Child Abuse and Neglect AAP Policy Recommendations

AMERICAN ACADEMY OF PEDIATRICS:

When Inflicted Skin Injuries Constitute Child Abuse

Committee on Child Abuse and Neglect

PEDIATRICS Vol. 110 No. 3 September 2002, pp. 644-645

Recommendations

1. Pediatricians must recognize that physical abuse consists of nonaccidental inflicted injuries.
2. Pediatricians should consider child abuse as the most likely explanation for inflicted skin injuries.
3. The Academy calls on state legislatures and Congress to avoid adoption of any laws or policies that create nonmedical definitions as to what constitutes nonaccidental inflicted skin injuries. Any existing laws and child protective services procedures that fail to conform to medical definitions of physical abuse should be repealed, and a clear statement should be made by state legislatures and Congress that protection of children is a state and national priority.
4. Pediatricians should work with legislatures and child protective services agencies at the state level to ensure implementation of this policy.
5. Pediatricians should counsel or provide appropriate referral to assist caregivers with appropriate behavior management of children.

AMERICAN ACADEMY OF PEDIATRICS:

Failure to Thrive as a Manifestation of Child Neglect

Robert W. Block, MD, Nancy F. Krebs, MD and the Committee on Child Abuse and Neglect and the Committee on Nutrition

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Recognition of Failure to Thrive (FTT) Secondary To Neglect or Abuse

The risk factors that should alert the pediatrician to the possibility of neglect as the cause of FTT include:

- parental depression, stress, marital strife, divorce;
- parental history of abuse as a child;
- mental retardation and psychological abnormalities in the parent(s);
- young and single mothers without social supports;
- domestic violence;
- alcohol or other substance abuse;
- previous child abuse in the family;
- social isolation and/or poverty;
- parents with inadequate adaptive and social skills;
- parents who are overly focused on career and/or activities away from home;
- failure to adhere to medical regimens;
- lack of knowledge of normal growth and development; and/or
- infant with low birth weight or prolonged hospitalization.

Guidance for the Pediatrician

1. Pediatricians are encouraged to recognize that child neglect is among the many causes of FTT.
2. Pediatricians are strongly encouraged to consider child abuse and neglect and to report cases of FTT that do not resolve with appropriate interventions.

AMERICAN ACADEMY OF PEDIATRICS:

Investigation and Review of Unexpected Infant and Child Deaths

Committee on Child Abuse and Neglect and Committee on Community Health Services

PEDIATRICS Vol. 104 No. 5 November 1999, pp. 1158-1160

The American Academy of Pediatrics recommends that:

1. Pediatricians advocate for proper death certification for children. Such certification is not possible in sudden unexpected deaths in the absence of a comprehensive death investigation, including scene investigation, autopsy, and review of previous medical records.
2. Individual pediatricians and those working through AAP chapters support state legislation that requires autopsies of all deaths of children younger than 18 years that result from trauma; that are unexpected, including SIDS; and that are suspicious, obscure, or otherwise unexplained. These same guidelines about unexplained deaths should apply to all children, even those with chronic diseases.
3. Individual pediatricians and those working through AAP chapters advocate for and support state legislation and other efforts that establish comprehensive child death investigation and review systems at the local and state levels.
4. Pediatricians accept the responsibility to be involved with the death review process, including serving as a member of a review team, providing information from case files to the medical examiner or other agency investigating the death of a child who was a patient, or by serving as a consultant to the child fatality team on medical issues that need clarification.
5. Pediatricians assist local public health, medical society, and other interested groups to become involved with the child death review process.
6. Pediatricians become involved in the training of death scene investigators so that appropriate knowledge of issues such as SIDS, child abuse, child development, and pediatric disease is used in the determination of the cause of death.
7. Public policy initiatives directed at preventing childhood deaths, based on information acquired at the local and state levels from adequate death investigations, accurate death certifications, and systematic death reviews, be supported at the national and chapter level.
8. The following recommendations pertaining to the investigation and review of child deaths, published by the US Advisory Board on Child Abuse and Neglect should be supported.
    - "The supply of professionals qualified to identify and investigate child abuse and neglect fatalities should be increased.
    - "There must be a major enhancement of joint training by government agencies and professional organizations on the identification and investigation of serious and fatal child abuse and neglect.
    - "States, military branches, and Indian Nations should implement joint criminal investigation teams in cases of fatal child abuse and neglect.

- "The Secretary of Health and Human Services and the United States Attorney General should work together to assure there is an ongoing national focus on fatal child abuse and neglect and to oversee an ongoing process to support the national system of local, state, and federal child abuse and neglect fatality review efforts.
- "Child death review teams should be established at the local or regional level within states."

AMERICAN ACADEMY OF PEDIATRICS:

Maltreatment of Children With Disabilities

Roberta A. Hibbard, MD, Larry W. Desch, MD, and the Committee on Child Abuse and Neglect and Council on Children With Disabilities

PEDIATRICS Vol. 119 No. 5 May 2007, pp. 1018-1025

1. Be capable of recognizing signs and symptoms of child maltreatment in all children and adolescents, including those with disabilities.
2. Be familiar with disabling conditions that can mimic abuse or pose an increased risk of accidental injury that can be confused with abuse.
3. Because children with disabilities are at increased risk of maltreatment, remain vigilant not only in assessment for indications of abuse but also in offerings of emotional support and provision of equipment and resources to meet the needs of children and families.
4. Ensure that any child in whom maltreatment has been identified is evaluated thoroughly for disabilities.
5. Advocate for all children, especially those who have disabilities or special health care needs, to have a medical home. If a child is hospitalized and does not have a medical home, the inpatient attending physician can help the family secure one before discharge, preferably as early as possible in the hospital course.
6. Be actively involved with treatment plans developed for children with disabilities and participate in collaborative team approaches.
7. Use health supervision visits as a time to assess a family's strengths and need for resources to counterbalance family stressors and parenting demands.
8. Advocate for changes in state and local policies in which system failures seem to occur regarding the identification, treatment, and prevention of maltreatment of children with disabilities.
9. Advocate for the implementation of positive behavioral supports and elimination of aversive techniques and unnecessary physical restraints in homes, schools, and other educational and therapeutic programs (both public and private), institutions, and settings for children who have disabilities.
10. Advocate for better health care coverage by both private insurers and governmental funding.

AMERICAN ACADEMY OF PEDIATRICS:

Shaken Baby Syndrome: Rotational Cranial Injuries

Committee on Child Abuse and Neglect

PEDIATRICS Vol. 108 No. 1 July 2001, pp. 206-210

The American Academy of Pediatrics recommends that pediatricians:

1. Become educated about the recognition, diagnosis, treatment, and outcome of shaken baby and abusive head-impact injuries in infants and children;

2. Be aware of and exercise their responsibility to report these injuries to appropriate authorities;
3. Provide pertinent medical information to other members of multidisciplinary teams investigating these injuries;
4. Support home visitation programs and any other child abuse prevention efforts that prove efficacious; and
5. Provide or have appropriate referrals to resources to educate parents about healthy coping strategies when dealing with their child.

AMERICAN ACADEMY OF PEDIATRICS:

Evaluation of Suspected Child Physical Abuse

Nancy D. Kellogg, MD and the Committee on Child Abuse and Neglect

PEDIATRICS Vol. 119 No. 6 June 2007, pp. 1232-1241

The interview of parents or caregivers of infants or children who present with serious injuries may be conducted in an outpatient or inpatient setting. If the child presents to a clinic with a serious injury that requires further medical care in a specialty (eg, orthopedics) or hospital setting, the clinician may opt to gather the minimum information to establish a need for reporting to child protective services. Any statements made by the caregiver regarding the injury should be documented accurately and completely. Once the clinician has assessed all the injuries, including approximate ages of injuries (when possible), a careful, complete, and detailed history should be obtained from the caregivers.

Explanations that are concerning for intentional trauma include:

1. no explanation or vague explanation for a significant injury;
2. an important detail of the explanation changes dramatically;
3. an explanation that is inconsistent with the pattern, age, or severity of the injury or injuries;
4. an explanation that is inconsistent with the child's physical and/or developmental capabilities; and
5. different witnesses provide markedly different explanations for the injury or injuries.

Information regarding the child's behavior before, during, and after the injury occurred, including feeding times and levels of responsiveness, should be gathered. Victims of significant trauma usually have observable changes in behavior. Access to caregivers and caregiver activities before, during, and after the injury occurred are also important to document. Frequently, infants and children present to medical settings with a history of a fall. Recent studies have indicated that short falls may result in bruising; however, more significant types of head trauma, including skull fractures, are exceedingly uncommon but possible.

Information should be gathered in a non-accusatory but detailed manner. Other information that may be useful in the medical assessment of suspected physical abuse includes:

1. past medical history (trauma, hospitalizations, congenital conditions, chronic illnesses);
2. family history (especially of bleeding, bone disorders, and metabolic or genetic disorders);

3. pregnancy history (wanted/unwanted, planned/unplanned, prenatal care, postnatal complications, postpartum depression, delivery in non-hospital settings);
4. familial patterns of discipline;
5. child temperament (easy to care for or fussy child);
6. history of past abuse to child, siblings, or parents;
7. developmental history of child (language, gross motor, fine motor, psychosocial milestones);
8. substance abuse by any caregivers or people living in the home;
9. social and financial stressors and resources; and
10. violent interactions among other family members.

AMERICAN ACADEMY OF PEDIATRICS:

The Evaluation of Sexual Abuse in Children

Nancy Kellogg, MD and the Committee on Child Abuse and Neglect

PEDIATRICS Vol. 116 No. 2 August 2005, pp. 506-512

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

Guidelines for Making the Decision to Report Sexual Abuse of Children

Data Available				Response	
History	**Behavioral Symptoms**	**Physical Examination**	**Diagnostic Tests**	**Level of Concern About Sexual Abuse**	**Report Decision**
Clear statement	Present or absent	Normal or abnormal	Positive or negative	High	Report
None or vague	Present or absent	Normal or nonspecific	Positive test for *C trachomatis*, gonorrhea, *T vaginalis*, HIV, syphilis, or herpes*	High†	Report
None or vague	Present or absent	Concerning or diagnostic findings	Negative or positive	High†	Report
Vague, or history by parent only	Present or absent	Normal or nonspecific	Negative	Indeterminate	Refer when possible
None	Present	Normal or nonspecific	Negative	Intermediate	Possible report,‡ refer, or follow

* If nonsexual transmission is unlikely or excluded.
† Confirmed with various examination techniques and/or peer review with expert consultant.
‡ If behaviors are rare/unusual in normal children.