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Contact Hours: **3**

Child Abuse Mandated Reporter Training for New York State

Identifying and Reporting Child Abuse and Maltreatment

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BY Sheree Goldman, MSN, RN, WHNP; Adrienne E. Avillion, DEd, MSN, RN; Nancy Evans, BS

LEARNING OUTCOME AND OBJECTIVES: Upon completion of this course, you will have gained the knowledge to identify and report child abuse, child neglect, and child maltreatment. Specific learning objectives include:

- Define child abuse, child maltreatment, and child neglect according to New York State law.
- Explain the risk factors contributing to child abuse.
- Recognize physical and behavioral indicators of child abuse and maltreatment.
- Describe situations in which mandated reporters must report suspected cases of abuse and maltreatment.
- Explain the process for placing a child into protective custody.
- Discuss the legal protections afforded mandated reporters as well as the consequences for failing to report.

INTRODUCTION

The government has a responsibility to protect children when parents or other persons legally responsible for a child's care fail to provide proper care and to intervene in cases of child maltreatment. Likewise, healthcare professionals have a responsibility to recognize and report suspected child abuse and maltreatment.

Parents have the primary responsibility for their children and the legal right to raise them as they see fit. This right falls under the 14th Amendment of the United States Constitution, which states

“no state [shall] deprive any person of life, liberty, or property without due process of law.” The Supreme Court states that “liberty” as referred to in the amendment denotes not merely freedom from bodily restraint but also the right of the individual to establish a home and bring up children (USDHHS, 2014).

Although the Constitution upholds the rights of parents, initially there were no laws to protect children. The first organization established with the purpose of protecting children from abuse and neglect was a nongovernmental agency; in 1874, the Society for the Prevention of Cruelty to Children was established in New York (NYSPCC, 2017). A federal Children’s Bureau was not founded until 1912, demonstrating that Congress officially acknowledged the government’s obligation to protect children from maltreatment. The Children’s Bureau is the first U. S. government agency to focus exclusively on improving the lives of children and families. It was also the first in the world to do so (Children’s Bureau, 2016).

The Child Abuse Prevention and Treatment Act of 1974 was signed into law many years later and was the first legislative effort of the federal government to improve the response to child abuse and neglect. In 1996, the Office on Child Abuse and Neglect was created to provide national leadership for child abuse and neglect policy and programs (CWIG, 2017b). In the year 2000, the Child Abuse Prevention and Enforcement Act was enacted. This legislation authorized law enforcement to enforce child abuse and neglect laws, promote child abuse prevention programs, and develop a system to track suspected offenders (USDHHS, 2010).

The goal of governmental child abuse laws and programs today is to develop a comprehensive child welfare system that supports children, families, and communities in ways that will prevent the occurrence of maltreatment in the future.

WHAT IS CHILD ABUSE?

Different states and government entities may vary in their definitions of child abuse. It is important for nurses to know the definitions of abuse in the state(s) in which they live and/or practice.

Legal Definitions

The term *child abuse* generally describes the most serious harms committed against children by the persons who are responsible for their care. The following definitions are specific to the state of New York.

ABUSE

Child abuse is defined in New York State’s Family Court Act, Article 10, Part 1, Section 1012(f) (Definitions) (NYS Legislature, 2018a) (emphasis added):



“Abused child” means a child less than 18 years of age whose parent or other person legally responsible for the child’s care:

- Inflicts or allows to be inflicted upon the child **physical injury** by other than accidental means which causes or creates a substantial risk of death, serious or protracted disfigurement, protracted impairment of physical or emotional health, or protracted loss or impairment of the function of any bodily organ; or
- Creates or allows to be created a substantial **risk of physical injury** to the child by other than accidental means which would be likely to cause death, serious or protracted disfigurement, protracted impairment of physical or emotional health, or protracted loss or impairment of the function of any bodily organ; or
- Commits or allows to be committed a **[sex] offense** against the child, as defined in article 130 of the penal law; allows, permits, or encourages the child to engage in any act described in sections 230.25, 230.30 or 230.32 of the penal law [promoting prostitution in the third, second, and first degree respectively]; commits any act described in sections 255.25, 255.26, and 255.27 of the penal law [incest]; or allows such child to engage in acts or conduct described in article 263 of the penal law [sexual performance by a child] . . .

[. . .]

“Person legally responsible” includes the child’s custodian, guardian, or any other person responsible for the child’s care at the relevant time. Custodian may include any person continually or at regular intervals found in the same household as the child when the conduct of such person causes or contributes to the abuse or neglect of the child.

MALTREATMENT

Maltreatment refers to the quality of care that a child receives. Section 412 of New York State’s Social Services Law, Article 6, Title 6, defines a maltreated child as a child less than 18 years of age who is defined as a neglected child by the Family Court Act or who has had serious physical injury inflicted upon him or her by other than accidental means (NYS Legislature, 2018b) (emphasis added):

Maltreatment occurs when a parent or other person legally responsible for the care of a child harms a child or places a child in imminent danger of harm by **failing to exercise the minimum degree of care** in providing the child with any of the following: food, clothing, shelter, education, or medical care when financially able to do so. Maltreatment can also result from **abandonment** of a child or from **not providing adequate supervision** for the child. Further, a child may be maltreated if a parent engages in **excessive use of drugs or alcohol** such that it interferes with their ability to adequately supervise the child.



NEGLECT

Neglect can be physical or emotional and involves acts of omission by the parent. Although the legal definitions of *maltreatment* and *neglect* are not exactly the same, the terms are often used interchangeably. However, maltreatment includes acts of omission and commission, whereas neglect includes only acts of omission. That is, maltreatment includes neglect, but neglect does not include maltreatment.

Child neglect is defined in Article 10, Part 1, Section 1012(f) of New York State’s Family Court Act (NYS Legislature, 2018a) (emphasis added):

“Neglected child” means a child less than 18 years of age:

- Whose physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of his parent or other person legally responsible for his care to **exercise a minimum degree of care**:
 - In supplying adequate food, clothing, shelter, education, or medical, dental, optometrical, or surgical care, though financially able to do so or offered financial or other reasonable means to do so; or
 - In providing the child with proper supervision or guardianship, by unreasonably inflicting or allowing to be inflicted harm or substantial risk of harm including the infliction of excessive corporal punishment; or by misusing a drug or drugs; or by misusing alcoholic beverages to the extent that the parent or other person legally responsible for the child’s care loses self-control of his or her actions; or by any other acts of a similarly serious nature requiring the aid of the court; or
- Who had been **abandoned** [by a parent or other person legally responsible for the child who shows an intent to give up his or her parental rights and obligations]

| COMPARING ABUSE AND MALTREATMENT/NEGLECT | |
|---|--|
| Abuse | Maltreatment/Neglect |
| Parent or other persons legally responsible: <ul style="list-style-type: none"> • Inflicts or allows to be inflicted serious injury • Creates or allows to be created substantial risk of injury • Commits or allows to be committed a sex offense | Parent or other persons legally responsible impair a child’s physical, mental, or emotional condition by: <ul style="list-style-type: none"> • Failing to provide basic needs of food, clothing, shelter, education, or medical care, or education when financially able • Inflicting excessive corporal punishment • Failing to provide adequate supervision • Engaging in excessive use of drugs or alcohol that interferes in the ability to provide adequate supervision |



CASE

Robert attends fifth grade. His mother provides him with lunch money or prepares a lunch for him to bring to school. Recently, Robert began to come home from school hungry every day and told his mother that he had given his lunch or his money to his classmate Kevin. He also let Kevin borrow a jacket, and it was never returned. Robert's mother queried him as to why he was doing this, and he said that Kevin was just really poor and hungry and cold every day. Robert denied any bullying behavior on Kevin's part.

Robert's mother contacted the school about this situation. The school nurse called Kevin into the office, and a sensitive discussion revealed that Kevin's parents were separated and that he was living with his father in a hotel room. His father was unemployed and drinking and using drugs daily, leaving little money for food or clothing to care for Kevin's needs. The nurse contacted Child Protective Services, and Kevin was found to be the victim of neglect. He was placed in the care of his mother, whose income was also below the poverty level, and Social Services assisted her in obtaining assistance in order to care for Kevin.

Types of Abuse and Neglect**PHYSICAL**

Physical abuse of a child includes any nonaccidental physical injury of a child that is inflicted by a parent or caretaker. Physical abuse injuries can range from superficial bruises and marks to fractures, burns, and serious internal injuries. In severe cases, the physical abuse may lead to death. The legal definition of physical abuse also includes actions that pose a substantial risk of physical injury to the child, even if no injury is sustained. In the United States, approximately 28% of adults report having been physically abused as a child (Childhelp.org, 2017).

Physical neglect is the failure to provide a child with adequate food, shelter, clothing, education, hygiene, medical care, and/or supervision needed for normal growth and development. Leaving a young child or children without supervision by a responsible person is a type of neglect (Childhelp.org, 2017). Infants and toddlers should never be left alone, even briefly. While older preteens may be responsible and independent enough to be left alone, some older teenagers are too irresponsible or have special needs that limit their ability to be safe if left alone.

Data from the Children's Bureau indicate that nationally an estimated 1,670 children died from abuse or neglect in fiscal year 2015. This is an increase of 5.7% compared to 2011 (CWIG, 2017a).

Physical abuse is described in New York's Family Court Act, Article 10, Part 1, Section 1012, as occurring when a child less than 18 years of age whose parent or other person legally responsible for his care:

- Inflicts or allows to be inflicted upon such child physical injury by other than accidental means which causes or creates a substantial risk of death, or serious or protracted



disfigurement, or protracted impairment of physical or emotional health or protracted loss or impairment of the function of any bodily organ, or

- Creates or allows to be created a substantial risk of physical injury to such child by other than accidental means which would be likely to cause death or serious or protracted disfigurement, or protracted impairment of physical or emotional health or protracted loss or impairment of the function of any bodily organ.

(NYS Legislature, 2018a)

SEXUAL

Sexual offenses are described in the New York Penal Code, Title H, Article 130, Sexual Offenses (NYS Legislature, 2018c). Sexual abuse includes situations in which the parent or other person legally responsible for a child under 18 years of age commits or allows any one of the following activities:

- Touching a child's mouth, genitals, buttocks, breasts, or other intimate parts for the purpose of gratifying sexual desire
- Forcing or encouraging the child to touch the parent, or other person legally responsible, in this way for the purpose of gratifying sexual desire
- Engaging or attempting to engage the child in sexual intercourse or any deviate form of sexual intercourse
- Forcing or encouraging a child to engage in sexual activity with other children or adults
- Exposing a child to sexual activity or exhibitionism for the purpose of sexual stimulation or gratification of another
- Permitting a child to engage in sexual activity which is not developmentally appropriate when such activity results in the child suffering emotional impairment
- Using a child in a sexual performance such as a photograph, play, motion picture, or dance regardless of whether the material itself is obscene
- Giving indecent material to a child

Sexual abuse and maltreatment also include such criminal offenses as rape, sodomy, other nonconsensual sexual conduct, and prostitution (NYS OCFS, n.d.).

EMOTIONAL

Emotional abuse is defined in New York's Family Court Act, Article 10, Part 1, Section 1012(h):

“Impairment of emotional health” and “impairment of mental or emotional condition” including a state of substantially diminished psychological or intellectual functioning in relation to, but not limited to, such factors as failure to thrive, control of aggressive or self-destructive impulses, ability



to think and reason, acting out, or misbehavior, including incorrigibility, ungovernability, or habitual truancy; provided, however, that such impairment must be clearly attributable to the unwillingness or inability of the respondent to exercise a minimum degree of care toward the child.

(NYS Legislature, 2018a)

Emotional neglect includes parent or other caretaker behaviors that cause or have the potential to cause serious cognitive, affective, or other behavioral health problems. The resulting emotional impairment must be clearly attributable to the unwillingness or inability of the parent or other person legally responsible for the child to exercise a minimum degree of care toward the child. These behaviors may include:

- Chronic use of verbally abusive language
- Harsh criticism
- Denigration
- Confinement
- Torture

Children can also be harmed by exposure to the abuse of others. Children who witness violence in the home experience changes in the anatomic and physiological make up of their central nervous system. A child witness of domestic violence may develop posttraumatic stress disorder (PTSD) if there is no intervention and may develop permanent changes to their personality as well as their ability to interact effectively in society as an adult. These children may demonstrate sleep disorders, irritability, repetitive play themes, and disorganization. Interventions before the age of 7 are the most successful, so it is important to recognize the symptoms and intervene as early as possible (Tsavoussis, 2014).

Special Definitions Relating to Children in Residential Care

ABUSED CHILD IN RESIDENTIAL CARE

An abused child can include a child with disabilities or special needs who is residing in a group residential care facility, such as one under the jurisdiction of the Department of Social Services, Division for Youth, Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, or State Education Department (Social Services Law, Article 6, Title 6, Section 412.8). The residential care law also applies to children residing in any of the following:

- New York State School for the Blind or the New York State School for the Deaf
- A private residential school which has been approved by the Commissioner of Education for special education services or programs
- A special act school district



- State-supported institutions for the instruction of the deaf and blind that have a residential component

In these settings, the definition of child may be extended beyond the age of 18.

NEGLECTED CHILD IN RESIDENTIAL CARE

Article 6, Title 6, Section 412.9, of the Social Services Law provides a separate definition of a neglected child in residential care (Adelphi University, n.d.).

A neglected child in residential care means a child whose custodian* impairs, or places in imminent danger of becoming impaired, the child's physical, mental, or emotional condition:

- By intentionally administering to the child any prescription drug other than in accordance with a physician's or physician's assistant's prescription
- By failing to adhere to standards for the provision of food, clothing, shelter, education, medical, dental, optometric, or surgical care, or for the use of isolation or restraint in accordance with the regulations of the state agency operating, certifying, or supervising such facility or program, which shall be consistent with the child's age, condition, service, and treatment needs
- By failing to adhere to standards for the supervision of children by inflicting or allowing to be inflicted physical harm, or a substantial risk thereof, in accordance with the regulations of the state agency operating, certifying, or supervising such facility or program, which shall be consistent with the child's age, condition, service, and treatment needs
- By failing to conform to applicable state regulations for appropriate custodial conduct

*A director, operator, employee, or volunteer of a residential care facility or program

This definition pertains to children residing in group residential facilities under the jurisdiction of the State Department of Social Services, Division for Youth, Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, or State Education Department.

MALTREATED CHILD IN RESIDENTIAL CARE

Article 6, Title 6, Section 412.2(c), of the Social Services Act also specifies that a maltreated child can include a child with a disability who may be up to 21 years of age when he or she is defined as a neglected child in residential care (as defined above).



CASE

Christine, age 17, suffering from severe depression, has attempted suicide twice in the past six months. She was experiencing panic attacks, agoraphobia, and self-cutting. She was treated as an outpatient during that time and was unable to attend school. In desperation, her parents agreed to residential treatment in a state-subsidized group home for a three-month evaluation.

Christine's symptoms seem to be getting worse. She is seldom allowed to have visits or even phone calls from her parents, who were told that all of the children had lost their privileges for phone calls and visitors for several weekends in a row. One Sunday, her parents decided to visit the home unannounced. They found Christine quarantined in a small sitting room with 11 other children. All of the children had been kept awake all night as a "punishment" because two children had attempted to run away. One staff member was banging pots and pans in the faces of the exhausted children, who were falling asleep sitting up, as they were not allowed to lie down.

Christine's parents took her home immediately, signing her out "AMA" (against medical advice), and contacted the Department of Social Services. An investigation followed, and the group home was closed for failure to conform to applicable state regulations for appropriate custodial conduct.

ABANDONED INFANT PROTECTION ACT

In 2000, New York State became one of the first states to enact a "safe-haven" law by passing the Abandoned Infant Protection Act (AIPA). The law designates specific locations as safe places for parents to relinquish their unharmed newborns. It helps ensure that unwanted infants are surrendered to persons who can provide immediate care for their safety and well-being. To date, all 50 states, the District of Columbia, and Puerto Rico have enacted safe haven legislation (CWIG, 2016). It also protects parents who feel that they have no choice other than abandonment and want to protect their child from harm.

Abandonment (discarding) of newborn infants in unsafe places is an example of extreme neglect. Under New York State penal law, Title O, Article 260, Section 260, it is considered a Class E felony and a Class A misdemeanor and must be reported by mandated reporters. Under the AIPA, amended in 2010, a parent will not be charged if the following criteria are met:

1. The abandoned infant can be no more than 30 days old.
2. The person abandoning the infant must have intended that the infant will be safe from physical injury and cared for appropriately.
3. The person leaves the infant with an appropriate person or leaves the baby in a suitable location such as a hospital, police station, or fire department. The person immediately notifies an appropriate person of the infant's location.
4. The person must intend to wholly abandon the infant by relinquishing responsibility for and rights to the care and custody of the infant.



Any mandated reporter who learns of abandonment is obligated to fulfill mandated reporter responsibilities (see “Reporting Child Maltreatment/Abuse” later in this course). Even if the reporter is unsure of the name of the person abandoning the child, he or she must make a report, simply listing the unknown person as “Unknown” (NYS OCFS, 2016a).

(See also AIPA in “Resources” at the end of this course.)

PREVALENCE AND RISK FACTORS

Nationally in 2015, an estimated 3.4 million children received either an investigation or alternative response at a rate of 45.1 children per 1,000 in the population. The number of children who received a Child Protective Services response increased by 9% from 2011 to 2015 (USDHHS, 2017).

In New York State in 2015:

- There were 156,994 total referrals for child abuse and neglect.
- There were 66,767 victims of abuse or neglect. This is a rate of 15.8 per 1,000 children and an increase of 2.5% from 2014.
- The number of child victims has decreased 8.2% in comparison to the number of victims in 2011.
(USDHHS, 2016)

Victim Demographics

Nationally, the youngest children are the most vulnerable to maltreatment. In 2015, states reported that:

- 27.7% of victims were younger than three years.
- The victimization rate was highest for children younger than 1 year.
- The percentages of child victims were similar for both boys and girls.
- The majority of victims were of three races or ethnicities: white (43.2%), Hispanic (23.6%), and African American (21.4%).
- African American children had the highest rate of victimization at 14.5 per 1,000 children in the population of the same race or ethnicity. Native American or Alaska Native children had the second highest rate at 13.8 per 1,000 children.
- About 75% of victims were neglected, 17.2% were physically abused, and 8.4% were sexually abused. Additionally, 6.9% of victims experienced other types of maltreatment



such as threatened abuse, parent's drug/alcohol abuse, or safe relinquishment of a newborn.

(USDHHS, 2017)

In 2015 in **New York State**, of the 66,676 victims of abuse or neglect, 95.3% were neglected, 9.7% were physically abused, and 3% were sexually abused. In 2015, there were 108 child deaths resulting from abuse or neglect reported in the state (USDHHS, 2016).

Risk Factors

Health professionals must remain alert for risk factors that may increase the likelihood of child abuse and maltreatment. Risk factors may be either characteristics of a caregiver or of a child and may go undetected.

The Centers for Disease Control and Prevention (CDC) cites the following **caregiver risk factors**:

- Parents' lack of understanding of children's needs, child development, and parenting skills
- Parents' history of child maltreatment in family of origin
- Substance abuse and/or mental health issues, including depression in the family
- Parental characteristics such as young age, low education, single parenthood, large number of dependent children, and low income
- Nonbiological, transient caregivers in the home (e.g., mother's male partner)
- Parental thoughts and emotions that tend to support or justify maltreatment behaviors (CDC, 2017)

The following **characteristics of children** were determined to be risk factors:

- Children younger than 4 years of age
- Special needs that may increase caregiver burden
- Physical disability
- Intellectual disability
- Mental health issues
- Chronic physical illnesses (CDC, 2017)



Additional risk factors include:

- Social isolation
- Family disorganization, dissolution, and violence, including intimate partner violence
- Parenting stress, poor parent-child relationships, and negative interactions
- Community violence
- Concentrated neighborhood disadvantage (e.g., high poverty and residential instability, high unemployment rates, and high density of alcohol sales outlets)
- Poor social connections
(CDC, 2017)

Presence of these factors signal the need for the professional to examine the situation more closely, carefully, and methodically. These factors seldom appear in isolation but rather in clusters.

PARENTAL SUBSTANCE ABUSE AND CHILD ABUSE

Parental substance abuse greatly increases the incidence of child abuse and neglect. A review of recent research on parental substance abuse and its impact on children showed that:

- 1 in 5 American children live in homes with parental substance abuse.
- Children who grow up in homes with prevalent substance abuse are more likely to misuse drugs and alcohol; this leads to multigenerational cycles of addiction.
- Parents who are struggling with substance use disorders are often unable to meet basic physical, psychological, and emotional needs for their children.
- Children whose parents use drugs and misuse alcohol are 3 times more likely to be physically, sexually, or emotionally abused than their peers.
- Children whose parents use drugs and misuse alcohol are 4 times more likely to be neglected than their peers.

(Bergland, 2016)

ACE STUDY

Many children suffer multiple types of abuse, which increases their risk of serious health consequences as adults. The Adverse Childhood Experience (ACE) study, published in 2009, investigated the association between childhood maltreatment and later-life health and well-being.



The findings suggest that certain negative experiences in childhood are major risk factors for illness, poor quality of life, and death later in life. The more adverse childhood experiences that were experienced by an individual, the greater the risk of developing:

- Risky health behaviors such as substance use and abuse
 - Chronic health conditions
 - Low life potential
 - Early death
- (CDC, 2016)

Protective Factors to Reduce Child Maltreatment

Protective factors safeguard children from being abused or neglected. There is scientific evidence to support that a supportive family environment and social networks have a protective effect. Several other potential protective factors have been identified. Ongoing research is exploring whether the following factors can buffer children from maltreatment:

- Nurturing parenting skills
 - Stable family relationships
 - Household rules and child monitoring
 - Parental employment
 - Adequate housing
 - Access to healthcare and social services
 - Caring adults outside the family who can serve as role models or mentors
 - Communities that support parents and take responsibility for preventing abuse
- (CDC, 2017)

The CDC (2017) also reports that evidenced-based programs can abate child maltreatment. Some examples of programs that have proven to prevent child abuse are government-sponsored child-parent centers, nurse family visits in the home, skill building through parent-child interaction therapy, and parent screening in the pediatric primary care setting.



RECOGNIZING PHYSICAL ABUSE

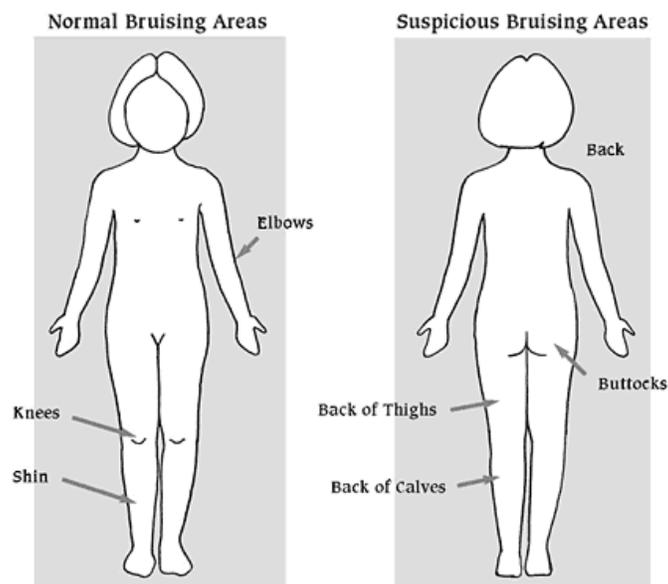
Physical Indicators of Physical Abuse

Healthcare professionals must be alert for physical injuries that are unexplained or inconsistent with the parent or other caretaker's explanation and/or the developmental state of the child.

BRUISING

It is important to know both normal and suspicious bruising patterns when assessing children's injuries. Some red flags for nonaccidental bruising, if observed, should signal suspicion. In particular, the following injuries are worrisome:

- Bruises in babies who are not yet cruising
- Bruises on the ears, neck, feet, buttocks, or torso (torso includes chest, back, abdomen, genitalia)
- Bruises not on the front of the body and/or overlying bone
- Bruises that are unusually large or numerous
- Bruises that are clustered or patterned (patterns may include handprints, loop or belt marks, bite marks)
- Black eyes
- Bruises around the wrists or ankles (indicating that someone may have tied up the child)
- Bruises that do not fit with the causal mechanism described
(Healthy Place, 2016; NSPCC, 2018)



Normal and suspicious bruising areas.
(Source: Research Foundation of SUNY, 2011.)





This pattern signals the blow of a hand to the face of a child.
(Source: Research Foundation of SUNY, 2011.)



Regular patterns reveal that a looped cord was used to inflict injury on this child.
(Source: Research Foundation of SUNY, 2011.)

LACERATIONS OR ABRASIONS

Typical indications of unexplained lacerations and abrasions that are suspicious include:

- To mouth, lips, gums, eyes
- To external genitalia
- On backs of arms, legs, or torso
- Human bite marks (these compress the flesh, in contrast to animal bites, which tear the flesh and leave narrower teeth imprints)
(Healthy Place, 2016; NSPCC, 2018)

BURNS

Typical indications of unexplained burns include worrisome:

- Cigar or cigarette burns, especially on soles, palms, back, or buttocks
- Immersion burns by scalding water (sock-like, glove-like, doughnut-shaped on buttocks or genitalia; “dunking syndrome”)



- Patterned like an electric burner, iron, curling iron, or other household appliance
- Rope burns on arms, legs, neck, or torso
(Healthy Place, 2016; NSPCC, 2018)



A steam iron was used to inflict injury on this child.
(Source: Research Foundation of SUNY, 2011.)

FRACTURES

Typical indications of unexplained fractures include:

- Fractures to the skull, nose, or facial structure
- Fractures to the ribs or the leg bones in babies
- Skeletal trauma with other injuries, such as dislocations
- Multiple fractures (especially bilateral)
- Fractures in various stages of healing
- Swollen or tender limbs
(Flaherty et al., 2014; NSPCC, 2018)

HEAD INJURIES

Typical indications of unexplained head injuries include:

- Absence of hair and/or hemorrhaging beneath the scalp due to vigorous hair pulling
- Subdural hematoma (a hemorrhage beneath the outer covering of the brain, due to severe hitting or shaking)
- Retinal hemorrhage or detachment, due to shaking
- Whiplash or pediatric abusive head trauma (see box below)
- Eye injury



- Jaw and nasal fractures
- Tooth or frenulum (of the tongue or lips) injury
(Healthy Place, 2016; NHAC, 2018)

PEDIATRIC ABUSIVE HEAD TRAUMA

Pediatric abusive head trauma (PAHT) is the third leading cause of head injury in children and the leading cause of serious head injury in the first year of life in the United States (Brown et al., 2016). The CDC defines pediatric abusive head trauma (AHT) as an injury to the skull or intracranial contents of an infant or young child (<5 years of age) due to inflicted blunt impact and/or violent shaking. Simply defined, AHT is child physical abuse that results in injury to the head or brain (Parks et al., 2012).

In 2009, the American Academy of Pediatrics recommended using the term *abusive head trauma* in place of *shaken baby syndrome*. Although the policy statement continued to recognize shaking as a potential cause of serious neurologic injury, the use of *abusive head trauma* includes all mechanisms of inflicted head injury, such as battering and other forms of trauma (AAP, 2009).

The clinical presentation of infants or children with AHT can vary. PAHT diagnosis generally includes subdural hematomas, retinal bleeding, fractures, cerebral edema, and rib or long bone fractures (Brown et al., 2016). Other possible findings associated with AHT may include:

- Lethargy/decreased muscle tone
- Extreme irritability
- Decreased appetite, poor feeding, or vomiting for no apparent reason
- Absence of smiling or vocalization
- Poor sucking or swallowing
- Rigidity or posturing
- Difficulty breathing
- Seizures
- Head or forehead appears larger than usual
- Fontanel (soft spot) bulging
- Inability to lift head
- Inability of eyes to focus or track movement; unequal size of pupils
- Vomiting
- Apnea

(Brown et al., 2016; Kidshealth.org, 2018)



Long-term effects of PAHT may include:

- Partial or total blindness
- Hearing loss
- Seizures
- Developmental delays
- Impaired intellect
- Speech and learning difficulties
- Problems with memory and attention
- Severe mental retardation

- Cerebral palsy
(KidsHealth.org, 2018)

Behavioral Indicators of Physical Abuse

Careful assessment of a **child's behavior** may also indicate physical abuse, even in the absence of obvious physical injury. Behavioral indicators of physical abuse include the following:

- Shows fear of going home, fear of parents
- Apprehensive when other children cry
- Exhibits aggressive, destructive, or disruptive behavior
- Exhibits passive, withdrawn, or emotionless behavior
- Reports injury by parents
- Displays habit disorders
 - Self-injurious behaviors (e.g., cutting)
 - Psychoneurotic reactions (e.g., obsessions, phobias, compulsiveness, hypochondria)
- Wears long sleeves or other concealing clothing, even in hot weather, to hide physical injuries
- Seeks affection from any adult
(Mayo Clinic, 2015)



Presence of the following **parent or other persons legally responsible behaviors** may also indicate an abusive relationship:

- Seems unconcerned about the child
- Takes an unusual amount of time to obtain medical care for the child
- Offers inadequate or inappropriate explanation for the child's injury
- Offers conflicting explanations for the same injury
- Misuses alcohol or other drugs
- Disciplines the child too harshly considering the child's age or what he or she did wrong
- Sees the child as bad, evil, etc.
- Has a history of abuse as a child
- Attempts to conceal the child's injury
- Takes the child to a different doctor or hospital for each injury
- Shows poor impulse control or lack of emotional control
- Lacks support network; is isolated from family and friends
- Has poor self-esteem
- Uses the child to meet his/her own physical and/or emotional needs
- Lacks parenting knowledge
- Lacks interpersonal skills
- Has unrealistically high standards and expectations for the child
(Clermont County CPS, 2018)

FACTITIOUS DISORDER IMPOSED ON ANOTHER

Factitious disorder imposed on another (FDIA), formerly known as Munchausen syndrome by proxy (MSP), is a mental illness as well as a form of child abuse. In FDIA, an adult perpetrator (most often the child's mother) falsifies an illness in the child to gain attention from healthcare professionals, family, friends, and, in some cases, general members of the community. There are not other obvious external rewards such as monetary gain (APA, 2013; Cleveland Clinic, 2014).

According to the *Diagnostic and Statistical Manual of Mental Disorders 5* (APA, 2013) **diagnostic criteria** for FDIA are:



- Falsification of physical or psychological signs or symptoms or induction of injury or disease in another, associated with identified deception.
- The individual presents another individual to others as ill, impaired, or injured.
- The deceptive behavior is evident even in the absence of obvious external rewards.
- The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.

It is important to note that the perpetrator, not the child, receives this diagnosis.

Possible warning signs of FDIA in children include:

- The child has a history of many hospitalizations often accompanied by an unusual set of symptoms.
 - Worsening of the child's symptoms is usually reported by the perpetrator and is not witnessed by healthcare professionals.
 - The child's reported condition and symptoms do not agree with results of diagnostic tests.
 - There might be a history of more than one unusual illness or death of children in the family.
 - The child's condition improves when hospitalized but worsens when the child returns home.
 - Blood in lab samples might not match the child's blood (e.g., parent "switches" the child's blood for someone else's blood).
 - There might be signs of chemicals in the child's blood, stool, or urine.
- (Cleveland Clinic, 2014)

RECOGNIZING PHYSICAL AND EMOTIONAL NEGLECT

Physical Neglect

Indicators of physical neglect include:

- Consistent hunger
- Poor hygiene (skin, teeth, ears, etc.)
- Inappropriate dress for the season
- Failure to thrive (physically or emotionally)



- Positive indication of toxic exposure, especially in newborns, such as drug withdrawal symptoms, tremors, etc.
- Delayed physical development
- Speech disorders
- Consistent lack of supervision, especially in dangerous activities or for long periods of time
- Unattended physical problems or medical or dental needs
- Chronic truancy
- Abandonment
 (Clermont County CPS, 2018)

Emotional Neglect

A **child** may demonstrate behavioral indicators of neglect such as:

- Begging or stealing food
- Extended stays at school (early arrival or late departure)
- Constant fatigue, listlessness, or falling asleep in class
- Alcohol or other substance abuse
- Delinquency, such as thefts
- Reports there is no caretaker at home
- Runaway behavior
- Habit disorders (sucking, nail biting, rocking, etc.)
- Conduct disorders (antisocial or destructive behaviors)
- Neurotic traits (sleep disorders, inhibition of play)
- Psychoneurotic reactions (hysteria, obsessive-compulsive behaviors, phobias, hypochondria)
- Extreme behavior (compliant or passive, aggressive or demanding)
- Overly adaptive behavior (inappropriately adult, inappropriately infantile)
- Delays in mental and/or emotional development
- Suicide attempt
 (Clermont County CPS, 2018)



A **parent or guardian (other person legally responsible)** exhibiting the following behavioral indicators may be emotionally maltreating/neglecting a child:

- Treats children in the family unequally
 - Seems not to care much about the child's problems
 - Blames or belittles the child
 - Is cold and rejecting
 - Behaves inconsistently toward the child
- (Clermont County CPS, 2018)

RECOGNIZING SEXUAL ABUSE

Child sexual abuse involves the coercion of a dependent, developmentally immature person to commit a sexual act with someone older. For example, an adult may sexually abuse a child or adolescent, or an older child or adolescent may abuse a younger child. A perpetrator does not have to be an adult in order to sexually abuse a child (RAINN, 2018).

Most perpetrators of child sexual abuse are people who are known to the victim. As many as 93% of children who are sexually abused under the age of 18 know the abuser (RAINN, 2018). Anyone, even a mother, can be a perpetrator, but most are male.

The fact that such abuse is carried out by a family member or friend further increases the child's reluctance to disclose the abuse, as does shame and guilt plus the fear of not being believed. The child may fear being hurt or even killed for telling the truth and may keep the secret rather than risk the consequences of disclosure. Very young children may not have sufficient language skills or vocabulary to describe what happened (Clermont County CPS, 2018; RAINN, 2018).

Child sexual abuse is found in every race, culture, and class throughout society. Girls are sexually abused more often than boys; however, this may be due to boys'—and later, men's—tendency not to report their victimization.

There is no particular profile of a child molester or of the typical victim. Even someone highly respected in the community—the parish priest, a teacher, or coach—may be guilty of child sexual abuse.

Negative effects of sexual abuse vary from person to person and range from mild to severe in both the short and long term. Victims may exhibit anxiety, difficulty concentrating, and depression. They may develop eating disorders, self-injury behaviors, substance abuse, or suicide. The effects of childhood sexual abuse often persist into adulthood (Clermont County CPS, 2018; RAINN, 2018).



Physical Indicators of Sexual Abuse

Physical evidence of sexual abuse may not be present or may be overlooked. Victims of child sexual abuse are seldom injured due to the nature of the acts. Most perpetrators of child sexual abuse go to great lengths to “groom” the children by rewarding them with gifts and attention and try to avoid causing them pain in order to ensure that the relationship will continue.

If physical indicators occur, they may include:

- Symptoms of sexually transmitted diseases, including oral infections, especially in preteens
- Difficulty in walking or sitting
- Torn, stained, or bloody underwear
- Pain, itching, bruising, or bleeding in the genital or anal area
- Bruises to the hard or soft palate
- Pregnancy, especially in early adolescence
- Painful discharge of urine and/or repeated urinary infections
- Foreign bodies in the vagina or rectum
- Painful bowel movements
(Clermont County CPS, 2018; RAINN, 2018)

Behavioral Indicators of Sexual Abuse

Children’s behavioral indicators of child sexual abuse include:

- Unwillingness to change clothes for or participate in physical education activities
- Withdrawal, fantasy, or regressive behavior, such as returning to bedwetting or thumb-sucking
- Bizarre, suggestive, or promiscuous sexual behavior or knowledge
- Verbal disclosure of sexual assault
- Being commercially sexually exploited (trafficked)
- Forcing sexual acts on other children
- Extreme fear of closeness or physical examination
- Suicide attempts or other self-injurious behaviors
- Inappropriate sexual behavior



- Inappropriate sexual knowledge for age
- Layered or inappropriate clothing
- Hiding clothing
- Lack of interest or involvement in activities
(Clermont County CPS, 2018; RAINN, 2018)

Sexually abusive **parents/guardians** or other persons legally responsible may exhibit the following behaviors:

- Very protective or jealous of child
- Encourages child to engage in prostitution or sexual acts in presence of the caretaker
- Misuses alcohol or other drugs
- Is geographically isolated and/or lacking in social and emotional contacts outside the family
- Has low self-esteem
(Clermont County CPS, 2018; RAINN, 2018)

SEX TRAFFICKING

The crime of sex trafficking of children is defined in the Trafficking Victims Protection Act (18 USC §1591) as “to recruit, entice, harbor, transport, provide, obtain, or maintain by any means a person, or to benefit financially from such action, knowing or in reckless disregard that the person has not attained the age of 18 years and will be caused to engage in a commercial sex act” (Cornell Law School, n.d.; U.S. Code, n.d.).

Commercial sexual exploitation of children (CSEC) victims are abused physically, psychologically, and emotionally. The perpetrator controls these victims even when they are not physically restrained or confined by their trafficker.

The United Nations Office on Drugs and Crime reported a rise in the percentage of child victims from 20% to 27% over a 3-year time period. Of every three child victims, two are girls and one is a boy (UNODC, 2012).

Additional data show that:

- Gender and age profile of victims detected globally are 59% women, 14% men, 17% girls, and 10% boys.
- 600,000 to 800,000 women, children, and men are bought and sold across international borders every year and exploited for forced labor or commercial sex.



- When internal trafficking victims are added to the estimates, the number of victims annually is in the range of 2 to 4 million.
- 50% of those victims are estimated to be children.
- It is estimated that 76% of transactions for sex with underage girls start on the Internet.
- 2 million children are subjected to prostitution in the global commercial sex trade.
- There are 20.9 million victims of trafficking throughout the world as of 2012.
- There are 1.5 million victims in the United States.
- The average age of victims is 11 to 14 years.
(Ark of Hope for Children, 2017)

Impacts of CSEC

Commercially sexually exploited youth frequently suffer from injuries and other physical and mental health issues:

- Anogenital trauma
- Bruises, abrasions, lacerations, burns
- Patterned injuries from belts, ligatures, etc.
- Head injuries
- Injuries resulting from being dragged or run over by a car
- Areas of alopecia due to hair being pulled out
- Pregnancy and abortion
- Fractures
- Sexually transmitted infections
- Tuberculosis
- Pelvic inflammatory disease
- Drug and alcohol addiction or withdrawal symptoms
- Urinary tract infections
- Gastrointestinal and respiratory problems
- Asthma, diabetes, and dental problems that are untreated or not diagnosed
- Headache and back problems



- Malnourishment, dehydration
- Poor hygiene
- Depression and suicidal thoughts
- Anxiety, panic attacks, agoraphobia
- Poor self-esteem, shame, guilt
- Fear for the safety of family
- PTSD and memory loss
(Ark of Hope for Children, 2017)

Screening for CSEC

Victims of sex trafficking are often accompanied by their pimp, whom they may refer to as their “boyfriend.” If trafficking is suspected, the two must be separated by the healthcare professional, for instance, assuring them that privacy for a physical exam is standard practice. Suggested questions when speaking with a child suspected to be a victim of trafficking include:

- Are you able to go to your home or job at will? Are you able to leave when you want to?
- Are you ever locked in at home or at work?
- Has anyone ever hurt you at home or on the job?
- Is anyone making you to do things you do not want to do at home or at work?
- Do you have full access to food, the bedroom, and the bathroom, or do you have to ask permission?
- Has anyone ever taken away your food or water?
- Has anyone ever not allowed you to sleep?
- Have you ever wanted to go the doctor or dentist, but you were not allowed?
- Has anyone ever threatened your family?
- Has anyone taken your driver’s license/passport/papers?

Sources: Ark of Hope for Children, 2017; Becker & Bechtel, 2015.



RECOGNIZING AND RESPONDING TO VICTIMS' DISCLOSURES

It is difficult for young children to describe abuse and they may only disclose part of what happened initially. It is important not to rush the child and to listen to his or her concerns. If a child discloses abuse, the following actions will help the child:

- Remain calm and do not allow the child to see your initial response of shock.
- Thank the child for telling you.
- Use age-appropriate language and use the terms that the child uses to describe anatomical parts.
- Ask who, what, when, and where so that you will have the information to report to CPS.
- Ask open-ended questions as opposed to leading questions.
- Do not make promises that you cannot keep.
- Explain to the child that he or she may need to repeat this information to someone else.
- Document what the child tells you using the child's own words. Use quotations whenever possible.

(Botash, 2014a; 2014b)

Victimized children may cry out in a variety of nonverbal or indirect ways, for example, a drawing left behind for the teacher, the counselor, or a trusted relative to see. Some children report vague somatic symptoms to the school nurse, hoping the nurse will guess what happened. To the child, this indirect approach is not betrayal of the abuser and therefore not grounds for punishment.

Some children may come to a trusted teacher or other professional and talk directly and specifically about their situation if that person has established a safe, nurturing environment and a sense of trust. More commonly, however, abused children use other, less direct approaches, such as:

- **Indirect hints.** "My brother wouldn't let me sleep last night." "My babysitter keeps bothering me." Appropriate responses would be invitations to say more, such as, "Is it something you are happy about?" and open-ended questions such as, "Can you tell me more?" or "What do you mean?" Gently encourage the child to be more specific. Let the child use his or her own language and do not suggest other words to the child.
- **Disguised disclosure.** "What would happen if a girl told someone her mother beat her?" "I know someone who is being touched in a bad way." An appropriate response would be to encourage the child to state what he or she knows about the "other child." It is probable that the child will eventually divulge who the abused child really is.
- **Disclosure with strings attached.** "I have a problem, but if I tell you about it, you have to promise not to tell anyone else." Most children know that negative consequences can



result if they break the silence about abuse. Appropriate responses would include letting the child know you want to help him or her and telling the child, from the beginning, that there are times when you too may need to get some other special people involved.

Forensic Interviewing for Sexual Abuse

Sometimes children and adolescents disclose sexual abuse to a trusted adult or there is cause for the adult to suspect sexual abuse. In those cases, the adult should **not** question the child further. He or she should instead contact Child Protective Services or, if the child is in imminent danger, the police. These professionals have protocols in place to interview the child by a child interview specialist while police, prosecutors, and caseworkers observe. Such forensic interviewers are trained to communicate in an age- and developmentally appropriate manner. Coordination of services with a child forensic interviewer is essential (USDOJ, 2015).

This multidisciplinary interview team approach may be utilized for other types of abuse as well. The expectation of this approach is that it will reduce the impact on the child if there is one interview rather than several by different concerned parties (USDOJ, 2015).

CASE

A mother brought her 12-year-old daughter, Haley, to the emergency department. She said that her daughter had been complaining about painful urination and wanted to check if she might have a bladder infection. The triage nurse, Janelle, asked the mother, who appeared to be in the last trimester of pregnancy, to fill out some paperwork while she took the girl to the bathroom for a urine specimen.

Janelle noticed that the daughter appeared fearful and sat in silence while her mother did all of the talking. When they were alone behind closed doors, Janelle asked Haley if there was anything that she wanted to talk about privately. The child responded by shaking her head no, but the nurse sensed that she was holding something back.

Haley was able to produce a clear, pale yellow urine specimen and then followed the nurse to an exam room. Janelle asked her if she had any pain when she urinated, and Haley said yes. The nurse asked her if she had begun menstruating, and the child said she had not.

Janelle brought the mother into the exam room to wait with her daughter. After obtaining a brief history from the mother, the doctor ordered a urinalysis. The urinalysis was negative. The doctor did an external genital exam that revealed numerous vesicular lesions on her labia. The child denied any sexual activity. The doctor cultured the lesions for herpes and asked the mother to step into his office to discuss his findings.

Once Janelle and Haley were alone again in the room, the child burst into tears and told the nurse that her mother's boyfriend had been rubbing his "private" on her and said that if she told anyone, her mother would go to jail. The nurse stopped questioning the child and reported her suspicion of child sexual abuse to CPS. The nurse knew that victims of child sexual abuse should only be minimally questioned until they can undergo a forensic interview.



On the following day, Haley was interviewed by a child forensic interview specialist in a child-friendly advocacy center. She and her mother, who was also a victim of child sexual abuse, received counseling for over a year. The mother's boyfriend was convicted of sexual abuse.

REPORTING CHILD ABUSE, MALTREATMENT, AND NEGLECT

Information in this section is taken from New York City Administration for Children's Services (2018) and New York State Office of Children and Family Services (2016b).

Anyone may report suspected child abuse at any time and is encouraged to do so. All reports are confidential and may be made anonymously by members of the public.

Who Must Report Abuse?

Physicians, nurses, teachers, police officers, dentists, therapists, and many others are legally required to report suspected cases of child abuse, maltreatment, and neglect. New York State law specifies these and other professionals and persons who are classified as **mandated reporters**.

MANDATED REPORTERS

Persons and officials required to report cases of suspected child abuse or maltreatment are as follows:

- Physician
- Registered physician assistant
- Surgeon
- Medical examiner
- Coroner
- Dentist
- Dental hygienist
- Osteopath
- Optometrist
- Chiropractor
- Podiatrist
- Resident
- Intern
- Psychologist



- Registered nurse
- Social worker
- Emergency medical technician
- Licensed creative arts therapist
- Licensed marriage and family therapist
- Licensed mental health counselor
- Licensed psychoanalyst
- Hospital personnel engaged in the admission, examination, care, or treatment of persons
- Christian Science practitioner
- School official, which includes but is not limited to school teacher, school guidance counselor, school psychologist, school social worker, school nurse, school administrator, or other school personnel required to hold a teaching or administrative license or certificate
- Social services worker
- Director of a children's overnight camp, summer day camp, or traveling summer day camp
- Day care center worker
- School-age child care worker
- Provider of family or group family day care
- Employee or volunteer in a residential care facility for children
- Any other child care or foster care worker
- Mental health professional
- Substance abuse counselor
- Alcoholism counselor
- All persons credentialed by the Office of Alcoholism and Substance Abuse Services
- Peace officer
- Police officer
- District attorney, assistant district attorney, or investigator employed in the office of a district attorney
- Other law enforcement official



What Situations Require That a Report Be Made?

New York State law requires mandated reporters to report suspected child abuse or maltreatment in the following three situations:

1. When a mandated reporter has reasonable cause to suspect that a child whom the reporter sees in his or her professional or official capacity is abused or maltreated
2. When a mandated reporter has reasonable cause to suspect that a child is abused or maltreated where the parent or person legally responsible for such child comes before them in his or her professional or official capacity and states from personal knowledge facts, conditions, or circumstances which, if correct, would render the child abused or maltreated
3. Whenever a mandated reporter suspects child abuse or maltreatment while acting in his or her professional capacity as a staff member of a medical or other public or private institution, school, facility, or agency, he or she shall immediately notify the person in charge of that school, facility, institution, or his or her designated agent, who will then (also) become responsible for reporting or causing a child abuse report to be made to the county Child Protective Services (CPS) agency

Mandated reporters can be held liable by both the civil and criminal legal systems for intentionally failing to make a report of suspected abuse that was encountered while acting in their professional capacity. (See also “Consequences for Failing to Report” below.)

CASE

Sharon, a sixth grade math teacher, stops by her friend Janie’s house for coffee on the way to work. While she is there, Janie’s 5-year-old son, Bobby, who has been diagnosed with autism, runs into the kitchen and for no apparent reason shoves his 2-year-old sister, who falls to the floor. The sister is not injured, but Janie rages at Bobby, picks him up, and throws him across the kitchen, where he slides into a cabinet, hitting the back of his head.

Sharon takes off her coat and examines Bobby, who is also okay. While she is not mandated to report a suspicion of child abuse since she is not currently acting in her professional capacity, Sharon recognizes the importance of taking action for the safety of her friend’s young son.

Sharon first sits down with Bobby on her lap to talk to Janie. She empathizes with her friend and expresses her concern for the family. She acknowledges how frightening and stressful it must be for Janie to have a child with a serious condition and asks Janie if she could refer Bobby to a program for autistic children that is provided by the school district. Janie tearfully agrees, and Sharon makes a few calls to the school district to gather information about the program.

Sharon makes a point to call Janie the next day and frequently thereafter. One month later, Janie tells Sharon that the school social worker has helped her find a program in which she has



learned appropriate new ways of dealing with Bobby's acting-out behaviors. Bobby has also been enrolled in the school district's program for autistic children and is doing much better.

REASONABLE CAUSE

There can be "reasonable cause" to suspect that a child is abused or maltreated if, considering the physical evidence observed or told about, and based on the reporter's own training and experience, it is possible that the injury or condition was caused by neglect or by nonaccidental means.

Certainty is not required. The reporter need not be certain that the injury or condition was caused by neglect or by nonaccidental means. The reporter need only be able to entertain the possibility that it could have been neglect or nonaccidental in order to possess the necessary "reasonable cause." It is enough for the mandated reporter to distrust or doubt what is personally observed or told about the injury or condition.

In child abuse cases, many factors can and should be considered in the formation of that doubt or distrust. Physical and behavioral indicators may also help form a reasonable basis of suspicion. Although these indicators are not diagnostic criteria of child abuse, neglect, or maltreatment, they illustrate important patterns that may be recorded in the written report when relevant.

When Must a Report Be Made?

The law requires that mandated reporters must "personally make a report to the Statewide Central Register of Child Abuse and Maltreatment (SCR)" and "immediately notify the person in charge of the institution, school, facility, or agency where they work or the designated agent of the person in charge that a report has been made."

In the case of suspected child abuse, maltreatment, or neglect, mandated reporters are required to make an oral **telephone report immediately** at any time of day, seven days a week. In addition, a **written report must be filed within 48 hours** of the oral report.

- Oral telephone reports should be made to the Statewide Central Register of Child Abuse and Maltreatment (SCR) by calling the statewide, toll-free telephone hotline at 800-635-1522.
- A written report on Form LDSS-221A, signed by the reporter, must be filed within 48 hours of the oral report with the local Department of Social Services (LDSS) assigned the investigation. Mandated reporters can request the mailing address of the local agency when making the oral report to the hotline. (A written report involving a child cared for away from the home [e.g., foster care, residential care] should be submitted to the New York State Child Abuse and Maltreatment Register, P.O. Box 4480, Albany, NY 12204-0480.) Written reports are admissible as evidence in any judicial proceedings; accurate completion is vital.



What Is Included in the Report?

At the time of an oral telephone report, the Child Protective Services (CPS) specialist will request the following information:

- The effect on the child
- Names and addresses of the child and parents or other person responsible for care
- Location of the child at the time of the report
- Child’s age, gender, and race
- Nature and extent of the child’s injuries, abuse, or maltreatment, including any evidence of prior injuries, abuse, or maltreatment to the child or his or her siblings
- Name of the person or persons suspected to be responsible for causing the injury, abuse, or maltreatment (“subject of the report”)
- Family composition
- Any special needs or medications
- Whether an interpreter is needed
- Source of the report
- Person making the report and where reachable
- Actions taken by the reporting source, including taking of photographs or X-rays, removal or keeping of the child, or notifying the medical examiner or coroner
- Any personal safety issues that may impact CPS worker investigations (e.g., weapons, dogs)
- Any additional information that may be helpful

Note: A reporter is not required to know all of the above information in making a report; therefore, lack of complete information does not prohibit a person from reporting. However, information necessary to locate a child is crucial.

SUBJECT OF THE REPORT

For purposes of reporting suspected cases of child abuse and maltreatment to the Statewide Central Register of Child Abuse and Maltreatment and Child Protective Services, it is important to understand the definition of who can be the “subject of the report” as defined by Section 412.4 of the Social Services Law.

- “Subject of the report” means any parent, guardian, custodian, or other person 18 years of age or older who is legally responsible for a child and who is allegedly responsible for causing—or allowing the infliction of—injury, abuse, or maltreatment to such child.



- “Subject of the report” also means an operator of or employee or volunteer in a home operated or supervised by an authorized agency, the Division for Youth, or an office of the Department of Mental Hygiene, or a family daycare home, daycare center, group family daycare home, or a day-services program who is allegedly responsible for causing—or allowing the infliction of—injury, abuse, or maltreatment to a child.

What Happens Once a Report Is Made?

The CPS unit of the local Department of Social Services is required to begin an investigation of each report within 24 hours. The investigation includes an evaluation of the safety of the child named in the report and any other children in the home and a determination of risk to the children if they continue to remain in the home.

If the Department records indicate a previous report concerning a “subject of the report,” other persons named in the report, or other pertinent information, the appropriate agency or local CPS must be immediately notified of this fact.

What Follow-Up Can Be Made by the Reporter?

Section 422.4 of the Social Services Law provides that a mandated reporter can receive, upon request, the findings of an investigation made pursuant to his or her report. This request can be made to the SCR at the time of making the report or to the appropriate local CPS at any time thereafter. However, no information can be released unless the reporter’s identity is confirmed.

If the request for information is made prior to the completion of an investigation of a report, the released information shall be limited to whether the report is “indicated” (i.e., substantiated), “unfounded,” or “under investigation,” whichever the case may be.

If the request for information is made after the completion of an investigation of a report, the released information shall be limited to whether a report is “indicated” or, if the report has been expunged, that there is “no record of such report,” whichever the case may be.

REPORTING AND HIPAA PROVISIONS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains privacy provisions that have caused confusion regarding the obligation of a mandated reporter to provide copies of written records that underlie the report. However, these **HIPAA provisions do not affect the responsibilities of mandated reporters** as they are defined in New York Social Services Law.



GATHERING FORENSIC EVIDENCE

Whenever there are allegations of suspected child abuse or neglect, the mandated reporter should keep in mind that any records of physical findings may be used as evidence at a trial. Photos, diagrams, and accurate reporting of medical examination findings are invaluable. The mandated reporter should use language that is not open to misinterpretation when documenting findings (Pulido, 2012).

Social Service Law Article 6, Title 6, Section 416, states:

Any person or official required to report cases of suspected child abuse and maltreatment may take or cause to be taken, at public expense, photographs of the areas of trauma visible on a child who is subject to report, and if medically indicated, cause to be performed a radiological examination on the child. Any photographs or X-rays taken shall be sent to Child Protective Services at the time the report is sent, or as soon thereafter as possible. Whenever such person is required to report under this title in his capacity as a member of the staff of a medical or other public or private institution, school, facility, or agency or his designated agent, who shall then take or cause to be taken, at public expense, color photographs of visible trauma and shall, if medically indicated, cause to be performed a radiological examination of the child.

Photographing Evidence

In New York State, parents or guardians must give permission for a minor child to be photographed **unless** suspected child abuse has been reported to the Statewide Central Register. If photographs will be needed, it is a good idea to inform the child or adolescent and encourage them to participate in the process.

Photographs are another form of medical documentation that can provide objective, visual documentation of abuse. There should be a protocol for releasing the photos after a formal request, and a chain of custody may be necessary as well.

Following are practices for taking good forensic photographs:

- Equipment such as a 35 mm digital camera and/or a colposcope with a camera attached produce images that can easily be transferred.
- In order to document bruises and other injuries accurately, a photograph of a color wheel is necessary for comparison.
- The child's face, body, identification number, and the date should be photographed first. Use good lighting and an uncluttered background.
- Employ the rule of three: take at least two photos of full body, mid-range, and close-up. Photograph the injury close-up with and without a scale.



- Photograph clothing if there is transfer evidence such as vegetation, gravel, or dirt. (Botash, 2015)

PLACING A CHILD IN PROTECTIVE CUSTODY

Mandated reporters may place an alleged abused or neglected child in protective custody under certain circumstances. A child may be taken into protective custody (without court order or parental consent):

1. If the child is in such circumstances or condition that continuing to stay in his or her residence or in the care and custody of the parent or other legally authorized caretaker presents an **imminent danger** to the child's life or health, and
2. If there is **not enough time** to apply to the Family Court for an order of temporary removal

However, protective custody should not be confused with the status of the child admitted voluntarily to the hospital by parent(s).

Other persons legally authorized to place the child into physical protective custody include:

- A peace officer (acting pursuant to his or her special duties)
- A police officer
- A law enforcement official
- An agent of a duly incorporated society for the prevention of cruelty to children
- A designated employee of a city or county Department of Social Services
- A person in charge of a hospital or similar institution

When a child is placed in protective custody, the authorized person must take the following actions:

- He or she must bring the child immediately to a place designated by the rules of the Family Court for this purpose, unless the person is a physician treating the child and the child is or soon will be admitted to a hospital.
- He or she must make every reasonable effort to inform the parent or other person legally responsible for the child's care about which facility the child is in.
- He or she must provide the parent or other person legally responsible for the child's care with written notice, coincident with removal of the child from their care (Family Court Act, 1024(b)(iii)).



- He or she must inform the court and make a report of suspected child abuse or maltreatment pursuant to Title 6 of the Social Services Law, as soon as possible (Family Court Act, 1024(b)).
- He or she must immediately notify the appropriate local Child Protective Services, which shall begin a child protective proceeding in the Family Court at the next regular weekday session of the appropriate Family Court or recommend that the child be returned to his or her parents or guardian. In neglect cases, pursuant to Section 1026 of the Family Court Act, the authorized person or entity (usually CPS) may return a child prior to a child protective proceeding if it concludes there is no imminent risk to the child's health. (NYS OCFS, n.d.-a)

LEGAL ISSUES FOR MANDATED REPORTERS

Consequences for Failing to Report

Any person, official, or institution required to report a case of suspected child abuse or maltreatment that willfully fails to do so:

- Can be charged with a **Class A misdemeanor** and subject to criminal penalties
- Can be **sued in a civil court** for monetary damages for any harm caused by such failure to report to the SCR

Failure to report also leads to broader repercussions. CPS cannot act until child abuse is identified and reported—that is, services cannot be offered to the family nor can the child be protected from further suffering (NYS OCFS, 2016b).

Immunity from Legal Liability

To encourage prompt and complete reporting of suspected child abuse and maltreatment, Social Services Law, Section 419, affords the reporter certain legal protections from liability. Any persons, officials, or institutions that in good faith make a report, take photographs, and/or take protective custody of a child or children have immunity from any liability, civil or criminal, that might result from such actions.

All persons, officials, or institutions who are required to report suspected child abuse or maltreatment are presumed to have done so in good faith as long as they were active in the discharge of their official duties and within the scope of their employment and so long as their actions did not result from willful misconduct or gross negligence (NYS OCFS, 2016b).

Confidentiality

The Commissioner of Social Services and the local Department of Social Services are not permitted to release to the subject of a report any data that identify the person who made the



report unless that person has given written permission for the SCR to do so. The person who made the report may also grant the local CPS permission to release his or her identity to the subject of the report. If a reporter needs reassurance, he or she should feel free to emphasize the need for confidentiality if the situation warrants (NYS OCFS, 2016b).

CONCLUSION

Research on child abuse and neglect over the past 20 years indicates that the incidence of child maltreatment can be reduced and its harmful effects can be diminished through prevention and treatment. The Institute of Medicine and the National Research Council formed a committee to make recommendations for further research in the area of child maltreatment. This committee advocates a national strategic plan with a coordinated agenda for child abuse and neglect research. They propose the establishment of standardized definitions of child abuse and neglect and a national surveillance system for data collection (Peterson et al., 2014).

Child maltreatment, abuse, and neglect negatively impact the health and well-being of society. Child victimization is not only a social problem but also a serious public health issue. Child abuse and neglect affect not only the victims while they are children but also shape the adults these children will become. The fundamental goal for prevention of child maltreatment is to stop child abuse and neglect from occurring at all in order to create healthy children who will in turn become healthy adults.

Individuals, communities, and society must change in order to provide safe environments for New York's children. Mandated reporters are obligated to report suspected child abuse, neglect, and maltreatment. Reporting suspected child abuse is their duty as professionals, but it is also an opportunity to help improve the health and well-being of children and take part in creating a healthier society.



RESOURCES

New York State

Abandoned Infant Protection Act (AIPA) Information Hotline
866-505-SAFE (7233)

Child Abuse Hotline (CPS)
800-342-3720

Child Advocacy Centers by county (American Academy of Pediatrics)
<https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Council-on-Child-Abuse-Neglect/Pages/New-York.aspx>

Frequently Asked Questions (Office of Children and Family Services)
<http://ocfs.ny.gov/main/cps/faqs.asp>



Prevent Child Abuse New York
<http://www.preventchildabuseny.org>
800-244-5373 (Helpline)

National

American Professional Society on the Abuse of Children
<http://www.apsac.org>

Child Welfare Information Gateway
<http://www.childwelfare.gov>

National Center for Missing and Exploited Children
<http://www.missingkids.com>
800-THE-LOST (843-5678)

National Clearinghouse on Child Abuse and Neglect Information
<https://cbexpress.acf.hhs.gov/index.cfm?event=website.viewArticles&issueid=46&articleid=715>

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TEST

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1. In New York, the definition of child “maltreatment” includes:
 - a. Committing a sex offense against a child.
 - b. Providing only a minimum degree of care for a child.
 - c. Failing to exercise the minimum degree of care in providing the child with food.
 - d. Causing the death or disfigurement of a child by accidental means.

2. A single mother who lives in poverty with her three school-age children frequently needs to send the children to school in soiled clothing and without showering. The school nurse alerts the district social worker that the children all smell bad and have worn the same clothes to school every day for the past week. The social worker’s investigation finds that the children are **not** maltreated because:
 - a. The mother is financially unable to provide the children with showers and clean clothing.
 - b. The children are enrolled in school and have good school attendance records and performance.
 - c. The body odor of school-age children is often foul smelling.
 - d. The mother is a single parent

3. A child witness of domestic violence may develop posttraumatic stress disorder and demonstrate:
 - a. Highly organized behavior.
 - b. Sleep disorders.
 - c. A very outgoing personality.
 - d. A cheerful disposition.

4. Under New York law, a maltreated child may be up to 21 years of age under which situation?
 - a. The child is a neglected child in residential care.
 - b. The child lives with his/her parents while attending school.
 - c. The child has a chronic physical illness.
 - d. The child has a juvenile criminal record.

5. Under the Abandoned Infant Protection Act, parents can avoid criminal prosecution when leaving an infant:
 - a. Who is up to 90 days old.
 - b. Who is over 30 days old.
 - c. In an unsafe environment.
 - d. At a police or fire station.



6. A mother brings her 2-month-old female baby to the infant's pediatric medical practice. She tells the triage nurse that the baby has been crying since yesterday afternoon after having fallen and "bumped her tummy and legs on some furniture." The nurse notes a bruise on the baby's abdomen that is in the shape of a small belt buckle. The area around the bruise is slightly swollen. Which statement validates the nurse's suspicions that the baby has been abused?
- The abdominal bruising indicates an object may have been used to make the bruise.
 - This type of bruising is normal for a 2-month-old baby.
 - Abdominal bruising is usually accidental.
 - The bruising is probably not abuse because the mother seems to be concerned about her child.
7. The mother of a baby boy reports that the baby was subdued when she picked him up from the babysitter the previous evening and that his lethargy has worsened over the past eight hours. The triage nurse suspects possible abusive head trauma when observing which other sign?
- Equal pupil sizes
 - Wheezing
 - Vomiting
 - Sunken fontanel
8. Which is a **true** statement about child sexual abuse?
- Most children readily report sexual abuse.
 - Victims may develop eating disorders that persist into adulthood.
 - Boys are more likely than girls to report being sexually abused.
 - The negative effects of child sexual abuse are nearly identical for each person.
9. When child sexual abuse is suspected, the **best** way to question a child is to:
- Establish trust by assuring the child you will not share his or her disclosure with others.
 - Extensively interview the child yourself to gather all the details that might be needed by the legal system.
 - Use only proper anatomic terms for genitalia instead of the child's own terms.
 - Avoid further detailed questioning after a child has disclosed abuse and report the abuse to authorities.
10. "Reasonable cause" to suspect child abuse or maltreatment requires:
- Certainty that an injury was nonaccidental.
 - Doubting what is personally observed or stated about an injury.
 - Believing what a parent says happened to an injured child.
 - Believing it possible that an injury occurred because of abuse or neglect.



- 11.** Mandated reporters are required to make an oral report of suspected child abuse, maltreatment, or neglect to the New York State Central Registry by telephone:
- Within 24 hours.
 - Within 7 days.
 - Immediately.
 - After completing Form LDSS-221A.
- 12.** A mandated reporter may take a child into protective custody without court order or parental consent under which circumstance?
- When it is common knowledge that the court is reluctant to grant such orders
 - When it is done in cooperation with law enforcement agencies
 - When the child is in imminent danger and there is no time to get a court order
 - When prior approval from Child Protective Services is obtained
- 13.** Which is a **true** statement about consequences for failing to report child abuse?
- Failure to report generally has no legal consequences.
 - Persons who fail to report cannot be sued in civil court.
 - Only physicians are subject to legal action if they fail to report.
 - Failure to report can result in being charged with a Class A misdemeanor.