



Attachment 9

Clinician Guide for Identifying, Treating and Preventing CHILD ABUSE and NEGLECT/MALTREATMENT

I PURPOSE

This guide was developed with the expertise of HHC's Child Protection Coordinators and other members of the Family Violence Workgroup to provide physicians, nurses, social workers, and other staff members with practical, up-to-date strategies to identify, document, and treat cases of child abuse and neglect/maltreatment. They are essentially an expanded and updated version of *Suspected Child Abuse and Neglect/Maltreatment: Protocol for Identification, Reporting, and Treatment* (also known as the "Green Book").

II DEFINITION

Child abuse and neglect/maltreatment are legally defined in the New York State Family Court Act, Section 1012, and the New York State Social Services Law, Section 412 (please refer to Appendix T, pages 115-119, "Legal Definitions" for abused child, abused child in residential care, neglected child, neglected child in residential care, maltreated child, maltreated child in residential care, and residential care).

III ASSESSMENT AND DOCUMENTATION

General Considerations: The medical record must include all information, both historical and medical, collected during the clinical evaluation. The medical record should be carefully prepared as it often becomes an integral component of medical/legal proceedings.

Documentation of cause for suspicion must be recorded in the medical record and must include the following:

1. Comprehensive medical history;
2. History of current problem;
3. Physical exam;
4. Indicated laboratory and radiographic studies; and
5. Appropriate consultations.

Collaboration among all members of the treatment team (physician, nurse, social worker, etc.) is essential to produce a thorough evaluation that documents physical, social, and emotional findings. Given the nature of the problem, every effort should be made to provide privacy for the child and the family.

The number of staff participating in the history-taking process should be kept to a minimum, to facilitate interaction, to reduce retraumatization, and to ensure confidentiality. The names of the individuals present for the interview must be documented. However, each professional involved in the case should record his or her assessment on the official patient record, regardless of possible overlap. Phone consults must be documented as part of the medical record. Maintaining parental cooperation is important, and repeated interrogation, confrontation, and accusation must be avoided.

When taking a history, it is important to be factual and observational. Make extensive use of quotes and record information (not conclusions). For example, avoid words that have a judgmental connotation, and be specific in describing conversation and behaviors. All informants should be clearly identified and relationships explained, including a translator, if applicable. The mental status, affect, and responsiveness of the informant(s) should be clearly noted. This information should be recorded in the official patient record to guarantee its admissibility in any legal proceeding.

Interpretation/Translation: It is advisable to generate a comprehensive list of existing personnel who speak a second or third language, including sign language. In the event that a language barrier exists between the provider and the patient, and an interpreter is required, conduct the interview in a safe environment:

1. Have a facility staff member act as the interpreter.
2. If facility staff member is not available, use an **objective** interpreter.
3. Always interview the patient in private when asking about possible abuse by a family member/guardian, including a parent.
4. Do not use any of the patient's family members, including children, as interpreters.
5. Do not use any person accompanying the patient as an interpreter.
6. Do not use any of the patient's friends as an interpreter.

Guidelines for Interviewing the Abused Child (Whenever possible, joint interviews, held preferably at a Child Advocacy Center should be conducted by the medical staff and ACS to minimize the number of interviews).

General Guidelines:

1. Introduce self and explain job to the child, e.g., "My job is to help children."
2. Establish rapport.
3. Select an area that is quiet and private.
4. Whenever possible, interview the child without parents or other individuals.
5. Take time to make the child feel comfortable.
6. Take accurate notes.
7. Obtain all background information before beginning, e.g., age, sex, what happened, whom did the child tell?
8. Always use age-appropriate language.
9. Never offer candy or food.

Examples of how to speak with and question children:

1. Questions that begin with "what," "where," "how," and "who" are good and are not leading questions. (When conducting an interview, avoid the use of leading questions. Leading questions influence the child's response by providing information not yet stated or by including the answer in the questions, e.g., *Incorrect:* "Did mom do that?" *Correct:* "I see you have bruises, what happened?")
2. Always use the child's own language when discussing body parts. Ask children what terms they use for body parts and have them identify areas on their own body (if possible).

3. Always ask the child the full name of the offender, e.g., Child: "My dad hit me";
Interviewer: "What is your dad's name?"
4. After the child discloses the abuse, always reassure and provide comfort. The following statements are all appropriate examples: "What happened wasn't your fault, it was good that you told someone"; "It is wrong for grownups to do that to children!"; or "This has not only happened to you. The same thing happens to many other children."
5. Inform children when members of liaison agencies are coming to interview them, e.g., "Ms. Smith from ACS and Detective Jones from the Police Department are coming to see you. Part of their job is to help children. They have helped many other children just like you."
6. Always tell the child the truth, convey the importance of the child telling the truth to you and always provide information at a level that the child can understand.

After the interview, document all statements the child made to you concerning the abuse. Document statements in quotes, both in the medical record and on the reporting form. Both are legal documents that can be entered into court records as evidence. Careful and concise documentation may prevent the need to testify in court.

History Taking: The complete history should include an assessment of the presenting complaint, medical history and social history.

1. **Presenting Symptoms or Complaint:** Record the history exactly as given by the informant. History must include:
 - a) exact dates, times, and sequences of events;
 - b) time lapse from onset of symptom or incident to arrival at the medical facility;
 - c) identification of person(s) responsible for care and supervision of the child at the time of the alleged incident;
 - d) identification of the alleged perpetrator, as well as of person making the accusation;
 - e) description of the physical home environment that may contribute to the evaluation of the incident; this may include type of dwelling (e.g., hotel, SRO, apartment house) and length of time patient has lived in current home; and
 - f) general appearance of parent/guardian and child, with specific examples of behavior.

When obtaining the above information, the provider should collect statements from both the parent(s)/guardian(s) and the child. Direct quotes should be used whenever possible. All persons referred to in the history should be identified, with addresses, if available. If an agency or the police are involved, the following should be obtained: name, title, name of agency, badge number and precinct, and telephone number.

2. **Past Medical History:** Obtain specific information concerning the patient's regular source of medical care (name of physician, institution, clinic, or child health station, dates of last visit and next appointment). If the patient has not routinely

sought medical care at your institution, determine why services are now being sought from your facility. Regardless of information provided about the source of care, medical records should always be reviewed for previous encounters. Information to be elicited includes:

- a) source(s) of past medical care (if care has been provided at your institution, obtain the medical record and previous radiological studies for immediate review; if patient is known to another institution, determine the reason for not now obtaining care at that institution);
- b) past history of episodes of trauma, whether or not medical care was sought;
- c) past hospitalization(s) and reason(s) for hospital stay(s); and
- d) complete history of immunizations (if possible, obtain immunization card).

3. **Social History:** A complete social history and evaluation should include:

- a) personal history of each parent, guardian, or other person living at home, including psychosocial evaluation and contacts with other agencies;
- b) information about the child and her/his role in the family, as perceived by parent/guardian;
- c) principal features of the family (structures, skills, roles);
- d) diagnostic impressions;
- e) assessment of danger to the child and other children in the family, now and in the future; and
- f) recommendations and treatment plan.

Medical Examination and Evaluation: It is imperative for the physician to conduct a detailed physical examination once the patient has been stabilized. The following information must be included, using clear, precise language, and documenting **clearly and legibly**:

1. General appearance (hygiene, clothing, etc.);
2. Height and weight;
3. Behavior toward parent/guardian, other relevant family members, and facility staff;
4. Careful and complete examination of entire body, noting all skin lesions and unusual findings (in the case of skin lesions, the location, size, pattern, and distribution **must** be carefully recorded; the body diagram should be done; photographs are not substitutes for a good description) (please refer to Appendix P, pages 97-105, "Child Body Maps");
5. Developmental assessment; if not feasible, note why assessment was not made; and
6. All necessary and appropriate laboratory and radiological studies to confirm or rule out the suspicion of abuse and neglect/maltreatment.

Psychiatric Consultation: A psychiatric evaluation of the parent/guardian may be required if the behavior of the parent/guardian is highly inappropriate or irrational; if the parent/guardian appears dangerous to self, others, or child; if the parent/guardian appears severely depressed or suicidal; or, if the degree of risk of child abuse needs to be determined. The psychiatrist should be contacted to do an assessment, make a diagnosis of the possible pathology and offer recommendations for treatment.

A psychiatric evaluation of the child should be obtained and formally documented in the record in the following situations:

1. Failure to thrive (FTT);
2. Bizarre behavior;
3. Age-inappropriate behavior, violent behavior; and/or
4. Severe depression or suicidal ideation.

Closure of First Visit: Medical staff must always reassure and support the child victim. Some strategies include:

1. Thanking the child for participating in the exam;
2. Discussing safety issues;
3. Avoiding making any promises to the child; and
4. Providing a concrete connection for future contacts.

Data Collection and Documentation: For each incident of child sexual abuse (including family and non-family) an HHC **Rape/Sexual Assault Tracking Form** must be completed by the Child Protection Coordinator or other designated staff person and forwarded to the facility's Rape/Sexual Assault Coordinator or designated staff person (please refer to Appendix S, pages 112-114, "Rape/Sexual Assault Tracking Form"). The Rape/Sexual Assault Tracking form is similar in purpose and scope to the Domestic Violence Tracking Form (please refer to Appendix R, pages 109-111, "Domestic Violence Tracking Form"). Tracking forms are analyzed at HHC Central Office, Office of Clinical Affairs.

High Risk Infants: There are many indicators suggesting that a newborn may be at risk. Evaluation of these indicators must be made expeditiously, prior to the newborn's hospital discharge:

1. Abandonment by parent(s);
2. Symptoms of drug withdrawal or fetal alcohol syndrome;
3. Toxicology testing based on high-risk indicators and reasonable suspicion of drug use by the mother; a positive toxicology test constitutes reasonable cause to suspect maltreatment and may be the basis of a report to the SCR, with rare exceptions (e.g., confirmed participation in a methadone program); and/or
4. A significant past history of child abuse or neglect/maltreatment.

A psychosocial assessment should also be conducted to determine if a report is necessary and if other conditions are present, including:

1. Admitted or suspected drug/alcohol use during pregnancy;
2. Minimal or no prenatal care;
3. Unsubstantiated prenatal care through other facility or clinic;
4. Very young or immature mother;
5. Inadequate visiting;
6. History of psychiatric illness;
7. Extramural delivery;

8. Lack of maternal attachment (as indicated by poor cuddling or lack of eye contact with the baby);
9. Disparaging remarks about the baby;
10. Postpartum depression; and/or
11. Social histories of significant family problems, e.g., psychosocial, financial, or drug/alcohol related.

Abandoned Infant Protection Act: This law was passed in New York State in July 2000 to encourage mothers who might otherwise abandon newborns into unsafe circumstance to bring the infant to a designated safe location. Under this law, the mother can avoid criminal prosecution for abandonment if she brings her unharmed infant, not more than 5 days old, to a designated safe location. In New York City, hospitals, fire stations and police stations are designated safe locations. (Please refer to “Abandoned Infant Protection Act Guidelines for NYC Health and Hospitals Corporation.”)

Assessing for Adult Domestic Violence: When working with abused children, it is essential to assess whether parent(s) or guardian(s) are victims of domestic violence as this may indicate that children are also at risk for abuse (for additional information on cross assessment, please refer to Part II- Domestic Violence within these Guidelines, pages 33-37, Section VI, “Medical and Psychosocial Assessment and Intervention.”)

IV REPORTING

New York State Law (Social Services Law, Section 413) requires that any health care professional who suspects (or has reason to suspect) that a child is being endangered or maltreated must report her/his suspicion to the New York State Central Register of Child Abuse and Neglect/Maltreatment (SCR). A report should be made to the SCR whenever there is a reasonable suspicion that a parent, guardian, custodian, or person legally responsible for the child is committing, or allowing to be committed, acts of abuse or neglect/maltreatment against the child. Reports should be filed even in situations where the parent, guardian, etc. has not been the perpetrator of the abuse, but is aware of the abuse or neglect/maltreatment and has taken no action to protect the child/adolescent. The SCR will refer to the local Child Protection Service (CPS), known in New York City as the Administration for Children’s Services (ACS), which is the agency charged with the investigation of child protective issues. Depending on the severity of the case, a police report may be initiated. Helplines are listed at the front of this book.

- A. **Persons Required to Report:** Any physician, surgeon, medical examiner, coroner, dentist, registered physician assistant, alcohol or substance abuse counselor, osteopath, optometrist, chiropractor, podiatrist, resident, fellow, intern, registered nurse, hospital personnel engaged in the admission, examination, care or treatment of persons, Christian Science practitioner, school official, social services worker, day care center worker or any other child care or foster care worker, mental health professional, peace officer, police officer or law enforcement official, psychologist, dental hygienist, employee or volunteer in a residential care facility, district attorney or assistant district attorney, family or group family day care provider (Social Services Law, Section 413).

- B. Reportable Cases of Child Abuse and Neglect/Maltreatment:** There is no check-list approach to the identification of possible child abuse or neglect/maltreatment. Although each case must be determined on an individual basis, there are general indicators that may be considered for all cases. Some indicators require automatic reporting to SCR, while others indicate a need for immediate assessment by hospital staff. The following indicators have been grouped according to these criteria. The list is not all-inclusive, nor does the presence of a single or several indicators prove child maltreatment (please refer below).

AUTOMATICALLY REPORTABLE CASES OF CHILD ABUSE AND/OR NEGLECT/ MALTREATMENT

Physical Abuse. Physical indicators include:

1. Unexplained skin lesions, soft tissue swelling, abrasions, hematomas, or bruises on various parts of the body (not explained after work-up) in different stages of healing.
2. Lesions in different body areas reportedly from the same injury.
3. Lesions that have distinctive patterns, e.g., an injury inflicted by a belt buckle, an extension cord, or a wire hanger.
4. Unexplained burns, such as rope burns, cigar or cigarette burns, occurring on hands, feet, back or buttocks, and others.
5. Burns with distinctive patterns, such as from an iron or radiator.
6. Burns reported as secondary to accidental immersion in hot water or scalding, e.g., glove or stocking pattern.
7. Unexplained lacerations to face, mouth, eyes or external genitalia.
8. Evidence on exam of old fractures and torsion fractures in young infants.
9. Unexplained bite marks.

Behavioral indicators of physical abuse include:

1. Child reports injury by parents.
2. Child is afraid to go home (information must be clearly defined).

Indicators from the family history include:

1. Parents or guardians admit abuse.
2. Parents provide a story that is at variance with clinical findings.
3. Histories vary according to intake staff, e.g., clerk, nurse, resident, social worker obtain different versions of episode.
4. Reluctance of parents to provide information on a particular injury.
5. Child is brought to hospital for complaint that exists in obvious contrast to one associated with maltreatment, e.g., cold, headache, stomach aches, etc.
6. Delay in seeking medical attention for serious injury or illness.

Indicators from radiologic evidence include:

1. Subperiosteal hemorrhages.
2. Epiphyseal separations.

3. Periosteal shearing.
4. Metaphyseal fragmentation.
5. Healed fractures of periosteal calcifications.
6. Spiral fractures.

Physical Neglect may be indicated by:

1. Failure to thrive, if not attributable to medical cause.
2. Obvious unattended serious medical, dental, optometry or surgical problems.
3. Lack of supervision or medical care, e.g., illness not followed that endangers the child.
4. Child reports absence of supervision or caretaker.

In newborns, indicators of physical neglect include abandonment, symptoms of drug withdrawal or fetal alcohol syndrome, and laboratory data which verifies substance abuse.

Sexual Abuse may be indicated by:

1. Presence of venereal disease in children under the age of 11 excluding newborns.
2. Pregnancy. (Pregnancy under age 14 demands a complete psychosocial and medical evaluation.)
3. Child reports sexual assault by caretaker.

NEEDS IMMEDIATE ASSESSMENT FOR CHILD ABUSE AND/OR NEGLECT/ MALTREATMENT

In certain cases which are not automatically reportable, there may be indications which suggest the possibility of abuse or maltreatment. An immediate assessment for child abuse and/or neglect/ maltreatment should be performed when these indicators are present.

Physical abuse in this category may be indicated by the same physical indicators listed above for automatically reportable cases. Behavioral indicators include:

1. Child is inappropriately wary of adult contacts.
2. Child is frightened of parents.
3. Child demonstrates behavioral extremes.
4. Child wears long-sleeved clothing or similar clothing to hide injury.

Indicators of physical abuse from the family history include:

1. Multiple visits to various hospitals and health facilities.
2. Use of hospital facilities in evenings and night shifts.
3. Parents' inappropriate response to the severity of the injury.
4. If abuse is mentioned, blame for injury is usually placed upon a third, and often unknown, party.
5. Social histories involving multiple family problems, e.g., psychosocial, financial, drug and/or alcohol abuse, etc.
6. Assessment for domestic violence (please refer to Part II-Domestic Violence within these Guidelines, pages 23-43).

Physical Neglect requiring an immediate assessment may be indicated by:

1. Poor hygiene, e.g., encrusted dirt or lice and smell of urine or feces.
2. Inappropriate clothing.
3. Fatigue, listlessness and consistent hunger.
4. Ingestions.

Behavioral indicators of physical neglect are:

1. Delinquency and antisocial behavior.
2. Constantly falling asleep in class.
3. Inappropriate behavior for age.

In newborns, indicators of physical neglect from the family history include:

1. Mother admitted or suspected of drug or alcohol use during pregnancy.
2. Minimal or no prenatal care.
3. Unsubstantiated prenatal care through other facility or clinic.
4. Extramural delivery.
5. Very young or immature mother.
6. Social histories involving multiple family problems, e.g., psychosocial, financial, drug and/or alcohol abuse, etc.
7. History of psychiatric illness.
8. Lack of maternal attachment.
9. Disparaging remarks about the baby.
10. Postpartum depression.
11. Infrequent visiting.

Sexual abuse may be indicated by these physical signs:

1. Pain, itching or injuries in genital area.
2. Bruises or bleeding in perineal area.
3. Venereal disease.
4. Difficulty in sitting or walking.
5. Pregnancy. (Please refer to Part II-Domestic Violence within these Guidelines, page 32 for additional information.)

Behavioral indicators of possible sexual abuse requiring immediate assessment include:

1. Sexual behavior or knowledge inappropriate for age.
2. Unwillingness to allow physical exam, to participate in gym classes or use locker rooms, etc.
3. Delinquent or runaway.
4. Poor peer relationships.
5. Withdrawal into fantasy/infantile behavior.

Emotional deprivation or maltreatment also may be suspected and require immediate assessment when these physical indicators are present:

1. Speech disorders.
2. Lags in physical development.
3. Failure to thrive.

Behavioral indicators include:

1. Overly fearful behavior.
2. Developmental delays.
3. Extremes of behavior.
4. Suicide attempts or gestures.
5. Conduct disorders: fighting in school, etc.
6. Habit disorders, e.g., rocking, sucking fingers.
7. Neurotic behaviors, e.g., speech disorders, sleep problems.
8. Psychoneurotic reactions, e.g., phobias, hysteria.



THE CITY OF NEW YORK

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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Thomas R. Frieden, M.D., M.P.H.
Commissioner

nyc.gov/health



HOW YOU CAN HELP REDUCE SIDS DEATHS

May 2004

Dear *[First Name, Last Name (of Hospital Administrator/Medical Provider/Nurse Administrator)]*:

Sudden Infant Death Syndrome (SIDS) is the leading cause of death among infants over the age of one month. The American Academy of Pediatrics recommends placing infants to sleep on their back at all times to reduce the risk of SIDS, unless otherwise recommended by a doctor.

WHAT YOU CAN DO

We support the AAP back-to-sleep recommendations, and encourage you and your staff to consider the following strategies for implementing the recommendations in your own hospital setting:

1. If your hospital does not consistently model the back-to-sleep position, we strongly encourage you and your staff to always place infants to sleep on their backs in all newborn nurseries, including intensive care settings, and to discuss the importance of back-to-sleep in reducing risk of SIDS with parents/caregivers.
2. If your hospital is currently practicing the supine position, we sincerely commend your efforts and encourage you to continue using the method — not only in newborn nurseries, but also in the NICU.
3. Encourage parents/caregivers to use the back-to-sleep position after discharge in all follow-up visits, so that use of the supine position is maintained, even several months after birth.
4. Recognize and acknowledge parents/caregivers for their value, importance and expertise in childcare. Provide positive reinforcement for what they are doing right and guidance on SIDS risk reduction methods that they are not practicing, especially back-to-sleep.
5. Please include grandmothers and other caregivers, whenever possible, during educational efforts regarding SIDS risk reduction, since some parents identify them as one of their most valuable sources of medical information.

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WHAT WE KNOW

Since the initiation of the Back-to-Sleep Campaign, the national rates of SIDS have declined dramatically. New York City SIDS rates have also decreased over the past decade and are lower than the national SIDS rates. Although SIDS rates in New York City have declined, there still remains a significant disparity among certain racial and ethnic groups. From 1999 to 2002, SIDS death rate (per 10,000 live births) among Black non-Hispanics (5.4) was nearly twice the rate of Hispanics (2.9) and more than 10 times the rate for White, non-Hispanics (0.5). The New York City Department of Health and Mental Hygiene (NYC DOHMH) 2003 Community Health Survey found that 36% of Black, non-Hispanics reported putting their infants to sleep on the stomach, compared with 11% of other respondents. Given these disparities, we are very concerned that the recommendation to put babies to sleep on their back is not being consistently practiced by parents and caregivers.

Recent focus groups conducted by the Bureau of Maternal, Infant and Reproductive Health (BMIRH), NYC DOHMH, found that the majority of mothers of African American or Black Caribbean descent received back-to-sleep education in the hospital, but most switched from supine sleeping to prone sleeping after one week – citing encouragement by their own mother, concerns about baby's discomfort, and fears of choking. African American/Black Caribbean parents and caregivers reported feeling disconnected from providers, often due to negative past experiences. Moreover, they often felt inappropriately singled out or implicitly blamed for SIDS – rather than being recognized as loving, caring parents/caregivers who want what is best for their children.

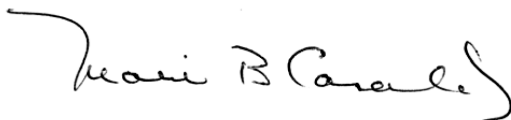
BACK-TO-SLEEP RECOMMENDATION & RESOURCES

Enclosed is the AAP recommendation on SIDS, infant sleep environment and sleep position. A SIDS provider education slide set is now available on the BMIRH website, www.nyc.gov/health/maternity, which you can download and modify as needed. If you would like to find out more about NYC DOHMH activities to reduce SIDS deaths, such as provider presentations, please contact Katrina Manzano at BMIRH, (212) 442-1756. We thank you for your support in this vital effort to promote back-to-sleep and reduce the risk of SIDS deaths for infants in New York City.

Sincerely,



Deborah Kaplan, RPA, MPH
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