VICTIM ASSISTANCE CHILD ABUSE AND NEGLECT

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U.S. Department of Justice
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Office for Victims of Crime

VICTIM ASSISTANCE
CHILD ABUSE AND NEGLECT

Prepared by

The National Association of
State Directors of
Law Enforcement Training

DISCLAMER

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CHILD PHYSICAL ABUSE

SUMMARY SHEET

1. LESSON TITLE: Introduction and Overview of Physical Abuse and Neglect Victims

   FUNCTIONAL AREA: This section introduces participants to an overview of the nature and effects of child physical abuse along with a brief discussion of the family dynamics involved in child physical abuse cases.

   CLASSIFICATION: Core module

   AUDIENCE: Recruit/First Responders and Specialized/ Investigators

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2. LESSON TITLE: Developmental Crisis Theory and the Child Victim

   FUNCTIONAL AREA: This section discusses crisis theory as it relates to the child victim and the family dynamics of the physically abusing family. A prerequisite to this course is the Crisis Theory and the Impact of Victimization module offered in the General Victimology course.

   CLASSIFICATION: Core module

   AUDIENCE: Recruit/First Responders and Specialized/ Investigators

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3. LESSON TITLE: Forms of Child Physical Abuse and Neglect

   FUNCTIONAL AREA: This section introduces participants to three categories of child physical abuse and neglect: physical violence, physical and emotional neglect, and emotional abuse.

   CLASSIFICATION: Core module

   AUDIENCE: Recruit/First Responders and Specialized/ Investigators

4. LESSON TITLE: Crisis Intervention and Interviewing with the Child Victim

FUNCTIONAL AREA: This module introduces participants to the problems associated with interviewing child victims in child physical abuse and neglect cases. Strategies officers can utilize when interviewing child victims are also discussed.

CLASSIFICATION: Core module

AUDIENCE: Recruit/First Responders and Specialized/ Investigators

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5. LESSON TITLE: Investigative Strategies in Child Physical Abuse

FUNCTIONAL AREA: This section introduces participants to guidelines for investigation and arrest in child physical abuse cases along with problems associated with interviewing offenders, adult family members, and child victims in such investigations.

CLASSIFICATION: Core module

AUDIENCE: Recruit/First Responders and Specialized/ Investigators

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6. LESSON TITLE: Child Victim Services and the Law

FUNCTIONAL AREA: This module discusses local statutory provisions regarding child physical abuse cases, and the role of law enforcement officers in civil and criminal litigation. Prosecutorial procedures are also addressed.

CLASSIFICATION: Core module

AUDIENCE: Recruit/First Responders and Specialized/ Investigators

7. LESSON TITLE: Child Welfare Services

FUNCTIONAL AREA: This module provides an overview of the local child welfare system as it relates to child physical abuse cases.

CLASSIFICATION: Core module

AUDIENCE: Recruit/First Responders and Specialized/ Investigators

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8. LESSON TITLE: Medical Issues and the Child Victim

FUNCTIONAL AREA: This module discusses with participants the medical issues involved in child physical abuse cases. Relevant physical examination and forensic issues are addressed.

CLASSIFICATION: Elective module

AUDIENCE: Recruit/First Responders and Specialized/ Investigators

CHILD PHYSICAL ABUSE AND NEGLECT

INTRODUCTION AND OVERVIEW OF

PHYSICAL ABUSE AND NEGLECT VICTIMS

This section will introduce the participant to an overview of the nature and effects of child physical abuse, physical and emotional neglect, and emotional maltreatment.

Child Sexual Assault information is not included in this module.

CHILD PHYSICAL ABUSE AND NEGLECT

LESSON PLAN WORKSHEET

LESSON TITLE: Introduction and Overview of Physical Abuse and Neglect Victims

FUNCTIONAL AREA: This section will introduce the participants to an overview of the nature and effects of child physical abuse, physical neglect, and emotional neglect.

PERFORMANCE OBJECTIVES: The trainee, at the completion of this module will, without reference to notes:

1. Define, verbally or in writing, the law enforcement officer's role in child physical abuse and neglect cases.
2. List, in writing, five effects of child physical abuse.
3. Define, verbally or in writing, your local law enforcement policy toward child physical abuse and neglect cases.

TOPICS:

I. The role of the law enforcement officer in child physical abuse and neglect cases varies with each department's policies.

   A. Child physical abuse and neglect is a crime under local criminal statutes and therefore it is the role of law enforcement to rigorously investigate and intervene.

   B. Training in this area will decrease the law enforcement officer's frustration. By giving an overview of the social factors that cause child physical abuse and neglect, law enforcement officers will have basic understanding of the problem and why it continues to occur.

C. It is the law enforcement officer's responsibility to investigate child physical abuse and neglect cases that result in serious physical injury to the child, including homicide.

D. Law enforcement officers in most states are mandated statutorily to report suspected child physical abuse and neglect cases to their state's human services department.

E. Many departments have specially trained officers and units assigned to investigate and follow-up on all child physical abuse and neglect cases. Trained officers in this area are important because the victim's age often effects how the investigator may proceed.

F. Law enforcement officers must enforce custody orders.

G. Local law enforcement departmental policy toward child physical abuse and neglect is important to understand.

-Note to trainer: Local law enforcement policy toward child physical abuse and neglect cases should be discussed here.

H. Other professionals who have important roles in child physical abuse and neglect cases are the social worker, the physician, the nurse, and the educator.

II. Historical perspective of child physical abuse and neglect

A. Historical Maltreatment of Children

1. Children have been mistreated over the centuries by <u>infanticide</u>, <u>ritual sacrifice</u>, and <u>exploitation of child labor</u>.

2. In the fourth century, B.C. Greece, a child was considered property of the father who decided on the child's fifth birthday whether he lived or died.

3. In ancient Roman law the father had power of life and death over children that extended into adulthood.

4. Early English common law entitled the father to custody of his children.

B. From the middle ages to colonial America, poor law concepts of child care for the orphaned, abandoned, indentured, or runaway youth focused on Child Labor, a system which often brutalized children. The two primary methods of child care were apprenticeship to a master by indenture (often for as long as seven years or until age 24), or under a contract that contained terms of placement often in almshouses.

C. The first recorded case of child maltreatment was in Massachusetts in 1655, where Masters was convicted of manslaughter against his twelve-year-old apprentice, John Walker.

D. Early organized efforts to combat Child Physical Abuse began in the 19th century:

1. The Reform Movement began in New Orleans in 1845.

2. The North Carolina legislature in 1866 moved to remove children from almshouses, but in 1880, 7,770 children of North Carolina between the ages of two and 16 remained in almshouses.

3. The Society for the Prevention of Cruelty to Children was founded in 1874. (NOTE: The Society for the Prevention and Cruelty to Animals was founded in 1866).

4. Around the turn of the century, juvenile courts were beginning to be established across the country, separating adults and juveniles, and in 1908 the Los Angeles Police Department created a separate juvenile bureau.

5. In 1964, twenty states had child physical abuse reporting laws and by 1977 every state in this country, had child abuse reporting laws in some form.

6. The National Center of Child Abuse and Neglect was established in 1974.

III. Nature of Problem

A. Family violence, including child physical abuse and neglect, occurs in all socio-economic, ethnic, racial and age groups. A preliminary analysis of the national survey data estimates that one-sixth of all American couples experience at least one violent incident each year.

-Note to trainer: It is recommended that reported child physical abuse and neglect statistics in your state be given to the class.

B. It is difficult to estimate how many children die as a result of child physical abuse in the United States because states are not mandated to report child physical abuse related homicides to any federal authority. In 1983 24 states reported 505 child physical abuse related deaths.

IV. Possible Effects of Child Physical Abuse and Neglect

A. Child may abuse own children

B. Failure to thrive which can result in stunted growth

C. Inability of a child to trust

D. Physical scars and deformation

E. Negative, aggressive or hyperactive behavior

F. Learning dysfunctions

G. Death

METHODS:

- Lecture
- Group Discussion

RESOURCE MATERIALS:

- Lesson Plan
- Easel/Blackboard
- Topical Bibliography

TIME REQUIREMENT:

- One Half Hour

CHILD PHYSICAL ABUSE AND NEGLECT

TOPICAL BIBLIOGRAPHY

Topics I & II - Role of Law Enforcement Officer

Broadhurst, D.D. and Knoeller, J.S., The Role of Law Enforcement in the Prevention and Treatment of Child Abuse and Neglect. Washington, D.C.: U.S. Department of Health, Education and Welfare, DHEW Publication No. (OHDS) 79-30193, pp. 7-9, 51 to 53, August 1979.

McGovern, James I., "Delicate Inquire: The Investigator's Role In Child Abuse", Victimology: An International Journal, Volume 2, Number 2, pp. 277-284, Summer 1977.

Topic III - Historical Perspective of Child Physical Abuse and Neglect

Carlson, Allan, Helfer, R.E. and Kempe, C.H., Child Abuse and Neglect: The Family and the Community. Cambridge, MA: Ballinger Publications, Introduction and Chapter 1, 1976.

Kempe, Ruth S. and C. Henry., Child Abuse. Cambridge, MA: Harvard University Press, Chapter 1, 1978.

Topic IV - Extent of Child Physical Abuse and Neglect

Local state statistics on reported cases.

Topic V - Possible Effects of Child Physical Abuse and Neglect

Broadhurst, D.D. and Knoeller, J.S., The Role of Law Enforcement in the Prevention and Treatment of Child Abuse and Neglect. Washington, D.C.: U.S. Department of Health, Education and Welfare, DHEW Publication No. (OHDS) 79-30193, p. 6, August 1979.

Topic V (con't)

Helfer, R.E. and Kempe, C.H. Child Abuse and Neglect: The Family and the Community. Cambridge, MA: Ballinger Publications, Chapters 4 and 5, 1976.

Helfer, R.E., and Kempe, C.H., eds., The Battered Child. Chicago, Illinois: University of Chicago Press, Chapters 3-5, 1974.

Kempe, Ruth S. and C. Henry., Child Abuse. Cambridge, MA: Harvard University Press, Chapters 3 and 4, 1978.

McNeese, M.C. and Hebeler, J.R., "The Abused Child - A Clinical Approach to Identification and Management", Clinical Symposia, V29, N5, pp. 3-11, 1977.

CHILD PHYSICAL ABUSE EDUCATIONAL MATERIAL

1. Ciba Child Abuse Slides

   From:

   Medical Education Division
   CIBA Pharmaceutical Company
   Summit, New Jersey 07901
   201-575-6510

2. Child Abuse/Neglect
   The Visual Diagnosis
   of Non-Accidential Trauma
   and Failure to Thrive (slides)

   From:

   American Academy of Pediatric:
   Publications Department
   P.O. Box 1034
   Evanston, IL 60204

3. Child Abuse: The Silent Epidemic (slides)

   Call Toll Free:

   US: 1-800-841-9532
   LA: 1-504-821-4922

   Syndistar, Inc.
   1424 S. Jeff Davis Parkway
   New Orleans, Louisiana 70125

4. Child Abuse: Physical and Behavioral Indicators
   (28 minute color video cassette)
   Media Library
   University of Michigan Medical Campus
   R440 Kresgel, Box 56
   Ann Arbor, MI 48109
   313-763-2074

CHILD PHYSICAL ABUSE AND NEGLECT
DEVELOPMENTAL CRISIS THEORY
RECRUIT/FIRST RESPONDER
SPECIALIZED/INVESTIGATOR

CHILD PHYSICAL ABUSE AND NEGLECT

DEVELOPMENTAL CRISIS THEORY AND THE CHILD VICTIM

This section will discuss with participants the crisis theory as it relates to the child victim and the family dynamics of the physically abusing family.

A prerequisite to this course is the Crisis Theory and the Impact of Victimization module offered in the General Victimology course.

CHILD PHYSICAL ABUSE AND NEGLECT

LESSON PLAN WORKSHEET

LESSON TITLE: Developmental Crisis Theory and the Child Victim

FUNCTIONAL AREA: This section will discuss crisis theory as it relates to the child victim and the family dynamics of the physically abusing family. A prerequisite to this course is the Crisis Theory and the Impact of Victimization Module offered in the General Victimology Course.

PERFORMANCE OBJECTIVES: The participant, at the completion of the module will:

1. Explain, verbally before the class, the concept of the cycle of violence.
2. List, verbally or in writing, four factors that may be present when child physical abuse occurs.
3. List, in writing, three characteristics of physically abusing parents and three characteristics of battering juveniles.

TOPICS:

I. The trainee should have general understanding of crisis theory as outlined in' the Lesson Plan Worksheet for Crisis Theory and the Impact of Victimization in the General Victimology Course of the NASDLET National Victim Assistance Law Enforcement Training Manual.

- Note to Trainer: It is recommended that a brief review of developmental crisis theory (Erik Erikson) be given here. A review can be found in the study guide. The trainer should refer back to developmental crisis theory after relevant teaching points.

II. Dynamics of Child Physical Abuse and Neglect

A. Good parenting can be defined as the ability to recognize (with or without clear understanding), the needs of a child which include:

1. Physical care and protection

2. Nuturance

3. Love and an opportunity to relate to others

4. Bodily growth and the exercise of physical and mental functions

5. Help in relating to the environment by way of organizing and mastering experience

- Note to Trainer: This section should be done as a class exercise beginning with the participants concept of what is good parenting.

B. Abusive parents come from all walks of life; rich and poor, well educated, and from all races and creeds.

1. It is useful to view parental physical abuse as an extreme response to stress.

2. Abusive parents are often individuals who were physically abused as children.

C. Theories of Child Physical Abuse

1. All parents/caretakers are exposed to many constant models of parenting as they observe the treatment of young children in their families and in the families around them. However, the ability to choose among models of parenting may be limited by the nature of the participant's own experience. Most abusive parents see physical punishment as an appropriate way to deal with babies and children. A cycle develops which begins with punishment, which in turn causes a deteriorating relationship between caretakers and child, which in turn, leads to

frustration, which then leads to further punishment. Then this punishment cycle developes into a cycle of physical abuse which is repeated from one generation to the next as the learned pattern of physical abuse, neglect, and parental loss or deprivation.

- Note to Trainer: It is important for the participants to be aware that physically abusive parents do not have the same characteristics as incestuous parents. (Refer to NASDLET Child Sexual Assault Course).

- Refer to Case Study #1:

- Refer to Handout #1

2. Law enforcement should be aware that there is a pattern of physical abuse called Special Child Syndrome. In the Special Child Syndrome type of child physical abuse, only one child is targeted for physical abuse. Usually this child is physically, emotionally, or psychologically handicapped and more difficult to care for in some way.

3. There are many individuals who believe punishment is an inherent right of parents.

III. Child Physical Abuse may occur in the presence of several factors:

A. The caretaker has' a background of emotional or physical deprivation and perhaps abuse as well and is affected by:

1. His/her own childhood experiences;

2. The need of approval from their parents; or

3. The caretaker may think the crying baby is accusing them of being "bad."

B. The child is seen as unlovable or disappointing.

1. The child may have been premature.

2. The child may remind the caretaker of a "bad" relationship or may be seen as ugly or as a demon.

C. There could be a crisis present.

1. External crisis such as loss of a job or a fight with landlord or spouse may be present.

2. Internal crisis such as emotional loss or health concerns may be present.

D. No line of communication or support exists for the caretaker at the moment of crisis.

1. The caretaker is often isolated and without confidantes.

2. The caretaker has trouble turning to others for help.

E. Something triggers the caretaker to the point of inappropriate action. The three major triggering mechanisms are: crying babies, lack of control of bodily functions, and alcohol abuse.

IV. Characteristics of Physically Abusive Caretakers may include:

- seem unconcerned about the child
- see the child as "bad", "evil", a "monster" or "witch"
- offer illogical, unconvincing, contradictory explanations or have no explanation of the child's injury.
- attempt to conceal the child's injury or to protect the identity of the person responsible
- routinely employ harsh, unreasonable discipline which is inappropriate to the child's age, transgressions, and condition
- were often physically abused as children
- were expected to meet high demands of their parents

- were unable to depend on their parents for love and nuturance
- cannot provide emotionally for themselves as adults
- have poor impulse control
- expect rejection
- have low self-esteem
- are emotionally immature
- are isolated, have no support system
- marry a spouse who is not emotionally supportive and who passively supports the abuse
- Refer to Handout #2

V. Characteristics of Neglectful Caretakers

- may have a chaotic home life
- may live in unsafe conditions-no food; garbage and excretement in living areas; exposed wiring; drugs and poison kept within reach of children
- may abuse drugs or alcohol
- may be mentally retarded, have low I.Q., or show no emotion during a conversation
- generally have not experienced success in life
- have emotional needs which are not met by their own parents
- have low self-esteem
- have little motivation or skill to effect changes in their lives
- tend to be passive
- Refer to Handout #2.

VI. Characteristics of the Battering Juvenile:

- A close, almost symbiotic, emotional bonding with one parent.
- An indirect, almost uninvolved, relationship with the other parent.
- Feels separate from family and has increasing autonomy from parents.
- Confusion over the inconsistent limits, restrictions and values set forth by parents.
- Feels intense hostility sometimes and guilt and shame at other times.
- Feels stress from being psychologically or physically separated from family.

VII. Substance Abuse as it Relates to Child Physical Abuse

A. A number of studies report a high association between violence and substance abuse indicating that alcohol/drugs and family violence (i.e. child physical abuse, spouse abuse, elderly abuse) are more closely tied.

B. The conventional wisdom regarding alcohol and violence is that alcohol serves as a disinhibitor which allows a person to release aggression. Many victims blame alcohol for the violence that occurs toward their children and state that when the caretaker is sober, neither violence nor abuse occurs.

C. The offender often believes that alcohol and drugs renders an individual powerless to control behavior, and thus, whatever happens is not his fault. These justifications may play a casual role in family violence by providing, in advance, an excuse for behavior that is normally prohibited by societal and familial norms and standards.

D. If substance abuse is evident in a child physical abuse and neglect case, the participants primarily must be concerned with the child and the risk at home. The parent's substance abuse problem should then be reported to the social worker or court personnel working on the case.

1. Alcohol usage by the offender usually increases the degree of injury to the child victim.

2. The participants must be aware that if an alcohol abuser is violent toward one family member that violent behavior often "spills over" to other family members.

E. Possible Child Physical Abuse and Neglect Court Defenses related to Substance Abuse

1. A defendant will quite often allege that he or she was intoxicated as a result of alcohol or drugs and these defenses are often alleged to negate intent.

2. Insanity is being increasingly used as a defense.

- Note to Trainer: Refer to NASDLET, Child Physical Abuse and Neglect, Child Victim Services and the Law Core Module.

METHODS:

- Lecture
- Group Exercise
- Group Discussion
- Case Study

RESOURCE MATERIALS:

- Lesson Plan
- Course Handouts
- Case Study #1
- Easel/Blackboard
- Topical Bibliography

TIME REQUIREMENTS:

- Two Hours

CHILD PHYSICAL ABUSE AND NEGLECT

TOPICAL BIBLIOGRAPHY

DEVELOPMENTAL CRISIS THEORY AND THE CHILD VICTIM

Topic I - Crisis Theory

Erikson, Erik, Identity: Youth and Crisis. New York: W.W. Norton and Company, Chapters 2-51, 1968.

National Association of State Directors of Law Enforcement Training, National Victim Assistance Law Enforcement Trainer's Manual, 1985.

Topics II & III - Dynamics of Child Physical Abuse and Neglect

McNeese, M.C. and Hebeler, J.R., "The Abused Child a Clinical Approach to Identification and Management", Clinical Symposia, V29, N5, pp. 6-13, 1977.

Topic IV - Factors Present in Child Physical Abuse and Neglect

Broadhurst, D.D. and Knoeller, J.S. The Role of Law Child Abuse and Neglect. Washington, D.C.: U.S. Department of Health, Education, and Welfare, DHEW Publication No, (OHDS) 79-30193, pp. 4-5, August 1979.

McNeese, M.C. and Hebeler, J.R., "The Abused Child A Clinical Approach to Identification and Management", Clinical Symposia, V29, N5, pp. 13, 1977.

Straus, M.A., Gelles, R.J., and Steimetz, S.K., Behind Closed Doors: Violence in the American Family. New York: Anchor Books, Conclusion, 1980.

Topic V - Characteristics of Physically Abusive Caretakers

Broadhurst, D.D. and Knoeller, J.S. The Role of Law Enforcement in the Prevention and Treatment of Child Abuse and Neglect. Washington, D.C.: U.S. Department of Health, Education, and Welfare, DHEW Publication No, (OHDS) 79-30193, pp. 21-23, August 1979.

Topic VI - Characteristics of Neglectful Caretakers

Broadhurst, D.D. and Knoeller, J.S., The Role of Law Enforcement in the Prevention and Treatment of Child Abuse and Neglect. Washington, D.C.: U.S. Department of Health, Education and Welfare, DHEW Publication No. (OHDS) 79-30193, pp. 21-23, August 1979.

Green, Arthur H. "Societal Neglect of Child Abusing Parents", Victimology: An International Journal, V. II, No. 2 pp. 285-293, Summer 1977.

Kempe, Ruth S. and C. Henry, Child Abuse. Cambridge, MA: Harvard University Press, Chapter 5, 1978.

Maden, M.F. and Wrench, D.F. "Significant Findings in Child Abuse Research," Victimology: An International Journal, V. II No. 2, pp. 196-213, Summer 1977.

CHILD PHYSICAL ABUSE AND NEGLECT
DEVELOPMENTAL CRISIS THEORY
RECRUIT/FIRST RESPONDER
SPECIALIZED/INVESTIGATOR
CASE STUDY #1

The T. family became involved with a treatment program when Jack T. sought help in controlling his impulses to hit Jacky, his 10 month old son. Mr. T., a 40 year old, intermittently employed housepainter, was referred from an alcoholism treatment center. He could not tolerate Jacky's crying, which he felt was designed to manipulate him. Mr. T.'s request for help was perceived with a sense of urgency, since he had previously abused two young daughters several years ago. Both of these children sustained multiple fractures and were subsequently placed in foster homes and eventually adopted. The T.'s first child died as a result of a crib death, but may have also been abused. Jacky was apparently conceived to relieve T.'s emptiness and depression caused by the loss of the three older children. This represented their final attempt to succeed as parents since Mrs. T. requested a tubal ligation after Jacky was born.

Rita T., Jack's 36 year old wife, presented herself as a depressed, confused woman who appeared much older than her age. She was obviously ineffective in caring for Jacky and managing the household, and often delegated these responsibilities to her husband. She was sad and embittered about the loss of her older children, for which she blamed Mr. T. After several joint interviews with both parents and the child, it was clear that Mr. T. was the dominate parent who usually held and tried to comfort Jacky, while Mrs. T. passively blended into the background. When she became more assertive with the baby at our urging, her husband would often criticize her.

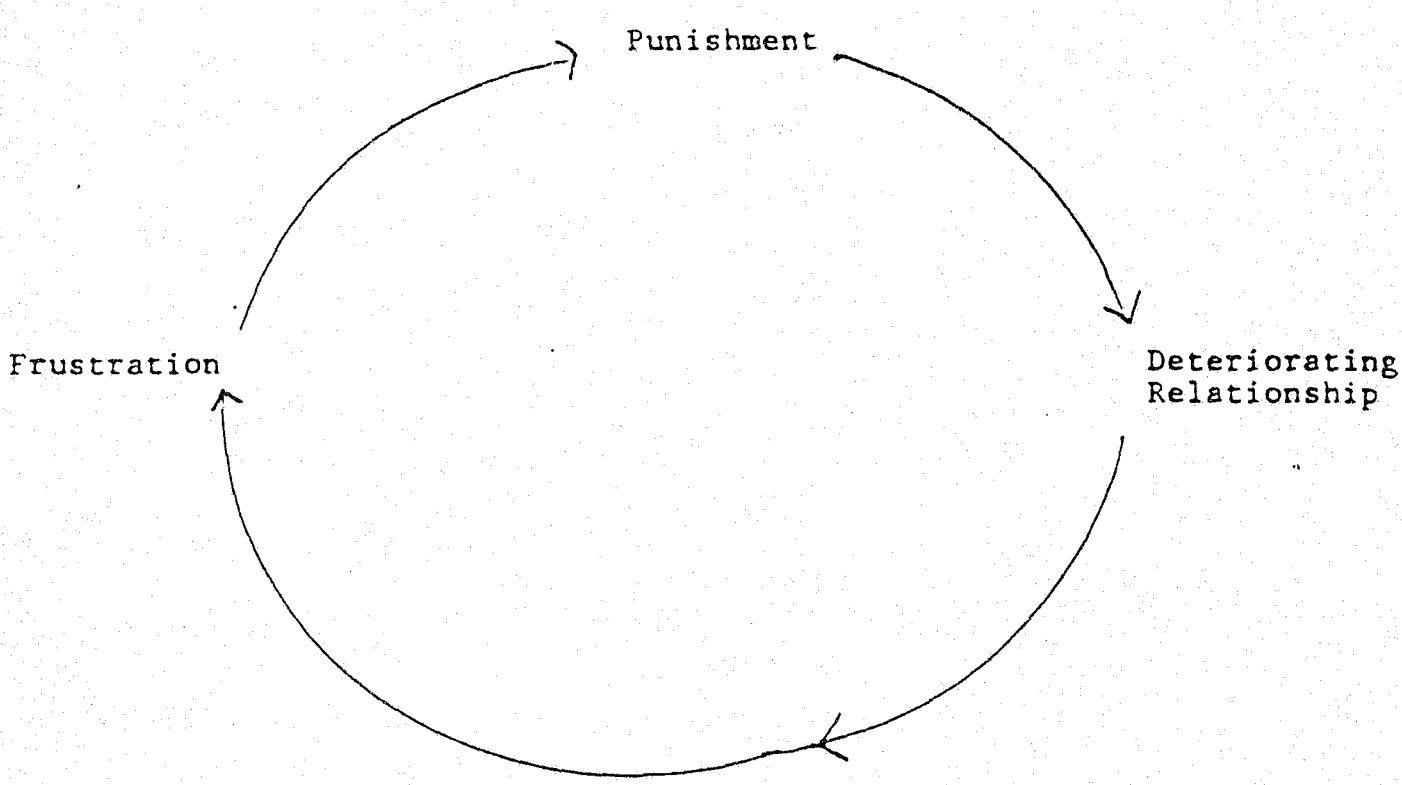
Mr. T.'s impulses to hit his son were mainly when he returned home for dinner, hungry and tired. At this time, he became enraged if Jacky was not quietly sleeping. If Jacky was being fed by Mrs. T. or if he was crying or fussing, Mr. T. experienced mounting resentment. After a short period in individual psychotherapy, Mr. T. recognized that he felt neglected and jealous of his son, when the latter was being cared for by Mrs. T. Mr. T. recalled painful memories about his early childhood, as a foundling, and a foster child. He remembered being hungry and lonely. He was always the last to be fed as the natural children of the foster parents "came first". Mr. T. also could identify with Jacky's cries of hunger, as he has suffered from malnutrition in one of his foster homes. He realized how these experiences left him ill-prepared to function as a devoted parent.

WHAT ARE THE FAMILY DYNAMICS PRESENT IN THIS CASE?

SOURCE: Freen, A.H., "Societal Neglect of Child Abusing Parents", Victimology: An International Journal, V II, No. 2, pp. 285-293, Summer 1977.

HILD PHYSICAL ABUSE AND NEGLECT
EVELOPMENTAL CRISIS THEORY
RECRUIT/FIRST RESPONDER
PECIALIZED/INVESTIGATOR
ANDOUT #1

CYCLE OF VIOLENCE



CHARACTERISTICS OF PHYSICALLY ABUSIVE AND NEGLECTFUL CARETAKERS

Characteristics of Abusive Caretakers:

seem unconcerned about the child

see the child as "bad", "evil", a "monster" or "witch"

offer illogical, unconvincing, contradictory explanations or have no explanation of the child's injury

attempt to conceal the child's injury or to protect the identity of the person responsible

routinely employ harsh, unreasonable discipline which is inappropriate to the child's age, transgressions, and condition

were often physically abused as children

were expected to meet high demands of their parents

were unable to depend on their parents for love and nuturance

cannot provide emotionally for themselves as adults

expect their children to fill their emotional void

have poor impulse control

expect rejection

have low self-esteem

are emotionally immature

are isolated, have no support system

marry a spouse who is not emotionally supportive and who passively supports the abuse

Characteristics of Neglectful Caretakers:

may have a chaotic home life

may live in unsafe conditions-no food; garbage and excrement in living areas; exposed wiring; drugs and poison kept within the reach of children

may abuse drugs or alcohol

may be mentally retarded, have low I.Q., or have a flat personality

may be impulsive individuals who seek immediate gratification without regard to long-term consequences

may be motivated and employed but unable to find or afford child care

generally have not experienced success in life

have emotional needs which are not met by their own parents

have low self-esteem

have little motivation or skill to effect changes in their lives

tend to be passive

CHILD PHYSICAL ABUSE AND NEGLECT
FORMS OF CHILD PHYSICAL ABUSE
RECRUIT/FIRST RESPONDER
SPECIALIZED/INVESTIGATOR

CHILD PHYSICAL ABUSE AND NEGLECT

FORMS OF CHILD PHYSICAL ABUSE AND NEGLECT

This section will introduce the participants to three categories of child physical abuse and neglect: physical violence, physical and emotional neglect, and emotional abuse.

Child Sexual Assault will not be discussed in this module.

CHILD PHYSICAL ABUSE AND NEGLECT

LESSON PLAN WORKSHEET

LESSON TITLE: Forms of Child Physical Abuse and Neglect

FUNCTIONAL AREA: This section will introduce the participants to three categories of child physical abuse and neglect: physical violence, physical and emotional neglect, and emotional abuse. Child sexual assault will not be discussed in this module.

PERFORMANCE OBJECTIVES: The participants, at the completion of this module will, without reference to notes:

1. Define, verbally or in writing, three categories of child physical abuse and neglect.
2. List, verbally, three behavioral indicators of child neglect.

TOPICS:

I. There are four categories used to classify abuse: PHYSICAL VIOLENCE, PHYSICAL AND EMOTIONAL NEGLECT, EMOTIONAL ABUSE AND CHILD SEXUAL ASSAULT. Child sexual assault will not be discussed in this training module.

A. PHYSICAL ABUSE - is described as physical harmful action directed at the child and is usually defined by any inflicted injury such as bruises, burns, head injuries or poisoning.

B. NEGLECT - is failure of a caretaker to act properly in safeguarding the health, safety and well-being of a child. It is difficult to determine physical or emotional neglect but neglect includes such things as:

1. Nutritional neglect which results from feeding a child inadequately, either by not enough food or by bizarre diet.

2. Failure to provide medical care.

3. Giving large adult doses of sedatives to an infant or hallucinogenic drugs to a small child.

C. EMOTIONAL NEGLECT - almost always occurs with physical neglect and is the most difficult to define. Specific behaviors or lack of behaviors on the part of a parent can emotionally effect a child and the way that child grows or interacts with others. Two examples would be a baby who is never picked up out of the crib or parents who are totally undemonstrative in loving or giving affection toward their children. Other examples of emotional neglect include: deprivation and distancing; depreciation; and domination of a child.

II. Most injuries to children are inflicted by the hand.

A. After the hand, the three most common household instruments used are:

- belt
- extension cord
- coat hanger

B. Physical Indicators of Physical Abuse may include:

- bruises and welts
- abrasions
- lacerations
- scars
- burns
- cigarette burns

- fractures
- internal injuries
- skull injuries
- Refer to Handout #1

C. How to identify types of injuries, weapon and angle of attack will be discussed further in the Investigative Strategies module.

D. Behavioral Indicators of Physical Abuse may include:

- The child may be wary of physical contact with adults (The child will often avoid it, sometimes even shrinking at the touch or approach of an adult).
- The child may become apprehensive when other children cry.
- The child may behave much differently than other children (extreme aggressiveness or extreme withdrawal are examples).
- The child may seem frightened of the caretakers.
- The child may state that he or she is afraid to go home may cry when it it time to return home.
- The child may report injury by a parent or caretaker.
- Refer to Handout #1

III. Neglect can be detected both physically and behaviorally

-Note to Trainer: This information is included because if the law enforcement officer views or suspects child physical neglect, the officer is statutorily mandated to report that information to the local Child Welfare Service agency. Also, if protective custody is needed, the law enforcement officer has the authority to bring a neglected child to Family Court.

A. Physical Indicators of Neglect may include:

- nutritional neglect
- poor hygiene
- consistent lack of supervision for long periods or during dangerous activities
- unattended physical problems/medical or dental neglect
- abandonment: leaving a child unattended or inadequately supervised for excessively long periods
- educational neglect
- Refer to Handout #2

B. Behavioral Indicators of Neglect may include:

- begging, stealing food

- extended stays at school (early arrival and late departure)
- constant failure, listlessness, or falling asleep in class
- alcohol or drug abuse
- delinquency (in younger aged children)
- states there is no caretaker
- truancy
- Refer to Handout #2

IV. Emotional Maltreatment generally occurs in two distinct ways and can leave a child with behavioral scars.

-Note to Trainer: This information is included because if the law enforcement officer views or suspects child emotional maltreatment, the officer is statutorily mandated to report that information to the local child welfare service agency.

A. Emotional neglect is the chronic failure by a parent to provide the child with the support and affection necessary to the development of a sound and healthy personality.

B. Emotional abuse is a chronic attitude or acts of a parent which are detrimental to the child's development of sound and healthy personality.

- Refer to Handout #3

V. It is recommended that the trainer show a slide presentation to graphically illustrate the problem of child physical abuse and neglect. (one slide presentation available is "The Visual Diagnosis of Non-Accidental Trauma and Failure to Thrive", 1978 edition, prepared by Barton D. Schmitt, M.D. and available through the C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect).

METHODS:

- Lecture
- Group Discussion
- Slide Presentation

RESOURCE MATERIALS:

- Lesson Plan
- Course Handouts
- Easel/Blackboard
- Topical Bibliography
- Slide Presentation

TIME REQUIREMENT:

- One Hour and Thirty Minutes

CHILD PHYSICAL ABUSE AND NEGLECT

TOPICAL BIBLIOGRAPHY

Topics I-IV - Forms of Child Physical Abuse and Neglect

Broadhurst, D.D. Knoeller, J.S., The Role of Law Enforcement in the Prevention and Treatment of Child Abuse and Neglect. Washington, D.C.: U.S. Department of Health, Education and Welfare, DHEW Publication No. (OHDS) 79-30193, pp. 13-20, August 1979.

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[redacted] OF CHILD PHYSICAL ABUSE
RECRUIT/FIRST RESPONDER
SPECIALIZED/INVESTIGATOR
HANDOUT #1 (1 of 8)

PHYSICAL AND BEHAVIORAL INDICATORS OF PHYSICAL ABUSE

Physical Indicators/ Suspect Inflicted	Observable Features of Injury	Accidental Explanations	Behavioral Indicators
Bruises and Welts:	**Timing of Bruises:**		
infant less than 9 months old	few hours red	Any bruises or welts which there is a good explanation	the child is wary of physical contact with adults. (the child will often avoid it, sometimes even shrinking at the touch or approach of an adult)
on face, lips, mouth	6-12 hours blue		
on torso, back buttocks, thighs	12-24 hours blk-purple	Single bruise on toddler's forehead or chin: child falls against hard surface	
in various stages of healing	4-6 days-green tint dark		the child becomes apprehensive when other children cry
clustered, forming regular patterns	5-10 days-pale green to yellow	front lower legs (shins) several bruises in preschool children	
reflecting shape of article used to inflict (electric cord, belt buckle.)		irregular shaped bruises over bony prominences (knees, elbows)	the child behaves much differently than other children (extreme aggressiveness or extreme withdrawal are examples)
both sides of face			the child seems frightened of the care-takers
both eyelids (black eyes)			
human bite marks			
appear regulary after absence, weekend or vacation			

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FORMS OF CHILD PHYSICAL ABUSE
RECRUIT/FIRST RESPONDER
SPECIALIZED/INVESTIGATOR
HANDOUT #1 (2 of 8)

PHYSICAL AND BEHAVIORAL INDICATORS OF PHYSICAL ABUSE

Physical Indicators/ Suspect Inflicted	Observable Features of Injury		Accidental Explanations	Behavioral Indicators
Abrasions:	**Timing of Abrasions**			
to mouth, lips gums, eyes	few hours	raw surface with oozing blood, clear fluid, moist surface.	Any abrasions for which there is a good explanation	SAME AS ABOVE PAGE
to external genitalia			scraped knees and elbows- not uncommon with skate- board accidents	
multiple as with bruises	more than 6 hours	dry red		
location as with bruises	24 hours	scabs formed	massive, over large areas of the body and extremities, on several surfaces of the body: not uncommon as a result of an automobile accident vs. where the child is dragged a distance under the car	
			Linear scraps on infant's face: from infant's finger- nails (self inflicted)	

PHYSICAL AND BEHAVIORAL INDICATORS OF PHYSICAL ABUSE

Physical Indicators/ Suspect Inflicted	Observable Features of Injury	Accidental Explanations	Behavioral Indicators
Lacerations:			
multiple to mouth, lips, gums to external genitalia amputation: ear, genitalia, sharp incisional rather than compression		Any lacerations for which there is a good explanation. 3/4" horizontal at the point of the chin in a toddler or preschooler- very common from fall on hard surface Fingers, hands: often self inflicted from play with sharp instruments, razors	The child states that he or she is afraid to go home or cries when it is time to leave The child reports injury by a parent or caretaker
Scars:			
multiple caretakers have no good explanation		Any scars for which there is a good explanation Multiple small round areas 1/4 to 1/2 inch may result from healed chicken pox, mosquito bites, impetigo or other skin infections; may be mistaken for cigarette burns	

FORMS OF CHILD PHYSICAL ABUSE
RECRUIT/FIRST RESPONDER
SPECIALIZED/INVESTIGATOR
HANDOUT #1 (4 of 8)

PHYSICAL AND BEHAVIORAL INDICATORS OF PHYSICAL ABUSE

Physical Indicators/ Suspect Inflicted	Observable Features of Injury	Accidental Explanations	Behavioral Indicators
Burns:	Distribution:		
liquid, forced immersion pattern, stocking or glove distribution, both ankles or hands and wrists, sharp edge which matches depth of liquid	immersion burn	Any burns for which there is a good explanation	
	spatter or liquid burn	Child is burned playing with matches, building fires	
	contact burn "branding"		
	open flame or cigarette burn	Small child pulls percolator off a counter or pot off a stove	
doughnut shaped on buttocks or genitalia from being held in tub of hot water: the doughnut "hole" is the skin area forced against the bottom of the tub and prolonged contact with the water		Child is burned by gasoline fire in go-cart, toy airplane or lawn mower	
		Child is burned playing with gun powder or explosives	
flame, holding hand in gas stove burner flame, or incense stick "to teach child it is hot"			
hot surface - pattern of instrument "brands skin" as in waffle marks of wallheater grill (a dry contact burn)			
spatter or liquid burn caused by throwing scalding liquid which burns a "splash" pattern in the skin			

PHYSICAL AND BEHAVIORAL INDICATORS OF PHYSICAL ABUSE

Physical Indicators/ Suspect Inflicted	Observable Features of Injury	Accidental Explanations	Behavioral Indicators

Burns Cont:

rope burns on arms, legs, neck or torso, caused by being bound or tied to furniture

gag burns caused by being bound and gagged

[redacted] IS [redacted] [redacted] PHYSICAL [redacted] ABUSE

RECRUIT/FIRST RESPONDER
SPECIALIZED/INVESTIGATOR
HANDOUT #1 (6 of 8)

PHYSICAL AND BEHAVIORAL INDICATORS OF PHYSICAL ABUSE

Physical Indicators/ Suspect Inflicted	Observable Features of Injury	Accidental Explanations	Behavioral Indicators
Cigarette Burns:	Timing of Cigarette Burns:		
usually multiple, especially on soles of feet, palms of hands, back or buttocks	Fresh-deeper center 1/8 to 1/4 inch deep, red ring around center healing-central scab-heals from center out to edges healed-round 1/4 inch scar		
Fractures:			
*must be diagnosed by x-ray		Any fracture for which there is a good explanation	
to skull, nose, facial structure		Single fracture in older child	
in various stages of healing		Skull fracture in infant without evident other injury; this may result from a surprisingly minor fall with or without local evidence of overlying injury to scalp, and the whole spectrum of no brain injury to brain death	
multiple fractures			
rib fractures			
chip fracture of tubular bones in child under 13 months caused by sharp yanking of arm or leg away from body with or without twisting			

[redacted] CHILD PHYSICAL ABUSE
RECRUIT/FIRST RESPONDER
SPECIALIZED/INVESTIGATOR
HANDOUT #1 (7 of 8)

PHYSICAL AND BEHAVIORAL INDICATORS OF PHYSICAL ABUSE

Physical Indicators Suspect Inflicted	Observable Features of Injury	Accidental Explanations	Behavioral Indicators
Subdural Hematoma *must be diagnosed by physician	**Mechanism of Subdural Hematoma**		
Collection of blood under the dural membrane of the skull if large amount presses against the soft brain, distorting vital brain tissue and function, the child may lose consciousness, experience seizures, blindness, paralysis or death	Blunt trauma - shifts brain toward point of impact then away from this point causing rupture of blood vessels (shearing); may also occur as a result of vigorous shaking; often associated with other hear injuries.	Falling, striking head, usually in infant, but may occur at any age	
Internal Injuries *must be diagnosed by a physician	**General Symptoms**		
blunt trauma to abdomen often has no surface bruises because skin gives with impact	shock-loss of blood	Automobile accident	
rupture of liver	unconscious	Accidental injury in contact sports	
rupture of spleen	vomiting	falls from bicycles or trees onto projecting objects such as handle-bars or branches	
bruising or actual rupture of kidney	fever		
	seizures		
	swelling of abdomen		

FORMS OF CHILD PHYSICAL ABUSE
RECRUIT/FIRST RESPONDER
SPECIALIZED/INVESTIGATOR
HANDOUT #1 (8 of 8)

PHYSICAL AND BEHAVIORAL INDICATORS OF PHYSICAL ABUSE

Physical Indicators Suspect Inflicted	Observable Features of Injury	Accidental Explanations	Behavioral Indicators
Ruptured small intestine causing spilling of intestinal contents into abdomen requires surgery	Intestinal obstruction - severe abdominal pain		
hemorrhage or bruising of the pancreas	All of these may occur within a few hours or 2-3 days depending on the severity of the injuries		

Source: Linda J. Romano, Training Specialist -National Association of State Directors of Law Enforcement Trainers

[redacted] SPECIALIZED/INVESTIGATOR
HANDOUT #2 (1 of 2)

PHYSICAL AND BEHAVIORAL INDICATORS OF PHYSICAL NEGLECT

Physical Indicators Suspect Inflicted	Observable Features of Injury	Accidental Explanations	Behavioral Indicators
nutritional neglect	consistent hunger malnourished poor skin tone abnormalities of mouth		begging, stealing food
poor hygiene	diapers are rarely changed ears, nose, and fingernails, are never clean clothes always dirty		
consistent lack of supervision, especially in dangerous activities or long periods	failure of caretaker to account adequately for a child's actions and whereabouts	first time run away from home, after an argument-may be gone one day	extended stays at school (early arrival and late departure) constant failure, listlessness, or falling asleep in class
	inappropriate or insufficient clothing	Note: if child is gone more than 24 hours or in the case of a small child the police should have been called	alcohol or drug abuse
	caretaker encourages youth to steal		delinquency (ie thefts)

[redacted]

FORMS OF CHILD PHYSICAL ABUSE
RECRUIT/FIRST RESPONDER
SPECIALIZED/INVESTIGATOR
HANDOUT #2 (2 of 2)

PHYSICAL AND BEHAVIORAL INDICATORS OF PHYSICAL NEGLECT

Physical Indicators Suspect Inflicted	Observable Features of Injury	Accidental Explanations	Behavioral Indicators
unattended physical problems, medical or dental neglect	failure to obtain eyeglasses rotting or discolored teeth poor hearing chronic unattended illness		
abandonment: leaving a child unattended or inadequately supervised for excessively long periods	leaving a young infant in an unlocked car while caretakers attend a movie		states there is no caretaker
educational neglect	caretaker refuses to permit child to attend school	youth truants school w/o parents knowledge and school has not notified family of such absences	truancy

SOURCE: Linda J.Romano, Training Specialist
National Association of State Directors of Law Enforcement Training

Emotional Maltreatment... it leaves scars, too

Each of us is guilty of having unkindly snubbed a child or of having criticized him too harshly, but emotional maltreatment is characterized by its being consistent and chronic behavior.

There are generally two types of emotional maltreatment: emotional neglect (an act of omission)—chronic failure by a parent to provide the child with the support and affection necessary to the development of a sound and healthy personality; emotional abuse (an act of commission)—chronic attitude or acts of a parent which are detrimental to the child's development of a sound and healthy personality

The Model Child Protection Act, developed by the National Center on Child Abuse and Neglect provides criteria to aid in identifying emotional maltreatment: Emotional maltreatment causes emotional or mental injury. The effect can be observed in the child's abnormal behavior and performance. The effect constitutes a handicap to the child. The effect is lasting rather than temporary.

Examples of Emotional Maltreatment

The Parent Chronically:

- belittles the child so he is made to feel he can do nothing right
- criticizes the child harshly
- blames the child for things over which the child has little or no control
- uses the child as scapegoat when things go wrong
- ridicules and shames the child
- threatens the child's safety and health
- takes little or no interest in the child and his activities and seems not to care about the child's problems
- treats the child coldly and is not demonstrably affectionate; actually withholds love
- treats the child differently from other children in the household
- engages in bizarre acts of torture or torment, such as locking the child in a closet

CHILD PHYSICAL ABUSE AND NEGLECT
FORMS OF CHILD PHYSICAL ABUSE
RECRUIT/FIRST RESPONDER
SPECIALIZED/INVESTIGATOR
HANDOUT #3 (2 of 2)

Behavioral Characteristics That May Indicate the Emotionally Maltreated Child

The signs of emotional maltreatment are less obvious to the untrained eye than physical abuse or neglect of a child. The child's behavior is the best indicator that emotional maltreatment is occurring. The child who persistently exhibits several of these behavioral characteristics is experiencing difficulties or family problems which need some type of intervention:

- habits, such as biting, rocking, head-banging, thumbsucking in an older child
- feeding disorders
- daytime anxiety and unrealistic fears
- sleep disorders, nightmares
- enuresis (involuntary bed-wetting in an older child)
- speech disorders, such as stuttering and stammering
- defiant
- withdrawn and antisocial
- poor relations with children of his own age
- distrustful and overly fearful of strangers
- irrational and persistent fears, dreads, or hatreds
- hypochondriacal (abnormally anxious about his health or imagines he is ill)
- low self-esteem
- lack of creativity and healthy exploration; seems not to know how to play
- apathetic; feels little or no emotion; indifferent and listless
- lacks purpose and determination
- seems oblivious to hazards and risks
- destructive
- obsessive or compulsive
- behavior extremes: aggressive or passive-dependent; assumes the parental role with other children or is infantile; behavior is rigid or overly impulsive
- daydreams frequently; has hallucinations; overfantasizes; seems removed from reality
- academic failure in that he does not achieve up to his ability; may seem almost mentally retarded
- sadomasochistic behavior (seems cruel and to get pleasure from hurting other children, adults, or animals; or, conversely, seems to get pleasure from being mistreated)
- self-destructive; may attempt suicide

Source: Child Abuse and Exploitatio Investigative Techniques Training Program Manual, Department of the Treasury, Federal Law Enforcement Training Center, Glynco, Georgia, February 1985.

CHILD PHYSICAL ABUSE AND NEGLECT
CRISIS INTERVENTION & INTERVIEWING
RECRUIT/FIRST RESPONDER
SPECIALIZED/INVESTIGATOR

CHILD PHYSICAL ABUSE AND NEGLECT

CRISIS INTERVENTION AND INTERVIEWING WITH THE CHILD VICTIM

This section will introduce the participants to the problems associated with interviewing child victims in Child Physical Abuse and Neglect cases. Strategies the law enforcement officer can utilize when interviewing child victims are also discussed.

This module should be taught directly before the Investigative Strategies in Child Physical Abuse and Neglect module.

CHILD PHYSICAL ABUSE AND NEGLECT

LESSON PLAN WORKSHEET

LESSON TITLE: Crisis Intervention and Interviewing with the Child Victim

FUNCTIONAL AREA: This section will focus on problems associated with interviewing child victim's in Child Physical Abuse and Neglect cases and strategies the law enforcement officer can utilize when interviewing child victims. This module should be taught directly before Investigative Strategies in Child Physical Abuse and Neglect.

PERFORMANCE OBJECTIVES: The trainee, at the completion of this module will, without reference to notes:

1. List, verbally or in writing, two reasons why children "keep the secret" of their physical abuse.
2. Discuss, with the class, at what age a child would be more likely to lie to a law enforcement officer.
3. Conduct a mock interview of a child using the techniques provided in this module.

TOPICS:

I. Law enforcement interviewing of children is not an easy task to perform. There are a number of barriers which may prevent any adult's immediate alliance with a child.

   A. Some children fear police officers because of superstitions or family biases.

   B. Some children have a generalized fear of adults because of the situation they live in.

II. Factors that determine the law enforcement officer's approach in interviewing a child include:

A. The child's age;

B. The child's ability to explain what has happened;

C. The possible impact of the interview on the child's emotional state;

D. The possible retaliation of a child if the parents "know he told;" and

E. Parental consent to conduct an interview

-Note to Trainer: The issue of parental consent to conduct an interview will be discussed in the Investigative Strategies Module.

III. Interviews with Child Victims Should be Private

A. The setting for the child victim interview may be his room, outside the household in the yard, in a medical facility, school or child care facility, or in an office.

B. Children over three are frequently afraid to speak in front of their parents.

C. Children over seven are known to bias their statements quite differently when their parents are in the room.

IV. Strategies for Interviewing Child Victims

A. Establishing An Alliance with the Child

1. It is important to communicate at the child's level, using language that he understands. For example, with small children it is appropriate to sit on the floor to conduct the interview. Remember that the interview process (as adults know it) is the least comfortable or natural form of communication to a young child.

2. Be very gentle in speech and movement.

3. Be sensitive to the child's emotional and physical reaction to what is happening.

4. Be calm and soothing to the child.

5. Be supportive of the child's reluctance to speak and take time with the child.

6. Tell the child that you understand how he feels, that you have seen other children who have been abused, and that you believe the child's story.

7. It is important to keep eye contact with the child and to have a non-threatening body posture.

B. The interviewer must try to relate on the same level as the child.

1. Be careful not to lead the interview or put "words in a child's mouth."

2. Two ways law enforcement officers can become more in tune with children's thoughts are:

a. If possible, watch cartoon programs on television; and

b. Interview your own or family member's children.

3. Children under ten can often give an account of an event when gently probed by a sympathetic listener.

- Note to Trainer: Developmental Crisis Theory should be briefly related here to emphasize what different aged children know. Refer to Study Guide.

4. When interviewing adolescents, they may show either extreme distress or very flat affect during the explanation of what happened to them.

C. Strategies in Interviewing Child Victims

1. The purpose of using child drawings is to put the child at ease and to aid the investigator in the investigation by possibly learning more clues.

2. The use of drawings as an initial interview strategy is especially good for "breaking the ice" with young children. Drawing is a natural form of communication for the child and the child will be eager to draw a picture. A progression of pictures may be:

   * Draw a picture of yourself
   * Draw a picture of family doing something
   * Draw a picture of <u>what</u> (the crime) happened
   * Draw a picture of where the crime happened

3. A second strategy is play interviewing. Play interviewing may be done with dolls or puppets which the child can identify as representing the members of the family. Ask the child to use the dolls/puppets to describe:

   * What happened
   * Conversation between child and offender
   * Child's fears about talking about the abuse

4. There are limitations to the interpretation a law enforcement officer can give to child drawings. Child drawing analysis should be done by an expert in the field of child drawings.

D. The law enforcement officer may need to complete a series of interviews.

1. Small children have a short attention span, approximately fifteen minutes.

2. Adolescents may need several meetings to learn to trust the interviewer.

E. It is important for the law enforcement officer to reinforce what the child is doing as a positive thing and something their mother or father want them to do.

F. A good way for the law enforcement officer to practice interviewing with children is to interview by asking open-ended questions of their own family members' children.

- Refer to Interview Guide for Children

V. Reasons why children don't tell the law enforcement about the physical abuse or neglect include:

A. The child cannot verbalize what happened.

B. The child may be taking care of their parents emotional needs (role-reversal).

C. The child may feel he/she deserved the abuse.

D. The child loves their parents.

VI. Children lie - myth or reality?

A. Experience of many child physical abuse protection teams and victim advocates note that children under age seven rarely are able to lie about what has happened to them. (This can be related to developmental crisis theory in that children underage seven have not learned how to lie yet. Young children's cognitive recall is not developed to an extent which will allow the retention of a lie over a period of time).

B. Children do not lie, but may embellish the truth.

1. Children may lie if they have been drilled or coached by a parent.

2. A child may extend or "exaggerate" an incident if he believes that the truth will not be believed by the interviewer.

VII. Many states require joint interviewing in Child Physical Abuse and Neglect cases or do so as a matter of policy.

A. Joint interviews generally consist of the law enforcement officer and a social worker or nurse.

B. The person with the best rapport with the child should actually ask the questions.

C. If one professional is male and another female, note the child's differential response and degree of comfort when each professional talks.

D. Some local agencies tape or video tape interviews with children. The issues surrounding this practice are discussed in the Child Victim Services and the Law Module.

-Note to Trainer: It is important to know your state's policies and procedures regarding the taping of interviews.

E. An automatic follow-up contact with the family should take place by a helping professional within twenty-four to forty-eight hours.

VII. Conduct a mock interview exercise (see suggested exercise in the Investigative Strategies in Child Physical Abuse and Neglect Module) and have the class critique the interview. Video tape the interview, if possible.

METHODS:

- Lecture
- Group Discussion
- Mock Interview

RESOURCE MATERIALS:

- Lesson Plan Worksheet
- Interview Guide
- Topical Bibliography
- Easel/Blackboard

TIME REQUIREMENTS:

- One Hour and One Half

CHILD PHYSICAL ABUSE AND NEGLECT

TOPICAL BIBLIOGRAPHY

Topics I to VII - Interviewing with Child Victims

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CHILD PHYSICAL ABUSE AND NEGLECT
CRISIS INTERVENTION & INTERVIEWING
RECRUIT/FIRST RESPONDER
SPECIALIZED/INVESTIGATOR
HANDOUT #1

Initial Interview Guide for the Child Victim of Crime
Recommended Model

I. Introductory Phase

SETTING: The interview should be conducted in a private setting, away from intrusion and, if possible, away from the crime scene. Police departments may have a private room in which to conduct the interview.

INTRODUCTION: The officer should identify himself, state the purpose of the interview and ask the child victim if he/she prefers to have a support person present during the interview. It is recommended that the child be interviewed separately from the parents. The officer should be aware that a child's attention span is relatively short and that a series of interviews may be necessary in order to establish a complete account of the crime.

II. Working Phase

The Crime

1. Circumstances of the crime:

   What kind of crime happened? When and where did the crime occur? When and where was the child victim approached? Why was the child victim there? Children may have difficulty accounting for specific dates and times. The officer may ask the child to recount the time of the crime by associating it with an activity familiar to the child (i.e. going to school, watching T.V., etc.)

2. Assailant (if applicable):

   Does the child victim know the assailant and does the child have a name for the assailant? (i.e. either a proper name or a slang name for the assailant.) Can the victims give a physical description of the assailant, including any distinguishing characteristics, marks, or odor? Number of assailants? Can the victim give a description of what the assailant was wearing?

3. Conversation:

What kind of conversation occurred, if any, prior to the crime being committed? Did the offender attempt to help or con the child victim? Were any verbal threats made? Were any humiliating comments made? Did the child victim respond to any conversations and in what way?

4. Physical and Verbal Threats:

Did the offender have a weapon? Did the offender indicate he had a weapon, but did not show the weapon? Did the offender threaten the child victim physically or verbally? Did the offender exert violence, such as slapping, kicking or hitting?

5. Struggle:

Was there a struggle between the child victim and the offender?

6. Alcohol/Drug Use by Offender/Victim:

Did the offender appear to be under the influence of drugs or alcohol?

AFTER THE CRIME

1. Seeking Help:

Where did the child victim go for help? Did the child victim talk to anyone immediately after the crime? Did the child victim do anything immediately after the crime?

2. Family and Friends:

Who are the child victim's family? Does the victim wish to tell other members of their family about the crime? Does the child victim have a family who can care for him/her?

3. Medical Intervention:

Does the child victim need or wish to go to a hospital? Does the child victim have a personal physician he/she would rather see?

4. Pressing Charges:

What are the child victim's concerns about the criminal justice process?

III. Concluding Phase

CLOSING THE INTERVIEW

1. Thank the child victim for answering all the questions.

2. Inform the child victim of any referrals/temporary care arrangements which are being made for the child.

3. Advise the child victims of follow-up procedures that the police department will have (i.e. additional officers arriving at scene, need to tell circumstances of the crime to others, etc.)

4. Prepare the child victim for future contact with the criminal justice system.

5. Advise child victim that you may need to speak with him/her again.

6. Ask the child victim if he/she has any questions for you.

NON-VERBAL AND VERBAL INTERVIEWING TECHNIQUES

Non-Verbal Techniques that Assist in Interviewing:

1. Language: The officer should use language which the child victim understands and is age-appropriate to the child.

2. Eye Contact: The officer who keeps looking directly at an individual's eyes will eventually establish contact. Direct eye contact is important for communicating to the victim that one is listening and concerned.

3. Body Posture: When interviewing victims, it is a good idea to monitor one's body posture to determine what is being communicated. For example, leaning towards the victim during the interview will indicate attentiveness; holding your head upright and sitting rigid indicates impersonality.

4. Personal Distance. Generally, the closer one stands the more one expresses intimacy. The greater the distance, the greater the feeling of formality. Make an attempt to be in a position "equal" to child. Do not sit or stand over child.

5. Vocalization. This term refers to the volume, speed, and pacing of speech. It is a good idea to speak to victims in a soft and slow voice, while allowing a few seconds to lapse between questions. Pacing questions slowly gives an impression of patience and concern.

6. Play and Art. Puppets, dolls and allowing a child to draw may ease the child during the interview and facilitate the interview process.

Verbal Techniques that Assist in Interviewing:

CLARIFICATION

We clarify when we interrupt the speaker to ask a question about what was just said. This indicates that we have been listening and that the details are important to us. It is best to clarify when the person has finished a segment of the story and not to interrupt repeatedly to ask about details. Once a child begins to talk, it is best to allow him/her to continue without interruption.

SUMMARIZATION:

When a person has completed a statement, one can show interest by summarizing what has been said so far. The summary need not be long. Its purpose is to demonstrate to the child victim that one has been following what was said. For example, an officer might say to the child victim just mentioned, "Let me see if I understand...Your Mom was angry and hit you with a telephone cord."

CHILD PHYSICAL ABUSE AND NEGLECT
CRISIS INTERVENTION & INTERVIEWING
RECRUIT/FIRST RESPONDER
SPECIALIZED/INVESTIGATOR
HANDOUT #1 (5 OF 5)

ALLOWING SILENCE:

Paradoxically, allowing silence to last is a way of showing that one is listening. Child victims often need time to collect their thoughts. The officer who lets a silence last after a question is asked demonstrates to the victim an awareness of this fact. The tendency is to rephrase a question if it is not immediately answered, and this can often be confusing to child victim, especially if he/she is somewhat anxious that the police are going to be impatient.

Source: Adapted from Burgess, A.W., and Holmstrom, L.L., "Crisis and Counseling Requests of Rape Victims," Nursing Research, V. 23 N3, May - June 1974.

CHILD PHYSICAL ABUSE AND NEGLECT
INVESTIGATIVE STRATEGIES
RECRUIT/FIRST RESPONDER
SPECIALIZED/INVESTIGATOR

CHILD PHYSICAL ABUSE AND NEGLECT

INVESTIGATIVE STRATEGIES IN CHILD PHYSICAL ABUSE AND NEGELCT

This section will introduce the participants to guidelines for investigation and arrest in child physical abuse cases along with problems associated with interviewing offenders, adult family members, and children victims.

A prerequisite to this course is the Crisis Intervention module offered in the General Victimology course.

CHILD PHYSICAL ABUSE AND NEGLECT

LESSON PLAN WORKSHEET

LESSON TITLE: Investigative Strategies in Child Physical Abuse

FUNCTIONAL AREA: This section will focus on guidelines for investigation and arrest in child physical abuse cases along with problems associated with interviewing offenders, adult family members and child victims in such investigations.

PERFORMANCE OBJECTIVES: The participants, at the completion of this module will, without reference to notes:

1. List, verbally or in writing, two (2) problems commonly encountered in an interview with an offender or adult family member in cases of suspected child physical abuse.

2. List, verbally or in writing, two (2) strategies for an interview with parents in cases of suspected child physical abuse.

TOPICS:

I. The trainee should have a general understanding of Crisis Intervention as outlined in the Lesson Plan Worksheet for Crisis Intervention in the General Victimology course of the NASDLET National Victim Assistance Law Enforcement Training Manual.

II. There are five purposes of interviewing in child physical abuse cases:

   A. Assessment of danger to child and the need for protective custody.

B. Determination whether physical abuse or neglect is occurring.

C. Determination of appropriate response to situation (i.e. protective custody and/or arrest of caretakers).

D. Identification of abuser.

E. Protection of legal rights of suspects if arrest is being considered.

III. Three questions need to be immediately addressed by law enforcement officers conducting a child abuse and neglect investigation.

A. Is the child in immediate physical danger?

B. Does the child need protective custody?

- Refer to Handout's #1 & #2

C. Question of immediate legal action against the caretaker, i.e. arrest must be considered.

IV. Factors to consider for Probable Cause to Arrest in Child Physical Abuse Cases.

A. The Law Enforcement officer must consider the "elements of the crime" factor when investigating.

1. Was a crime committed and what was it?

2. The officer must be familiar with the state statutes applicable to child physical abuse cases.

B. Injury to the Child Victim

1. Severity of the Injury

a. Physical condition of the child victim

b. Child has a known history of child physical abuse

c. Collection of physical evidence

2. The characteristics of the injury provide signals for the officer (ie. cigarette burns, shape of an instrument implanted on skin).

C. Explanation of how the injury occurred is important in finding probable cause to arrest.

1. Responsible party must be identified.

2. The injury is inconsistent with the account given.

3. Vague or evasive attitude by caretaker.

4. Conflicting stories given by each caretaker and/or child victim.

D. Confession by a caretaker/offender is sufficient grounds for arrest.

E. Protection of Legal Rights of caretaker/offender during interviews.

-Note to Trainer: It is suggested each legal right be reviewed.

1. Fourth Amendment "unreasonable search and seizure".

2. Fifth Amendment forbids that an individual be compelled "to be a witness against himself".

3. Miranda rights should be given when appropriate.

- Refer to Handout #3

V. Strategies and Issues when interviewing in Child Physical Abuse Cases.

A. A child physical abuse and neglect initial interview should include three phases: preparing for the interview, conducting the interview, and assessment of functional capacities of the family in relation to allegations.

B. An officer, when possible, should prepare for the interview by reviewing the source of the child physical abuse and neglect allegation, and any other available written information about the case.

C. An interview with an adult or a child should be conducted in three phases: introduction, working phase, and conclusion.

D. Non-Verbal and Verbal Interviewing Techniques

- Refer to Handout #4

E. Some Law Enforcement officers do hospital interviews in the following manner:

1. Parent is interviewed before child is viewed by the officer.

2. The officer views the child after speaking with the parent. Through the officer's knowledge about injuries, target areas, etc., a determination can be made about the parent's information.

3. If necessary, interrogation of parents.

-Note to Trainer: It is recommended slides with specific injuries and angle of attacks be reviewed here with the class.

F. X-Ray Bone Surveys are necessary in all child physical abuse and neglect cases. Also, remember to interview all hospital staff who have been in contact with the child victim.

G. Age and development skills of the victim are important for the investigator to consider:

1. Can the child verbalize his/her experience?

2. What is the child capable of doing?

3. Does the injury represent something?

H. Assessment of functional capacities of the family in relation to allegations, may take several forms.

1. The investigator should watch for parents playing the "if you don't believe that, will you believe this?" "game".

2. Temporary measures, such as taking the child into protective custody.

3. Referral to a social service agency for treatment.

4. Arrest of caretaker.

5. Referral to court for judicial action.

- Refer to Handout #5.

VI. Problems encountered in interviewing adults in child physical abuse and neglect cases.

A. Hostility and defensiveness by caretakers

1. Many caretakers perceive police intervention in their home situation with anger and fear.

2. Acting in a violent or sexual way toward their children may force caretakers to review their own childhood, often causing them to relive negative experiences. The resultant confusion, hostility, anger, and guilt seriously impair their ability to respond cooperatively when openly confronted by their alleged current abusive behavior.

3. The investigator's approach to the caretakers is necessarily low key. However, a firm stand must be taken if there is no recognition of the seriousness of their actions. Remember, the family's cooperation can be of great assistance in planning for the child.

4. As difficult as it can be, the best course for the officer may be to "wait out the rage" of the caretaker and remain calm.

B. Parental consent to interview or view a child is not necessary if the law enforcement officer is officially investigating a criminal action. However, if a parent repeatedly refuses to allow the officer to interview the child, the officer should proceed to the local court house to begin warrant proceedings.

C. One caretaker is often afraid to discuss the matter in the presence of the other caretaker. Reasons for this include: fear of retaliation, guilt, or fear for child's safety after the police have gone.

D. The dual role of conducting a criminal investigation and initiating non-punitive responses can be a difficult position to be placed in.

E. False Reports - Reports from estranged spouses, neighbors, and anonymous sources will sometimes be found to be untrue., The most diplomatic course is to explain the responsibilities of the state with regard to child abuse allegations and the need to determine the truth of each report it receives.

F. Discipline: Where does discipline end and physical abuse begin?

- Note to Trainer: It is recommended this section be done as a class group exercise.

1. Is the purpose of the discipline to correct the child's behavior, or primarily to punish or hurt?

2. Is the discipline appropriate to the child's age?

3. Is the discipline appropriate to the child's condition?

4. Is the discipline appropriate to the child's transgression (does the punishment fit the crime)?

5. When physical force is used as a disciplinary measure, is the force applied in a safe location (i.e. buttocks) or an unsafe location (i.e. head)?

- Refer to Handout #6

VII. Conduct a mock interview exercise (see suggested exercise) and have the class critique the interview. Video tape the interview, if possible.

METHODS:

- Lecture
- Group Discussion
- Mock Interview

RESOURCE MATERIALS:

- Lesson Plan
- Course Handouts
- Interview Guide,
- Easel/Blackboard
- Video Equipment (optional)
- Topical Bibliography

TIME REQUIREMENTS:

- Three Hours

CHILD PHYSICAL ABUSE AND NEGLECT

TOPICAL BIBLIOGRAPHY

Topic I - Crisis Intervention

NASDLET, National Victim Assistance Law Enforcement Trainer's Manual, 1985.

Warner, C.G. ed., Conflict Intervention in Social and Domestic Violence. Bowie, Maryland: Robert J. Brady Co., Chapters 10 and 13, 1981.

Topic II - Purpose of Interview

Broadhurst, D.D. and Knoeller, J.S., The Role of Law Enforcement in the Prevention and Treatment of Child Abuse and Neglect. Washington, D.C.: U.S. Department of Health, Education and Welfare, DHEW Publication No. (OHDS) 79-30193, pp. 34-43, August 1979.

McGovern, James I., "Delicate Inquiry: The Investigator's Role in Child Abuse", Victimology: An International Journal, Volume 2, Number 2, pp. 277-284, Summer 1977.

Topics III & IV - Protective Custody Decisions and Guidelines for Arrest

Broadhurst, D.D. and Knoeller, J.S. The Role of Law Enforcement in the Prevention and Treatment of Child Abuse and Neglect. Washington, D.C.: U.S. Department of Health, Education and Welfare, DHEW Publication No. (OHDS) 79-30193, pp. 45-49, August 1979.

McGovern, James I. "Delicate Inquire: The Investigator's Role in Child Abuse", Victimology: An International Journal, Volume 2, Number 2, pp. 277-284, Summer 1977.

Topic V - Effective Investigation

Broadhurst, D.D. and Knoeller, J.S. The Role of Law Enforcement in the Prevention and Treatment of Child Abuse and Neglect. Washington, D.C.: U.S. Department of Health, Education and Welfare, DHEW Publication No. (OHDS) 79-30193, pp. 34-39, August 1979.

International Association of Chiefs of Police, "The Training Keys", Professional Standards Division.

Topics VI - Problems Encountered in Interviewing Child Physical Abuse and Neglect Cases

Broadhurst, D.D. and Knoeller, J.S., The Role of Law Enforcement in the Prevention and Treatment of Child Abuse and Neglect. Washington, D.C.: U.S. Department of Health, Education and Welfare, DHEW Publication No. (OHDS) 79-30193, pp. 34-53, August 1979.

Warner, C.G. ed., Conflict Intervention in Social and Domestic Violence. Bowie, Maryland: Robert J. Brady Co., Chapter 13, 1981.

CHILD PHYSICAL ABUSE AND NEGLECT
INVESTIGATIVE STRATEGIES
RECRUIT/FIRST RESPONDER
SPECIALIZED/INVESTIGATOR
HANDOUT #1

GUIDELINES THAT MAY DETERMINE WHETHER PROTECTIVE CUSTODY IS INDICATED

1. The maltreatment in the home, present or potential, is such that a child could suffer damage to body or mind if left there. Caretakers' anger at the investigation must be considered (i.e. will the caretakers take their anger out on the child after the officer leaves?).

2. Although a child is in imminent need of medical or psychiatric care, the caretakers refuse to obtain it.

3. A child's age, physical, or mental condition makes self-protection impossible.

4. The child has some characteristics that the caretakers find completely intolerable.

5. The caretakers are torturing the child or resorting to physical force too severe to be considered reasonable discipline.

6. The physical environment of the home is an immediate threat to the child.

7. The caretakers physical or mental condition poses a threat to the child.

8. The family has a history of hiding the child from outsiders.

9. The family has a history of prior incidents or allegations of abuse and neglect.

10. Caretakers abandon the child.

Source: Broadhurst, D.D. and Knoeller, J.S., The Role of Law Enforcement in the Prevention and Treatment of Child Abuse and Neglect. Washington, D.C.: U.S. Department of Health, Education and Welfare. DHEW Publication No. (OHDS) 79-30193, August 1979.

CHILD PHYSICAL ABUSE AND NEGLECT
INVESTIGATIVE STRATEGIES
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HANDOUT #2

Physical Injuries

Guidelines for Identifying the Abused Child

- *Where is the injury? Is this type of injury what one expects for the child's age group?* Bruises on a preschooler found on the elbows, knees, shins, and forehead are considered normal for his age group. Bruises on the back, thighs, genital area, buttocks, back of the legs, or face should make one suspicious.
- *How many injuries does the child have? Are there several injuries occurring at one time? Or several injuries over a period of time?* The greater the number of injuries, the more likely abuse has occurred. The presence of many injuries at various stages of healing should make one suspicious.
- *What are the size and the shape of the injury?* Many injuries are inflicted with familiar objects: a stick, a board, a belt, a hair brush. A stick or a rope could cause a bruise in a straight line. A bruise might resemble the shape of a belt buckle or a hair brush or a looped electric wire. A small round burn could have been caused by a cigarette or cigarette lighter. Bruised or infected lips or chipped teeth on a small child may indicate forced feeding.
- *How did the injury occur?* If an injury is said to be accidental, there should be a reasonable explanation of how it happened, its severity, type, and location. When the history of how the injury occurred and the appearance of the injury do not seem related, one should be suspicious. Could a fall on the head have produced bruises all over the body? In view of the child's age, is the explanation reasonable?

IF THERE IS REASON TO SUSPECT ABUSE, IT SHOULD BE REPORTED.

Source: Child Abuse and Exploitation Investigative Techniques Training Program Manual, Department of the Treasury, Federal Law Enforcement Training Center, Glynco, Georgia, February 1985.

CHILD PHYSICAL ABUSE AND NEGLECT
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SPECIALIZED/INVESTIGATOR
HANDOUT #3

FACTORS TO CONSIDER FOR PROBABLE CAUSE TO ARREST IN CHILD PHYSICAL ABUSE CASES

A. Elements of the Crime.

1. What crime was committed?
2. Knowledge of state statutes applicable to child physical abuse is necessary.

B. Injury to the Child Victim.

1. Severity
2. Characteristics of the Injury.

C. Explanation of how the injury occurred.

1. Identification of responsible party.
2. Injury inconsistent with the account given.
3. Vague or evasive attitude by caretaker.
4. Conflicting stories.

D. Confession by a Caretaker/Offender.

E. Protection of Legal Rights of Caretaker/Offender.

CHILD PHYSICAL ABUSE AND NEGLECT
INVESTIGATIVE STRATEGIES
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HANDOUT #4

NON-VERBAL AND VERBAL INTERVIEWING TECHNIQUES WITH ADULTS

Non-Verbal Techniques that Assist in Interviewing:

1. Eye Contact. The officer who keeps looking directly at an individual's eyes will eventually establish contact. Direct eye contact is important for communicating to the victim that one is listening and concerned.

2. Body Posture. When interviewing victims, it is a good idea to monitor one's body posture to determine what is being communicated. For example, leaning towards the victim during the interview will indicate attentiveness, while holding your head upright and sitting rigid indicates impersonality.

3. Personal Distance. Generally, the closer one stands the more one expresses intimacy. The greater the distance, the greater the feeling of formality. A middle area, comfortable stance is recommended in Child Physical Abuse and Neglect Cases.

Verbal Techniques that Assist in Interviewing:

1. Vocalization. This term refers to the volume, speed, and pacing of speech. It is a good idea to speak to victims in a soft and slow voice, while allowing a few seconds to lapse between questions. Pacing questions slowly gives an impression of patience and concern.

2. Clarification. We clarify when we interrupt the speaker to ask a question about what was just said. This indicates that we have been listening and that the details are important to us. It is best to clarify when the person has finished a segment of the story and not to interrupt repeatedly to ask about details. For example, when a burglary victim has finished telling about finding the door open and is ready to begin describing what has been stolen, one might clarify by asking, "I didn't get about what time this was?"

3. Summarization. When a person has completed a statement, one can show interest by summarizing what has been said so far. The summary need not be long. Its purpose is to demonstrate to the victim that the interviewer has been following what was said. For example, an officer might say to the hypothetical burglary victim just mentioned, "Let me see if I have this straight...You came home from work about five and found the glass broken on the window and evidence that

that the heart of it?"

CHILD PHYSICAL ABUSE AND NEGLECT
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HANDOUT #4 (2 of 2)

4. Allowing Silence. Paradoxically, allowing silence to last is a way of showing that one is listening. Victims often are confused and need time to collect their thoughts. The officer who lets a silence last after a question is asked, demonstrates to the victim an awareness of this fact. The tendency is to rephrase a question if it is not immediately answered, and this can often be confusing to a victim, especially if he or she is somewhat anxious that the police are going to be impatient.

Source: Abstracted from Broadhurst, D.D., and Knoeller, J.S. The Role of Law Enforcement in the Prevention and Treatment of Child Abuse and Neglect. Washington, D.C.: U.S. Department of Health, Education an Welfare, DHEW Publication No. ' (OHDS) 79-30193, August, 1979 and Burgess, .W. and Holmstrom, L.L. "Crisis and Counseling Requests of Rape Victims," Nursing Research, V.23, No 3, May-June 1974.

CHILD PHYSICAL ABUSE AND NEGLECT
INVESTIGATIVE STRATEGIES
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HANDOUT #5

OBSERVATIONS IN THE HOME

SAMPLE INDICATORS FOR LAW ENFORCEMENT PERSONNEL

A. Non-Emergency Case

1. Observe the physical condition of the child.
2. Consider the attitude of the caretakers toward him.
3. Consider the child's general environment including living conditions and health and moral hazards.
4. Interview all parties involved including companions, child caretakers, neighbors, relatives and friends.
5. Check records of caretakers for previous child abuse involvement.
6. Check child's medical history for previous indications of abuse. This may require an inquiry to area hospitals and doctors, as well as determination that old and or repeated injuries are in different stages of healing.
7. Evaluate evidence of the abuse to determine if it may continue and endanger the safety of the child.
8. Record the incident fully and forward the report to the appropriate social agency.

B. Emergency Case

1. Remove child from home if he is endangered.
2. Ensure that injured child receives immediate medical attention.
3. Photograph injuries.
4. Write complete report of injuries including physician's remarks.
5. Collect physical evidence such as instrument used to inflict injuries.
6. Resume normal investigative actions as outlined in non-emergency cases after the emergency conditions have been met.
7. Also, check child's medical history for previous indications of abuse.

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HANDOUT #5 (2 of 4)

C. Indicators that should arouse the suspicious on law enforcement personnel.

1. The injury to the child is inconsistent with the account given by the caretaker. An example would be a report of a child's hand being accidentaly scalded by hot water and lacking from the report is any explanation of why the child did not withdraw his hand from the water before it was severely injured. In an instance like this, it is reasonable to suspect that someone held the child's hand in the water.

2. Certain characteristic of injuries provide signals to the officer, such as cigarette burns, the shape of an instrument imprinted on the skin or distended fingers and limbs.

3. Attitude of the caretaker may arouse suspicions. The caretaker may be purposely vague or evasive or may not volunteer any information.

4. Abusive caretakers often take the child to many different physicians for treatment. If the abused child has been taken to a hospital or physician located far from his house, this could be an indicator of abuse.

5. The child's behavior may also arouse suspicions. Statistically, the vast majority of abused children are under three years old. Nearly half of all reported cases involve children under six months old. Abused or neglected children of this age seldom cry. When they do, it is a hopeless, mournful sound that merely accompanies pain ans sorrow. The cry is not urgent. It contains no expectation of comfort and relief. Abused children may also be wary of physical contact with adults. Sometimes the child will exhibit extreme fright, reacting to any physical contact with whimpering or with attempts to hide. Others show extreme apathy and unresponsiveness.

D. Questions to ask in determining where discipline ends and physical abuse begins.

1. Is the purpose of the discipline to correct the child's behavior, or primarily to punish or hurt?

2. Is the discipline appropriate to the child's age?

3. Is the discipline appropriate to the child's condition?

4. Is the discipline appropriate to the child's transgression (does the "punishment fit the crime")?

5. When physical force is used as a disciplinary measure, is the force applied in a safe location (i.e., buttocks) or an unsafe location (i.e., head)?

Note: Sample indicators of living conditions, health hazards and emotional hazards are noted because law enforcement officers statutorily are mandated reporters of suspected child physical abuse which they may view when answering any routine call.

E. Living Conditions

Officers should consider the child's complete ENVIRONMENT and make particular effort to avoid associating low income as being synonymous with neglect.

1. Burned-out or condemmed buildings should be regarded as unsafe housing.

2. Unsanitary conditions, such as human and animal waste on the floors, are indicative of neglect.

3. Lack of heat in the house during winter months is neglect.

4. Danger of fire from open heating units such as buckets or burning wood or coal should be considered as unsafe conditions.

5. Children sleeping on cold floors or in beds that are dirty, soiled, and wet with human waste are neglected.

6. Infestation of rodents (rats and mice) demonstrates neglected homes.

F. Health Hazards

1. Malnutrition of children is indicated by their being underweight and small in stature.

2. Although failure to thrive and grow can be due to a number of medical conditions, most neglected children will appear obviously undernourished. When undernourishment is considered in light of the environment, it indicates parental neglect.

3. Officers should also be aware of the condition of the food in the house. If there is not any food for the children to eat, or if the food has spoiled, it indicates neglect.

4. The child's failing to thrive may be due to a legitimate medical condition that a doctor is attempting to cure.

5. Neglected children will not be receiving doctor's care.

G. Emotional Hazards

1. Children who are continually exposed to vice conditions (such as prostitution or stealing) are considered to be neglected.

2. They may be subject to sexual assault by patrons of prostitute mothers.

3. They may be beaten or maltreated by alcoholic or drug-addicted parents.

4. They may suffer emotionally from family discord.

5. They may lack proper supervision, resulting in school truancy.

SOURCE: Abstracted from "The Training Keys", Professional Standards Division of the International Association of Chiefs of Police and Broadhurst, D.D. and Knoeller, J.S., The Role of Law Enforcement in the Prevention and Treatment of Child Abuse and Neglect. Washington, D.C.: U.S. Department of Health, Education and Welfare, DHEW Publication No. (OHDS) 79-30193, August 1979.

CHILD PHYSICAL ABUSE AND NEGLECT
INVESTIGATIVE STRATEGIES
RECRUIT/FIRST RESPONDER
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HANDOUT #6

SUGGESTED INTERVIEW EXERCISE

THE PURPOSE OF THE INTERVIEW EXERCISE IS TO ASSIST THE PARTICIPANTS IN USING THE SUGGESTED INTERVIEW GUIDE EFFECTIVELY.

FOUR PARTICIPANTS ARE NEEDED TO PLAY THE FOLLOWING ROLES:

THE LAW ENFORCEMENT INVESTIGATOR

THE FEMALE CARETAKER, MRS. C

THE MALE CARETAKER, MR. C

THE CHILD VICTIM, TOMMY C

SITUATION: IT IS 10:00 A.M. ON A MONDAY MORNING AND THE LAW ENFORCEMENT INVESTIGATOR ARRIVES AT THE C'S HOME TO INVESTIGATE AN ANONYMOUS REPORT, EARLIER THAT MORNING, ALLEGING THAT TOMMY C IS BEATEN REGULARLY WITH AN EXTENSION CORD.

THE INVESTIGATOR WILL MEET THE FAMILY TOGETHER AND INTERVIEW EACH SEPARETELY FOR FIVE MINUTES.

NOTE TO THE TRAINER: IT IS SUGGESTED THE TRAINER STRUCTURE THE EXERCISE BY PICKING WHO WILL PARTICIPATE.

FOLLOWING THE INTERVIEWS THERE WILL BE CLASS DISCUSSION AND QUESTIONS.

SUGGESTED TIME: TWENTY FIVE MINUTES

NOTE: IF LOCAL STATUTE OR POLICY REQUIRES CHILD ABUSE/NEGLECT INTERVIEWS TO BE DONE JOINTLY WITH A SOCIAL WORKER, ADD THE ROLE OF SOCIAL WORKER.

CHILD PHYSICAL ABUSE AND NEGLECT
CHILD VICTIM SERVICES AND THE LAW
RECRUIT/FIRST RESPONDER
SPECIALIZED/INVESTIGATOR

CHILD PHYSICAL ABUSE AND NEGLECT

CHILD VICTIM SERVICES AND THE LAW

This module will discuss with the participants local statutory provisions regarding child physical abuse and neglect, and the role of law enforcement officers in the civil and criminal litigation of child physical abuse and neglect cases. Prosecutorial procedures will also be addressed.

CHILD PHYSICAL ABUSE AND NEGLECT

LESSON PLAN WORKSHEET

LESSON TITLE: Child Victim Services and the Law

FUNCTIONAL AREA: This module will discuss local statutory provisions regarding child physical abuse and neglect, and the role of law enforcement officers in the civil and criminal litigation of child physical abuse and neglect cases. Prosecutorial procedures will also be addressed.

PERFORMANCE OBJECTIVES: The participants, at the completion of this module will, without reference to notes:

1. Define, in writing, "abuse and neglect" under the terms of the state statute.
2. Discuss, verbally with the class, the provisions and procedures of the mandatory child abuse reporting statute, with emphasis on the reporting procedures.
3. Discuss, verbally with the class, three possible legal defenses used in child physical abuse and neglect cases.

TOPICS:

I. Every state in the nation has a child abuse mandatory reporting statute under which law enforcement officers are mandated reporters.

- Note to trainer: Provide copies of your state's mandatory reporting law and discuss its provisions.

II. Child protection orders are often used by judges to place children outside the home pending a child physical abuse and neglect investigation.

- Note to trainer: Determine local child protection order procedures and discuss with class.

III. Roles and Procedures of Civil Court and Criminal Court

A. The purpose of Civil Court (also referred to as Family Court) is protection of the child. Civil Procedures applicable to child physical abuse and neglect cases include mandatory reporting, child protection petitions, preliminary protection orders, final protection orders, enforcement of custody orders and interim care.

- Note to trainer: Determine the civil procedures applicable to child physical abuse and neglect cases in your state. Provide copies of the procedures to each participant.

1. A matter may proceed through both criminal court and civil court simultaneously. Procedures, Rules of Evidence and Standard of Proof are different in each court and while a criminal complaint may not result in a conviction, a civil procedure may result in obtaining help for the child victim.

2. The standard of proof is "Preponderance of Evidence" in a civil court proceeding and "Beyond a Reasonable Doubt" for a criminal proceeding.

a. A family court judge can order an emergency removal of the child from the home. However, a police officer can also remove the child if there appears to be imminent danger to the child. (Note: An authorized police officer acting in the good faith performance of his regular duties is immune from civil liability in removing an at risk child).

b. Family court testimony should be protected as it <u>MAY</u> be used as impeachment material in a subsequent criminal action.

c. Always alert the District Attorney if you have been subpoenaed to testify in Family Court. This keeps the District Attorney abreast of all aspects of the case and possible additional evidence.

B. The purpose of Criminal Court is prosecution of the offender and all Rules of Evidence apply. Criminal Procedures applicable to child physical abuse and neglect cases include kidnapping and criminal threatening, terrorizing, criminal restraint, criminal restraint by parent, abandonment of child, endangering the welfare of a child, or endangering the welfare of an incompetent person.

- Note to trainer: Determine the criminal procedures applicable to child physical abuse and neglect cases in your state. Provide copies of criminal statutes to each participant.

IV. Prosecutorial Procedures and Issues

A. Local prosecutorial procedures in prosecuting child physical abuse and neglect cases is important for law enforcement officers to know so they can conduct an effective investigation of child physical abuse and neglect cases. It is important for the law enforcement community and the prosecutor's office to work together in handling child physical abuse and neglect cases.

B. Right to Counsel

1. In many states (i.e. New York State), once an attorney has entered the scene, whether directly or indirectly, the right to counsel attaches.

a. An attorney enters the scene if defendant asks for one or an attorney calls in stating he represents the defendant.

b. Any statements taken subsequent to this point are inadmissible on the People's direct case, but may be used for impeachement purposes.

2. Once a warrant has been issued the right to counsel attaches and there can be no interrogation upon arrest without the presence of an attorney or the expressed waiver of the attorney by the defendant.

C. Co-Defendants

1. If there are two suspects, separate them during questioning, each may implicate the other.

2. As a point of information, under Burton v U.S., their trials must be severed if they cross implicate each other. It is the prosecuting attorney's descision to motion for severance.

D. Possible Defenses

1. The prosecution must prove the defendant INTENDED to cause injury to the child victim.

2. Quite often a defendant will allege that he or she was intoxicated as a result of alcohol or drugs. These defenses are often alleged to negative intent; be aware of the smell of alcoholic beverages, pills, marijuana, etc.

4. Be ready to rebut the defense of accidental injury's with specific measurements, photographs, lab tests, physical evidence.

5. It is not unusual for the abuser to say other children are responsible for the injury; speak to those children immediately.

6. If a child victim dies, caretakers often blame hospital malpractice. The offender may admit to the assault but not to a homicide.

7. Pre-Menstrual Stress Syndrome

E. Child Witness

1. It is important for the participants to be aware of local legislation and court policies regarding competency of a child victim to testify because child witnesses testimony may be the most important factor in a criminal or civil procedure.

2. Children and the Court

   a. Children's abilities to cope with the judicial process vary depending on age, circumstances and what their conceptions of the court process are (i.e. through TV; only men are judges, etc.).

   b. Children often fear facing the defendants.

   c. Children may be overwhelmed by certain aspects of the courtroom (i.e. the judge, the witness stand, strange people asking questions of them).

   d. Children feel anxiety over having to repeat their stories so many times.

   e. Children often feel they are in court because they have done something wrong and are being punished.

   f. Children often feel no one will believe them.

3. State competency standards may be found in state laws, court rules of evidence or codified rules of evidence. In order to assess the local current status of children as witnesses, consult the sources stated above.

4. Evaluation of a child's ability to testify is judged on several factors, including:

   - Capacity for truthfulness;
   - Mental Capacity;
   - Memory; and
   - Ability to communicate.

5. Attempts are being made to avoid direct confrontation between child victims and criminal dependents who are often a relative or friend of the family. This is being done to help alleviate much of the stress a child witness feels about going to court.

   a. Use of Closed Circuit Television

   b. Contact as a requirement of confrontation with accuser is an unsettled legal issue.

6. The use of video taped testimony is now being used in many courtroom procedures.

   a. Videotaping Child's First Statement

   b. Videotaping Testimony

   c. Legal Questions

      i. Hearing evidence issues

      ii. Violation of fundamental constitutional rights including: those of presence, confrontation, public trial, jury trail, and fair trial.

   d. Reasons <u>in favor</u> of videotaping a child victim's first statement include:

      -The child's memory is vivid and he/she can describe the incident in detail.

      -In family cases, the family often pressures a child to retract stories.

      -It may help reduce the number of interviews.

      -Many states permit hearsay at preliminary or grand jury hearings and a video tape could preclude the need for a child to testify.

   e. Reasons <u>against</u> videotaping a child victim's first statement include:

- First interviews are often not productive and child victims often have to be interviewed several times so a detailed statement can be made.

- If child victims expand their story, a pre-recorded first statement could be used to impeach the child.

- Any discrepencies between the first and subsequent statements may be exculpatory.

f. Reasons in favor of videotaping trial testimony include:

- Allowance for a child to testify in a private setting without facing the defendant may decrease trauma for the child victim.

- In cases with multiple continuances, the videotaped testimony will prevent a child from having to appear in court repeatedly.

7. The use of audiotaped testimony is now being used in may courtroom procedures, especially where videotaped equipment is not available. Generally, reasons for and against audiotaping are the same as cited for videotaping.

8. Preparing the Child Witness

a. The fewer people who interview the child the better.

b. The most important criteria is to develop rapport with the child.

c. Conversation should be at the child's level and in his or her language.

d. During one of the meetings with the child victim; he/she should be made aware of the fact that what has happened is wrong. Victims must understand that no blame is being placed on them by anyone.

e. A child's attention span is generally limited to 15 minutes.

f. Do not take notes during the interview.

g. Interviewing a child victim is not a simple process at any age. Developmental age of child must be taken into consideration. The investigator may need to interview the child victim many times.

- Note to Trainer: Refer back to Interview Guide

- Note to Trainer: It is recommended that the local prosecutor be a guest speaker to answer any questions the trainees may have.

METHODS:

- Lecture
- Guest Speaker: It is recommended that the local prosecutor either team teach this module or be invited as a guest speaker.
- Group Discussion

RESOURCE MATERIALS:

- Lesson Plan
- Chalkboard
- Topical Bibliography
- Model Legislation

TIME REQUIREMENT

- Four Hours

CHILD PHYSICAL ABUSE AND NEGLECT

TOPICAL BIBLIOGRAPHY

Topic I - Local Mandatory Reporting Statue

Topic II - Local Child Protection Procedure

Topic III - Local civil and criminal procedures applicable to child abuse and neglect cases

Topic IV - Prosecutorial Procedures and Issues

Department of Treasury, Child Abuse and Exploitation Investigative Techniques Training Program Manual. Glynco, Georgia: Federal Law Enforcement Training Center, February 1985.

Hennepin County, Minnesota vs. Sullivan, Minnesota Court of Appeals, January 8, 1985.

Whitcomb, D., Shapiro, E.R., Stellwagen, L.D., When the Victim is a Child: Issues for Judges and Prosecutors (Draft Report). Cambridge, MA.: Abt Associates, Inc., pp. 14-17 , 27-35, 41-52, March 4, 1985.

CHILD PHYSICAL ABUSE AND NEGLECT
CHILD WELFARE SERVICES
RECRUIT/FIRST RESPONDER
SPECIALIZED/INVESTIGATOR

CHILD PHYSICAL ABUSE AND NEGLECT

CHILD WELFARE SERVICES

This section will give the participants an overview of the local child welfare service system as it relates to child physical abuse and neglect cases.

CHILD PHYSICAL ABUSE AND NEGLECT

LESSON PLAN WORKSHEET

LESSON TITLE: Child Welfare Services

FUNCTIONAL AREA: This section will give to the participants an overview of the local child welfare service system as it relates to child physical abuse and neglect cases.

PERFORMANCE OBJECTIVES: The participants, at the completion of this module will, without reference to notes:

1. Discuss verbally, with the class, the local services provided to child physical abuse and neglect cases by the child welfare system.

2. Explain, verbally or in writing, the difference between the social worker role and the law enforcement role in the assessment and treatment of child physical abuse and neglect cases.

3. Explain, verbally or in writing, how to make an appropriate agency referral.

TOPICS:

I. Organizational overview of the local Child Welfare Service System. In every state there exists a Child Welfare or Human Service agency that is primarily responsible for the detection, investigation, and provision of services to child physical abuse and neglect victims.

-Note to Trainer: It is recommended that a representative of your states Human Service agency address the class regarding the authority, responsibilities and scope of services of the agency in child physical abuse and neglect cases. A panel discussion format could also be used.

II. The role of the law enforcement officer in child physical abuse and neglect cases can vary from mandatory reporting, detection, and criminal investigation agreements with the local Human Services department.

-Note to trainer: Determine local law enforcement policies and discuss with the trainees.

III. The role of a social worker/protective service worker is primarily to see the appropriate treatment and/or placement is provided to the child and family.

-Note to trainer: It is recommended that a representative from the local social service agency address the class about the social worker's role.

IV. How the law enforcement officer can make a community referral.

A. The officer should listen to the victim's request and immediately respond to that request (i.e. social services, court information, or medical needs).

B. The officer must identify the specific need of the victim and decide which of the available agencies is best suited to fill that need (i.e. local social service office, Court District Attorney's office or probation office, or local hospital).

C. Steps in making a referral to resources available to law enforcement:

1. The name, location, telephone number, and range of services offered by a particular agency is necessary to know.

2. Referral procedures or the procedures that the individual must preform in order to obtain the services should be clearly delineated.

3. The officer should bring the victim to the referral agency, if appropriate.

V. Panel discussion with local professionals on the practical usage of the Child Welfare System and interdisciplinary agencies.

VI. The National Center of Child Abuse and Neglect (PO Box 1182, Washington D.C. 20013, Telephone (301)-251-5157) provides consulting and information to public and private agencies, volunteer groups and interested citizens about the prevention and treatment of child abuse and neglect.

The National Victims Resource Center Office for Victims of Crime, Office of Justice programs, U.S. Department of Justice, Washington, D.C. 20531, Telephone (202)-724-6134) also provides consulting and information.

METHODS:

- Lecture
- Group Discussion
- Guest Speaker: It is recommended that a representative from the local social service agency address the class about the social worker's role.
- Panel Discussion by local professionals on the practical usage of the local child welfare system and interdisciplinary agencies.

RESOURCE MATERIALS:

- Lesson Plan
- Easel/Blackboard
- Topical Bibliography

TIME REQUIREMENTS:

- Three Hours

CHILD PHYSICAL ABUSE AND NEGLECT

TOPICAL BIBLIOGRAPHY

Topics I - VI - Overview on Child Welfare Services in Child Physical Abuse Cases

Attorney General's Task Force on Family Violence, Final Report, pp. 105-113, p. 121-126, September 1984.

Local State Statistics on reported Child Physical Abuse and Neglect cases.

Written material from Local Child Welfare Agency.

CHILD PHYSICAL ABUSE AND NEGLECT
MEDICAL ISSUES
RECRUIT/FIRST RESPONDER
SPECIALIZED/INVESTIGATOR

CHILD PHYSICAL ABUSE AND NEGLECT

MEDICAL ISSUES AND THE CHILD VICTIM

This module will introduce participants to a discussion of the medical issues involved in child physical abuse cases. Relevant physical examination and forensic issues are also addressed.

CHILD PHYSICAL ABUSE AND NEGLECT

LESSON PLAN WORKSHEET

LESSON TITLE: Medical Issues and the Child Victim

FUNCTIONAL AREA: This module will introduce participants to a discussion of the medical issues involved in child physical abuse cases. Relevant physical examination and forensic issues are also addressed.

PERFORMANCE OBJECTIVES: Trainees, at the completion of this module, will:

1. Identify, characteristics of injuries and wounds sustained by victims of child physical abuse.

2. List, in writing, the local hospital's policy and procedures with regard to child physical abuse cases.

TOPICS:

I. Introduction and Overview

A. Physicians are not responsible for investigating child physical abuse and neglect case cases, but they are responsible for discussing the medical information with the investigating officer. Therefore, it is essential for the law enforcement officer to be aware of medical issues involved when investigating child physical abuse, since physicians can make a medical diagnosis of of physical abuse by observing the pattern of inflicted injuries.

B. It is important to note that most physicians and/or pediatricians are not adequately trained in child physical abuse. Doctors who are not experts in this area can poorly influence a case and/or misdiagnose cases.

C. Historically, the medical community became involved in diagnosing child physical abuse cases when in 1946, Dr. Cafeey identified subdural hematoma's (hemorrhages of the brain) as being associated with child physical abuse. In 1961, Dr. Henry Kempe presented his Battered Child Syndrome theory which developed into a national concern over child physical abuse.

D. The officer must determine what hospital policies are in place locally regarding child physical abuse and neglect victims.

E. Officers should have some working knowledge of specialized medical units operating in their local area (i.e. burn units, bone specialists) as they may be working with some severe cases of child physical abuse.

-Note to trainer: A list of local hospitals and specialized medical units should be compiled and given as a handout.

F. In rural communities, officers should be familiar with practicing pediatricians in the area who are trained experts in the area of child physical abuse and neglect.

G. It is important to keep open communication channels with medical personnel. Open communication may have a positive influence on a doctor or nurse's cooperation in testifying in court on a particular case.

II. The Medical Exam of the Physically Abused and Neglected Child

A. Most infant deaths that occur before age one are attributed to Sudden Infant Death Syndrome (SIDS). Most infant deaths that occur after age one are attributed to trauma.

1. Nationally, most child phyical abuse deaths are caused by head injuries.

2. Nationally, the second cause of child phyical abuse deaths is trauma to the abdominal area (i.e. lacerations of the liver and spleen).

B. Physical Indicators of Child Physical Abuse and Neglect

-Note to trainer: It is highly recommended that the remainder of this module be taught by a doctor or law enforcement officer specifically trained in identifying child physical abuse and neglect cases.
-Note to trainer: It is highly recommended that slides be used for this presentation. A list of available material is attached.

The discussion of physical indicators of child phyical abuse and neglect should include the following:

1. Specific injuries such as bruises, welts, lacerations, bite marks, and abrasions.

2. Unexpalined fractures to skull, nose, and facial structure;

   a. Fractures in various stages of healing

   b. Multiple or spiral fractures

   c. OSTEOGENESIS IMPERFECTA - multiple bone fractures which generally cause infant death;

3. Wet burns versus dry burns - lines of immersion and splash marks should be discussed;

4. Accidental explantion of hair TOURNIQUET verus the abusive use of;

5. Raccoon eyes caused by severe blows to the top or back of the head;

6. Visceral organ damages;

7. Severely shaken babies may have no obvious bruising, but may have fractures at the tips of bones with calcium deposits. There also may be bleeding into the brain;

8. Mongoloid spots are birth marks often mistaken for briuses;

9. Specific physical neglect injuries include severe malnutrition and diaper rash.

III. Focus and Angle of Attack of Physical Injuries

A. Flexible versus rigid objects used in harming a child should be discussed. By identifying what type of instrument injured the child, most often the specific angle of how the instrument was used can also be determined.

a. The most common weapon used to physically injure a child is the hand.

b. Common household instruments are also used, such as belts, electrical cords, and coat hangers.

c. Closed loop and wraparound patterns can be identified by observing an injury.

B. Control type injuries such as grab marks or bite marks are easy to miss in a physical examination. These marks are henerally under the arms, on ear lobes or on the back of the neck and are caused by the abuser who is trying to control a child's behavior during punishment.

C. Defense wounds are injuries in an area other than point of attack, caused when a child attempts to defend himself/herself from attack. One common place for defense wounds is the back of the arms.

IV. Forensic Issues in Cases of Child Physical Abuse and Neglect

A. X-Ray surveys are a necessity in many child physical abuse and neglect cases and a total body survey should be completed. X-Rays can give valuable information to officers, such as date of injury, post injuries and phases of bone healing.

B. Color photographs are the state of the art techniques in child physical abuse and neglect investigations. Photographs are helpful in determing stages of injury healing. The officer should determine if the local court accepts color photopgraphs. When using color photographs it is essential to record the date and time of the photograph on the front or back of the photograph.

C. The officer must receive copies of all medical reports. The accurate interpretation of medical reports can help solve the case.

1. An expert witness (i.e. medical examiner, physician; nurse, etc.) may state his opinion as to relevant matters and may draw conclusions from the facts which are helpful in a trial. However, a physician who is not an expert in child physical abuse can badly damage a case.

2. Parts of the medical record are exceptions to the Hearsay Rule.

a. Statements made by a patient to medical personnel, influencing treatment.

b. Statements made by a patient to medical personnel regarding medical history.

c. Business records of any oragnization, for profit or not for profit, including hospital records.

Uniform Rule 803 (4) Federal Rules of Evidence and Uniform Rule 806 Federal Rules of Evidence.

- Note to trainer: Refer to the Adult Sexual Assault Investigation lesson plan worksheet which discusses the Hearsay Rule.

D. It is suggested that officers who will be working with child physical abuse and neglect cases on a regular basis obtain use of a medical dictionary.

METHODS:

- Lecture
- Guest Speaker: It is highly recommended that this module be taught with a physician specifically trained in identifying child physical abuse and neglect cases.
- Group Discussion
- Slide Presentation

RESOURCE MATERIALS:

- Lesson Plan
- Slide Projector and Screen
- Lesson Plan
- Slide Projector and Screen
- Medical Dictionary
- Handout - List of local hospitals and specialized medical units (to be developed by trainer)
- Sample - Hospital policy and procedure for child physical abuse and neglect cases
- Sample - Hospital data sheet for suspected child abuse
- Handout - Child physcial abuse educational material

TIME REQUIREMENT:

- Three and One Half Hours

CHILD PHYSICAL ABUSE AND NEGLECT

TOPICAL BIBLIOGRAPHY

MEDICAL ISSUES AND THE CHILD VICTIM

RECRUIT/FIRST RESPONDER AND SPECIALIZED INVESTIGATOR

Topic I - Introduction and Overview

Helfer, R.E. and Kempe, C.H. Child Abuse and Neglect: The Family and the Community. Cambridge, Ma.: Ballinger Publications, Chapters 1-3, 1976

Helfer, R.E. and Kempe, C.H., eds. The Battered Child. Chicago, Illinois: University of Chicago Press, 1974.

List of local hospitals and specialized medical units. Local hospital policy and procedure for child physical abuse and neglect cases.

Sample hospital data sheet for suspected child physical abuse cases. Taken from Mid-Maine Medical Center, Waterville, Maine, Policy No. 10-2, 115-712, Revised 9/84.

Sample hospital policy and procedure for child abuse cases. Taken from Mid-Maine Medical Center, Waterville, Maine, Policy No. 10-2, 115-712, Revised 9/84.

Topic II - The Medical Exam of the Physically Abused Child

Broadhurst, D.D. and knoeller, J.S., The Role of Law Enforcement in the Prevention and Treatment of Child ABuse and Neglect. Washington, D.C.: U.S. Department of Health, Education and Welfare, DHEW Publication No. (OHDS) 79-30193, August, 1979.

Topic II (con't) -

McNeese, M.C. and Hebeler, J.R., "The Abused Child - A Clinical Approach to Identification and Management,: Clinical Symposia, V29, N5, 1977.

Topic III - Focus and Angle of Attack of Physical Injuries

Child Abuse and Exploitation Investigative Techniques Training Program Manual, Department of the Treasury, Federal Law Enforcement Training Center, Glynco, Georgia, February 1985.

Topic IV -

Kanda, M., Thomas, J.N., Lloyd D., "The Role of Forensic Evidence in Child Abuse and Neglect", The American Journal of Forensic Medicine and Pathology, Vol. 6, No.1, pp. 7-15, March 1985.

McKean, Thomas and Laszlo, Anna, "The Documentation of Subjective Data in Medical Records," Medical Trial Techniques Quarterly, September 1979.

Uniform Rules 803 (4) and 806, Federal Rules of Evidence.

CHILD PHYSICAL ABUSE EDUCATIONAL MATERIAL

1. Ciba Child Abuse Slides

   From:

   Medical Education Division
   CIBA Pharmaceutical Company
   Summit, New Jersey 07901
   (201) 575-6510

2. Child Abuse/Neglect
   The Visual Diagnosis
   of Non-Accidental Trauma
   and Failure to Thrive (slides)

   From:

   American Academy of Pediatrics
   Publications Department
   P.O. Box 1034
   Evanston, IL 60204

3. Child Abuse: The Silent Epidemic (slides)

   Call Toll Free:

   US: 1-800-841-9532
   LA: 1-504-821-4922

   Syndistar, Inc.
   1424 S. Jeff Davis Parkway
   New Orleans, Louisiana 70125

4. Child Abuse: Physical and Behavioral Indicators
   (28 minute color video cassette)
   Media Library
   University of Michigan
   R440 Kresgel, Box 56
   Ann Arbor, MI 48109
   (313) 763-2074

SAMPLE HOSPITAL DATA SHEET FOR SUSPECTED CHILD ABUSE CASES

SUSPECTED CHILD ABUSE DATA SHEET

1. a) Physician involved in the ER _____
NAME DATE TIME

   b) Pediatrician _____
NAME DATE TIME

2. a) Notify Social Worker on-call _____
NAME DATE TIME

   b) Social Worker following case _____
NAME DATE TIME

3. Notify Administrator on-Call _____
NAME DATE TIME

4. After interdisciplinary assessment the Social Worker will, as appropriate, notify immediately the State Department of Human Services.
_____
NAME DATE TIME

5. Case summation written within 48 hours by Social Worker is requested by CPS.

6. Pictures

   a) needed _____yes _____no _____
   b) on chart _____yes _____no _____ If NO location of film or pictures.
   c) place pictures taken _____
   d) Follow-up pictures in unit - yes_____ no_____

7. Documentation needed:	YES	NO	Special Instructions
a) Parents visits	___	___	_____
b) Lab	___	___	_____
c) X-Ray	___	___	_____
d) Documentation & other injuries	___	___	_____
e) Abnormal child behavior	___	___	_____
f) Growth & development assessment	___	___	_____
g) Previous history	___	___	_____

MID-MAINE MEDICAL CENTER
Waterville, Maine

SUBJECT: Child Abuse Neglect

POLICY NO. 10-2, 115-712
Effective Date: 2/26/80 (Revised
Reviewed: 3/81
Revised 2/83
Revised 9/84

DEPARTMENTS RESPONSIBLE:

Administration
Social Work
ED, OPD
Well Child Clinic, Children's Development Project, Hill Center, and Prenatal Clinic
Medical Information Services
Nursing
Medical Staff

AUTHORIZATION:

President

Director, Social Work Services

Assistant to the President

Director of Emergency Services

Vice President - Nursing Affair

Chief of Staff

Chief of Pediatrics

Director of Learning Resource Center and Media

I. PURPOSE: To establish a policy and procedure for the Medical Center which provides for appropriate assessment, intervention, and treatment of suspected child abuse/neglect and to establish a framework for institutional reporting of same consistent with the requirements of Chapter 1071 of the Maine Public Laws. (See Appendix IV)

II. POLICY: The State Law of Maine makes it mandatory for all health professionals to report any situation in which there is "reasonable belief to suspect" child abuse/neglect. The professional does not have an option in the matter of reporting such cases for investigation. Reporting in good faith frees the professional from any liability if the report proves to be unfounded. Willful failure to report opens the professional to criminal or civil liabilities. The right to privileged communication and confidentiality between the physician and patient is waived by State Law in suspected child abuse cases.

Maine's reporting laws are endorsed by Mid-Maine Medical Center and are fully in effect. <u>At this hospital, all suspected cases of child abuse/neglect must be reported to the MMMC Social Work Department.</u>

To avoid duplication of effort, nurses are encouraged to confer with one another and with the attending physician (and vice versa) to determine whether contact has already been initiated with the MMMC Social Work Department and, if it has not, to decide who will notify. While a single, joint notification of MMMC's Social Work Department is preferred, this may not always be possible. When there is disagreement among staff as to the relative level of suspicion in

a given case, individual notification to MMMC's Social Work Department is appropriate.

It is the policy of the Medical Center to organize and complete a multidisciplinary -- medical, nursing, and social work -- assessment of minor patients (children under the age of 18) whenever there is cause to suspect abuse/neglect. Recommended approaches to this assessment are appended to this policy and filed in the following locations:

- Emergency Department
- Out-Patient Department
- Social Work Department
- Administrator On-Call Manual
- 3-11 Administrator Manual
- All nursing stations

Whenever the assessment leads to "reasonable belief" that a child has been abused or neglected, or is at risk of abuse or neglect, the Social Worker will make immediate telephone reports to the Administrator On-Call and to the State Department of Human Services, Office of Child Protective Services, and will prepare a follow-up written report within 48 hours.

In summary, it is the responsibility of all health professionals within Mid-Maine Medical Center to be alert to the signs of possible child abuse/neglect, and to conscientiously report such signs immediately to the MMMC Social Work Department.

III. RESPONSIBILITY: Departments and settings involved in the care and treatment of children; nurses; physicians; Social Work; Administration; and Medical Information Services as described below.

IV. PROCEDURE:

A. Definitions under State of Maine Law Chapter 1071, Subchapter I.

1. "Abuse or neglect' means a threat to a child's health or welfare by physicial or mental injury or impairment, sexual abuse or exploitation, deprivation of essential needs, or lack of protection from these by a person responsible for the child"

2. "Jeopardy to health or welfare' or 'jeopardy' means serious abuse or neglect as evidenced by:

   a. serious harm or threat of serious harm;

   b. deprivation of adequate food, clothing, shelter, supervision or care, including health care, when that deprivation causes threat of serious harm;

   c. absence of any person responsible for the child, which creates a threat of serious harm; or

   d. the end of voluntary placement when the imminent return of the child to his custodian causes a threat of serious harm."

3. "Serious harm' means:

   a. serious injury

   b. serious mental injury or impairment, evidenced by severe anxiety, depression or withdrawl, untoward aggressive behavior, or similar dysfunctional behavior, or

   c. sexual abuse or exploitation."

B. General procedure for all MSW health professionals.

If any employee or member of the Medical Staff suspects possible child abuse/neglect, he/she should:

1. Obtain the following facts:

   a. name and address of the child;

   b. name of parent or caretaker, if known;

   c. child's age, sex, and race; and;

   d. ascertain the nature and extent of injuries, including evidence of previous injuries.

2. Immediately contact the MSW Social Work Department (Extensions 286, 287, or 286). or the Social Worker On-Call after 4:30 p.m.

3. Refer to guidelines (attached) and to summaries below for additional instructions.

CLINICIANS' NOTE: If possible, before treating the child, wait for the Social Worker to arrive so that the patient and concerned others only have to be questioned once.

C. Summary of Nurse's Role in Suspected Child Abuse/Neglect Cases:

(For further information, see Guideline (A) attached.)

1. Expedite the evaluation of child abuse/neglect patients.

2. Participate in multidisciplinary assessment of child abuse/neglect patients.

3. Help physician arrive at correct diagnosis.

4. Direct physician to protocols on medical evaluation of these problems.

5. Help physician arrive at correct disposition of case.

6. Maintain helping approach toward child abuse/neglect parents.

7. Complete check list/data sheet of actions taken (see appendix V)

8. If the family becomes uncooperative after the child is admitted, the Social Worker and/or AOC should be notified immediately.

D. Summary of Physician's Role in Suspected Child Abuse/Neglect Cases.

(For further information, see Guideline (B) attached.)

1. Secure adequate history and physical exam, including full body x-rays, if appropriate.

2. Provide accurate diagnosis and treatment for physical problems.

3. Enter detailed documentation in medical record including photographs, if appropriate.

4. Hospitalize child in need of further study and/or protection.

5. In cooperation with MMMC's Social Work Department, assure attention to the child's manifold personal, medical, and psychological needs.

PHYSICIANS' NOTE: The physician is not responsible for determining with certainty that abuse did/did not occur or who the abusing person is; rather, ascertain whether there is reasonable belief to suspect and report same.

E. Summary of Social Worker's Role in Suspected Child Abuse/Neglect Cases.

(For further information, see Guideline (C) attached.)

1. Assist physician and nursing staffs in multidisciplinary assessment of suspected cases, with particular reference to psychosocial aspects of child/family unit.

2. Establish relationship with family/significant others.

3. Formulate plan for treatment, including arranging for other support services, as appropriate.

4. Notify Administrator On-Call of findings and of intention to report to Child Protective Services. Request that AOC alert police if police hold felt to be needed.

5. Contact Child Protective Services.

6. Provide formal written notification/report on suspected case to Administrator On-Call for signature and forward to Child Protective Services within 48 hours.

7. Follow-up to evaluate implementation of plan.

F. Summary of Administrator On-Call Role in Suspected Child Abuse/Neglect Cases.

(For further information, see Guideline (D) attached.)

1. Provide consultation/advice when requested by Social Worker.

2. Negotiate additional support and arrangements as needed. If child is in immediate jeopardy, contact the police for police hold. If there are legal questions, the AOC will arrange for necessary legal consultation at Social Workers request.

3. Receive oral notification from Social Worker if suspected child abuse/neglect is to be reported to Child Protective Services.

4. Receive and cosign written report of same prepared by Social Work Department.

G. Summary of Medical Information Services' Role in Suspected Child Abuse/Neglect Cases.

(For further information, see Guideline (E) attached.)

1. When requested, seek out all prior information pertaining to the patient.

2. Issue unit record number and start a unit record, if no previous record exists.

3. If requested by Social Work, flag the outside of the patient's chart with "Social Work" stamp.

4. Provide copies of medical records and related contents to Child Protective Services, as requested.

5. When reports of suspicion are proved by Child Protective Services to be negative, a notice to this effect will be placed in the patient's record by Social Work. Expunge flags from outside of the record.

H. Procedure when photos needed.

1. Photos will be taken by attending physician or nurse in whatever unit the child is, and attached to the medical record.

2. The Director of the Learning Resources Center and Media will be requested to make duplicates as soon as possible by the Social Worker or Medical Information Services. It takes two (2) hours to complete the duplicates if the Director of the Learning Resources Center and Media is avaiable. He prefers a workup time of two (2) days, if advised of an unusual situtations, he will try to speed up the process.

3. The duplicate photos will be returned to Medical Records and released from there to Child Protective Services.

4. The Department of Human Services is billed for the photos.

I. Release of confidential information:

1. If MMMC makes a report to Child Protective Services, the necessary medical and psychosocial information to substantiate the report may be released with out a Release of Information signed by the parents. Parental consent is not needed to take photos of injured.

2. In order to involve the parents in the plan and promote a positive outcome however, every effort should be made to advise the parents of what is happening to have them sign a release of information by the Social Worker.

3. If MMMC had not made a report to Child Protective Services, information about a child or family should not be released without a properly signed release of information in the child's record. Requests for information from Child Protective Services should be referred to the MMMC Social Worker or Medical Records, and not be responded to directly by nursing or other staff until the Social Worker has been involved.

V. DISTRIBUTION: This policy shall be distributed to all Master Manuals and hospital wide. Guidelines shall be distributed and maintained on file in the following locations: Emergency and Out-Patinet Departments, Social Work , Administrator On-Call Manual, 3-11 Administrator Manual, and all nursing stations.

VI. FILING INSTRUCTIONS: This policy is to be filed in the MMMC Policy Manual under Section 10, Administration. This policy supersedes any former policy on this subject.

CHILD ABUSE/NEGLECT GUIDELINES

(Guideline A)

A. ROLE OF THE NURSE IN SUSPECTED CHILD ABUSE/NEGLECT CASES.

1. Expedite the evaluation of child abuse/neglect patients.

Cases of suspected child abuse/neglect should be given high priority. Even when they are not medical emergencies, suspected child abuse cases are social emergencies. Within the Emergency or Out-Patient Departments, such cases are classified "triage Category II".

The Emergency Department (ED) triage nurse is in an especially strategic position to expedite these cases by detecting them during intake and notifying the Social Services Department and the ED physician on duty as soon as possible.

2. Help the physician arrive at the correct diagnosis.

In some instances, the nurse may consider the diagnosis inflicted injury before the physician. If the physician is reluctant to consider this diagnosis, the nurse can provide the data that are believed to confirm child abuse/neglect. The nurse can also remind the physician that both of them are obligated by State Law and Hospital Policy to report all suspected cases of child abuse/neglect. Indeed, if a nurse continues to suspect child abuse and the physician thinks otherwise, the nurse, after conferring with the physician, should report it alone to the MMMC Social Work Department.

The primary nurse assigned to the patient and/or the triage nurse, as appropriate, should assist the physician and the Social Worker in conducting the multidisciplinary evaluation and assessment.

3. Direct the physician to the protocols on complete medical evaluation of these problems.

See Appendices I, II, and III attached.

4. Help the physician arrive at a correct disposition.

5. Maintain a helping approach toward child abuse/neglect parents.

Feeling angry with child abuse/neglect parents is natural, but expressing this anger is very damaging to parent cooperation. Keep in mind that most of these parents are lonely, frustrated, unloved, or otherwise needy people, who actually love their children but who have lashed out at them in anger. The nurse should attempt to keep clinical and support staffs supportive and therapeutic in these cases and ensure that the parents are kept informed of what is happening to their child at all times.

CHILD ABUSE/NEGLECT GUIDELINES

Guideline B

B. ROLE OF THE PHYSICIAN IN SUSPECTED CHILD ABUSE/NEGLECT CASES.

1. General responsibilities and guidelines.

The physician's main role in suspected child abuse/neglect is to be an accurate diagnostician. His/her other roles are to report suspected cases to the MMMC Social Services Department; to hospitalize the child in need of diagnosis and protection; and, to fully arrange for the evaluation of the abused child's personal, medical, and psychological needs.

When doubt exists regarding a suitable report of suspected child abuse/ neglect, physicians are cautioned to err in favor of reports.

It is important to maintain a helping approach toward the parents of children suspected of abuse or neglect. Feeling angry with suspected child abuse/ neglect parents is natural, but expressing this anger is very damaging to parent cooperation. Repeated interrogation, confrontation, and accusation must be avoided. Keep in mind that most person who abuse or neglect children are themselves lonely, frustrated, unloved, or otherwise needy people who actually love their children, but have lost control of their lives and emotions.

2. Contact the MMMC Social Work Department.

Contact the Social Work Department as soon as abuse/neglect is suspected so that the Social Worker may assist in the multidisciplinary (medical, nursing, social work), assessment of the situation and help plan for appropriate intervention and follow-up treatment.

3. Hospitalize selected cases.

a. Out-Patient, Well Child Clinic, Children's Development Project, Pre-Natal Clinic, Dental Clinic, Hill Center, EEG, and etc.

When Child Protective Services workers or police officers bring the child to an outpatient service, they may only want an evaluation to document evidence of physical abuse. Children who have been abandoned, left unsupervised, or live in other adverse environments, may also be brought in for a physical check-up. In some cases where the home is unsafe, Child Protective Services will take the child to a foster home after medical evaluation is completed.

b. Emergency Department.

When a parent or guardian brings a child with suspected abuse or neglect to the Emergency Department, the child usually should be hospitalized so that he/she will be in a protective environment until a definitive diagnosis can be established or ruled out. The extent of the injury is not relevant to this requirement. The reason given to the parents for the hospitalization can be that "further studies are needed". In the Emergency Department, it is often not helpful to mention the possibility of child abuse/neglect. Keep incriminating questions to a minimum.

c. Post Admission

Once the child is safely admitted to Pediatrics, the parents should be fully informed regarding the possible diagnosis of child abuse/neglect and the need for full evaluation. If the parents refuse hispitalization a "police hold" can be obtained by the Administrator On-Call. The police hold is rarely needed and should not be a routine procedure.

d. When Not to Protectively Hospitalize

The case can be safely evaluated without hospitalization in some instances such as where Child Protective Services (CPS) is already involved, or where the alleged offenders can no longer have ready access to the child (e.g., a boyfriend who is in jail or a babysitter who is not longer employed). Serious homocidal threats (e.g., "If I have to spend another minute with that child, something bad is going to happen.....") also requires admission and pediatric consultation.

4. Elicit a detailed history of the injury.

A complete history should be obtained by one physician as to how the injury allegedly happened. The history should elicit the informant, date, exact time, place, sequence or events, people present, time lag before medical attention sought, etc. The parents can be pressed for exact details when necessary. No other professional should have to repeat this detailed probing interview. If the parents are not present, the physcian can request that the person who brought the child to the hospital (e.g. police officer or Child Protective Services worker) also bring the parents to the hospital for the interview. It is also important for the physician to talk directly with the parents so that this history is not looked upon as heresay evidence (second-hand information) in court. If the child is old enough to have a complete history (usually over age six (6)), the parents may not have to be brought in. In this instance, the child should be seen alone. If two caretakers or parents are present, it is usually advisable to have them interviewed separately so that any discrepancy in the history can be elucidated at that time.

5. Perform a thorough physical exam. (Refer to Appendix I, "Differential Diagnosis of Child Abuse".)

All bruises should be listed by site and recorded by their size, shape, and color. If they resemble strap marks, grab marks, slap marks, bite marks, loop marks, tie marks, choke marks, cigaretteburns, the outline of a blunt instrument, or any other identifiable object, this should be recorded. Special attention should be paid to the retina, eardrums, oral cavity, and the genitals for signs of physical trauma. All bones should be palpated for tenderness and joints tested for full range of motion. The height and weight of the child should be plotted. If the child appears malnourished, arrangements should be made for a follow-up evaulation.

6. Order radiologic survey of bones (including hands and feet), a lateral thoracic and lumbar vertebrae and AP and lateral skull and cervical spine.

7. Order a bleeding disorder screen on selected cases.

(Guideline B Page 3)

If there are bruises and the parents deny inflicting them or claim the child has "easy bruising", a bleeding disorder screen (platelet count, bleeding time, partial thormboplastin time, and prothrombin time) should be ordered.

8. Complete a report on the suspected child abuse case.

It is the policy of Mid-Maine Medical Center that episodes of suspected child abuse/neglect require an in-house multidisciplinary (medical, nursing, social work) approach. The Social Work Department should be contacted as soon as possible so that a Social Worker may participate in the assessment of the situation and provide information about psycho-social factors. When involved in the assessment, the MMMC Social Worker will assume responsibility for making the appropriate immediate telephone reprot and written reports within 48 hours on behalf of the Hospital to the Maine State Department of Human Services, Child Protective Services. The MMMC Social Worker can also provide ongoing assistance to the physician and to the family in coordinating appropriate follow-up plans. If the MMMC Social Worker is not involved the physician assumes all responsibility for making the State required report.

As long as the medical record of the in-patient unit, clinic, Emergency or Out-Patient Department visit contains the following data, the official typed medical report (required to be filed within 48 hours) can be extracted from it. After completing your chart notes, give the chart to the MMMC Social Worker.

To prepare an adequate report, chart notes must include:

a. History

(1) Date and time the child abuse/neglect patient was brought into the clinical care area.

(2) Name or names of persons who accompanied the patient and of professionals who attended/cared for patient.

(3) Informant (parent, child, or both).

(4) Date, time, and place of the abuse incident.

(5) How the abuse occurred.

(6) Who allegedly abused the child.

(7) Any history of past abuse.

b. Physical Exam (description of the injury or injuries)

(1) List the injuries by site (e.g. head, arms, legs, back, buttocks, chest, abdomen, genitalia).

(2) Describe each injury by size, shape, color, etc.

(3) If the injury identifies the object that caused it, always say so (e.g., sharp mark, cigarett burn.)

(4) Use nontechnical terms like "cheek" instead of "zygoma"

(5) Use inches instead of centimeters, where possible.

NOTE: A diagram of the body's surfaces is helpful, but it is not as important as the verbal description of the same.

c. Lab tests -- x-rays, bleeding tests, etc.

d. Conclusion -- Concluding statement on reasons why this represents an abuse/neglect case.

NOTE: Whenever possible, efforts should be made to take or cause to be taken, color photographs in duplicate of any area of trauma visible on the child. The parent's or custodian's consent to the taking of photographs is not required by law. A poloroid camera is available for this purpose in the Emergency Department. Also, the Director of the Learning Resource Center, Media Services may be contacted for assistance.

9. Provide follow-up appointments

A physically abused child who is not placed in a foster home needs close follow-up of his/her physical condition. The first appointment is usually made at a one to two week interval. If the child has a primary physician the child should be reappointed to that physician; otherwise, return him/her to the pediatrician on-call for follow-up.

10. Role of Child Protective Services

A report to the MMMC Social Work Department or Child Protective Services is not an accusation and does not require clinical confirmation of suspicion. Rather, the report should be looked upon as a request for further investigation and counseling by professionals who have a broad range of experience in differentiating and dealing with these kinds of problems.

11. Sexual abuse of children

a. General guidelines

The same procedure as delineated above for multidisciplinary assessment of child abuse/neglect including treatment planning and reporting should be followed. Additional guidance in conducting the physical examination and treatment for sexually abused children may be obtained from appendix VI.

b. Diagnostic indicators

(1) Strong evidence:

- Gonococcal infections: urethritis, pharyngitis, arthritis, conjunctivitis
- Trichomonas infection
- Veneral warts
- Syphilis
- Sperm or acid phosphatase present on body or clothes of victim
- Pregnancy

(2) Probable evidence:

. Vaginal or anal laceration
. Perineal bruises or abrasions

(3) Possible evidence:
. Monilial vaginitis
. Haemophilus vaginitis
. Hematuria (secondary to trauma)

12. SIDS

One must be aware of SIDS (Sudden Infant Deatn Syndrome) as a real possibility whenever an infant less than one year of age is brought in DOA. The health professional should be supportive of the parents rather than accusatory. A mandatory autopsy will usually clarify whether the death was related to abuse or SIDS.

Guideline C Policy No. 10-2

ROLE OF SOCIAL WORK DEPARTMENT IN SUSPECTED CHILD ABUSE/NEGLECT CASES.

1. Identification:

   a. Social Services Department staff will respond immediately whenever a case of suspected child abuse/neglect is brought to attention — whether by case finding or referral. After working hours, the Social Worker On-Call will come in whenever notified.

2. Assessment:

   a. Consult with attending physician and obtain any available information from attending physician, nursing, or other staff.

   b. Ascertain what, if any, action has already been taken, when, and by whom. For example, are the police involved; has the Administrator On-Call been notified; and, has the Department of Human Services been called?

   c. An effort will be made to keep to a minimum for child, family, or caretaker unnecessary repetition of the incident or problem, but the Social Worker should talk with the family and child to obtain relevant history and to complete the psychosocial assessment.

      (1) While seeing child and family to obtain assessment, the Social Worker's goal is to establish a relationship based on concern and helpfulness with the purpose of encouraging family to utilize available services.

      (2) The Social Worker should be open and honest about his/her role and the purpose of the interview. Whenever possible, the parents or caretaker should be told if a report to Child Protective Services is necessary, and this should be presented in a light of obtaining needed help and support for the family. If possible, an Authorization to Release Information should be obtained, as with any other referral, although it is not necessary to make the report.

      (3) The Social Worker should not play inquisitor or be judgmental. It is not as important to find out "who did what" as it is to use the incident as an entree into forming a therapeutic alliance and providing comprehensive services for the family.

      (4) Needed information:

         (a) Family composition

         (b) Significant events, stresses, or crises

         (c) Child development history and parental response to developmental stages

         (d) Observations re: appropriateness of family members' behavior and reactions

e. Evaluation of continued risk

f. Agencies or support networks involved with the child.

3. Plan:

a. Interdisciplinary work is crucial to the identification, assessment and ongoing treatment plans. The Social Worker should work closely with all other members of the hospital team, and is responsible for contacting and coordinating the work of appropriate outside agencies and services with the family and with other members of the team.

b. Short-term plans.

(1) Assessment reveals no suspected child abuse or neglect.

(a) Arrange for any other appropriate and needed services.

(b) Or, no further action required.

(2) Assessment reveals "reasonable"suspicion of child abuse/neglect.

(a) Determine whether child should be admitted to the Medical Center for immediate protection.

(b) Notify Administrator On-Call of findings and of intention to report to Child Protective Services.

(c) Contact Child Protective Services.

(d) Work on plans to protect other children as appropriate.

(e) If problems occur in obtaining the necessary information or if problems are expected in obtaining family cooperation, help should be sought from the Administrator On-Call. The Administrator On-Call should be asked to contact the police if a "police hold" of up to six (6) hours is necessary to prevent the parents from removing the child at risk from the Medical Center. This will be needed only rarely. The Administrator On-Call should also be contacted if any legal problems arise. If it is felt that the family may be uncooperative, the Social Worker should request that the Administrator On-Call notify the police of the potential problem and possible need for a police hold.

(f) When MMMC is filing the report with the Department of Human Services, the same procedure is to be followed whether or not the child is actually admitted to the hospital. MMMC's responsibility begins when the child's situation becomes known to MMMC regardless of the status (i.e., in-patient, out-patient, etc.)

(g) The Social Worker shall work with the physician and Administrator On-Call to determine final disposition including whether or not to release the child from MMMC and to whom, including documentation of this.

c. Long-term plans:

If Child Protective Services (CPS) accepts the referral, feedback

is needed to determine what ongoing services, if any, are needed from MMMC, and to be prepared for further admissions.

4. Documentation:

a. Concise and objective notes should be made in the social work notes in the medical record on the presenting problem, psychosocial assessment, plan, and action taken, and include:

(1) Symptoms that cause suspicion of child abuse and neglect.

(2) History and psychosocial assessment.

(3) Dates of referral to Social Work Services, of interviews with Child Protective Services, and other appropriate contacts.

(4) Collaboration with health care team and with community agencies.

(5) Compliance with MSRA, Chapter 1071, Subchapter II on Reporting of Abuse and Neglect.

(6) Short-term and long-term plans for child and family.

(7) Follow-up from Child Protective Services re: their disposition of the report.

(8) The medical records of all suspected cases of child abuse/neglect should be appropriately flagged.

5. Follow-up.

a. The Social Worker is responsible for obtaining follow-up and case disposition information from Child Protective Services and entering it in the medical record, so that in the event of readmissions, appropriate follow-up by MMMC can be provided. Similarly, if the investigation by Child Protective Services does not bear out suspicion of child abuse/neglect, this finding should be noted in the record by the Social Worker responsible.

6. Reporting Requirements:

a. After notifying Administrator On-Call of suspected episode of child abuse/neglect, establish immediate phone contact with Child Protective Services as mandated by MSRA 1071, Subchapter II. During the day, calls should be made to the appropriate regional office. Most often that would be Augusta (1-800-452-4640 or 289-3271) or Skowhegan (1-800-452-4602 or 474-5551). After normal working hours, the report should be made to 1-800-452-1999.

b. A written report should be made within 48 hours if requested by the Department of Human Services. The report should include information about the following:

(1) Name and address of the child and persons responsible for his care or custody.

(2) The child's age and sex.

(3) The nature and extent of abuse/neglect, including a description of injuries and any explanation given for them.

(4) A description of sexual abuse or exploitation.

(5) Family composition and evidence of prior abuse/neglect of the child or his siblings.

(6) The source of the report, the person making the report, his occupation, and where he can be contacted.

(7) The actions taken by the reporting source, including a description of photographs or x-rays taken.

(8) Any other information that the person making the report believes may be helpful.

(9) Any copies of medical record information are released.

c. The written report shall be signed by both the Social Worker and the Administrator On-Call. Copies of all reports should be sent to the President of MMMC and to the Director of Social Work ~~Services~~, as well as the patient's chart.

7. Requests to Testify:

a. The Social Worker should discuss all child abuse and neglect cases in full with his/her supervisor. All requests to testify, subpoenas, etc., should be reported immediately to the Director of Social Work through the medical information department. No one else should copy medical recoreds for CPS.

Guideline D

ROLE OF THE ADMINISTRATOR ON-CALL IN SUSPECTED CHILD ABUSE/NEGLECT CASES.

The Administrator On-Call will:

1. Receive the Social Worker's verbal report of suspected child abuse/neglect;
2. notify the President at the earliest time thereafter; and
3. cosign the written report to Child Protective Services.
4. In the event of a need to arrange for emergency protection of the child, the Administrator On-Call (AOC) will assist the other principals in the necessary arrangements for admission, notifying the police, obtaining legal consultation, or taking other appropriate actions. The Social Worker will advise the AOC as to the childs needs and resources needed.

ROLE OF THE MEDICAL INFORMATION SERVICES DEPARTMENT IN SUSPECTED CASES OF CHILD ABUSE/NEGLECT.

1. When requested, Medical Information Services will seek out all prior information pertaining to the patient.

2. For Out-Patient or Emergency Department patients suspected of being victims of child abuse/neglect, Social Work will request that Medical Information Services establish a unit record number if no previous record exists. The record number should be entered in the upper right hand corner of the Emergency Department (ED) record or Out-Patient (OPD) record. Once requested to provide a unit record number, Medical Information Services will create a unit record for that patient and will file the ED and OPD records in it.

3. Medical Information Services will flag the outside of the patient's chart at the request of Social Work Whenever that patient is readmitted, Medical Information Services will notify Social Services.

4. When a report of child abuse/neglect is made by MMMC to Child Protective Services, pertinent copies of medical records, lab and x-ray reports, or photographs may be sent to Child Protective Services without parental consent.

5. If Child Protective Services requests information regarding a patient about whom MMMC has not made a report, the usual procedures for releasing confidential information shall be followed. Refer to MMMC policies No. 110-1 and No. 110-9.

6. Recognizing that "suspicion of child abuse or neglect" does not necessarily mean that abuse/neglect actually is occuring, it is essential for all staff involved with the family to treat any information with special respect for the family's privacy and confidentiality. Information or suspicion should not be shared with any agency other than Child Protective Services.

7. When reports of suspicion are proved by Child Protective Services to be negative, a notice to this effect will be placed by the Social Services Department in the patient's record and flags expunged from outside of the record.

8. All medical record information is released to Child Protective Services only by medical information department.