded the treatment of newborns and older infants with readily identifiable medical problems, including genetic disorders, malformations and deformations, and, to some extent, extreme prematurity and/or low birth weight. Scientific understanding and improved technology have permitted reductions in mortality for infants affected by an enlarging list of conditions. A better appreciation of what can be done to help many infants with disabilities and social considerations of fairness have led to the application of life-saving medical interventions to critically ill newborns and infants who, not long ago, physicians might not have treated vigorously. Concern that some infants, eg, those with Down syndrome and gastrointestinal obstruction, received insufficient treatment led to the federal legislation (the 1984 Child Abuse Amendments) and regulations that sought to ensure appropriate medical therapy for all disabled infants.

Looking back, the measures to prevent undue discrimination against disabled infants seem to have produced at least two unintended consequences. First, it seems that many persons in the health care and child advocacy professions, along with the general public, misunderstand the various federal and other legal requirements regarding treatment decisions for infants with critical illnesses.[5-7] Thus, misconceptions about the Baby Doe rules may have become de facto benchmarks for treatment decisions about critically ill newborns and older infants. Second, attention concentrated on saving the lives of infants, some with permanent, severe disabilities or neurodegenerative disorders, has hampered sufficient attention to the possible overuse of LSMT.

With regard to the first point, the actual language of the 1984 Child Abuse Amendments may permit more physician discretion than some realize. Although the law mandates provision of LSMT to most seriously ill infants, it does provide for exceptions in the case of permanent unconsciousness, "futile" treatment, and "virtually futile" therapy that imposes excessive burdens on the infant. Physicians, with parental agreement, may even forgo giving hydration and nutrition when they think these measures are not "appropriate." (Quoted words and phrases come directly from the law.[3])

With regard to the second point, possible overuse of LSMT, several book-length studies,[8-11] one personal account from parents,[12] and recent essays by pioneering neonatologists[13,14] have suggested that modern newborn care may, at times, constitute overtreatment. Articles for the general public have communicated the same message.[15-17] As previously noted, after the Child Abuse Amendments of 1984, two reports of a survey of neonatologists[5,6] indicated that many who specialize in the care of sick newborns believe they are legally constrained to provide LSMT to infants, even when their medical judgments and the views of the parents concur that withholding treatment is preferable.

Although many would like to have simply interpreted and easily applied substantive standards for clinical decisions about critically ill infants, medical and moral complexity make such rules imprudent. Scientific uncertainty regarding outcome continues in the neonatal intensive care unit. Some very tiny infants with documented brain insults, such as those that may occur with periventricular hemorrhage, defy expectations and survive with no apparent clinical deficits. Available evidence, however, continues to indicate that the decreased mortality brought about by neonatal intensive care has been accompanied by increased morbidity, ie, serious mental and physical limitations among survivors that impose burdens on affected children and their families.[18,19] These factors also play legitimate roles in decision making.[20,21]

A few well-publicized cases in the early 1980s led some to conclude that physicians and parents commonly denied beneficial treatment to imperiled newborns. However, no reliable evidence that decisions endangering children have been widespread exists. Most cases of lethal nontreatment seem to have involved infants with trisomy 21 and myelomeningocele.[22-24] However, by the early 1980s professional and public views about infants with Down syndrome and spina bifida had generally shifted to favor treatment.[25] This view is supported by results from a survey of pediatricians done in Massachusetts in the mid-1980s.[24]

The AAP supports parental involvement in decisions about imperiled infants from the earliest possible moment. Obstetricians and pediatricians need to inform and counsel parents about available options when prenatal diagnostic procedures identify disorders in fetuses. Women may legitimately decide about the treatment they and their fetuses receive.[26,27] Once parturition occurs, parents continue

to have a vital role in decision making under the presumption that they accept responsibility for nurturing the infant and providing reasonable care.[28]

The AAP believes that parents and physicians should make reasoned decisions together about critically ill infants using the principles of informed parental permission recently articulated by the AAP.[29] Such decisions should consider the benefits and burdens of treatment alternatives. Physicians should remember that many parents want a strong role in these decisions[30] and that parents may bring values to the process that differ sharply from those of the physician. In rare instances, as required by law and sound ethical standards, it may be necessary to invoke established child protective mechanisms if parents wish to forgo LSMT, physicians disagree, and the parties cannot resolve their differences with help from subspecialists, ethics consultants, or ethics committees.

## CHILDREN BEYOND INFANCY

As with infants, two basic questions arise in the care of children beyond the first year: Which values and whose authority ought to govern in medical treatment decisions about the critically ill? Published court cases indicate that parents have been permitted to exercise broad discretion when acting on their children's behalf,[31-36] even when court-appointed guardians ad litem or other counsel opposed the parental choice.[37-39] Laws in some states permit parents to execute advance directives on behalf of minors (*Choice and Dying. State laws regarding end-of-life decision making for minors*. New York, NY: Choice and Dying; September 1995:1-2).[40] In addition to according due respect to the beliefs, feelings, and needs of the family as expressed by parents, as children get older and acquire cognitive skill, experience, and emotional maturity, their individual views deserve careful consideration. Sensitive clinicians and parents acknowledged this in the professional literature as long as 20 years ago.[41]

In the realm of pediatric critical care, the North American literature provides sparse evidence of systematic approaches to limiting LSMT.[42,43] The pediatric intensive care unit, however, unlike the neonatal intensive care unit, has not been the focus of bureaucratic or political debate and action. Pediatric intensivists and their colleagues and consultants in ethics have tended to make decisions about discontinuing LSMT similar to the way clinicians, loved ones, ethicists, and the courts make such decisions for incompetent adult patients.[44,45]

## RESOURCE ALLOCATION AND DECISIONS TO LIMIT LSMT

Recently, concerns about the high cost of critical care have led to attempts to manage critical care resources through the use of quantitative indicators of prognosis.[46-51] Some physicians, administrators, and planners would like to use increasingly accurate statistical predictors of outcome to exclude patients from receiving intensive care services. Indeed, population-based mathematical tools may prove helpful in evaluating the effectiveness of various interventions, in comparing outcomes of similar treatments used at different sites, and in informing parents of the probability of the outcome of treatment. Such studies, however, have an important inherent limitation--their results apply to groups of patients, not individuals. In the absence of perfect outcome prediction (100% survival or death, based on experience with large numbers of patients), statistical indicators cannot tell clinicians which particular patient will die or live (and with what residual problems). Moreover, even overwhelming odds of success or failure of treatment cannot take into account the complex values that individuals, including patients, family members, physicians, and other health care providers, bring to a treatment decision. Therefore, the AAP opposes the use of these formulas as the principal determinants of whether individual patients receive intensive care.

The controversy over the usefulness of critical care resources has been most poignantly highlighted by public debates about futile medical treatment.[52-56] In these discussions, physicians and other care givers have demonstrated concern that medical resources are being used inappropriately and that continued treatment violates deeply held beliefs about what properly constitutes professional activities. Others feel that professional objections to so-called futile treatment masks prejudices about those who are disabled, who come from disadvantaged social groups, or who are dying.

The AAP thinks that judgments about which diagnostic categories of patients should receive or be denied intensive care based on considerations of resource use are social policy deliberations and should

be made after considerable public discussion, not ad hoc at the bedside.

## CONCLUSIONS

Our society has reached a consensus that some critically ill infants previously denied treatment should receive advanced medical and surgical care. A large majority of physicians and other persons agree that most infants with Down syndrome with gastrointestinal obstruction and most infants with myelomeningocele should have surgery and other treatment they need.

There is less agreement, however, about how much treatment to provide other critically ill infants and children. Medical and public controversy still rages about the appropriate limits, if any, to place on the treatment of extremely low birth weight and premature infants, about infants with hypoplastic left heart syndrome,[57] about children with chromosomal abnormalities with known very limited life spans, about infants with complex congenital abnormalities, and about children in the final stages of terminal cancer or other fatal chronic disorders. Many think that laws, regulations, and government policies have unduly constrained parents and physicians from exercising reasonable judgments about whether to forgo LSMT.

A judicial and legislative consensus has developed that the values of patients, rather than those of physicians or policy makers, should determine the extent of the application of LSMT.[58] As noted, some states have empowered proxy decision makers to execute advance directives regarding LSMT on behalf of minors. Legislation and regulation about disabled infants conflict with the legal trends governing all other patients. In the absence of compelling evidence that infants require special legal protection, the AAP thinks that parents of newborns should have the same decision-making authority they have with older children.

Limited resources may require equitable limits on medical treatment. Such restrictions require careful consideration of their social, cultural, and economic consequences and deserve to be made at a public policy level, not at the bedside.

## RECOMMENDATIONS

1. Decisions about critical care for newborns, infants, and children should be made similarly and with informed parental permission.
2. Physicians should recommend the provision or forgoing of critical care services based on the projected benefits and burdens of treatment, recognizing that parents may perceive and value these benefits and burdens differently from medical professionals.
3. Decisions to forgo critical care services on the grounds of resource limitations, generally speaking, are not clinical decisions, and physicians should avoid such "bedside rationing."

However, because many in the American public think that our health care system spends excessively on critical care services, society should engage in a thoroughgoing debate about the economic, cultural, religious, social, and moral consequences of imposing limits on which patients should receive intensive care.

### COMMITTEE ON BIOETHICS, 1995 TO 1996

Joel E. Frader, MD, Chairperson  
Lucy S. Crain, MD  
Kathryn L. Moseley, MD  
Robert M. Nelson, MD  
Ian H. Porter, MD  
Felipe E. Vizcarrondo, MD

### LIAISON REPRESENTATIVES

Watson A. Bowes, MD  
American College of Obstetricians and  
Gynecologists

Alessandra Kazura, MD

American Academy of Child and Adolescent  
Psychiatry  
Ernest Krug, MD  
American Board of Pediatrics

### SECTION LIAISON

Donna A. Caniano, MD  
Section on Surgery

### LEGAL CONSULTANT

Nancy M. P. King

## REFERENCES

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## The Initiation or Withdrawal of Treatment for High-Risk Newborns

### AMERICAN ACADEMY OF PEDIATRICS

Committee on Fetus and Newborn

As medical technology has advanced, outcomes for high-risk newborns have greatly improved. With advanced technology such as assisted ventilation, it is now possible to keep some terminal, severely ill, or extremely premature infants alive for long periods of time. The result of such treatment is that dying may be prolonged or that the infant will survive with profound neurologic or other debilitating problems.[1] The medical treatment of infants should be based on what is in their best interest. However, because the infant's "best interest" is not always clear, parents and health care givers are often faced with difficult treatment decisions when faced with the situation of a severely ill, extremely premature, or terminally ill infant.

#### The Treatment Dilemma

If intensive treatment uniformly resulted in saving infants at risk, it would be the obvious choice for all severely ill infants. This outcome, of course, does not always occur. If intensive treatment is not provided to very ill infants, most of them will die, but some may survive with significant neurodevelopmental disability, in part because specific treatments were withheld. The following dilemma therefore exists: intensive treatment of all severely ill infants sometimes results in prolongation of dying or occasionally iatrogenic illness; nonintensive treatment results in increased mortality and unnecessary morbidity. The overall outcomes of either approach are disappointing.

#### Strategy for Care

A reasonably acceptable approach to this dilemma is an individualized prognostic strategy.[2,3] In this setting, care is provided for the individual infant at the appropriate level based on the expected outcome at the time care is initiated. In this strategy, the infant is constantly reevaluated, and the prognosis is reassessed based on the best available information in conjunction with the physician's best medical judgment. This approach places significant responsibility on the physician and health care team to evaluate the infant accurately and continuously. The family of the infant must be kept informed of the infant's current status and prognosis. They must be involved in major decisions that ultimately could alter the infant's outcome.[4] For this approach to be successful, one physician should be designated as the spokesperson for the health care team and should discuss treatment options with the family. When the health care team is unable to agree on a treatment strategy, the physician, serving as the team leader, should attempt to resolve existing differences by using an independent medical consultant or reference data, or by consulting with the hospital bioethics committee. When there is more than one valid approach to care, the physician should present these options to the family for their consideration and opinion.

The physician spokesperson must be sensitive to the parents' concerns and desires, which are often based on a complex combination of values and influences derived from their cultural, religious, educational, and ethnic backgrounds.[3,4] Physicians are ethically and legally obligated to provide appropriate care for the infant based on current medical information and infant assessment. Parents are

encouraged to take an active role in the decision-making process. Decisions to continue, stop, or alter care must not be based on the financial status of the parents or the financial interests of the physicians, the hospital, or the insurance carrier or other third-party payer.

The rights of parents in decision making must be respected. However, physicians should not be forced to undertreat or overtreat an infant if, in their best medical judgment, the treatment is not in compliance with the standard of care for that infant. When there is a conflict or disagreement between the recommendations of the physician and the desires of the infant's parents, one option is to consult with the hospital bioethics committee. Another option is for the physician and family to seek another physician willing to provide care for the infant in the manner desired by the family. This disagreement between the physician and the family may result in the involvement of the court. In that case, the physician should continue to serve as an advocate for the infant.

In all of these considerations, there is no distinction between initiation or withdrawal of life-sustaining treatment.

### RECOMMENDATIONS

1. Ongoing evaluation of the condition and prognosis of the infant is essential, and the physician as the spokesperson for the health care team must convey this information accurately and openly to the parents of the infant.
2. Parents should be active participants in the decision-making process concerning the treatment of severely ill infants.
3. Humane care must be provided to all infants, including those from whom specific treatment is being withheld. Parents should be encouraged to participate in the care of their infant as much as they wish.
4. If the viability of the infant is unknown, or if the curative value of the treatment is uncertain, the decision to initiate or continue treatment should be based only on the benefit to the infant that might be derived from such action. It is inappropriate for life-prolonging treatment to be continued when the condition is incompatible with life or when the treatment is judged to be futile.

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Health

#### LIAISON REPRESENTATIVES

Garris Keels Conner, RN, DSN, American

#### AAP SECTION LIAISON

Jacob C. Langer, MD, Section on Surgery

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Policy Statement

Pediatrics

Volume 101, Number 1

January 1998, pp 134-135

## Gonorrhea in Prepubertal Children

### AMERICAN ACADEMY OF PEDIATRICS

Committee on Child Abuse and Neglect

**ABSTRACT.** This statement updates a 1983 statement on this topic and reminds physicians that sexual abuse should be strongly considered when a gonorrheal infection is diagnosed in a child after the newborn period and before the onset of puberty.

Sexual abuse should be strongly considered when a gonorrheal infection (ie, genital, rectal, oral, or ophthalmologic) is diagnosed in a child after the newborn period and before the onset of puberty. A sexually transmitted disease may be the only physical evidence of sexual abuse in some cases.<sup>1</sup> Sexually abused children may deny that abuse has occurred. The Centers for Disease Control and Prevention provides the following guideline: "The identification of a sexually transmissible agent from a child beyond the neonatal period suggests sexual abuse."<sup>2</sup> This statement does not address gonorrheal infection in adolescents, which may result from sexual abuse or consensual sexual activity. The Committee on Adolescence statement on sexually transmitted diseases provides additional guidance for the pediatrician evaluating adolescents.<sup>3</sup>

### EPIDEMIOLOGIC FACTORS

The risk of acquiring sexually transmitted diseases as a result of sexual abuse during childhood is unknown. Reported rates of gonococcal infection range from 3% to 20% among sexually abused children.<sup>4,5</sup> The incidence of *Neisseria gonorrhoeae* in a given population of children who may have been sexually abused is determined by the type and frequency of sexual contact, the age of the child, the regional prevalence of sexually transmitted diseases in the adult population, and the number of children referred for evaluation of possible sexual abuse.<sup>6</sup> The presence of *N gonorrhoeae* infection in a child is diagnostic of abuse with very rare exception.<sup>7</sup>

### CLINICAL FINDINGS

A gonococcal infection may be diagnosed in the course of an evaluation of a medical condition such as conjunctivitis, in which no suspicion of abuse existed, or it may be diagnosed during an assessment for possible sexual abuse. In the prepubertal child, gonococcal infection usually occurs in the lower genital tract, and vaginitis is the most common clinical manifestation. Pelvic inflammatory disease and perihepatitis can occur, but are uncommon. Infections of the throat and rectum typically are asymptomatic and may go unrecognized. If no source of the infection is identified, a conclusion that the transmission was perinatal or nonsexual in nature is unacceptable.

## LABORATORY FINDINGS

Laboratory confirmation of *N gonorrhoeae* is essential before sexual abuse is reported to the local child protective services agency solely on the basis of a positive *Neisseria* culture. However, an immediate report should be made if other compelling indicators of abuse are evident. A carefully structured laboratory protocol must be used to ensure identification of the organism.<sup>7</sup> An accurate diagnosis of gonococcal infection can be made only by using Thayer-Martin or chocolate blood agar-based media. Positive cultures must be confirmed by two of the following methods: carbohydrate utilization, direct fluorescent antibody testing, or enzyme substrate testing.<sup>1,8,9</sup> A culture reported as *N gonorrhoeae* from the pharynx of young children can be problematic because of the high number of nonpathogenic *Neisseria* species found at this site. To prevent an unwarranted child abuse investigation, confirmatory tests must be performed to differentiate *N gonorrhoeae* from organisms such as *Neisseria meningitidis*, *Neisseria lactamica*, and *Neisseria cinerea* that may be normal flora.[9] Currently, the use of nonculture methods (ie, DNA probes or enzyme-linked immunosorbent assay) for the documentation of *N gonorrhoeae* is investigational. If a nonculture method is used, a positive result *must* be confirmed by culture. No current data are available for the pediatric population, but studies of adults have shown a significant incidence of false-positive indirect tests compared with the incidence obtained by culture methods.<sup>10,11</sup>

By law, all known cases of gonorrhea in children must be reported to the local health department. A report also should be made to a child protective services agency. An investigation should be conducted to determine whether other children in the same environment who may be victims of sexual abuse are also infected. A child in whom a culture is positive for *N gonorrhoeae* should be examined for the presence of other sexually transmitted diseases such as syphilis, chlamydia infection, hepatitis B, and human immunodeficiency virus infection.

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American Academy of Child and Adolescent Psychiatry

Larry S. Goldman, MD  
American Medical Association  
Gene Ann Shelley, PhD  
Centers for Disease Control and Prevention

### SECTION LIAISONS

Carole Jenny, MD  
Section On Child Abuse And Neglect

### CONSULTANT

Margaret T. McHugh, MD, MPH

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This statement has been approved by the Council on Child and Adolescent Health

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## Guidelines for the Evaluation of Sexual Abuse of Children: Subject Review

### AMERICAN ACADEMY OF PEDIATRICS

#### Committee on Child Abuse and Neglect

**ABSTRACT.** This statement serves to update guidelines for the evaluation of child sexual abuse first published in 1991. The role of the physician is outlined with respect to obtaining a history, physical examination, and appropriate laboratory data and in determining the need to report sexual abuse.

**ABBREVIATIONS.** AAP, American Academy of Pediatrics; STDs, sexually transmitted diseases; HIV, human immunodeficiency virus.

Few areas of pediatrics have expanded so rapidly in clinical importance in recent years as that of sexual abuse of children. What Kempe called a "hidden pediatric problem"<sup>1</sup> in 1977 is certainly less hidden at present. In 1996, more than 3 million children were reported as having been abused to child protective service agencies in the United States, and almost 1 million children were confirmed by child protective service agencies as victims of child maltreatment.<sup>2</sup> According to a 1996 survey, physical abuse represented 23% of confirmed cases, sexual abuse 9%, neglect 60%, emotional maltreatment 4%, and other forms of maltreatment 5%.<sup>2</sup> Other studies have suggested that approximately 1% of children experience some form of sexual abuse each year, resulting in the sexual victimization of 12% to 25% of girls and 8% to 10% of boys by age 18.<sup>3</sup> Children may be sexually abused by family members or nonfamily members and are more frequently abused by males. Boys may be victimized nearly as often as girls, but may not be as likely to disclose the abuse. Adolescents are perpetrators in at least 20% of reported cases; women may be perpetrators, but only a small minority of sexual abuse allegations involve women. The child care setting, an otherwise uncommon setting for abuse, may be the site for women offenders. Pediatricians may encounter sexually abused children in their practices and may be asked by parents and other professionals for consultation. These guidelines are intended for use by all health professionals caring for children. In addition, specific guidelines published by the American Academy of Pediatrics (AAP) for the evaluation of sexual assault of the adolescent by age group should be used.<sup>5</sup>

Because pediatricians have trusted relationships with patients and families, they are often able to provide essential support and gain information that may not be readily available to others involved in the investigation, evaluation, or treatment processes. However, some pediatricians may not feel adequately prepared at present to perform a medical evaluation of a sexually abused child without obstructing the collection of essential evidence. Pediatricians need to be knowledgeable about the available resources in the community, including consultants with special expertise in evaluating or treating sexually abused children.

## DEFINITION

Sexual abuse occurs when a child is engaged in sexual activities that the child cannot comprehend, for which the child is developmentally unprepared and cannot give consent, and/or that violate the law or social taboos of society. The sexual activities may include all forms of oral-genital, genital, or anal contact by or to the child, or nontouching abuses, such as exhibitionism, voyeurism, or using the child in the production of pornography.<sup>1</sup> Sexual abuse includes a spectrum of activities ranging from rape to physically less intrusive sexual abuse.

Sexual abuse can be differentiated from "sexual play" by determining whether there is a developmental asymmetry among the participants and by assessing the coercive nature of the behavior.<sup>6</sup> Thus, when young children at the same developmental stage are looking at or touching each other's genitalia because of mutual interest, without coercion or intrusion of the body, this is considered normal (ie, nonabusive) behavior. However, a 6-year-old who tries to coerce a 3-year-old to engage in anal intercourse is displaying abnormal behavior, and the health and child protective systems should be contacted although the incident may not be legally considered an assault. Children or adolescents who exhibit inappropriate sexual behavior may be reacting to their own victimization.

## PRESENTATION

Sexually abused children are seen by pediatricians in a variety of circumstances: 1) They may be seen for a routine physical examination or for care of a medical illness, behavioral condition, or physical finding that would include child sexual abuse as part of the differential diagnosis. 2) They have been or are thought to have been sexually abused and are brought by a parent to the pediatrician for evaluation. 3) They are brought to the pediatrician by social service or law enforcement professionals for a medical evaluation for possible sexual abuse as part of an investigation. 4) They are brought to an emergency department after a suspected episode of sexual abuse for evaluation, evidence collection, and crisis management.

The diagnosis of sexual abuse and the protection of the child from further harm depends in part on the pediatrician's willingness to consider abuse as a possibility. Sexual abuse presents in many ways,<sup>7</sup> and because children who are sexually abused generally are coerced into secrecy, a high level of suspicion may be required to recognize the problem. The presenting symptoms may be so general (eg, sleep disturbances, abdominal pain, enuresis, encopresis, or phobias) that caution must be exercised when the pediatrician considers sexual abuse, because the symptoms may indicate physical or emotional abuse or other nonabuse-related stressors. Among the more specific signs and symptoms of sexual abuse are rectal or genital bleeding, sexually transmitted diseases, and developmentally unusual sexual behavior.<sup>8</sup> Pediatricians evaluating children who have these signs and symptoms should at least consider the possibility of abuse and, therefore, should make a report to child welfare personnel if no other diagnosis is apparent to explain the findings.

Pediatricians who suspect sexual abuse has occurred or is a possibility are urged to inform the parents of their concerns in a calm, nonaccusatory manner. The individual accompanying the child may have no knowledge of, or involvement in, the sexual abuse of the child. A complete history, including behavioral symptoms and associated signs of sexual abuse, should be sought. The primary responsibility of the pediatrician is the protection of the child, sometimes requiring a delay in informing the parent(s) while a report is made and an expedited investigation by law enforcement and/or child protective services can be conducted.

## TAKING A HISTORY/INTERVIEWING THE CHILD

In many states, the suspicion of child sexual abuse as a possible diagnosis requires a report both to the appropriate law enforcement and child protective services agencies. All physicians need to know their state law requirements and where and when to file a written report. The diagnosis of sexual abuse has



civil (protective) and criminal ramifications. Investigative interviews should be conducted by the designated agency or individual in the community to minimize repetitive questioning of the child. This does not preclude physicians asking relevant questions to obtain a detailed pediatric history and to obtain a review of systems. The courts have allowed physicians to testify regarding specific details of the child's statements obtained in the course of taking a medical history to provide a diagnosis and treatment. Occasionally, children spontaneously describe their abuse and indicate who abused them. When asking young children about abuse, the use of line drawings,<sup>9</sup> dolls,<sup>10</sup> or other aids<sup>11</sup> are generally used only by professionals trained in interviewing young children. The American Academy of Child and Adolescent Psychiatry and American Professional Society on the Abuse of Children have published guidelines for interviewing sexually abused children.<sup>12,13</sup> Children may also describe their abuse during the course of the physical examination. It is desirable for those conducting the interview to use nonleading questions; avoid showing strong emotions such as shock or disbelief; and maintain a "tell me more" or "and then what happened" approach. If possible, the child should be interviewed alone. Written notes in the medical record or audiotape or videotape should be used to document the questions asked and the child's responses. Most expert interviewers do not interview children younger than 3 years.

A behavioral history may reveal events or behaviors relevant to sexual abuse, even in the absence of a clear history of abuse in the child.<sup>7</sup> The parent(s) may be defensive or unwilling to accept the possibility of sexual abuse, which does not necessarily negate the need for investigation.

When children are brought for evaluation by protective personnel, little or no history may be available other than that provided by the child. The pediatrician should try to obtain an appropriate history in all cases before performing a medical examination. The child may spontaneously give additional information during the physical examination, particularly as the mouth, genitalia, and anus are examined. History taking should focus on whether the symptoms are explained by sexual abuse, physical abuse to the genital area, or other medical conditions.<sup>14</sup>

## PHYSICAL EXAMINATION

The physical examination of sexually abused children should not result in additional emotional trauma. The examination should be explained to the child before it is performed. It is advisable to have a chaperone present — a supportive adult not suspected of involvement in the abuse.<sup>15</sup> Children may be anxious about giving a history, being examined, or having procedures performed. Time must be allotted to relieve the child's anxiety.

When the alleged sexual abuse has occurred within 72 hours, or there is bleeding or acute injury, the examination should be performed immediately. In this situation, protocols for child sexual assault victims should be followed to secure biological trace evidence such as epithelial cells, semen, and blood, as well as to maintain a "chain of evidence." When more than 72 hours has passed and no acute injuries are present, an emergency examination usually is not necessary. An evaluation therefore should be scheduled at the earliest convenient time for the child, physician, and investigative team.<sup>5</sup>

The child should have a thorough pediatric examination, including brief assessments of developmental, behavioral, mental, and emotional status. Special attention should be paid to the growth parameters and sexual development of the child. In the rare instance when the child is unable to cooperate and the examination must be performed because of the likelihood of trauma, infection, and/or the need to collect forensic samples, consideration should be given to using sedation with careful monitoring. Instruments that magnify and illuminate the genital and rectal areas should be used.<sup>16,17</sup> Signs of trauma should be carefully documented by detailed diagrams illustrating the findings or photographically. Specific attention should be given to the areas involved in sexual activity — the mouth, breasts, genitals, perineal region, buttocks, and anus. Any abnormalities should be noted.

In female children, the genital examination should include inspection of the medial aspects of the thighs, labia majora and minora, clitoris, urethra, periurethral tissue, hymen, hymenal opening, fossa navicularis, and posterior fourchette.

Various methods for visualizing the hymenal opening in prepubertal children have been described. Many factors will influence the size of the orifice and the exposure of the hymen and its internal structures. These include the degree of relaxation of the child, the amount of traction (gentle, moderate) on the labia majora, and the position of the child (supine, lateral, or knee to chest).<sup>17,18</sup> The technique used is less important than maximizing the view and recording the method and results (see below for discussion of significance of findings). Speculum or digital examinations should not be performed on the prepubertal child.

In male children, the thighs, penis, and scrotum should be examined for bruises, scars, chafing, bite marks, and discharge.

In both sexes, the anus can be examined in the supine, lateral, or knee to chest position. As with the vaginal examination, the child's position may influence the appearance of anatomy. The presence of bruises around the anus, scars, anal tears (especially those that extend into the surrounding perianal skin), and anal dilation are important to note. Laxity of the sphincter, if present, should be noted, but digital examination is not usually necessary (see below for discussion of significance of findings). Note the child's behavior during the examination, and ask the child to demonstrate any events that may have occurred to the areas of the body being examined. Care should be taken not to suggest answers to the questions.

## LABORATORY DATA

Forensic studies should be performed when the examination occurs within 72 hours of acute sexual assault or sexual abuse. The yield of positive cultures is very low in asymptomatic prepubertal children, especially those whose history indicates fondling only.<sup>19</sup> The examiner should consider the following factors when deciding whether to obtain cultures and perform serologic tests for sexually transmitted diseases (STDs): the possibility of oral, genital, or rectal contact; the local incidence of STDs; and whether the child is symptomatic. The Centers for Disease Control and Prevention and the AAP also provide recommendations on laboratory evaluation.<sup>20,21</sup> The implications of the diagnosis of an STD for the reporting of child sexual abuse are listed in [Table 1](#). Pregnancy prevention guidelines have been published by the AAP.<sup>5</sup>

## DIAGNOSTIC CONSIDERATIONS

The diagnosis of child sexual abuse often can be made based on a child's history. Physical examination alone is infrequently diagnostic in the absence of a history and/or specific laboratory findings. Physical findings are often absent even when the perpetrator admits to penetration of the child's genitalia.<sup>22-24</sup> Many types of abuse leave no physical evidence, and mucosal injuries often heal rapidly.<sup>25-27</sup> Occasionally, a child presents with clear evidence of anogenital trauma without an adequate history. Abused children may deny abuse. Findings that are concerning, but in isolation are not diagnostic of sexual abuse include: 1) abrasions or bruising of the inner thighs and genitalia; 2) scarring or tears of the labia minora; and 3) enlargement of the hymenal opening. Findings that are more concerning include: 1) scarring, tears, or distortion of the hymen; 2) a decreased amount of or absent hymenal tissue; 3) scarring of the fossa navicularis; 4) injury to or scarring of the posterior fourchette; and 5) anal lacerations.<sup>18,26-28</sup> The physician, the multidisciplinary team evaluating the child, and the courts must establish a level of certainty about whether a child has been sexually abused. [Table 2](#) provides suggested guidelines for making the decision to report sexual abuse of children based on currently available information. The presence of semen, sperm, or acid phosphatase; a positive culture for gonorrhea; or a positive serologic test for syphilis or human immunodeficiency virus (HIV) infection makes the diagnosis of sexual abuse a

medical certainty, even in the absence of a positive history, when congenital forms of gonorrhea, syphilis, and congenital or transfusion-acquired HIV (as well as needle sharing) are excluded.

Other physical signs or laboratory findings that are suspicious for sexual abuse require a complete history from the child and caregivers. If the child does not disclose abuse, the physician may wish to observe the child closely to monitor changes in behavior or physical findings. If the history is positive, a report should be made to the agency authorized to receive reports of sexual abuse.

The differential diagnosis of genital trauma also includes accidental injury and physical abuse. This differentiation may be difficult and may require a careful history and multidisciplinary approach. Because many congenital malformations and infections or other causes of anal-genital abnormalities may be confused with abuse, familiarity with these other causes is important.<sup>14,18</sup>

Physicians should be aware that child sexual abuse often occurs in the context of other family problems including physical abuse, emotional maltreatment, substance abuse, and family violence. If these problems are suspected, referral for a more comprehensive evaluation is imperative. In difficult cases, pediatricians may find consultation with a regional child abuse specialist or assessment center helpful.

After the examination, the physician should provide appropriate feedback and reassurance to the child and family.

## **RECORDS**

Because the likelihood of civil or criminal court action is high, detailed records, drawings, and/or photographs should be kept. The submission of written reports to county agencies and law enforcement departments is encouraged. Physicians required to testify in court are better prepared and may feel more comfortable if their records are complete and accurate. The more detailed the reports and the more explicit the physician's opinion, the less likely the physician may need to testify in civil court proceedings. Testimony will be likely, however, in criminal court, where records alone are not a substitute for a personal appearance. In general, the ability to protect a child may often depend on the quality of the physician's records.<sup>28</sup>

## **TREATMENT**

All children who have been sexually abused should be evaluated by the pediatrician or mental health provider to assess the need for treatment and to measure the level of parental support. Unfortunately, treatment services for sexually abused children are not universally available. The need for treatment varies depending on the type of sexual molestation (whether the perpetrator is a family member or nonfamily member), the duration of the molestation, and the age and symptoms of the child. Poor prognostic signs include more intrusive forms of abuse, more violent assaults, longer periods of sexual molestation, and closer relationship of the perpetrator to the victim. The parents of the victim may also need treatment and support to cope with the emotional trauma of their child's abuse.

## **LEGAL ISSUES**

The legal issues confronting pediatricians in evaluating sexually abused children include mandatory reporting with penalties for failure to report; involvement in the civil, juvenile, or family court systems; involvement in divorce or custody proceedings in divorce courts; and involvement in criminal prosecution of defendants in criminal court. In addition, there are medical liability risks for pediatricians who fail to diagnose abuse or who misdiagnose other conditions as abuse.

All pediatricians in the United States are required under the laws of each state to report suspected as well as known cases of child sexual abuse. These guidelines do not suggest that a pediatrician who evaluates a child with an isolated behavioral finding (nightmares, enuresis, phobias, etc) or an isolated physical

finding (erythema or an abrasion of the labia or traumatic separation of labial adhesions) is obligated to report these cases as suspicious. If additional historical, physical, or laboratory findings suggestive of sexual abuse are present, the physician may have an increased level of suspicion and should report the case. Pediatricians are encouraged to discuss cases with their local or regional child abuse consultants and their local child protective services agency. In this way, agencies may be protected from being overburdened with high numbers of vague reports, and physicians may be protected from potential prosecution for failure to report.

Increasing numbers of cases of alleged sexual abuse involve parents who are in the process of separation or divorce and who allege that their child is being sexually abused by the other parent during custodial visits. Although these cases are generally more difficult and time-consuming for the pediatrician, the child protective services system, and law enforcement agencies, they should not be dismissed because a custody dispute exists. Allegations of abuse that occur in the context of divorce proceedings should either be reported to the child protective services agency or followed closely. A juvenile court proceeding may ensue to determine if the child needs protection. The pediatrician should act as an advocate for the child in these situations and encourage the appointment of a guardian ad litem by the court to represent the child's best interests. The American Bar Association indicates that the majority of divorces do not involve custody disputes, and relatively few custody disputes involve allegations of sexual abuse.<sup>28</sup>

In both criminal and civil proceedings, physicians must testify to their findings "to a reasonable degree of medical certainty."<sup>27</sup> For many physicians, this level of certainty may be a focus of concern because in criminal trials the pediatrician's testimony is part of the information used to ascertain the guilt or innocence of an alleged abuser.

Pediatricians may find themselves involved in civil malpractice litigation. The failure of a physician to recognize and diagnose sexual abuse in a timely manner may lead to a liability suit if a child has been brought repeatedly to the physician and/or a flagrant case has been misdiagnosed. The possibility of a suit being filed against a physician for an alleged "false report" exists; however, to our knowledge there has been no successful "false report" suit against a physician as of this writing. Statutes generally provide immunity as long as the report is done in good faith.

Civil litigation suits may be filed by parents against individuals or against institutions in which their child may have been sexually abused. The physician may be asked to testify in these cases. In civil litigation cases, the legal standard of proof in almost all states is "a preponderance of the evidence."

## CONCLUSION

The evaluation of sexually abused children is increasingly a part of general pediatric practice. Pediatricians are part of a multidisciplinary approach to prevent, investigate, and treat the problem and need to be competent in the basic skills of history taking, physical examination, selection of laboratory tests, and differential diagnosis. An expanding clinical consultation network is available to assist the primary care physician with the assessment of difficult cases.<sup>29</sup>

### COMMITTEE ON CHILD ABUSE AND NEGLECT, 1998-1999

Steven W. Kairys, MD, MPH, Chairperson  
Randell C. Alexander, MD, PhD  
Robert W. Block, MD  
V. Denise Everett, MD  
Lt Col Kent P. Hymel, MD  
Charles F. Johnson, MD

### LIAISON REPRESENTATIVES

Larry S. Goldman, MD  
American medical association

Gene Ann Shelley, PhD

Centers for Disease Control and Prevention  
Karen Dineen Wagner, MD, PhD  
American Academy of Child and Adolescent Psychiatry

### SECTION LIAISON

Carole Jenny, MD  
Section on Child Abuse and Neglect

### CONSULTANT

Judith Ann Bays, MD

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**TABLE 1.** Implications of Commonly Encountered Sexually Transmitted Diseases (STDs) for the Diagnosis and Reporting of Sexual Abuse of Infants and Prepubertal Children

STD Confirmed	Sexual Abuse	Suggested Action
Gonorrhea*	Diagnostic†	Report‡
Syphilis*	Diagnostic	Report
HIV§	Diagnostic	Report
<i>Chlamydia</i> *	Diagnostic†	Report
<i>Trichomonas vaginalis</i>	Highly suspicious	Report
Condylomata acuminata* (anogenital warts)	Suspicious	Report
Herpes (genital location)	Suspicious	Report
Bacterial vaginosis	Inconclusive	Medical follow-up

\* If not perinatally acquired.

† Use definitive diagnostic methods such as culture or DNA probes.

‡ To agency mandated in community to receive reports of suspected sexual abuse.

§ If not perinatally or transfusion acquired.

|| Unless there is a clear history of autoinoculation. Herpes 1 and 2 are difficult to differentiate by current techniques.

**TABLE 2.** Guidelines for Making the Decision to Report Sexual Abuse of Children

<b>Data Available</b>			<b>Response</b>	
History	Physical Examination	Laboratory Findings	Level of Concern About Sexual Abuse	Report Decision
None	Normal	None	None	No report
Behavioral changes†	Normal	None	Variable depending upon behavior	Possible report*; follow closely (possible mental health referral)
None	Nonspecific findings	None	Low (worry)	Possible report*; follow closely
Nonspecific history by child or history by parent only	Nonspecific findings	None	Intermediate	Possible report*; follow closely
None	Specific findings‡	None	High	Report
Clear statement	Normal	None	High	Report
Clear statement	Specific findings	None	High	Report
None	Normal, nonspecific or specific findings	Positive culture for gonorrhea; positive serologic test for HIV; syphilis; presence of semen, sperm acid phosphatase	Very high	Report
Behavior changes	Nonspecific findings	Other sexually transmitted diseases	High	Report

\* A report may or may not be indicated. The decision to report should be based on discussion with local or regional experts and/or child protective services agencies.

† Some behavioral changes are nonspecific, and others are more worrisome.<sup>7</sup>

‡ Other reasons for findings ruled out.<sup>13</sup>

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## Medical Necessity for the Hospitalization of the Abused and Neglected Child

### AMERICAN ACADEMY OF PEDIATRICS

Committee on Hospital Care and Committee on Child Abuse and Neglect

**ABSTRACT.** The child suspected of being abused or neglected demands prompt evaluation in a protective environment where knowledgeable consultants are readily available. In communities without specialized centers for the care of abused children, the hospital inpatient unit becomes an appropriate setting for their initial management. Medical, psychosocial, and legal concerns may be assessed expeditiously while the child is housed in a safe haven awaiting final disposition by child protective services. The American Academy of Pediatrics recommends that hospitalization of abused and neglected children, when medically indicated or for their protection/diagnosis when there are no specialized facilities in the community for their care, should be viewed as medically necessary by both health professionals and third-party payors.

Physicians and other health care personnel have an ethical, moral, and legal obligation to diagnose and treat abused or neglected children. Similarly, hospitals have an equally compelling responsibility to accept these children for admission if hospitalization is deemed appropriate and necessary for medical or safety reasons. Peer review organizations, however, may deny that such admissions are medically required, identifying child abuse as a social rather than a medical problem. Nonetheless, denial of payment or rigid prescriptions for length of hospital stay by managed care and review organizations must not preclude the medical judgment of the attending physician and other members of the hospital care team.

Some communities have "crisis intervention centers" or other nonhospital facilities that are specifically developed to provide emergency shelter and efficient evaluation of children suspected of being abused or neglected. Not only do such centers offer more cost-effective and socially appropriate alternatives to hospitals for medically stable children, they are also staffed by experts in the field of abuse who are readily available for the evaluation and care of the children and their families.

Where there are no specialized facilities for the management of abused or neglected children, the hospital inpatient unit becomes an appropriate setting for their emergency placement and initial assessment for several reasons. First and foremost, the hospital may be the only safe haven in the community that is accessible on short notice, particularly during weekends and holidays when child protective services and safe, temporary placements may not be available. Often, emergency department personnel choose to admit these children because they are not familiar with the patients or their families. In addition,

diagnostic studies necessary to determine the presence or extent of injury and appropriate consultation may not be immediately available in communities in which resources are limited. In such situations, to return a child to a potentially unsafe environment while awaiting further reevaluation could be life-threatening. Finally, not only may an abused child be treated efficiently and thoroughly in an inpatient setting, the hospitalization may also provide a unique opportunity for detailed observations of parent-child interaction by personnel of the medical, nursing, social services, and behavioral sciences staff.

### RECOMMENDATIONS

The American Academy of Pediatrics recommends:

1. In communities with no specialized child protection centers, children requiring evaluation and treatment for suspected abuse or neglect be hospitalized for their initial management until they are determined to be medically stable and safe alternative facilities for their placement are available pending completion of their assessment.
2. Hospitalization of children requiring evaluation and treatment for abuse or neglect should be viewed by third-party payors as medically necessary.

#### COMMITTEE ON HOSPITAL CARE, 1996 TO 1997

James E. Shira, MD, Chairperson  
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 Mary E. O'Connor, MD  
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#### LIAISON REPRESENTATIVES

C. Stamey English, MD  
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 National Association of Children's Hospitals and  
 Related Institutions  
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 Society of Pediatric Nurses  
 Paul R. VanOstenberg, DDS, MS  
 Joint Commission on Accreditation of Healthcare  
 Organizations  
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 American Hospital Association  
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 Association for the Care of Children's Health

#### SECTION LIAISON

Theodore Striker, MD  
 Section on Anesthesiology

#### COMMITTEE ON CHILD ABUSE AND NEGLECT, 1996 TO 1997

Judith Ann Bays, MD, Chairperson  
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 Robert W. Block, MD  
 Charles F. Johnson, MD  
 Steven Kairys, MD, MPH  
 Mireille B. Kanda, MD, MPH

#### LIAISON REPRESENTATIVES

Larry S. Goldman, MD  
 American Medical Association  
 Gene Ann Shelley, PhD  
 Centers for Disease Control and Prevention  
 Karen Dineen Wagner, MD, PhD  
 American Academy of Child and Adolescent  
 Psychiatry

#### SECTION LIAISONS

Robert H. Kirschner, MD  
 Section on Pathology  
 Carole Jenny, MD  
 Section on Child Abuse and Neglect

### REFERENCES

1. American Academy of Pediatrics, Committee on Hospital Care. Medical necessity for the hospitalization of the abused and neglected child. *Pediatrics*. 1987;79:300
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## Oral and Dental Aspects of Child Abuse and Neglect

### JOINT STATEMENT OF THE AMERICAN ACADEMY OF PEDIATRICS AND THE AMERICAN ACADEMY OF PEDIATRIC DENTISTRY

#### AMERICAN ACADEMY OF PEDIATRICS

Committee on Child Abuse and Neglect

#### AMERICAN ACADEMY OF PEDIATRIC DENTISTRY

Ad Hoc Work Group on Child Abuse and Neglect

**ABSTRACT.** In all states, physicians and dentists recognize their responsibility to report suspected cases of abuse and neglect. The purpose of this statement is to review the oral and dental aspects of physical and sexual abuse and dental neglect and the role of physicians and dentists in evaluating such conditions. This statement also addresses the oral manifestations of sexually transmitted diseases and bite marks, including the collection of evidence and laboratory documentation of these injuries.

**ABBREVIATION.** ABFO, American Board of Forensic Odontology.

In all 50 states, physicians and dentists are required to report suspected cases of child abuse and neglect to social service or law enforcement agencies.<sup>1-4</sup> Physicians receive minimal training in oral health and dental injury and disease and thus may not detect dental aspects of abuse or neglect as readily as they do child abuse and neglect involving other areas of the body. Therefore, physicians and dentists should collaborate to increase the prevention, detection, and treatment of these conditions.

#### PHYSICAL ABUSE

Craniofacial, head, face, and neck injuries occur in more than half of the cases of child abuse.<sup>5-14</sup> Careful intraoral and perioral examination is necessary in all cases of suspected abuse. Some authorities believe that the oral cavity may be a central focus for physical abuse because of its significance in communication and nutrition.<sup>15</sup> The injuries most commonly are inflicted with blunt trauma with an instrument, eating utensils, hands, or fingers or by scalding liquids or caustic substances. The abuse may result in contusions; lacerations of the tongue, buccal mucosa, palate (soft and hard), gingiva alveolar mucosa or frenum; fractured, displaced, or avulsed teeth; facial bone and jaw fractures; burns; or other injuries. These injuries, including a lacerated frenum, also can result from unintentional trauma. Discolored teeth, indicating pulpal necrosis, may result from previous trauma.<sup>16,17</sup> Gags applied to the

mouth may leave bruises, lichenification, or scarring at the corners of the mouth.<sup>18</sup> Multiple injuries, injuries in different stages of healing, injuries inappropriate for the child's stage of development, or a discrepant history should arouse suspicion of abuse. Age-appropriate nonabusive injuries to the mouth are common and must be distinguished from abuse based on history, the circumstances of the injury and pattern of trauma, and the behavior of the child, caregiver, or both. Consultation with or referral to a pediatric dentist is appropriate.

## SEXUAL ABUSE

The oral cavity is a frequent site of sexual abuse in children.<sup>19</sup> The presence of oral and perioral gonorrhea or syphilis in prepubertal children is pathognomonic of sexual abuse.<sup>20</sup> When gonorrhea or syphilis is diagnosed in a child, the case must be reported to public health authorities for investigation of the source and other contacts. A multidisciplinary child abuse evaluation for the child and family should be initiated.<sup>21</sup> Pharyngeal gonorrhea is frequently asymptomatic. Therefore, when a diagnosis of gonorrhea is suspected, lesions should be sought in the oral cavity, and appropriate cultures should be obtained even if no lesions are detected.<sup>22-26</sup>

When obtaining oral or pharyngeal cultures for *Neisseria gonorrhoeae*, the physician must specifically ask for culture media that will grow and differentiate this organism from *Neisseria meningitidis*, which normally inhabits the mouth and throat. Gonococci will not grow in routine throat cultures.<sup>27</sup> Even when selective media is used, nonpathogenic *Neisseria* species can be confused with *N gonorrhoeae*. Laboratory confirmation using two different types of tests is needed to properly identify *N gonorrhoeae*. Detection of semen in the oral cavity is possible for several days after exposure. Therefore, during examination of a child who is suspected of experiencing forced oral sex, cotton swabs should be used to swab the buccal mucosa and tongue, with the swabs preserved appropriately for laboratory analysis of the presence of semen.

Unexplained erythema or petechiae of the palate, particularly at the junction of the hard and soft palate, may be evidence of forced oral sex.<sup>28,29</sup> Although cases of syphilis are rare in the sexually abused child, oral lesions also should be sought and dark-field examinations performed. Oral or perioral condylomata acuminata, although probably most frequently caused by sexual contact, may be the result of contact with verruca vulgaris or self-inoculation.<sup>30</sup>

## BITE MARKS

Bite marks are lesions that may indicate abuse. Dentists trained as forensic odontologists may be of special help to physicians for the detection and evaluation of bite marks related to physical and sexual abuse.<sup>31</sup> Bite marks should be suspected when ecchymoses, abrasions, or lacerations are found in an elliptical or ovoid pattern. Bite marks may have a central area of ecchymoses (contusion) caused by two possible phenomena: 1) positive pressure from the closing of the teeth with disruption of small vessels or 2) negative pressure caused by suction and tongue thrusting. The normal distance between the maxillary canine teeth in adult humans is 2.5 to 4.0 cm, and the canine marks in a bite will be the most prominent or deep parts of the bite. Bites produced by dogs and other carnivorous animals tend to tear flesh, whereas human bites compress flesh and can cause abrasions, contusions, and lacerations but rarely avulsions of tissue. If the intercanine distance is <2.5 cm, the bite may have been caused by a child. If the intercanine distance is 2.5 to 3.0 cm, the bite was probably produced by a child or a small adult; if the distance is >3.0 cm, the bite was probably by an adult. The pattern, size, contour, and color(s) of the bite mark should be evaluated by a forensic odontologist or a forensic pathologist if an odontologist is not available. If neither specialist is available, a pediatrician or pediatric dentist experienced in the patterns of child abuse injuries should observe and document the bite mark characteristics photographically with an identification tag and scale marker in the photograph. The photograph should be taken at a right angle (perpendicular) to the bite. A special photographic scale was developed by the American Board of Forensic Odontology (ABFO) for this purpose, as well as for documenting other patterned injuries and should be obtained in advance from the vendor (ABFO No. 2 reference scale. Available from Lightning

Powder Co, Inc, 1230 Hoyt St SE, Salem, OR 97302-2121). Names and contact information for the ABFO certified odontologists may be obtained from their Web site ([www.abfo.org](http://www.abfo.org)). Written observations and photographs should be repeated daily for at least 3 days to document the evolution and age of the bite. Because each person has a characteristic bite pattern, a forensic odontologist may be able to match dental models (casts) of a suspected abuser's teeth with impressions or photographs of the bite.

Blood group substances can be secreted in saliva. DNA is present in epithelial cells from the mouth and may be deposited in bites. Even if saliva and cells have dried, they should be collected on a sterile cotton swab moistened with distilled water, dried, and placed in a cardboard specimen tube or envelope. A control sample should be obtained from an uninvolved area of the child's skin. All samples should be sent to a certified forensic laboratory for prompt analysis.<sup>32</sup> The chain of custody must be maintained on all samples submitted for forensic analysis. Questions of evidentiary procedure should be directed to a law enforcement agency.

## DENTAL NEGLECT

*Dental neglect*, as defined by the American Academy of Pediatric Dentistry,<sup>33</sup> is "the willful failure of parent or guardian to seek and follow through with treatment necessary to ensure a level of oral health essential for adequate function and freedom from pain and infection." Dental caries, periodontal diseases, and other oral conditions, if left untreated, can lead to pain, infection, and loss of function. These undesirable outcomes can adversely affect learning, communication, nutrition, and other activities necessary for normal growth and development.<sup>33</sup>

Failure to seek or obtain proper dental care may result from factors such as family isolation, lack of finances, parental ignorance, or lack of perceived value of oral health.<sup>34</sup> The point at which to consider a parent negligent and to begin intervention occurs after the parent has been properly alerted by a health care professional about the nature and extent of the child's condition, the specific treatment needed, and the mechanism of accessing that treatment.<sup>35</sup>

The physician or dentist should be certain that the caregivers understand the explanation of the disease and its implications and, when barriers to the needed care exist, attempt to assist the families in finding financial aid, transportation, or public facilities for needed services. Parents should be reassured that appropriate analgesic and anesthetic procedures will be used to assure the child's comfort during dental procedures. If, despite these efforts the parents fail to obtain therapy, the case should be reported to appropriate child protective services.<sup>33,35</sup>

## CONCLUSION

When a child has oral injuries or dental neglect is suspected, the child will benefit from the physician's consultation with a pediatric dentist or a dentist with formal training in forensic odontology.

Pediatric dentists and oral and maxillofacial surgeons, whose advanced education programs include a mandated child abuse curriculum, can provide valuable information and assistance to physicians about oral and dental aspects of child abuse and neglect. The Prevent Abuse and Neglect Through Dental Awareness (also known as PANDA) coalitions that have trained thousands of dentists and dental auxiliaries is another resource for physicians seeking information on this issue (telephone: 573/751-6247; e-mail: [moudeL@mail.health.state.mo.us](mailto:moudeL@mail.health.state.mo.us)).

Physician members of multidisciplinary child abuse and neglect teams should identify such dentists in their communities to serve as consultants for these teams. In addition, physicians with experience or expertise in child abuse and neglect should make themselves available to dentists and to dental organizations as consultants and educators. Such efforts will strengthen our ability to prevent and detect child abuse and neglect and enhance our ability to care for and protect children.

COMMITTEE ON CHILD ABUSE AND  
NEGLECT, 1998-1999

Steven W. Kairys, MD, MPH, Chairperson  
Randell C. Alexander, MD, PhD  
Robert W. Block, MD  
V. Denise Everett, MD  
Lt Col Kent P. Hymel, MD  
Charles F. Johnson, MD

LIAISON REPRESENTATIVES

Larry S. Goldman, MD  
American Medical Association  
Gene Ann Shelley, PhD  
Centers for Disease Control and Prevention  
Karen Dineen Wagner, MD, PhD  
American Academy of Child and Adolescent  
Psychiatry

SECTION LIAISON

Carole Jenny, MD  
Section on Child Abuse and Neglect

CONSULTANT

Robert A. Kirschner, MD

AMERICAN ACADEMY OF PEDIATRIC  
DENTISTRY AD HOC WORK GROUP ON  
CHILD ABUSE AND NEGLECT

Stephen M. Blain, DDS, MS  
Paul E. Kittle, Jr, DDS  
John P. Kenney, DDS, MS  
Robert J. Musselman, DDS, MSD  
Howard L. Needleman, DMD  
Lynn D. Mouden, DDS, MPH (PANDA  
Consultant)

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This statement has been approved by the AAP Child and Adolescent Health Action Group

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The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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## Ohio Sexual Abuse Protocol



Medical  
Photographs of  
Child Abuse

2



# OHIO PEDIATRIC SEXUAL ABUSE PROTOCOL

(Ohio AAP 2000 Sexual Abuse Protocol)

August 2000

This protocol was developed by the Committee on Child Abuse and Neglect of the Ohio Chapter of the American Academy of Pediatrics, the Ohio Department of Health and the Ohio Attorney General's office.

**A copy of this protocol may be obtained from the Internet in PDF format at the address below:**

<http://www.cincinnatichildrens.org/mayerson>

Click on the "Professionals' Toolkit" link found on the left side of the web page  
then choose [Diagnosis and Treatment Reference Materials](#).  
the protocol is labeled [Ohio Pediatric Sexual Abuse Protocol](#), August 2000 (488kb).

Comments and questions should be addressed to:

Robert Shapiro, MD  
Mayerson Center for Safe and Healthy Children  
Children's Hospital Medical Center  
3333 Burnet Avenue  
Cincinnati, Ohio 45229

Fax (513-636-0024)  
E-mail: [robert.shapiro@chmcc.org](mailto:robert.shapiro@chmcc.org)

# OHIO PEDIATRIC SEXUAL ABUSE PROTOCOL

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# PROTOCOL FOR THE EVALUTION AND TREATMENT OF SEXUAL ABUSE

## I. INTRODUCTION

In order to provide comprehensive, standardized, non-judgmental, equitable treatment of pediatric victims of sexual abuse, the Ohio American Academy of Pediatrics Committee on Child Abuse and Neglect has written this protocol in collaboration with the Ohio Department of Health and the Ohio Attorney General's office. This protocol is a modification of the Ohio Department of Health Protocol For The Treatment Of Sexual Assault Survivors. This protocol is intended to facilitate the provision of consistent, comprehensive health care treatment to include emotional, social, and crisis intervention as well as provide information about available follow up services in the community. Particular attention has been given to basic requirements of the legal system and evidence collection. The focus of this protocol is on the evaluation and treatment of victims of sexual abuse. It is recommended that, when possible, children be taken to a children's hospital, child abuse clinic or Children's Advocacy Center for an examination related to sexual abuse.

Child sexual abuse is defined as sexual activity, which may include sexual touching and fondling, genital to genital contact, exposing children to pornography or adult sexual activity, exploitation of children, rape, attempted rape, and incest. It can be violent or non-violent in nature. Child sexual abuse can take place within the family or outside of the home. Regardless of the type of sexual abuse, the child victim often develops a variety of distressing feelings and thoughts and the long-term emotional and psychological damage can be devastating.

While the 1980's showed an increase in sexual abuse awareness, current statistics suggest that sexual abuse continues to go under-reported. Because there are often no physical signs of sexual abuse, it is extremely important that parents, social workers, and others allow children to feel comfortable enough to disclose abuse. Children will benefit from repeated assurance that they are believed and will be kept safe.

### *Indicators of Sexual Abuse May Include:*

- New fears of persons or places
- Sexual play beyond what is considered normal
- Unusual interest in or avoidance of all things of sexual nature
- Sleep problems or nightmares
- Depression or withdrawal from friends/family
- Fear that there is something wrong with their genital area
- School refusal/Runaway
- Unusual aggressiveness
- Suicidal behavior
- Other severe behavior changes
- Vaginal or urethral discharge
- Genital or rectal pain, bleeding or trauma
- Sexually transmitted infections

### *Two aspects of child sexual abuse create difficulties in recognition and management:*

1. A relative or acquaintance usually sexually abuses children. Consequently, family ties may be strained to the point where the reported assailant is protected. It is not unusual for the child to be blamed for the incident. His or her caretakers may even deny the child's report. Frequently, parents may find the occurrence of sexual abuse unbelievable or may be unable or unwilling to believe that someone they know and trust could do anything like this to their child.
2. Frequently, little or no physical evidence may be found to corroborate the child's story since a) physical

force is usually not used when children are sexually abused and b) children are often brought for evaluation of sexual abuse days to months after the event. This reinforces denial by the family.

Disclosure of abuse may be a process that occurs over time. Be conscious not to “shut the door” when a child begins to disclose abuse. Instead, ask open-ended questions such as, “Can you tell me more about that?” Stress to the child that it is not his/her fault. Report all alleged child sexual abuse to the appropriate Children’s Protective Services agency or Law Enforcement.

Sexually abused children and their families need professional evaluation and treatment. An expert forensic evaluation will determine the type and extent of the abuse and mental health treatment can help reduce the risk of low self-esteem, feelings of guilt, and emotional trauma. The identification of child pedophiles can help prevent future episodes of sexual abuse.

Providing services to individuals who have been victims of sexual abuse requires special sensitivity. Social, cultural, ethnic and religious backgrounds must be considered and may be a cause of additional stress for sexual abuse victims. Hospital and clinic staff are encouraged to seek out reliable information and training on practices and beliefs specific to people from culturally diverse backgrounds who may utilize the services of the hospital or clinic. Resources may be obtained by contacting the Rape Prevention Program at the Ohio Department of Health at 614/466-2144 or the Ohio Coalition On Sexual Assault (OCOSA) at 614/268-3322.

Economic status may be a factor with some individuals who already feel victimized and underserved in the community. This may affect their attitude as well as degree of cooperation with hospital staff, police officials, or others they view as authority figures or as representing the system. Emotional and/or psychological trauma may not always be apparent when the patient arrives at the hospital or clinic. Psychological trauma may be evidenced in many different forms, from unusual calm to indifference, to hysteria, to laughter.

It is imperative that evidence is properly collected and analyzed so that, should the assailant be prosecuted, the necessary evidence will be in the hands of appropriate law enforcement officials. Proper collection and handling of evidence is vital. Legal protocol dictates a “chain of evidence” wherein each individual handling the evidence documents receipt and delivery of the specimens. This procedure helps rule out possible improper handling of evidence. Should prosecution occur, proper collection of evidence increases the probability of conviction.

This protocol should facilitate the cooperation and communication among organizations providing services to abuse victims. All communities are encouraged to utilize or establish a specialized service/team where children who allege sexual abuse can receive an expert evaluation. A child sexual abuse team may include representatives from the hospital child abuse program, emergency department, a Pediatric Sexual Assault Nurse Examiner, trained Pediatric Nurse Practitioner, law enforcement, the prosecutor’s office and social service agencies. Communities with access to a Children’s Advocacy Center should utilize that Center’s expertise and support services. Communities that lack medical child abuse expertise are encouraged to establish a Pediatric Sexual Assault Nurse Examiner (PSANE) program. With good information and evidence collection procedures in place and an effective referral network established, the child and family should be able to utilize the available supportive services with a minimum potential for having to reenact the abuse through repetition of the event to service providers.

## II. DEFINITION

Sexual assault and sexual abuse are medical and legal terms. Legally, child sexual abuse includes any sexual activity with a child, including exposure; touching and penetration, defined by the Ohio revised Code 2151.421. Sexual assault includes rape and sexual battery defined by the Ohio revised Code 2907.01 as any sexual penetration, however slight, using force or coercion against the person's will.

## III. THE SEXUAL ABUSE EVALUATION

To assure adequate physical and emotional care of the sexual abuse patient this protocol can be used by hospital emergency department personnel, children's advocacy centers, child abuse clinics, or other child abuse providers when a child or adolescent presents with the complaint of sexual abuse or rape. This protocol must be followed when submitting invoices for payment to the Office of the Ohio Attorney General. To ensure an effective case for prosecution, it is important to protect the integrity of the evidence.

Only a physician trained and experienced in the evaluation and treatment of the sexual abuse patient, or a health professional, who is under the supervision of an experienced physician, such as a Pediatric Sexual Assault Nurse Examiner, resident, or fellow, should perform the examination.

Hospital personnel are responsible for identifying the victim(s) and reporting the incident to the county Department of Human Services or Children Services Board, law enforcement, or the hospital social worker, as designated by your medical center or clinic. Whenever possible, child sexual abuse victims should be referred to the local Child Advocacy Center or Child Abuse Clinic.

### A. INDICATIONS FOR THE EMERGENCY USE OF THIS PROTOCOL

Children must be seen on an emergency basis if trace forensic evidence needs to be collected or if there are other indications requiring an emergency evaluation. Trace forensic evidence must be collected, using the approved evidence box, when either of the conditions listed below are true.

- #1. The last episode of sexual abuse / assault occurred within the past 72 hours **AND**
  - a. The history indicated contact with the alleged perpetrator's genitalia **OR**
  - b. The history indicates contact with the alleged perpetrator's semen, blood or saliva **OR**
  - c. The history indicates a struggle that may have left skin or blood of the alleged perpetrator's to be lodged under the victim's fingernails, on the victim's body or clothing **OR**
  - d. The victim's clothing or body may be covered by trace evidence (debris, fibers, etc) from the alleged crime scene.

*Evidence can be collected up to 72 hours after an assault (in rare cases beyond 72 hours).*

- #2. The history of contact with the alleged perpetrator is unclear (i.e. child too young to provide a history or a history is unavailable) & there is reason to believe that conditions described in #1 above are true.

**This protocol must be followed if submitting invoices for payment to the Ohio Attorney General.**

### B. INDICATIONS FOR THE DEFERRED USE OF THIS PROTOCOL

If there is no indication for an emergency evaluation, the hospital or clinic may elect not to complete this protocol, use an internal sexual abuse protocol instead, and if indicated, refer the patient to a child abuse clinic or advocacy center for a forensic evaluation. When sexual abuse is suspected, the hospital / clinic is



responsible under Ohio law to make a report of suspected sexual abuse to a mandated agency (i.e.: the police, the Department of Human Services or Children's Protective Services). When patients present to a hospital or clinic, it is the responsibility of the hospital or clinic to determine if trace evidence collection is indicated. When doubt exists, it is better to collect trace evidence than not.

All children who allege sexual abuse should be examined by a trained provider in a timely manner. Many sexual abuse victims first present days to months after the sexual abuse event or are assaulted in such a way that trace forensic evidence collection is not necessary. In this situation, the Ohio Sexual Assault/Abuse Evidence Collection Kit is not needed. However, forensic interviews, forensic examination, testing, treatment, referral and reporting will need to be done. These children should be given an appointment for an outpatient forensic evaluation with a Child Advocacy Center or Child Abuse Clinic.

## **IV. PROTOCOL SECTIONS**

### **SECTION 1 Patient triage**

- A. A rape/sexual abuse patient should be viewed as a priority patient and should be given immediate privacy. A physician, the charge nurse, a health care examiner, or professional staff person should see this patient within 15 minutes of arrival or as soon thereafter as possible.
- B. The intake worker elicits sufficient information to complete the registration process as quickly as possible and in private, if possible.
- C. The intake worker informs the designated sexual abuse specialist and/or the primary nurse that a sexual abuse patient has presented for evaluation. A sexual abuse specialist is a staff person who may be designated to be responsible for the coordination and assurance of care for the patient.
- D. If law enforcement or social service personnel do not accompany the patient, they are to be notified by hospital/clinic staff. The hospital/clinic is obligated under Ohio law to report alleged or suspected sexual abuse whether the patient wants to speak with law enforcement or not. It is the responsibility of hospital/clinic personnel to inform the patient that law enforcement and/or social services will be notified that a sexual assault/abuse has been reported to the hospital/clinic. Unlike adult sexual assault, the name of the sexual abuse victim must be reported to the legally mandated authorities even when the patient or family wishes not to report the sexual abuse.
- E. Reporting to the legally mandated agencies (i.e. law enforcement and the county social service agency) is mandatory. Otherwise, information concerning the sexual abuse shall not be given by anyone to the media or any other person(s) seeking information without the written consent of the patient or legal guardian.
- F. When appropriate, the hospital/clinic should inform the patient of the option and benefits of having additional support throughout this process. If a parent or guardian does not accompany the child, hospital/clinic staff should offer to call in social work personnel, local sexual abuse advocates, or suggest to the patient that she/he summon a family member or friend to be present during the process.
- G. Ohio law states that the patient is not to be billed for the collection of forensic evidence in sexual assault cases. See Ohio Revised Code #2907.28. Bills are to be sent to the Ohio Attorney General. This protocol must be followed when evaluating a patient for alleged sexual abuse if a bill is to be submitted to the Ohio Attorney General.
- H. Whenever possible the patient should be given priority for a room assignment in a private area.

- I. Hospital/clinic personnel should assure that the patient's questions are answered and information is provided and provide support to the patient, family and friends. Give the "Child Sexual Abuse & Assault: What will happen during the evaluation handout", or equivalent, to the patient / family. This handout is printed in Appendix A.
- J. Under Ohio law, Ohio Revised Code #2907.29, each patient reporting a sexual assault must be informed of available venereal disease, pregnancy, medical and psychiatric services.
- K. The parent or guardian must give consent for the evaluation. In cases of sexual abuse, specific consent is NOT required before obtaining colposcope documentation, photographs and tests which may document injuries from abuse. A signed release of information regarding the collected forensic evidence is **not** required in cases of child sexual abuse. The standard consent to treat is sufficient in sexual abuse cases.
- L. A minor who is a victim of sexual abuse or assault does not need to have the written consent of a parent or legal guardian before proceeding with the examination. However, according to Ohio Revised Code #2907.29, parents or guardian must be notified in writing after the exam. In cases of child sexual abuse, safety issues for the child victim need to be considered before notifying a parent or guardian and the issue of safety for the child may override the requirement to notify a parent/guardian if in the opinion of the medical personnel such notification is likely to endanger or cause harm to the child. Although the Ohio Revised Code and the Ohio Department of Health adult sexual assault protocol state a minor's parent or guardian must be notified after a sexual assault/abuse examination, staff should follow the protocol determined by local law enforcement and children's protective services in cases where the suspected abuser is a parent or guardian.
- M. Hospital personnel must advise the minor patient about the requirement to notify a parent or guardian concerning the treatment. It is recommended that a custodial person (parent or guardian), be notified at the time of the hospital visit, **by the minor**, if this is possible. If the alleged perpetrator is also the parent or guardian who will receive the notification, the county Department of Human Services, the law enforcement agency involved, and the minor child shall all be advised of the nature of the notification letter and the approximate date when it will be mailed. Coordination with the Department of Human Services must be done to insure the safety of the child. The issue of safety for the child may override the requirement to notify a parent/guardian, if in the opinion of medical personnel such notification is likely to endanger or cause harm to the child. When a child is examined at the request of the Department of Human Services, it shall be the responsibility and discretion of the Department, taking into account safety issues, to notify parents/guardians who are the alleged perpetrators.
- N. If an unwilling minor is brought in for a sexual abuse exam by a parent or guardian, the minor **must agree** to submit to the exam after discussion with the physician, the nurse, social worker or other health care provider, without the necessity of restraints or sedation. If the patient does not consent to the examination, force should not be used. In this case, the examination should be postponed and scheduled for another time.

## SECTION 2 Support

- A. Upcoming steps in the examination, and their rationale must be explained to the patient throughout the medical examination and interviewing processes.
- B. If disagreement arises between service providers and/or with support persons, discussion should be carried on at a later time or away from the patient.

## **SECTION 3 Abuse History, Medical History, Examination & Evidence Collection**

### **A. Assault/Abuse History.**

If collection of trace forensic evidence is indicated, use the “Assault/Abuse History and Examination Form” found in the Ohio Sexual Assault/Abuse Evidence Collection Kit. A copy of this form is also available in appendix K. In cases of sexual abuse beyond 72 hours or when other indications for using the evidence kit are absent, the evidence kit should not be used in the forensic evaluation. The information to be obtained includes:

1. Time, date and place of the abuse
2. Date, time of the exam
3. Sex, number and relationship of assailant(s), if known
4. Type of weapon used, if any
5. Type of penetration, if any
6. Did the patient douche, change clothes, bathe, urinate, defecate, brush teeth, rinse mouth etc. since the last assault?
7. Was patient menstruating at time of assault? At time of exam?
8. Was the assailant injured or bleeding?
9. Was a tampon present at time of assault? At time of exam?
10. Was a condom used?
11. Description and condition of clothing (e.g. torn, dirty, bloody, etc.)
12. Has there been consensual intercourse within 72 hours?
13. Narrative history (as described by the patient). Record the patient’s description of the abuse. When obtaining the history from a child, it is imperative that the interviewer asks only non-leading questions and that the vocabulary used is chosen by and understood by the victim.
14. The Sexual Abuse History must be documented in triplicate on the Assault/Abuse History and Examination Form. The original should be retained with the medical record. One copy goes to the forensic lab with the Sexual Assault/Abuse Evidence Collection Kit. The second copy goes with the report of alleged sexual abuse to law enforcement or the Department of Human Services.

### **B. Patient Medical History:**

An “Optional Medical History & Examination Form” is provided for your convenience. Institutional forms that cover the following items may be used in its place. A copy of this form is also available in appendix K.

1. Patient demographic and personal information
2. Others accompanying the patient
3. Vital signs (as warranted)
4. Allergies
5. Last tetanus
6. Current Medications
7. Acute Illnesses
8. Past Surgeries
9. Last Menstrual Period (or indicate patient is pre-menstrual)
10. Gravida (if adolescent patient)
11. Para (if adolescent patient)
12. Contraception used (if adolescent patient)
13. Approximate weight/height
14. Family physician
15. Gynecologist (if indicated)

### **C. Physical Examination and Evidence Collection**

The “Assault/Abuse History and Examination Form” found in the Ohio Sexual Assault/Abuse Evidence

Collection Kit and already used in “A” above, must be used to document injuries noted during the examination. This form is also available in appendix K. The “Optional Medical History & Examination Form” is provided for your convenience to record complete examination findings. Institutional forms that cover the following items may be used in place of the Optional Medical History & Examination Form.

Examination findings that need to be documented include:

1. General appearance (including description of condition of clothing e.g. torn, dirty, bloody, etc.)
2. Emotional status (objective observation)
3. Pertinent general physical findings (also mark anatomical drawings)
4. Body surface (locate & describe injury, mark findings on anatomical drawings)
5. External genitalia (describe pubertal status and general appearance)
6. Female: perineum, periurethral area, urethra, anus, rectum, labia majora, labia minora, clitoris, vestibule, posterior fourchette, fossa navicularis, vagina, vaginal discharge, hymen, cervix (if visualized). Note: An internal vaginal examination is contra-indicated in the pre-pubertal patient unless internal bleeding/trauma is present. An internal vaginal examination of a pre-pubertal patient usually requires deep sedation.
7. Male: glans penis, foreskin, shaft, testicles, discharge from penis, anus, rectum.

All significant physical findings should be noted. Indicate body areas that were involved in the abuse on the Assault/Abuse History and Examination Form. Indicate on the drawings all marks or evidence of trauma including subjective findings such as pain or tenderness. Record the names of those present during the exam.

A colposcopic exam should be performed to record the genital and rectal examinations. If a colposcope is not available, the use of a high intensity light source along with magnification will often result in a better examination. Consider the use of Toluidine Blue Dye staining techniques to help define injuries.

**When collection of trace forensic evidence is indicated:**

1. Follow carefully all directions provided in the Ohio Sexual Assault/Abuse Evidence Collection Kit and maintain the chain of evidence. Follow the “Procedure for Evidence Collection checklist (20 steps)” which is printed on the inside lid of the evidence box. Refer to the “Detailed Instructions for Ohio Department of Health Sexual Assault/Abuse Evidence Collection Kit” for detailed specimen collection instructions. These instructions can be found in appendix J.
2. An ultraviolet (UV) lamp exam (Wood’s lamp, Blue Max or similar lamp) should be performed in a dark room checking all skin areas likely to be stained by semen or saliva or that may have been subjected to bruises. Early bruising is often evident with use of a UV lamp. Many materials will fluoresce besides semen and saliva. A fluorescent stain is NOT evidence of semen or saliva but these stains should be collected for analysis by the crime lab.
3. The law enforcement agency may ask for additional tests and/or specimens. These requests should be honored if forensically indicated. Tests related to the medical work-up should be done at the discretion of the treating physician or health care provider.

**SECTION 4 Photo documentation**

- A) Still or video photographic documentation of the genital examination is required in order to receive payment for the examination from the Ohio Attorney General. This documentation should be of sufficient quality to allow for expert review of the images. Copies of these photos should be given to the mandated law enforcement or social service agency. There are two exceptions to this photo documentation requirement:
- 1) When trace forensic evidence is collected using the Ohio Sexual Assault/Abuse Evidence Collection Kit, photo documentation is strongly encouraged but not required.

- 2) If the physical examination is performed and documented by an examiner who is recognized in Ohio as an expert in sexual abuse, photo documentation is strongly encouraged but not required.
- B) Close-up photographs should be taken of all trauma areas. A measuring device to document the size of the trauma area (cut, bruise, scratch, etc.) should be included in the photographic frame. The photos should be identified (labeled) with the patient's name, medical record number and date. A measuring device may not be needed when documenting genital or rectal trauma. Two sets of photos are recommended. Both sets remain with the medical records unless a law enforcement or social services agency requests the trauma photos for their files.

## **SECTION 5 Treatment and Tests**

1. Hospital/clinic personnel must discuss and offer options for post-coital contraception with the female adolescent patient when indicated. Treatment is at the discretion of the treating physician with the permission of the patient. Should an institution or physician be precluded from providing post-coital contraception for religious reasons, referral to another physician, health care institution or agency must be made and information about this option must be provided as an important part of the treatment and healing process for the patient.. Post coital prophylactic treatment should be based on current medical practice. Hospital/clinic personnel should inform the patient that some medications might lessen the effectiveness of post coital contraception and determine if the patient is taking such medication.
2. When indicated, hospital/clinic personnel must discuss and offer prophylactic treatment for sexually transmitted infections including gonorrhea, chlamydia, syphilis and hepatitis. Treatment is at the discretion of the treating physician with the permission of the patient. Prophylactic treatment should be based on current guidelines from the Centers for Disease Control. Prophylactic treatment is usually not indicated for the pre-pubertal child but the treating physician / health care provider should consider obtaining cultures and tests for sexually transmitted infections. The results of these cultures/tests may have legal implications.
3. When indicated, hospital/clinic personnel must discuss HIV/AIDS testing with the patient including the difference between confidential and anonymous testing. Post exposure prophylaxis (PEP) treatment should also be discussed/offered. See Appendix 16 of the adult sexual assault protocol for information about HIV/AIDS, Appendix 17 of the adult sexual assault protocol for a sample HIV/AIDS testing consent form and Appendix 18 of the adult sexual assault protocol for a listing of HIV/AIDS testing sites. Prophylactic treatment should be based on current guidelines from the Centers for Disease Control (CDC).
4. Testing for date rape drugs is discussed in appendices C and D.
5. Document all treatment given and tests completed on the "Child Sexual Abuse After-care Handout" (appendix A).

## **SECTION 6 Referrals and Follow-up**

1. Refer patient to locations for follow-up tests for, gonorrhea, and chlamydia in two weeks if medically indicated. Referral for follow-up serologist tests for syphilis, hepatitis and HIV should be made in 12 weeks. Preferable locations are the local Child Advocacy Center or child abuse clinic.
2. Refer patient to locations for follow-up (anonymous or confidential) HIV/AIDS testing in six months if medically indicated. See Appendix 18 of the adult sexual assault protocol for Ohio locations.
3. Refer patient and family to a local counseling agency(ies) which can provide follow-up services related

to the sexual abuse.

4. Give the “Child Sexual Abuse: After-Care Handout” and the “Child Sexual Abuse: Common Reactions & Follow-up Services handout” to the patient and note that they have been given to the patient. These two handouts are in the kit and in appendix A.
5. Note all referrals on the Child Sexual Abuse After-Care Handout.

## **SECTION 7 Written Documentation**

Health professionals should write only objective information relating to the medical findings and treatment needs of the patient and should use patient quotes whenever possible. If the health professional is performing only the medical examination, with or without evidence collection, they should not make legal statements about whether or not rape or sexual abuse occurred. In this situation, the use of terms such as reported sexual abuse or sexual assault, rather than alleged, probable, or possible, is preferable. Child abuse consultants and experts, however, should make a statement about the likelihood or probability of sexual abuse when based on the forensic interview, the examination and the lab findings.

## **SECTION 8 Handling of the Completed Evidence Kit**

The nurse, physician, social worker or forensic nurse completes the documentation and signs the Ohio Sexual Assault/Abuse Evidence Collection Kit chain of evidence forms.

The “Assault/Abuse History and Examination form” and the Ohio Sexual Assault/Abuse Evidence Collection Kit are to be personally handed to the law enforcement officer or locked in a secure storage area where chain of evidence collection can be assured. Each item in the kit is labeled as to best-recommended storage. The Ohio Sexual Assault/Abuse Evidence Collection Kit is to be refrigerated as soon as possible. Even though the kit no longer contains blood tubes, it needs to be refrigerated to preserve the swabs in the event they are not completely dry. The paper bags for clothing should not be refrigerated.

## **SECTION 9 Patient Discharge**

1. The designated sexual abuse specialist, primary nurse or sexual assault nurse examiner checks all forms for completeness of information and signatures. Procedures for handling the paperwork should follow each hospital's / clinic's own policies.
2. The "Child Sexual Abuse: After-Care Handout" (patient discharge information) must be completed and given to the patient along with the " Child Sexual Abuse: Common Reactions and Follow-up Services handout" (appendix A). She/he should also be given a verbal explanation of the aftercare instructions and offered a final opportunity to explore any acute concerns prior to discharge. If the patient is admitted to the hospital, both pages are to remain with her/him.
3. Hospital / clinic staff must coordinate discharge planning with law enforcement, the Children Services Board or the Department of Human Services. The child must be discharged to an environment that is safe from further abuse.

## **V. APPENDICES**

### **A. Handouts**

#### **Child Sexual Abuse & Assault: What will happen during the evaluation handout.**

You are here for an evaluation of sexual abuse or sexual assault. The hospital staff is here to help. During the evaluation, you may be asked questions that are difficult and sometimes embarrassing to answer. We will try and be sensitive and understanding of your needs during the evaluation.

The information and specimens obtained will enable us to get a complete medical history, treat and identify any medical problems, and to investigate the allegations of abuse/assault. The specimens will help document circumstances and events in regard to the assault. Doctors, nurses and other medical staff will ask some of these questions so that they can provide the best medical care to ensure your physical health. A law enforcement officer or social worker may ask some of the same and additional or similar questions as part of their investigation.

After the history is collected, you (your child) will be examined. Some of your (your child's) clothes may be retained as a part of evidence collection. If you did not bring additional clothing to wear home, you may call a family member or friend and ask them to bring clothes to the hospital or inform hospital personnel of your need for clothing.

A doctor or qualified nurse examiner will examine you (your child) for physical injury. Because much of the evidence of the assault could be on your (your child's) body, it is important that specimens be taken from various areas, including the fingernails, hair, swabs of the inside of the mouth, genitalia, and rectum. A blood sample may be drawn. Depending upon the kinds of injury, x-rays may be taken. You may want to discuss with the attending physician, nurse or social worker your concerns about pregnancy and sexually transmitted infections, including HIV/AIDS.

We recognize that you have been through a terrible experience. We are here to help. Information about other services that may assist you will be provided before you leave.

**Child Sexual Abuse:  
After-Care Handout**

Page 1 of 2

*ID stamp or label if available*

Patient	Examiner
Hospital	Examiner's Phone
Date of Exam	Hospital Phone

Specimens were collected from you to provide evidence in court should the case be prosecuted. The following additional tests medical were collected to provide information about your health status, as of today. It may be important to compare today's results with follow-up tests in the near future.

- |  |   |
|--|---|
| <input type="checkbox"/> A blood test for syphilis infection | <input type="checkbox"/> Test(s) for HIV antibody           |
| <input type="checkbox"/> Test(s) for gonorrhea infection     | <input type="checkbox"/> Test(s) for pre-existing pregnancy |
| <input type="checkbox"/> Test(s) for chlamydia infection     |   |
| <input type="checkbox"/> other tests _____                   |   |

- ☐ You were given the following medications to prevent infection

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

- ☐ You were not given this preventive treatment because: \_\_\_\_\_

- ☐ You were given a post-coital contraceptive to prevent pregnancy

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

You may experience the following side effects: \_\_\_\_\_

- ☐ You were not given a post-coital contraceptive because: ☐ there is no risk of pregnancy  
☐ of a pre-existing pregnancy ☐ you did not want it ☐ too long an interval had elapsed  
other reasons \_\_\_\_\_



You have been scheduled -- or should make an appointment -- for the following kinds of care:

	Where	Date	Time	Phone
<input type="checkbox"/> Follow-up medical exam				
<input type="checkbox"/> Follow-up check for infection				
<input type="checkbox"/> Follow-up pregnancy testing				
<input type="checkbox"/> Follow-up counseling				
<input type="checkbox"/> Other				

If you wish to get counseling, or follow-up testing and treatment for venereal infection, or pregnancy prevention/management, elsewhere than this hospital / clinic or medical center, call one of these agencies:

1. \_\_\_\_\_ Phone \_\_\_\_\_

2. \_\_\_\_\_ Phone \_\_\_\_\_

Other important names and numbers that may be helpful to you:

• Rape Crisis Center: \_\_\_\_\_ Phone \_\_\_\_\_

Child Advocacy Center or Child Abuse Clinic

• Detective's name: \_\_\_\_\_ Phone \_\_\_\_\_

name of Police Department: \_\_\_\_\_

• Hospital support person \_\_\_\_\_ Phone \_\_\_\_\_

name of hospital: \_\_\_\_\_

• Mental Health Center \_\_\_\_\_ Phone \_\_\_\_\_

• Victim Witness Program \_\_\_\_\_ Phone \_\_\_\_\_

• Rape Abuse & Incest National Network (a 24-hour computer system that will relay your call to the nearest rape crisis center) Phone: 1-800-656-HOPE (toll-free call)

• Ohio AIDS Hotline (information about free testing) Phone: 1-800-332-AIDS or 1-800-332-2437 (toll-free call)

• Crime Victim Compensation

a. To apply for compensation, contact the clerk in your County's common pleas court.

b. This program is designed to pay expenses that are not covered by insurance or other benefits.

*If eligible for the program, you may use the money to pay for medical, drug and rehabilitation expenses such as damage to teeth or eyes, replacement of eyeglasses, counseling, transportation, costs of medical exams if not covered elsewhere, etc.; for wages lost as a result of the crime; for replacement services costs (the cost of services the victim can no longer perform); for dependent's economic loss in death claims; and for funeral expenses.*

c. For more information about financial compensation for crime victims, call the Ohio Court of Claims at 1-800-824-8263 (toll-free call).

☐ **I have received this Child Sexual Abuse After-Care handout.**

☐ **I have received the "Child Sexual Abuse Common Reactions and Follow-up Services" handout.**

☐ **I do not wish to receive either of these forms**

\_\_\_\_\_  
(Patient/Parent/Guardian signature)

\_\_\_\_\_  
(Date)

*Original to Patient / Carbon to Chart*

## Child Sexual Abuse: Common Reactions and Follow-up Services handout

(Page 1 of 2)

### Common Reactions

Rape or any form of sexual assault or abuse is one of the most painful and upsetting things that can happen to a person. After the assault or abuse, a person may be frightened, angry, experience restlessness, and an inability to concentrate. A person may experience disbelief or denial, depression, mistrust of people and a lack of confidence. Feeling guilty, embarrassed and ashamed are also common reactions. All of these reactions are normal, understandable reactions.

With time and understanding, these feelings and experiences will subside. Sexual assault or abuse causes a great deal of disorganization in your life. Give yourself permission to take as long as you need to heal and recover. It often helps to talk with someone, particularly someone trained in rape issues, about the feelings you are experiencing.

If you are the parent or guardian of a child sexual abuse / assault victim, you may find the following suggested responses to common reactions helpful.

Reaction	Response
<i>Fear</i> A child may not want to separate from you and may need constant reassurance.	Reassure the child that he / she is safe now.
<i>Embarrassed / Guilt</i> A child may be embarrassed to talk about what happened. Older children and boys often feel a sense of guilt.	Tell the child that they are not at fault and or not responsible for what happened.
<i>Anxiety/Loss of Control</i> A child may feel out of control or vulnerable. He/she may develop a low self-image of him/herself.	Create situations in which the child feels in control and empowered.
<i>Withdrawal:</i> A child may refuse to talk, may be emotionally incapable of remembering or talking about the abuse, may develop immature behaviors (i.e. bedwetting, thumb sucking, loss of toilet training).	Help the child feel secure and in control. Explain the purpose of the legal investigation, the medical exam, and treatment.
<i>Difficulty sleeping</i> Not wanting to sleep alone, nightmares, disrupted eating habits (hoarding food or reluctant to eat), reluctance to go to school, stomach-ache or headache.	Allow the child to talk about his/her fears. Show understanding about his/her physical complaints and reassure child that he/she is safe.

**What to expect from this point on**

**Follow-up investigation**

Whether or not the perpetrator is prosecuted, the law enforcement officer and/or social worker may be back in touch with you. You will probably have an interview with an individual who is trained in sexual abuse and assault investigation. If a child was removed from her/his home for protective reasons, the Juvenile Court will decide if and when it is safe for the child to return home.

**Follow-up medical treatment**

The examining physician or nurse may recommend that you be checked for venereal diseases and AIDS in the near future. This might involve a blood test and another examination. You will then have more information available to you to enable you to make choices about your health and future.

Depending on your age and the type of assault or abuse, you may want to have a pregnancy test conducted at this same time as well.

You may make appointments for these tests with your personal doctor, local city or county health department, women's health center, hospital or neighborhood health clinic. In addition, children may schedule appointments with a Child Advocacy Center, the child's primary care physician or a children's hospital or clinic.

For information about free AIDS testing you may call 1-800-332-2437 (no cost for call). Your doctor can provide you with information about the risk of AIDS infection.

**Support services**

People who have been trained to work with survivors of rape and victims of child sexual abuse are available to talk with you about your feelings and the issues that arise. Crisis counseling after assault or abuse can make a difference. Referrals to support professionals are listed on the "After Care Information and Follow-up Services" form.

**Additional Information On Sexually Transmitted Diseases (STDs) and Pregnancy**

It is virtually impossible to tell immediately after sexual assault or abuse if you have contracted any sexually transmitted diseases or have become pregnant. Any tests you may have been given at the hospital would only determined whether you had any infections or were pregnant at the time of the evaluation. The tests for sexually transmitted diseases may need to be repeated. Your doctor or the follow-up examiner will discuss your risk of infection with you.

## **B. Guidelines For Child Abuse Reporting Of Consensual Sexual Activity**

A report of sexual abuse may be required when minors engage in consensual sexual activity. Under Ohio Law, the need to report is based upon the ages of the participants, any history of force, misuse of authority, as well as other issues. Due to a high risk for abuse, a sensitive assessment for sexual abuse is indicated when evaluating young sexually active adolescents.

When evaluating children for possible sexual abuse, obtain a history of the sexual activity, the age of the child's partner(s), any history of force or coercion, and identify the relationship between the patient and partner(s) (i.e., authority figure, relative, etc.).

The section below is a guideline for reporting sexual abuse when patients describe consensual sexual activity.

---

### **Patient Age 12 or younger**

Children under 13 years old cannot legally consent to sexual activity in Ohio. All children under 13 who report consensual sexual activity must be screened for sexual abuse.

File a report of sexual abuse if:

- the sexual partner is 13 years old or older
- the sexual partner used force or coercion
- the sexual partner misused their authority (i.e., baby sitter, etc)
- there is a significant difference in maturity levels between the patient and the sexual partner (i.e., victim is mentally retarded or there is a large difference in ages)
- there are protective issues (i.e., the child lives on the street or there is a significant lack of supervision which puts the child at risk for abuse, injury, etc.)

---

### **Age 13, 14, 15 years**

File a report of sexual abuse if:

- the sexual partner is 4 or more years older than the patient
- the sexual partner used force or coercion
- the sexual partner misused their authority (i.e., parent or authority figure)
- there was a significant difference in maturity levels between the patient and sexual partner (i.e., victim is mentally retarded)
- there was mental or cognitive impairment (i.e., developmental delay, intoxication) rendering the person unable to consent
- there are protective issues (i.e., the child lives on the street or there is a significant lack of supervision which puts the child at risk for abuse, injury, etc.)

Consider reporting if:

- the sexual partner is over the age of 18 but less than 4 years older than the patient. In this situation, the police might charge the partner with the corruption of a minor.

The decision NOT to report consensual sexual activity may be considered when:

- there is less than four years age difference, a thorough history eliminates the above criteria, and the parent and child agree not to file a report.

The guidelines above may not prove applicable in all situations. Professional judgment must be used. In 13,

14 and 15 year olds, abuse may be present even when the age difference between partners is only 2-3 years. The professional must carefully assess the situation before deciding against reporting and may want to seek consultation with the child abuse team or with the police jurisdiction.

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**Age 16 or Older**

Sixteen is the age of consent in Ohio. However, if the girl is 16 and her partner is 18 or older, a parent can file charges with Juvenile Court prosecutors. The misdemeanor charge would be contributing to the unruliness or delinquency of a minor. In this situation, we would not file an abuse report.

When interviewing an adolescent, be alert for issues of force, coercion, deception, identify the relationship of the sexual partner (relative, authority figure, etc.) and history of physical or mental impairment (such as intoxication or drugs). When these factors are present, a report of sexual abuse should be made.

### C. Suspected Drug Facilitated Rape / Sexual Abuse: Evaluation Protocol

- A. Drug facilitated rape refers to an assault in which the perpetrator surreptitiously administers a drug to the victim, most often through adding it to a drink, in order to incapacitate her/him so that she/he is unable to prevent the assault. There are several dozen different drugs that have been used for this purpose.
- B. Reported symptoms experienced by the victim may include:
- |                        |                           |
|------------------------|---------------------------|
| a. confusion           | g. lack of muscle control |
| b. decreased heartbeat | h. loss of consciousness  |
| c. dizziness           | i. nausea                 |
| d. drowsiness          | j. reduced blood pressure |
| e. impaired judgement  | k. reduced inhibition     |
| f. impaired memory     |                           |
- C. If the decision is made to test for drugs, follow the following evidence collection procedures:
1. Determine time of the ingestion of the drug.
  2. If ingestion occurred within 96\* hours or less, 100 ml of urine should be collected in sterile urine collection containers. If it is not possible to collect 100 ml of urine, collect as much as possible. Immediately refrigerate; follow chain of custody procedures.
  3. If ingestion occurred within 24\* hours or less, 20 ml of blood should be collected in “gray-topped” blood collection tubes. Two 10 ml gray topped tubes could be used. Immediately refrigerate; follow chain of custody procedures.
  4. When conducting a full drug screen, confirm that the laboratory is testing the urine and blood samples for: Benzodiazepines, Amphetamines, Muscle Relaxants, Sleep Aids, Antihistamines, Cocaine, Marijuana, Barbiturates, Opiates, Ethanol, GHB, Ketamine, Scopolamine, and any other substances that depresses the central nervous system

**These forensic toxicological specimens should be collected in addition to any blood or urine specimens collected for other medical or forensic purposes.** Evidence collection kits specifically for drug testing may be purchased commercially. Contact the ODH Rape Prevention Information for more information about purchasing these kits.

It becomes increasingly unlikely that drugs will be detected as time passes. Some toxicologists recommend shorter time frames within which it is reasonable to test for these drugs. If the laboratory conducting the analysis recommends a different time frame than recommended here, contact the Ohio Department of Health Rape Prevention Program to verify that the change is within current guidelines.

If the victim has vomited, treat the vomit as a supplemental specimen for forensic toxicology purposes. Collect as much of the liquid and solid portions of the vomit as possible by using a spoon, eyedropper-type suction device, or other tool that is consistent with biohazard procedures. The vomit should be placed in a urine collection container or other appropriate container that has a lid with a tight seal. Then immediately place the container in a freezer; however, if vomit will be submitted to a toxicologist within five days, it is acceptable to refrigerate (rather than freeze) the container containing the vomit. If any vomit is on clothing, sheet, or other objects put the items in an appropriate container to prevent leakage and contamination and then immediately freeze the items while packaged in the container. Follow biohazard procedures when handling any body fluids. Follow chain of custody procedures.

- D. To assist the toxicologist, document the following:

- a. Date and time the drug was probably ingested
  - b. Date and time that the specimen(s) are collected
  - c. All available information about what drugs may have incapacitated or contributed to the incapacitation of the victim.
- D. Specimens collected for the purpose of drug testing **should not be included with the evidence collection kit.** Only send specimens to labs approved for this type of drug testing. Contact ODH (614-466-2144) for information about qualified labs.

#### **D. Drug Facilitated Sexual Assault: The Facts**

There are a number of ways in which the use of alcohol or drugs may contribute to an act of sexual assault. The substance most frequently involved in sexual assaults is alcohol, which the victim may consume voluntarily. Providing alcohol to a minor is a criminal offense. Increasingly, cases have been reported in which offenders, to further impair the ability of the victim to prevent the assault, use a variety of drugs. Rohypnol and GHB (gamma hydroxybutyrate) are the drugs most frequently referred to in this context but there are several dozen drugs that could be used for this purpose, many readily available in this country. The drug may be added to the victim's drink without her knowledge or administered in a variety of other ways.

The decision to test for drug-facilitated rape is complicated by the effects of the drugs that may mimic severe inebriation. Hospital/medical personnel will be in the position of evaluating whether or not substance-related sexual assault is a probability, given the known factors of the situation. The victim's memory of events may be substantially impaired, complicating the assessment of the situation. Effects may be similar to the effects of a surgery patient coming out of anesthesia. See the list in the OHIO AAP protocol (Section VI) for likely symptoms. Some of these symptoms are also typical posttraumatic stress symptoms that may be present regardless of the use of substances.

The drugs can be very difficult to detect. Reasons for this include the speed with which the drug leaves the body and the fact that for multiple reasons a victim may not be tested within the ideal timeframe. For all sexual assaults, reporting may be delayed as victims struggle with issues of self blame resulting from stereotypes and misconceptions about sexual assault and with discomfort and embarrassment with going through the evidence collection process. Where alcohol and drugs are involved, the victim may be unconscious or disoriented during the majority of the time that the drug is still in their system, or need time to piece together what happened to them or recover from the effects of the experience. Because of these difficulties in detecting the drug, there is a high probability that even if a drug was used the test will come back negative. This can be emotionally difficult for the victim to hear and could potentially undermine the investigation.

The period of time that rape drugs will remain in the urine or blood depends on a number of variables, including the type of drug, amount ingested, the victim's body size and rate of metabolism, whether the victim has a full stomach, and whether she previously urinated. A urine specimen is preferable to a blood specimen because the drugs and their metabolites can be detected in urine for a longer period of time. GHB may only remain in blood for 4- 8 hours and in urine for up to 12 hours. Benzodiazepines, which include Rohypnol, may be detected in blood only within 4 - 12 hours and in urine, typically only within 48 hours.<sup>1, 2</sup>

When conducting a full drug screen, confirm that the laboratory is testing the urine and blood samples for: Benzodiazepines, Amphetamines, Muscle Relaxants, Sleep Aids, Antihistamines, Cocaine, Marijuana, Barbiturates, Opiates, Ethanol, GHB, Ketamine, Scopolamine, and any other substances that depresses the central nervous system.

Not every crime lab will have the capability of testing the samples at the adequate levels to detect the drug administered. Contact the Rape Prevention Program at ODH at (614) 466-2144 for information to be used in assessing the capability of your local lab or for information regarding qualified labs.

References: Copies of both articles are available by calling the ODH Rape Prevention Program @ 614/466-2144.

1. Marc LeBeau, et al, Recommendations for Toxicological investigations of Drug Facilitated Sexual Assaults, 44 J. Forensic sci. 227-230 (1999)
2. Marc LeBeau, Toxicological Investigations of Drug-Facilitated Sexual Assaults, 1 Forensic Science Communications (April 1999).



E. **Billing □ Payment for the sexual abuse examination**



**Attorney General  
Betty D. Montgomery**

June 26, 2000

Dear Hospital Administrator or Medical Professional:

Our crime victim's bill has now been signed by Governor Taft. As you know, it will allow the Ohio Attorney General to reimburse your facility for the cost incurred in conducting a medical examination of a victim of sexual assault for the purpose of gathering physical evidence for a possible prosecution. Any examination conducted on or after July 1, 2000 should be submitted to the Ohio Attorney General for reimbursement if the following criteria are met:

1. Your facility conducted the examination in accordance with proper protocols adopted by the Ohio Department of Health, or the Committee on Child Abuse and Neglect of the Ohio Chapter of the American Academy of Pediatrics if the patient is a child or young adolescent; and
2. Your facility properly used a state-approved sexual assault collection kit in compliance with the above protocols (with some exceptions).

**Municipalities, counties and other political subdivisions will no longer be responsible for paying these costs.**

The goals of this legislation are to provide better services to victims of sexual assault, to improve the accuracy of forensic evidence collection and analysis, and to fairly compensate those providing these services. Following a universal protocol and using a standard sexual assault evidence collection kit should help us reach these goals. We want to thank you for your help in developing these protocols. **Your facility will be promptly reimbursed at the flat rate of \$500.00 per examination only if an approved kit is used and the proper protocols are followed.** However, the program is allowing a 60-day grace period for medical facilities to obtain the approved protocols and sexual assault examination kits. It is unlawful to bill the victim or the victim's insurer for the cost of a sexual assault examination conducted to collect evidence. For information about available training in forensic evidence collection, please contact Dr. Liz Benzinger at 1-740-845-2508.

Enclosed are billing instructions, two master Reimbursement Request Forms (one for examinations conducted during the grace period, and one for examinations conducted on or after September 1, 2000), and an instruction sheet for sexual assault survivors. Please make several copies of the Reimbursement Request Forms for your monthly billing activity. Also, each sexual assault survivor treated at your facility should receive a copy of the instruction sheet that provides information about the new Ohio Victims of Crime Compensation Program. Please note that medical providers will receive direct payment from the new compensation program if the patient meets eligibility requirements.

Thank you in advance for your participation in the Attorney General's Sexual Assault Forensic Examination (SAFE) Program.

Sincerely,

Brian C. Cook, Chief  
Crime Victims Services Section

Crime Victims Services / 65 East State Street, 8th Floor / Columbus, Ohio 43215-4231

Phone: (614) 466-5610 1-800-582-2877 Fax: (614) 752-2732

[www.ag.state.oh.us](http://www.ag.state.oh.us)

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**OHIO ATTORNEY GENERAL  
SEXUAL ABUSE FORENSIC EXAMINATION (SAFE) PROGRAM  
BILLING PROCEDURES**

1. The SAFE Program will reimburse a hospital or other emergency medical facility for costs incurred in conducting a medical examination of a victim of sexual assault for the purpose of gathering physical evidence for a possible prosecution, including the cost of any antibiotics administered as part of the examination. *Ohio Revised Code 2907.28(A)*
2. A hospital or other emergency medical facility must follow the Ohio Department of Health 1999 Protocol for the Treatment of Sexual Assault Survivors when conducting a medical examination of an adult or older adolescent victim of sexual assault to qualify for reimbursement from the SAFE Program.
3. A hospital or other emergency medical facility must follow the protocol adopted by the Ohio Chapter of the American Academy of Pediatrics when conducting a medical examination of a child or younger adolescent victim of sexual assault to qualify for reimbursement from the SAFE Program.
4. A hospital or other emergency medical facility must use a sexual assault examination kit that meets the protocol as specified above to qualify for reimbursement from the SAFE Program. Furthermore, the kit must be completed without omissions, according to the directions supplied in the kit. However, examinations conducted from July 1, 2000 through August 31, 2000 are exempt from this requirement. If the victim is a child or younger adolescent, and the most recent abuse is outside the time period for collecting forensic evidence, the SAFE Program can provide payment if physical evidence is gathered by procedures such as colposcopic documentation of injuries and collection of cultures to detect pre-existing sexually transmitted diseases.
5. A hospital or other emergency medical facility should bill the SAFE Program on a monthly basis by submitting a Reimbursement Request form (enclosed) for each examination conducted during that particular month. This form should be photocopied so that an ample supply is available. A hospital or other emergency facility must certify that all required protocols were followed in conducting the examination and that a sexual assault evidence collection kit was used that meets the required protocol (with the exception noted in #4).
6. An itemized statement of all services provided during the sexual assault examination must be attached to each Reimbursement Request form for verification that emergency services were in fact provided.
7. The Reimbursement Request form must include the first six digits of the patient's social security number. The patient's name and last three digits of the social security number may be redacted from the attached itemized statement. However, the Attorney General may request more complete information during its annual audit of SAFE Program reimbursements.
8. Administrative Rule 109:7-1-02 states that a hospital or emergency medical facility shall accept a flat fee payment of \$500.00 as payment in full for any cost incurred in conducting a medical examination of a victim of sexual assault for the purpose of gathering evidence for a possible prosecution including the cost of any antibiotics administered as part of the examination.
9. A hospital or other emergency medical facility may not bill a victim or victim's insurer for any cost incurred in conducting a medical examination of a victim of sexual assault for the purpose of gathering evidence for a possible prosecution, including the cost of any antibiotics administered as part of the examination. *Ohio Revised Code 290.7.28(B)*
10. The Attorney General's SAFE Program will reimburse a hospital or other emergency medical facility within 30 days of receiving a monthly packet of completed Reimbursement Request forms.
11. A victim may submit an application to the Ohio Victims of Crime Compensation Program for costs not covered by the SAFE Program. If a victim is eligible, medical providers are paid directly by the program for outstanding medical bills for the treatment of the victim's injuries resulting from the crime. An information sheet about the program is included. Please make several photocopies and provide the information to each victim or victim's family during the emergency room intake process. You can order applications and other materials by calling 1-877-584-2846 (or 466-5610 if in Columbus).

Reimbursement Request Form (For Exams Conducted On or After 9/1/00)  
Ohio Attorney General Sexual Assault Forensic Examination (SAFE) Payment Program

<b>Name of Medical Facility and Billing Address</b>	<b>Name(s) of Medical Professional(s) Conducting Examination</b>	<b>First 6 Digits of Patient's Social Security Number</b>	<b>Treatment Date/Time</b>
<b>Please Answer All Questions in this Section if the Patient was an Adult or Older Adolescent</b>			
Was this patient an adult or older adolescent, a victim of suspected sexual assault/abuse, and treated at the above facility on an emergency basis?		Yes	No
Was a sexual assault evidence collection kit properly used in compliance with the ODH 1999 Protocol for the Treatment of Sexual Assault Survivors?  <b>Name of Kit:</b>		Yes	No
Was the completed sexual assault evidence collection kit given to a law enforcement agency? Your answer has no bearing on eligibility for reimbursement but is required for statistical purposes.  <b>Which agency?</b>		Yes	No
<b>Please Answer All Questions in this Section if the Patient was a Child or Younger Adolescent</b>			
Was this patient a child or younger adolescent, a victim of suspected sexual assault /abuse, and treated at the above facility on an emergency basis?		Yes	No
Was a pediatric exam and history performed which conforms to the Ohio AAP 2000 Sexual Abuse Protocol?		Yes	No
Was a sexual assault evidence collection kit properly used in compliance with the Ohio AAP 2000 Sexual Assault Protocol?  <b>Name of Kit :</b>		Yes	No
If no kit was collected, please list what procedures were performed to collect physical evidence for possible prosecution (i.e., colposcopic documentation of injuries, cultures for existing STD):			
Was the collected kit and/or physical evidence given to a law enforcement agency? Your answer has no bearing on eligibility for reimbursement but is required for statistical purposes.  <b>Which agency?</b>		Yes	No
<b>***** An Itemized Statement of All Services Provided Must be Attached (For Verification That Emergency Services Were In Fact Provided) *****</b>			
My signature certifies that the information given above is accurate.			
_____ Signature		_____ Print Name	
_____ Title			
Please Submit To:  Ohio Attorney General SAFE Program Attention: Finance Supervisor 65 East State Street, 8 <sup>th</sup> Floor Columbus, Ohio 43215-4231		For Questions About Billing, Please Call:  (800) 582-2877 or (614) 466-5610	

## **FOR SEXUAL ASSAULT VICTIM / SURVIVORS IMPORTANT INFORMATION ABOUT YOUR MEDICAL BILL**

### **SEXUAL ASSAULT FORENSIC EXAMINATION (SAFE) PAYMENT**

There are two purposes for you to receive a sexual assault evidentiary examination:

- 1) to assure that any physical injuries you may have received from the sexual assault, including sexually transmitted diseases, are cared for, and
- 2) to collect any physical evidence of sexual assault, in case you decide to report to law enforcement.

The part of the examination that collects physical evidence of sexual assault is paid for by the Ohio Attorney General's Sexual Assault Forensic Examination (SAFE) Payment Program. This includes the physical examination, laboratory tests and medicine you received to prevent sexually transmitted disease.

- YOU DO NOT HAVE TO REPORT THE CRIME TO LAW ENFORCEMENT FOR THE STATE TO PAY FOR A SEXUAL ASSAULT EXAMINATION
- YOU ARE NOT RESPONSIBLE FOR THE COST OF A SEXUAL ASSAULT EXAMINATION FOR THE PURPOSE OF GATHERING EVIDENCE FOR A POSSIBLE PROSECUTION, INCLUDING THE COST OF ANY ANTIBIOTICS ADMINISTERED AS A PART OF THE EXAMINATION. THE HOSPITAL WILL BILL THE STATE DIRECTLY.

### **OHIO VICTIMS OF CRIME COMPENSATION PROGRAM**

You may be eligible for the Ohio Victims of Crime Compensation Program to pay for medical care you needed that was not part of the sexual assault forensic examination. Medical care you can be compensated for might include x-rays, stitches, hospitalization, pain medication, and counseling you receive as a direct result of the crime victimization. Compensation is also available for clothing or bedding that was held as evidence and for lost wages you suffered as a result of the crime. Immediate family members may be eligible for reimbursement for the cost of mental health counseling.

- THE HOSPITAL OR CLINIC WILL BILL YOU FOR EXAMINATION AND CARE THAT IS NOT FOR THE COLLECTION OF SEXUAL ASSAULT EVIDENCE.
- YOU ARE RESPONSIBLE FOR THOSE BILLS, HOWEVER, YOU MAY BE ELIGIBLE TO HAVE THEM PAID BY THE OHIO VICTIMS OF CRIME COMPENSATION PROGRAM
- TO BE ELIGIBLE FOR THE OHIO VICTIMS OF CRIME COMPENSATION PROGRAM, YOU MUST REPORT THE CRIME TO LAW ENFORCEMENT WITHIN 72 HOURS OF ITS OCCURRENCE UNLESS GOOD CAUSE IS SHOWN FOR LATE REPORTING.
- YOU MUST FILE A COMPLETED APPLICATION WITH THE PROGRAM WITHIN TWO YEARS OF WHEN THE CRIME HAPPENED, OR BY A MINOR VICTIM'S 20th BIRTHDAY.

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For more information call.

OHIO VICTIMS OF CRIME COMPENSATION PROGRAM  
ATTORNEY GENERAL'S OFFICE  
65 East State Street, 8<sup>th</sup> Floor  
Columbus, OH 43215  
(614) 466-5610  
*Toll-Free General Information*  
(877) 584-2846 (877-5VICTIM)

## **F. Crime Victims Compensation**

The Crime Victims Compensation Office of the Crime Victims Services Section of the Ohio Attorney General's Office investigates applications for compensation filed under Ohio's Crime Victims Compensation Law, a law that provides for payment to victims of violent crime to cover their economic losses. Upon completing the investigation, a recommendation is made to the Court of Claims concerning the outcome of the application. An application for patient reimbursement can be made on-line at <http://www.ag.state.oh.us/crimevic/crimevic.htm>.

Information about the Ohio Victims Compensation program should be given to the patient prior to leaving the hospital. Recent changes to the Ohio Victims Compensation program are outlined below. Information can be obtained by calling (614) 466-5610 or Toll Free at (877) 584-2846.

### **SUMMARY OF OHIO CRIME VICTIMS COMPENSATION PROGRAM CHANGES**

#### **Procedural Changes**

<b>Previously</b>	<b>As of July 1, 2000</b>
Attorney General investigates claim.	Attorney General investigates claim.
Attorney General issues finding of fact and recommendation to Court of Claims.	Attorney General issues finding of fact and decision within 120 days, will reconsider its decision if victim objects, and issues final decision within 60 days of receiving a request for reconsideration.
Court of Claims Single Commissioner issues decision.	Panel of Commissioners hears appeal and issues final decision within 150 days of receiving notice of appeal.
Court of Claims Panel of Commissioners hears first appeal.	Court of Claims Judge hears second appeal and issues final decision.
Court of Claims Judge hears second appeal and issues final decision.	

### Benefits Added By Proposed Legislation

Previously	As of July 1, 2000
No reimbursement for cost of crime scene cleanup (\$750 per claim).	Reimbursement for cost of crime scene cleanup (\$750 per claim).
No reimbursement for cost of replacing property destroyed by evidence collection.	Reimbursement for property destroyed by evidence collection (\$750 per claim).
No reimbursement for mental health counseling of an immediate family member or household member of a victim.	Reimbursement for mental health counseling needed by an immediate family member of a victim of homicide, sexual assault, domestic violence, or a severe and permanent incapacitating injury resulting in paraplegia or similar life-altering condition (\$2,500 per family member).
\$7.50 filing fee.	\$7.50 filing fee eliminated.
	Reimbursement for the cost of sexual assault examinations conducted pursuant to ORC 2907.28.
	Transfer \$2.5 Million to the Ohio Department of Health to fund rape crisis centers.

### Eligibility For Participation (Expansions)

Previously	As of July 1, 2000
Victims who have engaged in violent or non-violent felonious <b>behavior</b> within 10 years prior to being victimized, or while claim is pending, are ineligible to participate.	Victims who have engaged in <b>non-violent</b> felonious <b>behavior</b> , except drug trafficking, within 10 years prior to being victimized, or while claim is pending, will be eligible to participate.

### Eligibility for Participation (Restrictions)

Previously	As of July 1, 2000
A victim is eligible for participation if convicted of a misdemeanor charge of domestic violence or child endangering within 10 years prior to being victimized, or while claim is pending.	A victim is ineligible for participation if convicted of a misdemeanor charge of domestic violence or child endangering within 10 years prior to being victimized, or while claim is pending.

### Codification of Existing Case Law

Previously	As of July 1, 2000
By case law, a victim who engaged in felony drug abuse at the time of being victimized will be denied compensation.	By statute, a victim who engaged in felony drug abuse at the time of being victimized will be denied compensation.
By case law, a passenger (age 16 or older) in a vehicle driven by a driver under the influence of alcohol or other drugs is ineligible to participate (except when 16- or 17-year-old is with parent, guardian, or care provider).	By statute, a passenger (age 16 or older) in a vehicle driven by a driver under the influence of alcohol or other drugs is ineligible to participate (except when 16- or 17-year-old is with parent, guardian, or care provider).

### Attorney Fees

Previously	As of July 1, 2000
Program reimburses attorney at the rate of \$60 per hour, with a maximum of \$720 for the decision of the single commissioner, a maximum of \$1,020 through the first level of appeal, or a maximum of \$1,320 through the second level of appeal.	Program will reimburse attorneys similar to current practice, but maximum of \$750 on claim of no appeal; \$1,020 if appeal to the panel of commissioners, and \$1,320 if appeal to the Judge of the Court of Claims. (Plus \$30 per hour travel expenses for appeals if attorney is outside central Ohio).

## **Direct Pay to Providers of Medical, Funeral, and Other Services**

<b>Previously</b>	<b>As of July 1, 2000</b>
Victims are given a check for the total amount of loss incurred, including any amount they owe to a provider of medical, funeral, and other services. The system depends on victims to pay these outstanding debts with the award.	The program will directly pay providers of medical, funeral, and other services any outstanding amounts covered by the award. Victims will receive reimbursement for bills paid out of their own pockets, and for other eligible expenses.

## **Medical Cost Containment**

<b>Previously</b>	<b>As of July 1, 2000</b>
Awards to victims include dollar for dollar coverage of any costs for medical and psychological services. Bills are evaluated to determine if the expenses incurred are related to the crime, not to determine reasonableness of the charges. There is no legal authority to adjust bills for cost containment purposes.	Establishes legal authority for the attorney general to adjust medical bills (and bills for psychological services) for cost containment purposes, in accordance with guidelines developed by the Bureau of Workers' Compensation. Bills will be evaluated to determine their reasonableness, and only reasonable charges will be reimbursed.



## Attorney General's Subrogation Rights

Previously	As of July 1, 2000
Very general subrogation language exists, granting the Attorney General the right of subrogation against offenders and responsible third parties to recover damages equal to the amount of the award granted to the victim from the reparations fund.	Specifically establishes that the Attorney General is the legal representative of the reparations fund; that a copy of the indictment and certified judgment of conviction are admissible as evidence to prove an offender's liability for payment; establishes that the reparations fund is an eligible recipient for payment of restitution; provides that the Attorney General has six years from the date of the last payment of reparations to exercise its subrogation rights by filing an action in the Franklin County Common Pleas Court; requires a claimant to notify the Attorney General when filing a civil action against an offender or other responsible third party to recover damages related to the crime; declares that any release from liability negotiated without notifying the Attorney General shall not release a party from liability to the reparations fund; declares that an offender is jointly and severally liable to pay to the reparations fund the full amount of the reparations award granted to the victim; and provides that the costs and attorney fees of the Attorney General in enforcing its subrogation rights are fully recoverable from the liable offender or third party.

## **G. Outline of the Criminal Justice System**

### **Complaint Made**

Once there has been a report of a sexual abuse/assault, a crew is dispatched in a marked cruiser. At this time, the responding officer will obtain preliminary information about the sexual assault/abuse from the parent or guardian.

### **Detective Investigation\***

After the responding officer has taken down the preliminary information needed from the parent or guardian, the case will be assigned to a detective. The child will be taken to a secure, child friendly location (Child Advocacy Center or similar facility). The Child Protective Services (CPS) worker, the detective and, if available, a forensic child sexual abuse/assault interviewer will meet the child at that location. The interviewer, preferably one who is trained in the forensic child sexual abuse interview, will interview the child separated from the parents or guardian. The other investigators will observe the interview via closed circuit video or through one-way glass. Separate interviews by each investigator are to be avoided. If the above facilities and expertise are not available in the local community, referral and transfer to an ODHS Regional Center of Excellence is strongly recommended. The ODHS Regional Centers of Excellence are located at:

Children's Hospital Medical Center of Cincinnati  
Columbus Children's Hospital  
Children's Hospital Medical Center of Akron  
Cleveland Metro Health System  
Cleveland Rainbow, Babies and Children's Hospital  
Children's Medical Center, Dayton  
Mercy Children's Hospital at Toledo

### **Case Presented to the Prosecutor**

Police present all the evidence to the Prosecutor. The Prosecutor decides whether or not to accept the case. If accepted, an affidavit is filed in Municipal Court.

### **Arraignment (Initial appearance before Municipal Judge)**

Once the affidavit is filed and the defendant is arrested, the defendant appears before the Municipal Court Judge. The appearance is for the purpose of reviewing the amount set for bail, furnishing the defendant with a copy of the complaint, confirming legal counsel, and setting a date for preliminary hearing.

### **Preliminary Hearing**

The preliminary hearing is held in the Municipal Court. The defendant, his attorney, the arresting officer, the County Prosecutor and the witnesses are present at this hearing. The burden is on the Prosecutor to prove that there is probable cause to believe a crime has been committed and that this defendant probably committed it. If there is sufficient evidence, the case is then bound over to the Grand Jury. Sexual assault/ abuse victims bypass the preliminary hearing.

### **Grand Jury Hearing**

The Grand Jury consists of nine to twelve jurors. During witness testimony, only the jurors and the County Prosecutor are present in the room. The Prosecutor may ask some questions for clarification. There is no cross-examination. After all the witnesses are heard by the Grand Jury, a vote is taken to determine if the defendant is to be indicted. If the defendant is indicted, the case proceeds through the system. If the case is ignored by the Grand Jury, there are no grounds for appeal. However, a case can be re-presented to the Grand Jury, if additional evidence is presented.

**Arraignment (In Common Pleas Court: On the Indictment)**

A court hearing is held where the defendant is told about the charges pending against him, and the right to a lawyer and trial. The defendant enters a plea on the Grand Jury indictment, his bond is re-examined and pre-trial conference is scheduled.

**Pre-Trial Motions**

Motions are heard at the request of an attorney (Prosecutor or Defense) regarding issues that do not reflect the merits of the case. For example, motions for discovery, motions for continuance, motions for psychiatric evaluation, motions to suppress, etc.

**Pre-Trial Conference\***

This is a conference between the victim/witnesses and the Prosecutor to discuss the facts and status of the case.

**Trial\***

In a trial, the Prosecutor presents the case for the State, attempting to prove beyond a reasonable doubt that the defendant did commit the crime as charged. The defendant may present his/her side through the use of an attorney. It is the defendant's choice whether a judge or a twelve-person jury will decide the verdict. The trial "time table" is usually as follows: the case must come to trial within 90 days if the defendant is kept in custody and within 120 days if he is out on bond. This may be extended in either case if there are continuances approved by the judge.

**Sentencing**

After a verdict or plea of guilty, the judge sets a date for sentencing. During this time period the Adult Probation Officer will evaluate the defendant's potential for rehabilitation and prepare a sentence recommendation. The judge then considers that recommendation and other evidence. The sentence must be within the limits set by the legislature for the particular crime.

\* Indicates points at which the child victim may be required to relate details of the incident.

Taken from "Guidelines for Treatment of Sexual Assault Victims." Developed by the Montgomery County Prosecutor's Office and the Miami Valley Regional Crime Lab in conjunction with the Greater Dayton Hospital Council, The Montgomery County Medical Society, and the Dayton District Academy of Osteopathic Medicine.

## **H. Selected Reading: Child Sexual Abuse**

1. American Academy of Pediatrics, Committee on Adolescence. Sexual Assault and the Adolescent. *Pediatrics* 94: 761-765, 1994.
2. American Academy of Pediatrics, Committee on Child Abuse and Neglect. Guidelines for the Evaluation of Sexual abuse of Children: Subject Review. *Pediatrics* 103, 186-190, 1999. Erratum p. 1049.
3. Giardino AP, Finkel MA, Giardino ER, Seidi T, Ludwig S. *A Practical Guide to the Evaluation of Sexual Abuse in the Prepubertal Child*. Sage Publication, Newbury Park, CA, 1992.
4. Heger A, Emans Si. *Evaluation of the Sexually Abused Child A Medical Textbook and Photographic Atlas*. Oxford University Press, New York, 1992.
5. Reece RM. *Child Abuse: Medical Diagnosis and Management*. Lea and Febiger, Philadelphia, 1994.
6. Christian CW. Forensic Evidence Findings in Prepubertal Victims of Sexual Assault. *Pediatrics* 2000;106:100-104

## I. Definitions

Air Dry	Dry at room temperature. Do not use any heat. Keep away from direct sunlight.
Sealing envelopes	Do not lick the flaps of envelopes. If necessary, use a damp sponge or paper towel to moisten envelope flaps. Use patient identification stickers as a seal over each fastened envelope flap. Use paper envelopes only: never plastic.
Slightly moisten	Use just enough sterile, saline or distilled water to facilitate collection of a dried external stain or prevent discomfort during the vaginal and rectal examination. Flooding the swabs decreases their absorbing power and should be avoided.
Swabbing	<p>When swabbing a stain or body cavity allow the swab to soak up as much as possible in order to maximize the recovery of evidence.</p> <p>NOTE: Depending upon the type of sexual abuse, semen may be present in the mouth, vagina and rectum. However, embarrassment, trauma or a lack of understanding of the nature of the abuse may cause a victim to be vague or mistaken about the type of sexual contact that actually occurred. For these reasons, and because there also can be leakage of semen from the vagina or penis onto the anus, even without rectal penetration, it is recommended that the patient be encouraged to allow examination of all three orifices and specimens collected from them.</p> <p>In cases where a patient insists that contact or penetration involved only one or two orifices (or in some circumstances, no orifices at all), the victim should still be encouraged to allow a complete examination. However, ultimately the patient may refuse these additional tests.</p> <p>The patient should be cautioned not to use bathroom facilities prior to the collections of these specimens. However, if the use of such facilities is necessary, the patient should be cautioned that semen or other evidence may be present in the pubic, genital and rectal areas and to take special care not to wash or wipe away those secretions until after the evidence has been collected.</p>

## J. Detailed Instructions for Ohio Department of Health Sexual Assault/Abuse Evidence Collection Kit

Please proceed in numerical order and complete all steps. If the patient refuses a step, write “patient declined” on the collection envelope. These items may be used in court to prosecute a sexual offense. Therefore, it is important to follow instructions and write legibly. Remove strip to seal envelopes (do not lick). The Medical Information and Patient Discharge Information forms are for your convenience and may be replaced by institutional forms.

### Step 1 Authorization

Allow the patient or parent/guardian to read Information You Should Know as a Survivor of Sexual Assault/Abuse. Explain to the patient what the sexual assault exam will entail.

Complete and have the patient or guardian sign the Consent for Exam and Release of Evidence form.

**The release is not necessary for child abuse cases.**

### Step 2 Oral Swabs

Collect four oral swabs **regardless of the assault/abuse history**. If necessary, slightly moisten the swabs with sterile water or saline. Rub two swabs back and forth between the left cheek and lower gum and as far back on the tongue as possible without triggering the gag reflex. Using two more swabs, repeat for the right side. Use any one of the swabs to make the smear. Make the smear by rolling the swab forward and back once in the center of the pre-labeled slide. **Do not discard the swab.** Do not use any fixative on the slide. Air dry the smear and place it in the slide mailer. Place the slide mailer in the envelope. Air dry all four oral swabs in the boxes. Close the boxes and place in the envelope. Label and seal the envelope.

*Hospital examination of wet mounts or smears is not necessary.*

### Step 3 Oral Culture for Gonorrhea (Children Only)

If indicated, culture the pharynx for gonorrhea. Non-culture tests, such as ELISA and DNA probes, may not be acceptable as evidence of infection in a court of law. **Send culture to the hospital lab. DO NOT PLACE CULTURES IN THE EVIDENCE BOX.**

### Step 4 Assault/Abuse History Form

In order to reduce the number of times the patient must describe the assault or abuse, this step may be combined with the law enforcement and/or social services interview. Complete the first two pages of the Assault/Abuse History form. In the **Patient Narrative** section, record the patient’s description of the assault/abuse. Pay particular attention to information that will assist you in locating injuries and body fluid evidence. **Do not** record your subjective observations and opinions.

At this time the law enforcement and/or social services representative leaves the room and the physical examination begins. A rape crisis worker, family member or other support person may remain in the room during the examination if the patient so desires.

*Note: The **Medical History** Form is provided for convenience.  
Institutional forms may be used in its place.*

## Step 5 Fingernail scrapings/Cuttings

Scrape under the patient's nails using the tool provided in the nail scrapings envelope. Collect the scrapings into the envelope. If a fingernail is broken, or if blood or other foreign material is noted on the nails, use scissors to clip off the broken end and place into the envelope. Label and seal the envelope.

## Step 6 Debris Collection

Lay a clean sheet on the floor. Unfold and place the exam paper provided over the sheet. The purpose of the sheet is to protect the exam paper from unrelated debris on the exam room floor. Have the patient disrobe over the paper. Collect any debris from patient's body onto the exam paper. **After completing Step 7**, fold the paper so as to contain any debris which has fallen on it. Place it in the envelope. Label and seal the envelope.

## Step 7 Clothing Collection

Collect all clothing worn during or immediately after the assault/abuse, even if no damage or staining is apparent. As the patient disrobes, place one garment item in each bag. **Do not shake out the garments, as evidence such as hairs and fibers may be lost.** Two large bags are provided for outer garments. Two small bags are provided for intimate clothing articles. Label and seal the bags. Place the bag containing the underwear in the kit. Keep the other clothing bags with the kit. If any of the items are wet or damp, inform the law enforcement officer to ensure that the clothing can be properly air dried.

If the patient is not wearing the clothing worn at the time of the assault/abuse, collect only the items that are in direct contact with the genital area (underpants/pantyhose). Inform the law enforcement officer so that the clothing worn at the time of the assault/abuse can be collected.

**Do not cut through any existing holes, rips or stains in the patient's clothing. If a panty liner or pad is in place, leave it attached to the underwear.**

## Step 8 Dried Stains

Ejaculation onto the patient's body, leakage from the patient's body and the suspect's use of his mouth on the patient's body may have occurred. Use a Wood's lamp or other ultraviolet light to examine the patient's body for dried stains. Collect any dried stains by slightly moistening one or two swabs with sterile water or saline and swabbing the stained area. Collect each stain in a separate envelope.

**Ask if the assailant used his/her mouth anywhere on the patient.  
Swab these areas as above. Any bite marks should be swabbed  
and photographed close-up.**

## Step 9 Pubic Hair Combings

With the patient standing, hold the envelope under the pubic area and use the comb provided to comb through the pubic hairs several times. Comb directly into the envelope. Place the comb into the envelope. Label and seal the envelope. If the patient does not have pubic hairs, please note this on the envelope.

**Collect any stray hairs from the genital area**

## Step 10 Pubic hair standards

After completing Step 9 above, give the patient an exam glove to wear and ask her/him to gently pull 10 – 15 hairs from various areas of the pubic region. The glove will permit a better grip. It should be possible for the patient to obtain sufficient pulled hairs standards without pulling hard enough to cause extreme pain. **Do not cut the hairs.** Stop if this cannot be done without extreme pain. Place the pubic hairs in the envelope provided. Label and seal the envelope.

## Step 11 Rectal/Perianal Swabs and Smear

Collect four rectal swabs **regardless of assault/abuse history**. If necessary, the swabs may be slightly moistened with sterile water or saline. If there is no evidence or report of anal penetration, it is acceptable to swab the perianal area rather than inserting the swabs. Use any one of the swabs to make the smear by rolling the swab forward and back once in the center of the pre-labeled slide. Do not discard the swab. Do not use any fixative on the slide. Air dry the smear and place it in the slide mailer. Place the slide mailer in the envelope. Air dry all four rectal/perianal swabs in the boxes. Close the boxes and place in the envelope. Label and seal the envelope.

*Hospital examination of wet mounts or smears is not necessary.*

## Step 12 Rectal/Perianal Cultures (Children Only)

If indicated, culture the rectum for gonorrhea and chlamydia. Non-culture tests, such as ELISA and DNA probes, may not be acceptable as evidence of infection in a court of law. Do not use swabs with wooden applicators to collect chlamydia cultures. **Send cultures to the hospital lab. DO NOT PLACE CULTURES IN THE EVIDENCE BOX.**

## Step 13 Vaginal (or Penile) Swabs and Smear

If the patient is using a tampon, it should be collected and packaged separately into one of the **Step 8 (Dried Stains)** envelopes. Do not place other items in this envelope.

**For females:** Collect four vaginal swabs **regardless of assault/abuse history**. Collect two swabs at a time, swabbing any pooled fluid and the cervical area. Use any one of the swabs, make the smear by rolling the swab forward and back once in the center of the pre-labeled slide. Do not discard the swab. Do not use any fixative on the slide. Air dry the smear and place it in the slide mailer. Place the slide mailer in the envelope. Air dry all four vaginal or penile swabs in the boxes. Close the boxes and place in the envelope. Label and seal the envelope.

If a tampon is present, air dry and place in the **Step 8** envelope. Label and seal the envelope.

**For males:** Collect four penile swabs. Slightly moisten the swabs with sterile water or saline and swab the glans and shaft of the penis using two swabs at a time. Follow the instructions above for smears and packaging.

**For pre-pubertal females:** If there is evidence of vaginal injury or discharge and the vagina can be swabbed without causing pain, collect four swabs from within the vagina. Make a smear as above. If the vagina cannot be swabbed without causing pain, swab the external genitalia with four slightly moistened swabs and make a smear as above.

**NOTE: A speculum examination is almost never indicated and may add to the child's trauma.**



*Hospital examination of wet mounts or smears is not necessary.*

#### **Step 14      Vaginal (or Penile) Cultures   (Children Only)**

If indicated, culture the vagina or urethra for gonorrhea and chlamydia. Non-culture tests, such as ELISA and DNA probes, may not be acceptable as evidence of infection in a court of law. Do not use swabs with wooden applicators to collect chlamydia cultures. **Send cultures to the hospital lab. DO NOT PLACE CULTURES IN THE EVIDENCE BOX.**

#### **Step 15      Speculum**

After completing the pelvic examination, air dry the speculum and place it in the bag. Label and seal the bag.

#### **Step 16      Head hair standards**

Give the patient an exam glove to wear and ask her/him to gently pull 10 – 15 hairs from various areas of the head. The glove will permit a better grip. It should be possible for the patient to obtain sufficient pulled hair standards without pulling hard enough to cause extreme pain. **Do not cut the hairs.** Stop if this cannot be done without extreme pain. Place the head hairs in the envelope provided. Label and seal the envelope.

#### **Step 17      Blood Standard**

Collect the patient's blood standard. Wearing gloves, label the filter paper with the patient's name and date. If blood is being drawn for other purposes, place two or three drops of blood from the blood collection tube onto the filter. If no blood is being drawn, clean the patient's finger with an alcohol swab, use the fingerstick device provided and place two or three drops of blood on the filter paper. Allow the filter paper to air dry before placing it in the envelope. Label and seal the envelope.

**For Children: Omit blood standard if it cannot be collected without further trauma.**

#### **Step 18      Anatomical Drawings and Documentation of Injuries**

Complete the third page of the **Assault/Abuse History** form. Take photos of the patient to assist recall and to document any physical injuries. Do not place photos in kit. Keep these photos with your records. Using the anatomical outlines provided, indicate all signs of physical trauma – e.g. bruises, scratches, marks, discolorations (size and color) or bite marks on any part of the patient's body.

Note: The use of a **Wood's Lamp, Colposcope or Toluidine Blue Dye** to help visualize stains and injuries is recommended. Refer to the ODH Sexual Assault Protocol manual for more information.

Step 19      Give the Patient Discharge Information form to the patient or guardian.

Discuss STD and pregnancy prophylaxis with the patient if applicable. Consider collecting urine and blood samples for toxicological screening for “date rape” drugs if unexplained impairment or gaps in patient recall exist. Refer to the ODH Sexual Assault Protocol manual for more information.

Step 20      Seal the Kit

#### Final Instructions

1. Make sure that all of the information requested on the collection envelopes and forms has been completed. Make sure that all of the envelopes are sealed.
2. **Place the carbon copy of all three pages of the Assault/Abuse History form into the kit.** Place all collection envelopes and the underwear bag (whether these items have been collected or not) into the kit.

**DO NOT place STD cultures or drug screen samples in kit.**

3. Using the seal provided, seal and initial the kit, and **fill out all of the information requested on the box lid.**
4. Complete the top portion of the Chain of Custody forms (**found at the bottom of the Step 1 Consent form and on the lid of the kit box**). Hand the sealed kit and sealed paper bags to the law enforcement officer and have him/her complete the bottom portion of both Chain of Custody forms. One copy of the Step 1/Step 20 Consent and chain of custody form stays at the hospital. Once copy stays with law enforcement officer.
5. If the evidence is not immediately released to law enforcement, the kit should be stored refrigerated (if possible) in a secure area. Clothing should be stored at room temperature in a secure area.

**K. Forms****Assault/Abuse History and Examination Form (3 pages)****Step 4****Assault / Abuse History and Examination Form****Page 1**

Patient Information			
Patient Name		Age	Sex
Assault/Abuse History			
Date/Time of Assault/Abuse		Date/Time of Exam	
Assault/abuse was by:  (stranger, acquaintance, spouse, relative, date, etc.)		Sex of assailants	Number of assailants
<b>Which of the following occurred?</b> <input type="checkbox"/> Oral Penetration <input type="checkbox"/> Penetration with an object—describe: _____ <input type="checkbox"/> Vaginal Penetration <input type="checkbox"/> Digital Penetration <input type="checkbox"/> Ejaculation--where? _____ <input type="checkbox"/> Rectal Penetration <input type="checkbox"/> Oral Copulation <input type="checkbox"/> Other: _____			
<b>Since the assault/abuse, patient has:</b> <input type="checkbox"/> Douched <input type="checkbox"/> Defecated <input type="checkbox"/> Bathed/Showered <input type="checkbox"/> Brushed Teeth or Used Mouthwash <input type="checkbox"/> Urinated <input type="checkbox"/> Vomited <input type="checkbox"/> Changed Cloths <input type="checkbox"/> Had Food or Drink			
<b>At time of <u>assault/abuse</u>, was:</b>  Patient menstruating <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know injured/bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Tampon present? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Where is tampon now? _____ Condom used? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Where is condom now? _____			
<b>At time of <u>exam</u> was:</b> Tampon present? <input type="checkbox"/> Yes <input type="checkbox"/> No Patient menstruating? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Consensual intercourse within 72 hours?</b> Date:      Time:			
_____ nurse or physician completing form—print name      nurse or physician completing form—signature			
<b>Hospital:</b>		<b>City:</b>	

**This copy for hospital      Place carbon copy in kit**

**Narrative History (as described by patient)**

**This copy for hospital      Place carbon copy in kit**

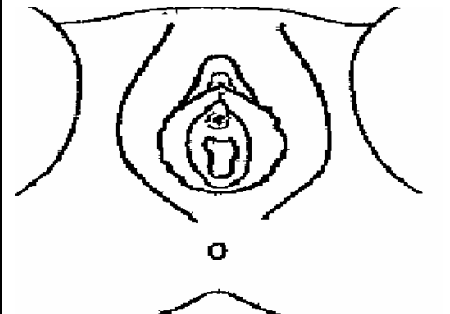
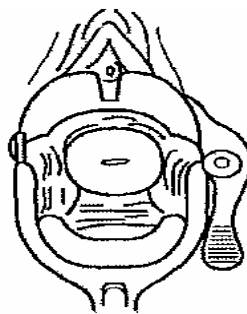
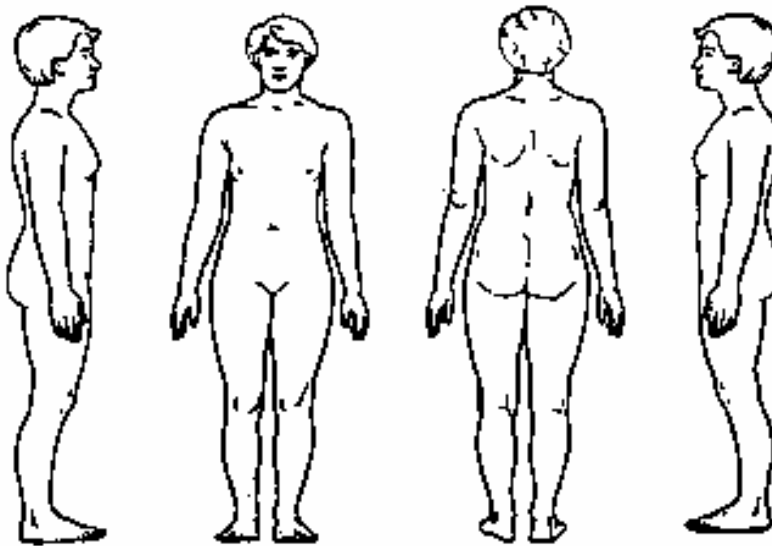
## Anatomical Diagrams to Record Location of Injuries

Method of Examination (circle all that apply)

direct visualization	yes	no	colposcopic exam	yes	no
bimanual exam	yes	no	Woods (or other UV) lamp	yes	no
speculum exam	yes	no	toluidine blue dye	yes	no

Photographs	35 mm	Polaroid	Digital Still	Colposcopic prints	Colposcopic Video Files
Number Taken:	_____	_____	_____	_____	_____

Taken by: \_\_\_\_\_



Indicate the location and type of injury: abrasions, bruises (detail shape), erythema, contusions, induration, lacerations, fractures, bites, burns and stains/foreign materials.

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## Optional Medical History and Examination Form (3 pages)

### Optional Medical History and Examination Form for Sexual Assault/Abuse

Page 1

(Institutional Forms May be Substituted)

<b>Patient Information</b>			
Patient Name	DOB	Sex	Race
SS#	Phone Number		
Address			
City	State	Zip	
<b>Vital Signs (as warranted)</b>			
Admission	P	R	BP
Discharge	P	R	BP
<b>Medical History</b>			
Allergies			
Last Tetanus			
Current Medications			
Acute Illnesses			
Past Surgeries			
LMP	Gravida		Para
Contraception Used?		Type	
Approximate Weight		Height	
Family Physician			
Gynecologist			

**Optional Medical History and Examination Form  
for Sexual Assault/Abuse**

**Page 2**

Physical Examination
General Appearance (including condition of clothing)
Emotional Status (objective observation)
Pertinent General Physical findings (also mark pictures)
<p>Body Surface (locate and describe injury, draw findings on pictures)</p> <p>mouth/face</p> <p>head/neck</p> <p>back/buttocks</p> <p>chest/breast</p> <p>abdomen</p> <p>upper extremities</p> <p>lower extremities</p>
External genitalia (describe Tanner stage and general appearance)
<b>Female</b>
<p>Perineum</p> <p>.....</p> <p>Periurethral area</p> <p>.....</p> <p>Urethra</p> <p>.....</p> <p>Anus</p> <p>.....</p> <p>Rectum</p> <p>.....</p> <p>labia majora</p>

**Optional Medical History and Examination Form  
for Sexual Assault/Abuse**

**Page 3**

labia minora
Clitoris
Vestibule
Posterior fourchette
fossa navicularis
Vagina
Vaginal discharge
Hymen
Cervix
Male
glans penis
penis foreskin
penis shaft
Testicles
Discharge from penis
Anus
Rectum
Names of Those Present During the Exam
<div><div>_____</div><div>nurse or physician completing form—print name</div></div> <div><div>_____</div><div>nurse or physician completing form—signature</div></div>



## Medical Photographs of Child Abuse

# 2

Medical pictures are available in the hard copy version of the Child Abuse and Neglect Reference Guide for Medical Professionals. See page 1 for information on how to obtain a copy of the manual.



Bob Taft, Governor  
Barbara E. Riley, Director  
Ohio Department of Job and Family Services  
Office for Children and Families

JFS 01495 (rev. 3/2005)

Equal Opportunity Employer