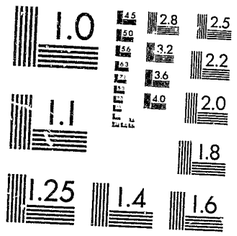

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CHILD ABUSE & NEGLECT

A Primer For Medical or Health Professionals

How Long Does a Child Have to Wait for Help?

South Dakota
DEPARTMENT OF SOCIAL SERVICES
Children, Youth & Family Services

FACTS ABOUT CHILD ABUSE AND NEGLECT

Child abuse and neglect cuts across all class, cultural, and educational groups.
Child abuse and neglect may be a cyclical or generational phenomenon.
Child abuse and neglect is a symptom of family dysfunction or crisis.
An abused child is at high risk of being reinjured.

As a member of the medical or health profession, you may be the first professional to come into contact with a family where abuse or neglect is occurring. In many cases, the medical professional may be the only person who is in a position or is qualified to recognize and diagnose suspected child abuse and neglect. Under South Dakota law, you are mandated to report any suspicion of abuse or neglect to your local South Dakota Department of Social Services Office or local law enforcement agency. Research has shown that when a "child who has been physically abused is returned to his parents without intervention, 5% are killed and 35% are seriously reinjured."[1] In order to begin the intervention necessary to protect the child and help the family, the medical professional must be knowledgeable in recognizing cases of suspected child abuse and neglect and in the proper methods of handling evaluation and referral.

Many times, the first clue a medical professional may have that abuse or neglect has occurred is an implausible history that is offered to explain a child's injury or condition. When presented with child injury, the medical professional should consider the history provided in light of these questions:

- Is the extent of the injury/condition exhibited compatible with the history provided?
- Is the injury consistent with the child's developmental ability to injure himself/herself?
- Does the injury appear to conform to or suggest the use of an instrument?
- Is the appearance of the injury consistent with the sequence of events (time element) described in the explanation?
- Does there appear to have been a delay in the presentation of the child for medical attention?
- Are there other unexplained injuries present on the child?
- Does the explanation seem vague or confused?

If there appears to be a discrepancy between the history provided and the injury/condition exhibited, a thorough examination should be conducted. This should include full skeletal x-rays and an evaluation of the child's height, weight, and general nutritional and developmental status. Photographs of areas of trauma should be taken. Photographs should be specifically labeled and dated on the back. Marks on the surface of a photograph may render it as inadmissible evidence in court.

Documentation is a critical part of the medical professional's role in cases of suspected child abuse and neglect. For future diagnosis and as evidence if legal process is undertaken, it is important to record each injury noted during examination. Special attention should be given to:

- size
- shape
- location
- color
- degree of healing

1 B. Schmitt and C. Kempe, "Neglect & Abuse of Children", in V. Vaughn and R. McKay (eds.), Nelson Textbook of Pediatrics, 10th ed., W.B. Saunders, Philadelphia, 1976, pp. 120-126.

PROFILE OF ABUSIVE OR NEGLECTFUL PARENTS

Abusive or neglectful parents are likely to share several of the following characteristics:

- They are isolated from family supports, such as friends, relatives, neighbors, and community groups.
- They consistently fail to keep appointments, discourage social contact, rarely or never participate in school activities.
- They seem to trust no one.
- They are reluctant to give information about the child's injuries or condition. They are unable to explain the injuries or they give far fetched explanations.
- They respond inappropriately to the child's condition, either by over-reacting or seeming hostile and antagonistic when questioned; or they under-react, showing little concern or awareness and seem more occupied with their own problems than those of the child.
- They refuse to consent to diagnostic studies of the child.
- They delay or fail to take the child for medical care - for routine checkups or for treatment of injury or illness. Or they may choose a different doctor or hospital each time.
- They are overcritical of the child and seldom discuss the child in positive terms.
- They have unrealistic expectations of the child, expecting or demanding behavior that is beyond the child's years or ability.
- They believe in harsh punishment.
- They seldom touch or look at the child.
- They ignore the child's crying or react with impatience.
- They keep the child confined - perhaps in a crib or playpen - for very long periods of time.
- They seem to lack understanding of the child's physical and emotional needs.
- They are hard to locate.
- They may be misusing alcohol or drugs.
- They appear to lack control or fear that they may lose control.
- Their behavior may generally be irrational, they may seem incapble of child-rearing, and may seem to be cruel and sadistic.

PROFILE OF ABUSED OR NEGLECTED CHILDREN

Abused or neglected children are likely to share several of the following characteristics:

- They appear to be different from other children in physical and emotional makeup or their parents describe them as being different or bad.
- They seem afraid of their parents.
- They may bear bruises, welts, sores, or other skin injuries, which seem to be untreated.
- They are given inappropriate food, drink, or medication.
- They are left alone or with inadequate supervision.
- They are chronically unclean.
- They exhibit extremes in behavior: cry often or cry very little and show no real expectation of being confronted; they are excessively fearful or seem fearless of adult authority; they are unusually aggressive or extremely passive or withdrawn.
- They are wary of physical contact, especially with an adult. They may

be hungry for affection yet have difficulty relating to children and adults. Based on their experiences, they feel they cannot risk getting close to others.
- They exhibit a sudden change in behavior, exhibit regressive behavior, such as wetting their pants or bed, thumb-sucking, whining, or becoming uncommonly shy or passive.
- They have learning problems that cannot be diagnosed. Their attention wanders and they easily become self-absorbed.
- They are habitually truant or late to school. Frequent or prolonged absences from school may result from the parent's keeping an injured child at home until the evidence of abuse disappears. Or they may arrive at school early and remain after classes instead of going home.
- They are tired and often sleep in class.
- They are not dressed appropriately for the weather. Children who wear long sleeves on hot days may be dressed to hide bruises or burns or other marks of abuse or they may be dressed inadequately and suffer frostbite or illness from exposure to the weather.

THE THREE ELEMENTS IN ABUSE

Abuse most often occurs in the home. Three elements are usually involved and create the environment for an incident of abuse to occur: 1) the abuser, 2) the abused, and 3) a crisis

1) The Abuser (usually the parent or caretaker).

Although all parents have the potential to be abusive, the chronic abusive parent has certain characteristics and a behavior pattern not representative of good parenting. Many abusers have a history of having been abused themselves or at least brought up in very strict families. Abusive parents keep to themselves, move from place to place, and usually are young. They pick a mate who is of little help to them, who is rather passive. The mate almost always knows about the abuse, ignores it, even may participate in it.

2) The Abused (the child victim).

Usually only one child in the family is abused. Some children are more vulnerable to abuse than others. Children under six are considered a high-risk population. Children with handicaps have a higher incidence of abuse, as do hyperactive and emotionally disturbed children.

Some children are difficult to care for, so difficult that they irritate the parent to the point of losing control. A child may even provoke abuse in attempting to get attention. Some children are seen by the parents as stubborn and deliberately annoying.

3) A Crisis

A crisis is the precipitating factor that sets the abusive parent in motion. The parent overreacts as the result of other stresses that have become too numerous or too complex to cope with. The abuse is the result of this frustation and anxiety. Many things can precipitate a crisis. Loss of a job, divorce, illness, death

in the family. The child refuses to eat, he wets his pants again, he won't stop crying. As a result, the parent suddenly loses control, and the child is abused.

WARNING SIGNALS:

Can we recognize a potentially abusive parent BEFORE a baby is born?

In many cases, abuse or neglect might have been prevented had high-risk families been identified early. Certain characteristics are often present in high-risk families and may be particularly noticeable before the birth of a child.

The characteristics of a potentially abusive parent are given here. They are warning signals only. Their presence does not mean that abuse or neglect will occur, but that the potential for its occuring is high. A single characteristic or even a few characteristics displayed for a short time may be the result of the normal anxiety a new mother or father experiences; however, if many of the characteristics are present and continue, the parent should look for help.

A potentially abusive parent may show several of these characteristics:

- The mother denies the pregnancy, refuses to talk about it, has made no plans whatsoever.
- The mother is very depressed over the pregnancy.
- The mother is not willing to gain weight during the pregnancy.
- The mother is alone and frightened, especially frightened of the prospect of delivery.
- The mother lacks support from husband or family.
- The parent is overly concerned with what the sex of the baby will be.
- The parent is overly concerned with how the baby will perform, whether it will meet up to standards.
- The parent feels that the child is going to be one too many children.
- The parent wanted an abortion but did not go through with it or waited until it was too late.
- The parents considered giving up the child, but changed their minds.
- The parents are isolated, do not have relatives or friends around.
- After delivery of the baby, the parent shows no active interest in it, doesn't want to touch or hold it, seems hostile toward it, is disappointed over the baby's sex.
- After the baby comes home, the parent is very bothered about the baby's crying; sees the baby as too demanding, yet frequently ignores the baby's needs, not comforting it when it cries; finds changing diapers distasteful.
- The parent doesn't have fun with the baby, doesn't talk to the baby, says mostly negative things about it.
- One parent resents the time the other spends with the baby and is jealous of any affection shown toward the baby.

MEDICAL INDICATORS OF CHILD ABUSE AND NEGLECT

Certain injuries and/or conditions are frequently seen in cases of child abuse and neglect. Medical professionals should be aware of these warning signals and examine the possibility of the occurrence of abuse or neglect when exhibited. These indicators should be considered in light of the explanation provided, the child's/family's medical history, and the child's ability to inflict such injury. Presence of any of these injuries or conditions may indicate a need for immediate referral to the local children services agency and additional protective action.

SKIN TRAUMA

Bruises/Lacerations

Suspected Child Abuse
- clustered bruises
- bruises in different stages of healing
- bruises on buttocks or lower back
- facial bruises (especially on infant)
- lacerated frenula of lips or tongue
- bruises/scars which show resemblance to an instrument
  - loop marks
  - lash marks
  - linear marks
  - rectangular marks
- human bite marks
- pinch marks
- subgaleal hemorrhages
- circumferential bruises
- bruises at corners of mouth
- bald patches interspersed with normal hair growth
- abrasions/lacerations
- periorbital hematoma

Differential Diagnosis
- Mongolian spots
- bleeding disorders
- petechiae

Burns

Suspected Child Abuse
- cigarette burns (circular; often found on palms, soles, abdomen)
- rope burns
- electrical burns
- chemical burns
- burns on lip or tongue
- immersion burns—characteristically produce sharp lines of demarcation, appear on buttocks, perineum, genitalia, or extremities—"glove" or "stocking" distribution
- contact burns
- burns in configuration of common household utensil or appliance

Differential Diagnosis
- bullous impetigo

INTERNAL/FACIAL INJURIES

Suspected Child Abuse—Blows to midline area
- laceration of liver or spleen
- renal injury
- laceration of the pancreas with subsequent pancreatitis and pseudocyst formation
- fractured ribs
- spinal cord injury with attendant paralysis and urinary incontinence
- projectile vomiting and tenderness in abdomen
- ruptures of small intestine or large bowel (acute abdomen)
- hematoma of the duodenum or jejunum (acute abdomen)
- rupture of the inferior vena cava
- contusion or pneumo-/hemothorax of the lung
- fever, rigid abdomen, signs of peritonitis, low or decreased bowel sounds and rebound tenderness

Suspected Child Abuse—Severe shaking or blow to the head
- dislocated lens
- retinal hemorrhage
- periorbital ecchymosis
- detached retina, especially bilateral detachments
- hemorrhages in pinna
- septal hematoma
- subdural hematoma
- subgaleal hematoma
- cephalhematoma
- subconjunctival hemorrhage
- hemorrhage in vitreous
- choroidal rupture
- hyphema
- rupture of tympanic membrane without infection
- deviation of nasal septum
- dislocation of the spine, bleeding in and around spinal cord
- loosened, missing teeth
- bruising over mastoid
- bald patches in hair

SKELETAL INJURIES

Suspected Child Abuse

- metaphyseal fracture: if suspected, a repeat examination should be done within two weeks

  initially observed--may appear as a subtle nick or break in the cortex or a small chip in metaphysis

  after first week of trauma--area of periosteal new bone at the metaphysis or early new bone in the diaphysis

  several weeks/months--external cortical thickening, metaphyseal cupping and deforming

  frequently, all bones surrounding a single joint are affected, especially at knee

- epiphyseal separation

  may occur as a gross displacement or as a minor irregularity in the line of radiolucent cartilage between epiphyseal ossification center and shaft

  two weeks after injury--revascularization reflected by subepiphyseal or metaphyseal demineralization

- periosteal reaction or elevation

  seven to ten days--thin rim of periosteal new bone at the outer edge of hematoma or bleeding into bone

  several weeks--periosteal new bone becomes thicker and shaft remodels

- separated periosteum

  produces new bone so that a calcified envelope or involucrum surrounds the denuded portion of bone

- rib fractures

  seven to ten days--development of callous formation

- skull trauma

  soft tissue manifestations with focal soft tissue swelling

  more extensive intracranial damage if frank skull fracture evident

  new fractures may have crisp linear edge to fracture line

  old fractures may be difficult to evaluate because skull fracture fragment often will have fibrous union but not bony union

  focal soft tissue usually an *acute injury;* lack of soft tissue swelling more likely to be *former trauma*

- fracture of the mandible
- fracture of sternum or scapulae
- non-bony injury to brain

  intracerebral hemorrhage

  intraventricular hemorrhage

  subdural hemorrhage--*old* subdural hemorrhage may manifest radiographically as a curvilinear calcific density in the area of the subdural hematoma

- spinal shaft fracture
- spinal trauma

SKELETAL INJURIES
Suspected Child Abuse (continued):

- notching of vertebral body
- compression of vertebral body
- multiple injuries in various stages of healing

  careful dating of injuries is medically and legally important, may serve as photo-history of abusive pattern

- recurrent injury to same site

  will produce abundant subperiosteal new bone

Differential Diagnosis	Differential Point
• underlying bony tumors, e.g., focal osteogenic sarcoma	long bone survey clinical history
• perinatal trauma cephalhematoma subdural hematoma caput succedaneum	perinatal history
• scurvy--produces massive subperiosteal hematoma in healing stage	all bones show generalized osteoporosis cortices thin trabecular architecture ill-defined bones have "ground glass" appearance
• osteogenesis imperfecta can cause long bone fracture	general bony demineralization positive family history signs of fracture present in bones not involved in immediate trauma blue scleri (in some patients)
• infantile cortical hypertosis (Caffey's disease) characterized by subperiosteal new bone formation	no metaphyseal irregularities
• hypophosphatasia	
• leukemia	petechiae
• metastic tumors metastic neuroblastoma sequelae of osteomyelitis septic arthritis	
• hemophilia	bleeding around large joints bruising (males)
• hemarthrosis	
• congenital syphilis	periosteal reaction bilateral along with decreased movement of one or more extremities (Parrot's paralysis)

SEXUAL ABUSE

Suspected Sexual Abuse
- lacerated hymen
- lacerated fourchette
- injury to the perineum
- infected lesions
- vaginitis
- vulvitis
- tears or infected lesions of the mouth or anus
- presence of semen
- discharge
- vulvar hematoma
- bruised or swollen scrotum or penis
- anal lacerations
- poor sphincter tone
- pregnancy
- presence of venereal disease
- recurrent urethritis
- laceration, bruise or bleeding from external genitalia, vagina or anal region
- torn, stained or bloody underclothes
- pain or itching in genital area

Differential Diagnosis
- accidental injury, "straddle injury"

NEGLECT

Suspected Child Neglect
- poor skin hygiene
  -severe untreated diaper rash with associated secondary infection and hypo- or hyperpigmentation
  -severe insect infestation
  -severe bedsores
- lack of medical attention for infections or injuries
  -prolonged symptoms of pain, diarrhea, vomiting or respiratory disease
  -skin lesions
- non-organic failure to thrive
  differential point established through hospitalization
  -weight gain of one ounce per day is considered significant
- wasting of subcutaneous tissue
- dull, "vacant" appearance
- pallor suggesting anemia
- long-standing, untreated medical problems
  -chronically inadequate dental care
  -lack of necessary immunizations
  -failure to provide required medication and/or in-home medical care
  -repeated broken appointments
- chronic malnutrition
  -significant and prolonged deficiency of elements necessary to child's health and well-being
- flat head on infant
- bald spots on infant
- deprivational dwarfism
  -small stature
  -distended abdomen
  -below normal weight
  -retarded skeletal maturation
- severe cradle cap

Differential Diagnosis
- contributing social factors, such as poverty, inadequate parenting knowledge
- constitutional short stature
- severe acute malnutrition
  -extreme thinness
  -near normal bone growth
- organic failure to thrive
  -genetic causes, such as cystic fibrosis, degenerative brain disease, chromosomal abnormalities, metabolic or endocrine disease or congenital anomalies
  -intrauterine or postpartum infection
  -birth trauma
  -subsequent brain trauma

PRINCIPLES OF EFFECTIVE INTERVIEWING IN CHILD ABUSE AND NEGLECT

Interviewing abusive or neglectful parents can be difficult, frustrating, and anxiety-provoking for medical professionals. The difficulties can be accentuated by uncertainty on the part of the interviewer about his/her role with the parent, the purpose of the interview, or concerns with the parent's right to privacy. Certain principles of interviewing can be applied to the medical interview which will help clarify the role of the interviewer and the process of conducting the interview. Thoughtful application of these principles should help the professional attain his/her objectives in the interview. The following outline provides details of these principles as they specifically relate to the needs of the medical interview in suspected cases of child abuse and neglect.

Principles in Effective Interviewing

I. Before the interview

A. Establishing the purpose of the interview

1. Make sure you understand the purpose of the interview. Clarifying the purpose for yourself will enable you to conduct a direct and straightforward interview.

2. Define your objectives. Examples of objectives for the interview are:

a. to determine whether abuse or neglect is occurring in the family
b. to identify problems and needs as a basis for treatment planning
c. To establish rapport for ongoing relationships with the family.

B. Determining the content

1. Decide on the specific information you want to elicit. The kinds of information include:

a. medical history of the child
b. social history and environmental context in which the family lives
c. family dynamics
d. history of injury

C. Formulating questions

1. Formulate questions that satisfy the objectives and content of your interview.

2. Use language in the interview that is easily understood by the parent and adds to his/her comfort.

3. Avoid ambiguities in your questions; make sure the parent knows what is being asked.

4. Avoid accusatory questions or statements. The purpose of the medical interview is to gather data and establish rapport--not to establish the identity of the perpetrator.

5. Be supportive of the parent in asking questions and in listening to the response.

II. During the Interview

A. Setting the stage

Let the parents know from the beginning that this is a formal interview, that answers to any questions or statements that they might make will be on the record, and that some action will be taken as a result of the interview. This action may include reporting the case as one of suspected child abuse or neglect, recommending further evaluation, or asking that the child remain in a medical facility for observation. This approach to the interview is not meant to threaten or frighten the parents, but to establish open, honest communication upon which the parents can depend.

B. Clarifying your role

Because parents may be confused, skeptical, or hostile, it is crucial to be explicit from the outset about what your role is as a medical or health professional; e.g., as a public health nurse referred by the family's private physician or local county health department; as a physician in the emergency room of a hospital who has noticed evidence of inflicted trauma and is concerned for the child's well-being. Especially important is defining your position in relation to the criminal justice system, so that parents know what action you can and cannot take with respect to legal intervention. In this part of the interview include:

1. An explicit statement of your role as the interviewer

2. The purpose of the interview

3. The content and focus of the interview

4. The steps that will be taken to protect the parent's confidentiality

C. Setting expectations

It is crucial to encourage the parents to maintain expectations of what you can or cannot do for them or what will happen to them as a result of the interview. Setting clear expectations will avoid undue frustration, fear, or feelings of betrayal and can help build an ongoing relationship with the family.

D. Listening

In any interview there exists unstated communication. In some cases, information or feelings are implied in what the client says; in others, nonverbal behavior offers clues to how a respondent is feeling or types of information that may not be stated outright. In cases of abuse or neglect, parents frequently feel a need to protect themselves with professionals. They may omit or falsify information, or present facts that they feel will be more acceptable to the interviewer. The task of the

interviewer in listening is to be aware of clues that omission or falsification may be occurring, while remaining sensitive to the needs or fears of abusive or neglectful parents that may, in fact, precipitate the omission of fabrication.

E. Questioning procedures

Abusive and neglectful parents need a great deal of support in answering sensitive questions and involving themselves in a helping or treatment relationship with professionals, paraprofessionals, or even friends. They may expect rejection and criticism and will go to great lengths to protect themselves if they sense or actually receive accusations and criticism.

It is important to learn to ask questions in a manner that is supportive and non-accusatory. This means phrasing questions in a way that is open-ended, allowing the parent to respond in a manner comfortable for him or her, rather than feeling trapped by accusatory or offensive kinds of questions. Examples:

1. Close-ended, accusatory question--"Was this burn on Janet's hand inflicted by either you or your wife?"

2. Open-ended, non-accusatory question--"Tell me again how Janet's hand was burned."

3. Supportive questions that express a sympathetic attitude toward the parent--"It's obvious you've been having trouble with this child--would you like to tell me about it?" "What is your child like?"

Supportive, open-ended questions allow for:

1. establishing trust and rapport

2. greater detail in responses and therefore the opportunity to delve more deeply into the information provided

3. obtaining a true profile of the parent, the family, and the child, rather than one which fits only preconceived ideas of the injury and the family dynamics

Close-ended questions cut off discussion by forcing yes or no answers, and often betray the interviewer's bias.

III. Terminating the interview

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

SOUTH DAKOTA CHILD ABUSE AND NEGLECT LAWS

SDCL

26-4-9. Enforcement of laws for protection of children. The Department of Social Services shall assist in the enforcement of all laws relating to the welfare of children, including child labor laws, laws relating to cruelty, contributory delinquency and dependency, nonsupport, desertion, sex offenses against children, compulsory education, and all other laws designed to protect and assist the child and shall take the initiative in securing the enforcement of laws for the protection of children where no adequate provision is made for such enforcement.

26-8-6. Neglected or dependent child defined. In this chapter unless the context otherwise plainly requires "neglected or dependent child" means a child:

1. Whose parent, guardian, or custodian has abandoned him or has subjected him to mistreatment or abuse;
2. Who lacks proper parental care through the actions or omissions of the parent, guardian, or custodian;
3. Whose environment is injurious to his welfare;
4. Whose parent, guardian, or custodian fails or refuses to provide proper or necessary subsistence, education, medical care or any other care necessary for his health, guidance, or well-being; or
5. Who is homeless, without proper care, or not domiciled with his parent, guardian, or custodian through no fault of his parent, guardian or custodian.
6. Who is threatened with substantial harm.
7. Who has sustained emotional harm or mental injury as indicated by an injury to his intellectual or psychological capacity evidenced by an observable and substantial impairment in his ability to function within his normal range of performance and behavior, with due regard to his culture.
8. Who is subject to sexual abuse, sexual molestation or sexual exploitation by his parent, guardian, custodian or any other person responsible for his care.

Provided however, not withstanding any other provision of this chapter, no child who in good faith is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof shall, for that reason alone, be considered to have been neglected within the purview of this chapter.

26-10-1. Abuse of or cruelty to minor as felony. Any person who abuses, exposes, tortures, torments or cruelly punishes a minor in a manner which does not constitute aggravated assault, is guilty of a Class 4 Felony.

26-10-1.1. Spiritual treatment by accredited practitioner of recognized church not considered abuse. Not withstanding any other provision of this chapter, no parent or guardian who in good faith is providing to a child treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church through a duly accredited practitioner shall for that reason alone be considered to have abused or intentionally neglected the child.

26-10-10. Practitioners, hospital and school personnel, law enforcement officers and coroners to report child abuse and neglect cases -- Failure as misdemeanor -- Reports by other persons. Any physician, surgeon, pathologist, dentist,

doctor of podiatrist, psychologist, religious healing practitioner, social worker,hostipal intern or resident, parole or probation officer, nurse, licensed or registered child welfare provider or coroner, having reasonable cause to suspect that any child under the age of eighteen years, has been starved, neglected as defined in § 26-8-6, or has had physical injury or injuries inflicted upon him by abuse or intentional neglect other than by accidental means, or hs been subjected to circumstances or conditions which would reasonably result in abuse or neglect, by any person, including a parent or other person responsible for his care, shall report or cause reports to be made in accordance with §26-10-12. Any person who intentionally fails to make a report required of him is guilty of a Class 1 misdemeanor. Any person who knows, suspects, or has reason to believe that a child has received physical or emotional injury or injuries as the result of abuse or intentional neglect may make a report as provided by law. with the provisions of § 26-10-11 and § 26-10-12. Any person herein-before described who knowingly and intentionally fails to make a report required of him is guilty of a Class 1 misdemeanor. Any person who knows, suspects, or has reason to believe that a child has received physical or emotional injury or injuries as the result of abuse or intentional neglect may make a report as provided by law.

26:10:10.1. Any person who has reasonable cause to suspect that a child has died as a result of child abuse, sexual abuse or neglect shall, in addition to the report required under §26-10-10, report that information to the medical examiner or coroner. Upon receipt of such report the medical examiner or coroner shall cause an investigation to be made and submit his findings in writing to the state's attorney and the department of social services. Any person required to report under this section who knowingly and intentionally fails to make a report is guilty of a Class 1 misdemeanor.

26-10-11. Child abuse reports by hospital personnel -- Failure as misdemeanor. When the attendance of any person under §26-10-10 with respect to a child is pursuant to the performance of services as member of a staff of a hospital or similar institution such person shall, in addition to the report required by §26-10-10, forthwith notify the person in charge of the institution or his designated delegate, who shall report or cause reports to be made in accordance with the provisions of §26-10-12. Any such person in charge or delegate who knowingly and intentionally fails to make a report required of him is guilty of a Class 1 misdemeanor. Each hospital or similar institution shall have a written policy on reporting of child abuse and neglect.

26-10-11.1. When the presence of any person under §26-10-10 is pursuant to the performance of services as a teacher, school nurse, school counselor, school official or administrator, such person shall, in addition to the report required by §26-10-10, notify the school principal or school superintendent or his designate who shall report or cause reports to be made in accordance with the provisions of §26-10-12. Any such school principal or superintendent or their delegate, who knowingly and intentionally fails to make a report required of him is guilty of a Class 1 misdemeanor. Each school district shall have a written school district policy on reporting of child abuse and neglect.

26-10-12. Oral report of child abuse -- To whom made. The report required by §§ 26-10-10 and 26-10-11 shall be made orally and immediately by telephone or otherwise to the state's attorney of the county in which the child resides or is present, or to the department of social services, or to the county sheriff, or to the city police. The state' attorney, the police department or the county sheriff, upon receiving a report shall immediately notify the department of social services, the department of social services, upon receiving a report,

shall immediately notify the state's attorney, the police department or the county sheriff. Anyone receiving a report of suspected child abuse shall keep the report confidential as provided in SDCL 26-10-12.3.

26-10-12.1. Investigation or oral report -- Other actions permitted -- Prosecution of action -- Counsel for child. Upon receipt of a report pursuant to §26-10-12, an investigation shall be made by the department of social services or any county sheriff or city police. Such investigation does not prohibit any other lawful action. If such investigation and report indicate that child abuse has occurred, the state's attorney shall commence an appropriate action.

26-10-12.2. Report to social services department -- Contents -- Filing -- Central information registry -- Release of information restricted. The court shall make a report to the office of the department of social services which shall include the name and address of the parents, guardian or responsible persons, the date and place of birth of the child, the date of the report, the suspected or proven physical or emotional abuse or intentional neglect and the disposition of the proceedings. Such report shall be filed within ten days of the date of any judgment or order entered by the court. The department of social services shall be the central registry for such information and shall release such information only to the attorney general, the state's attorneys, a law enforcement agency investigating a report of known or suspected abuse and neglect, the judges of the court, a child protection team, a protective services worker who is investigating a reported incident of abuse and neglect, a public official and his authorized agent who requires such information in connection with the discharge of his official duties, an agency having the legal responsibility or authorization to care for, treat or supervise a child who is the subject of a report, and to any person by order of the court as provided herein or to a state, regional or national registry of child abuse and neglect cases and to courts of record of other states on request. Such information shall only be released to such persons upon proof that it is necessary in the performance of official functions relating to child abuse, or neglect and all such information so released or furnished shall be held in confidence by the person receiving it, provided however, the court may order the release of information necessary for determination of an issue before such court.

26-10-12.3. Child abuse information confidential -- Unauthorized disclosure as misdemeanor. All investigative and case records, files and information concerning child abuse reports are confidential, and no disclosure of such reports, files or information shall be made except as provided in § 26-10-12.2. Any person who shall knowingly violate the confidential nature of such records, files or information shall be guilty of a Class 1 misdemeanor.

26-10-14. Immunity from liability -- Persons reporting abuse -- Child protection teams -- Public officials or employees -- Persons cooperating. Anyone participating in good faith in the making of a report pursuant to §§ 26-10-10 to 26-10-12, inclusive, or under any other provision of this chapter, shall have immunity from any liability, civil or imposed, and shall have the same immunity with respect to participation in any judicial proceeding resulting from such report. Immunity shall also extend in like manner to persons requesting the taking of photographs and X-rays pursuant to section 10 of this Act, to persons taking the photographs and X-rays and to child protection teams established by the secretary of social services, public officials or employees involved in the investigation and treatment of child abuse and neglect or who make a temporary placement of children pursuant to this chapter, or to any person who in good faith cooperates with a child protection team or the department of social services in an investigation, placement or treatment plan. The provisions of

this section or any other section granting or allowing the grant of immunity may not be extended to any person alleged to have committed an act or acts of child abuse.

26-10-15. Communications not privileged in child abuse or neglect cases. The confidential relation privilege set forth in §§ 19-2-3, 19-2-5/1. and 19-13-6 to 19-13-15, inclusive, may not be claimed in any judicial proceeding involving child abuse or child neglect or resulting from the giving of any report concerning a child's injury or neglect or the cause thereof, pursuant to §§ 26-10-10 to 26-10-12, inclusive.

26-10-16. Child protection teams. The secretary of social services may appoint one or more child protection teams within the state to assist in the prevention and treatment of child abuse and neglect. A child protection team may consist of, but is not limited to, licensed or certified medical and health professionals, a court service worker recommended by the presiding judge of a judicial circuit in which the team is to operate, the secretaries of social service and health or their designees, a representative of a mental health center, a representative of public school district in which the team shall operate, an attorney and one or more representatives of the public.

26-10-17. Notwithstanding the provisions of §26-8-22.2, the court shall appoint counsel for any child alleged to be abused or neglected in any judicial proceeding. The counsel shall be charged with representation of the child's best interests and may not be the counsel for any party, governmental agency or social sgency involved. The court may designate other persons who may or may not be attorneys licensed to practice law to assist in the performance of the counsel's duties.

26-10-18. Any person receiving a report under §26-10-10 may cause to be taken color photographs of of the areas of trauma visible on a child who is the subject of a report and may cause to be performed a radiological or other medical examination or testing of the child without the consent of the child's parents, guardian or custodian. All photographs taken pursuant to this section shall be taken by law enforcement officials or by the department of social services upon the request of any person required to report child abuse or neglect. All photographs, X-rays, test results or copies of them, shall be sent upon request to the appropriate law enforcement agency, state's attorney or to the department of social services.

REPORTING CHILD ABUSE AND NEGLECT

Why should you?

First and foremost, to protect the child. That's why you should not hesitate to report and promptly. It is not the intent of the law to remove the child from the home unless the child clearly is in danger. Nor is it the intent of the law to punish the parents. Instead, in most cases, the family can be helped so that parents and child can stay together. If you understand that the intent of the law is to get help to the family, then you will report and you will report early.

In South Dakota you are protected by law when you report what you suspect to be a case of child abuse or neglect. This means that you are protected or immune from civil or criminal liability.

All medical practitioners are required by law to report suspected child abuse or neglect SDCL 26-10-10 and 26-10-11.

HOW TO REPORT CHILD ABUSE AND NEGLECT

Telephone your local South Dakota Department of Social Services Office or contact your local law enforcement agency.

WHAT INFORMATION TO GIVE:

- The name and address of the child you suspect is being abused or neglected.
- The age of the child.
- The name and address of the parent or caretaker of the child.
- The name of the person you suspect is abusing or neglecting the child.
- Why you suspect the child has been abused or neglected.
- Any other helpful information.

TO REPORT ABUSE OR NEGLECT, CONTACT THE NEAREST DEPARTMENT OF SOCIAL SERVICES OFFICE

Aberdeen **622-2388**
422 S. Washington, P.O. Box 1300, 57401

Brookings **692-6301**
629 Fifth Avenue, P.O. Box 500, 57006

Chamberlain **734-6581**
704 N. Main, P.O. Box 430, 57325

Custer **673-4347**
Courthouse, 57730

Deadwood **578-2402**
668 Main Street, P.O. Box 607, 57732

Eagle Butte **964-4484**
P.O. Box 360, 57625

Hot Springs **745-5100**
602 Jennings, Box 830, 57747

Huron **352-8421**
Christen-Holm Bldg, P.O. Box 1436, 57350

Lake Andes **487-7607**
210 Main, P.O. Box 156, 57356

Martin **685-6521**
P.O. Box 236, 57551

Mission **856-4489**
Main Street, P.O. Box 269, 57555

Mitchell **996-7630**
116 E. 11th Street, 57301

Mobridge **845-2922**
920 West 6th, P.O. Box 160, 57601

Pierre **773-3521**
804 N. Euclid, 57501

Pine Ridge **867-5865**
Airport Building, P.O. Box 279, 57770

Rapid City **394-2434**
2301 E. St. Charles, P.O. Box 2440, 57709

Sioux Falls **339-6477**
405 S. 3rd Avenue, P.O. Box 1504, 57101

Sisseton **698-7675**
119 E. Cherry Street, P.O. Box 230, 57262

Vermillion **624-8606**
419 Cherry Street, 57069

Watertown **886-7000**
312 9th Ave. SE, P.O. Box 933, 57201

Winner **842-0400**
649 West 2nd Street, 57580

Yankton ..... **665-3671, Ext 241**
114 E. Third Street, 57078

IF A CHILD IS IN IMMEDIATE DANGER, CALL THE DEPT. OF SOCIAL SERVICES, OR CALL YOUR LOCAL POLICE DEPT.

If you would like additional information on child abuse and neglect, or if you have questions, please feel free to contact the Protective Services' Program Specialist at 605-773-3227 or South Dakota Dept. of Social Services, Children, Youth & Family Services, 700 N. Illinois, Kneip Building, Pierre, SD 57501.

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