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Module 1: The Hotline and Child Maltreatment Index

The Florida Abuse Hotline
- 65C-30.001(55): DCF’s central abuse reporting center, receives and processes calls/reports of known/suspected child maltreatment and special conditions referral 24 hours a day, 7 days a week
- processes the intakes
- voice records all incoming and outgoing calls/reports related to maltreatment pursuant to FS 39.201(2)(i). These recordings may be released to:
  - LE and SA for investigating and prosecuting criminal charges
  - the agency for investigating and seeking administrative penalties
- 39.201(7): Unaccepted reports to the hotline by identified relatives must be reviewed by a component of quality assurance.

How Is a Report Made to the Hotline?
- Telephone: 1-800-962-2873 (1-800-96ABUSE)
- Telephone Device for the Deaf (TDD): 1-800-453-5145
- Mail and FAX: 1-800-914-0004
- Web Based Reporting (EMAIL): http://state.fl.us/cf_web
- Cannot report via on-line if reporter wishes to remain anonymous

The Hotline Receives Intakes of:
- child maltreatment intakes (In-Home and institutional)
- elderly and/or disabled adult maltreatment and exploitation intakes
- special-conditions referrals
- Child on Child Sexual Abuse
- Foster Care Referral
- Parent Needs Assistance
- Caregiver(s) Unavailable
- prevention referrals

Who Must Report?
- Any person who knows, or has reasonable cause to suspect, a child is being maltreated by a parent, legal custodian, caregiver, or other person responsible for the child’s welfare, must report.
- Personnel at the abuse hotline must decide if the intake meets the statutory definition of child maltreatment and/or special conditions.

Reporters Who Must Provide Their Name 39.201(1)(b)
- physician, osteopathic physician, medical examiner, chiropractic physician, nurse or hospital personnel engaged in the admission, examination, care or treatment
- health/mental health professionals
- practitioner who relies solely on spiritual means of healing
- school teachers/school personnel
- social workers; day care/child care workers; foster care, residential, or institutional workers
- judges and law enforcement officers
Responsibilities of the Abuse Hotline and Reporting Requirements

What are the responsibilities of the Hotline?

- seek as much information about allegation to develop a complete description of the maltreatment incident, the individuals involved, their addresses, etc.
- determines type of maltreatment/special conditions
- compares allegations with maltreatment criteria in the Child Maltreatment Index to decide if an intake will be accepted
- checks for —open cases or current intakes on the family
- checks for previous intakes
- completes criminal history checks through FCIC on all subjects of the intake age 12 or older.
- completes Department of Corrections and sexual predator records on applicable subjects
- completes delinquency checks for all subjects of the intake age 12-26.
- checks to see if the family is receiving other services (as provided by Developmental Services, a mental health center, etc.)
- assigns response priority for the intake-immediate or within 24 hours
- inputs data
- sends intake to the region/circuit
- notifies the region/circuit of intakes assigned an immediate response priority.

What are the criteria for accepting a report of child maltreatment?

- There is reasonable cause to suspect that a child (less than 18 years old) who could be located in Florida has been harmed or is believed to be threatened with harm by a person responsible for the care of the child.
- If the abuse occurred out of state and the child and alleged perpetrator are out of state, the hotline relays the information to the appropriate state.
- If the abuse is not alleged against a parent, legal custodian, caregiver, or other person responsible the hotline immediately transfers the call to the sheriffs’ offices in the appropriate county.

Besides child maltreatment, what other kinds of intakes are received by the Hotline?

- elderly and/or disabled adult abuse, neglect, or exploitation
- special conditions referrals (such as the serious injury or death of a child’s parents which would necessitate intervention to provide placement or services)
- prevention referrals
What occupations are required by Florida Statute to provide their names when reporting maltreatment?

- physician, osteopathic physician, medical examiner, chiropractic physician, nurse, or hospital personnel engaged in the admission, examination, care, or treatment
- other health/mental health professionals
- practitioners—spiritual means for healing
- school teachers/other school personnel
- social workers, day care center workers, child care, foster care, residential, or institutional workers
- law enforcement officers
- judges

During an open investigation or service provision, when is a call to the Hotline required?

- During service provision, when you suspect or know that a new incident of maltreatment has occurred, a call to the Hotline is required.
- During an investigation, when you know or suspect that a child died because of abuse or neglect, a call to the Hotline is required.
- You cannot add the death maltreatment to an open investigation.
- When information of maltreatment is discovered while assessing a special conditions referral a call must be made to the Hotline.

When is an investigator not required to call the Hotline?

- During an open investigation, you may add new maltreatments, new victims or other children, new perpetrators or adults that are related to the current investigation and NO call to the Hotline is required.
- For example, you are investigating physical abuse allegations and learn that domestic violence occurred; you must add this code to the current intake and address the maltreatment with appropriate findings.
- During service provision, when you learn that the parent has not complied with one or more case plan tasks, a call to the Hotline is NOT required.
  - The court must be notified as soon as possible.
  - For example, you learn Mom is not taking the child to therapy as required in the case plan. Some may argue that this is neglectful; however, you must inform the court of this lack of compliance with a task that is in the case plan.
  - An exception to this would be if the non-compliance constitutes a new incidence of maltreatment.

How does the Hotline decide which calls meet the criteria for acceptance of an intake?

- They use the Florida Statutes and the Child Maltreatment Index.
- Hotline counselors thoroughly question the reporter to obtain as much information about the incident(s) and risk factors in the family and then decide if call requires investigation.
The Hotline Intake

Intakes are linked to an existing case or used to create a new case.

Intake Name
- Name of the intake is the youngest child victim’s name. Cases are named as follows:
  - Birth (or adoptive) mother’s last and first name, if known, and has custody at time of case initiation or removal; (Last name, First Name)
  - Birth (or adoptive) father’s last and first name, if known, and has custody at time of case initiation or removal; (Last name, First Name)
  - Other Relative’s last and first name, if known, and relative has been primary caregiver at time of case initiation or removal; (Last name, First Name)
  - Child’s last and first name, if mother, father and relatives are deceased, unknown; or all parental rights have been terminated as of case initiation or removal; if sibling group, use oldest child’s name

Intake Number
- ID generated for the Child Abuse Intake
- Displayed as 2008-123456-01
- Service Referrals have unique system generated number that differs from intake numbering

County
- The county to which the intake is assigned
  - The county of assignment: location of victim at time of call even if not consistent with child’s residence and/or where the maltreatment occurred.
  - The county of assignment (Responsible County) automatically populates in sequence intakes and is not editable.

Date and Time Intake Received
- The time the intake is received at the hotline.
- Mandates the time for commencement of the investigation.

Program/Sequence Type
- Identifies intake as child or adult and if intake is an initial, additional or supplemental

Investigative Sub-type
- In-Home
- Institutional

Provider Name
- Name of institution if institutional maltreatment

Worker Safety Concerns
- Specifies if there are worker safety concerns regarding the intake

Prior Involvement
- Specifies if priors exist involving subjects of the intake
- Prior intakes and service records are described on separate page
Law Enforcement Notified
Specifies if Intake was sent to Law Enforcement

Response Time
- Identifies assigned response priority of the intake based on child’s risk level.
  - Immediate
  - 24-hour
- Response priorities for Service Referrals differ and can be any of the following:
  - Blank
  - 3 days
  - 5 days
  - 7 days
  - 10 days

Name - Worker
- Names assigned Hotline Worker

Name - Supervisor
- Names Supervisor of assigned Hotline Worker

I. Family Information
- Name - Family
  - The name of the intake - refer to naming protocol
- Telephone Number
  - Family’s telephone numbers
- Address - Street
  - Family’s address
  - Unit Designator
  - City, State and Zip Code
- Primary Language
  - Specifies primary language of family
- Interpreter Needed
  - Specifies if interpreter is needed
- Directions to House
  - Provides text directions for investigator

Part A. Participants
- Name
- ID Number
  - Social Security Number if known
- Role
  - Service Referrals must have role of identified child
  - Each participant must have at least one role
  - Must have at least one victim and one A/P for child intakes
  - Someone must be identified as the report name
  - Only one participant may be assigned report name
The following roles are available in FSFN:

- Victim - V
- Alleged Perpetrator - AP
- Child in Home - CH
- Household Member - HM
- Non Household Member - NM
- Parent/Caregiver - PC
- Significant Other - SO
- Referral Name - RN
- Intake Name - IN
- Identified Child - IC

Up to 5 roles may be selected for each participant.

- Gender
- DOB
- Est. Age
- Ethnicity
- Race
- Disability - Adult Intakes Only

Part B. Address and Phone Information

- Provides name, type of residence, address and telephone number for participants

Part C. Relationships

- Specifies the relationships between all participants
- Participants over 18 are listed on the left side of the screen and the participants under 18 are listed on the right side of the screen.

Part D. Alleged Maltreatment

- Applies to child and adult intakes only
- Provides name of victim and specific maltreatment/special conditions alleged.
- The following maltreatments/special conditions are available:

<table>
<thead>
<tr>
<th>Abandonment</th>
<th>Inadequate Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asphyxiation</td>
<td>Internal Injuries</td>
</tr>
<tr>
<td>Bizarre Punishment</td>
<td>Malnutrition/Dehydration</td>
</tr>
<tr>
<td>Bone Fracture</td>
<td>Medical Neglect</td>
</tr>
<tr>
<td>Burns</td>
<td>Mental Injury</td>
</tr>
<tr>
<td>Death</td>
<td>Physical Injury</td>
</tr>
<tr>
<td>Environmental Hazards</td>
<td>Sexual Abuse</td>
</tr>
<tr>
<td>Failure to Protect</td>
<td>Substance Misuse</td>
</tr>
<tr>
<td>Failure to Thrive</td>
<td>Threatened Harm</td>
</tr>
<tr>
<td>Family Violence Threatens Child</td>
<td>Foster Care Referral</td>
</tr>
<tr>
<td>Caregiver(s) Unavailable</td>
<td>Child on Child Sexual Abuse</td>
</tr>
<tr>
<td>Parent Needs Assistance</td>
<td>Human Trafficking</td>
</tr>
</tbody>
</table>
Part E. Location of Incident
- Provides address and telephone information as to location of the alleged maltreatment

II. Narratives
Part A. Allegation Narrative
- Summarizes information received from the reporter about what was heard, seen or done, and any relevant family dynamics or prior incidents.
- Includes risks to the victim or children.
- This narrative and priors are the basis of the information the PI will have before initial contact with the family.
- Additional information is located under the reporter information. The Hotline records information here when it may divulge confidential information that only the reporter would know.
- Since the reporter’s name is highly confidential, the allegation narrative must not provide clues as to the reporter’s identity.

Part B. Narrative for Worker Safety Concerns
- Summarizes information received from the reporter about any safety concerns that may be present to allow PI to prepare and take necessary safety precautions.

III. Agency Response
Part A. Probationary Worker Recommendation
- When the probationary Hotline worker makes a screening decision it must be forwarded to a Hotline Supervisor for review and approval. Used for training purposes by the hotline.

Part B. Worker/Supervisor Decision
- Documents decision made if intake must be generated and linked to a case. The date and time the decision is made as well as the reason and explanation are recorded.
- Names the Hotline Counselor who received and documented the alleged maltreatment/special conditions from the reporter.

IV. Crime Intelligence Unit Documentation
- The CI Unit at the Hotline performs criminal history checks on all known subjects prior to assigning the intake for regions in which PIs are employees of DCF.
- The Sheriff’s Offices are responsible for completing their own criminal background checks upon receipt of the intake within their regions.
- Information obtained as a result of these checks is available in the on-line link in FSFN for 72 hours from the time the results are posted and is only viewable by individuals with appropriate security clearance.
- The CI unit is then responsible for notifying the regions of the intake.
First Call Attempted Date/Time
- Time the first call to the region/unit was completed

Completed Call Date/Time
- Date and time the call to the region/unit was completed

Called Log
- Information regarding number of calls, specific telephone numbers and attempt number

Called Out By
- Names staff person at the CI Unit who completed the call to the specific region/unit

Called To
- Region/unit staff person who accepted the call from the CI Unit

Reporter Narrative
- Specific information regarding the individual who reported the maltreatment
- Reporter related information does not populate into the printed intake
- Services Referrals do not have reporter information.

Name - Worker
- Name of Hotline Counselor

Name - Reporter
- Name of individual who contacted the Hotline

Reporter Type
- Relationship of reporter to victim

Reporter Caller ID
- Provides number to use to contact the reporter for additional information about the family, victim, or the alleged maltreatment and/or safety concerns
- Must get Supervisor approval before using the caller ID# to contact the reporter
- Never use the caller ID# unless the number is the same contact number given by reporter
- Refer to existing agency policies regarding use of caller ID

Reporter Requests Contact
- Specifies if reporter wants to be contacted prior to and during the investigation

Report Method
- Information as to how the reporter notified the Hotline of the allegation
- Options: Phone, Fax, Written, Email, etc.
Home Phone
- Home telephone number of the reporter, if available

Work Phone
- Work telephone number of the reporter, if available

Other Phone
- Additional means of contact for the reporter, cell phone and/or fax

Reporter Narrative
- Information regarding the identification of the reporter

Source Information
- Additional information regarding individuals who may have access to information about the intake

Background Summary
- Summary of information regarding criminal background checks on subjects of the intake
  - Florida Crime Information Center (FCIC)
  - Department of Juvenile Justice (DJJ)
  - Department of Corrections (DOC)
  - Sexual Predator

Prior Intakes and Service Providers
- The Intake is the Abuse Report created by the Hotline staff. This is different from the Investigation, which is the piece of work that is completed by the CPI.
- Information about historical intakes involving persons included on the current intake.
- Information provided is grouped by intake type (Child Intake, Adult Intake, Special Conditions, and Services Referrals) and sorted by date/time received within each intake grouping in reverse chronological order.
- The information displayed is as follows:
  - Date Intake Received
  - Intake Number
  - Report Name
  - Intake Type
  - Screening Decision
  - Case ID
  - Finding (Overall Investigative Finding)
  - Worker Safety Concerns

Types of Intakes
Initial Intake
- Original intake received by the Hotline
- INVESTIGATIVE RESPONSE REQUIRED
- CI Unit background checks completed
Additional Intake - 65C-29.002(7)(e)1.
- Intakes identified by the Hotline while completing a record check on the subjects of a new call
- Contain new information about one or more subjects of an existing intake
- Can be created if investigation has open status and call is received within 30 days of original intake receipt
- CI Unit background checks completed
- Sequence number added.
- The new information received includes any of the following: A new
  - alleged perpetrator in the same household
  - maltreatment
  - incident of the same maltreatment
  - victim
  - subject in the same household
  - piece of information requiring an immediate response
- INVESTIGATIVE RESPONSE REQUIRED
  - New on-site visit (commencement) and, when necessary, daily attempts to see all children
  - Repeat notification of all required parties
  - Attempted contact with a new reporter
  - Any other investigative activities/referrals required due to new subjects or new maltreatments

Supplemental Intakes - 65C-29.002(7)(e)2.
- Intakes identified by the Hotline while completing a record check
- Enhancements to the intake already received or under investigation
- No new allegations or subjects are reported
- Improves what is already known such as a more precise address, different name spelling or new potential collateral contacts
- Can be created if an investigation has open status and call is received within 60 days of original intake receipt
- CI Unit background checks completed
- Sequence number added
- The new information received must involve the same alleged perpetrator, same victim, same maltreatment(s), and same incident
- A supplemental intake may be added even if there is a disposition date or findings for the existing intake provided the initial intake is not more than 60 days old.
- A supplemental intake can be added even if the victim is in a different county.
- NO INVESTIGATIVE RESPONSE REQUIRED
  - It may expand the collateral contacts
  - Reporter must be contacted
• Additional allegations discovered during the course of an investigation
  • Allegations must be added and documented.
  • No call to the Hotline is necessary to add maltreatments in the field, except for Death.
  • Maltreatment discovered while assessing a child on child sexual abuse referral must be reported to the Hotline for a new intake.
  • Maltreatment discovered that occurred in another state must be reported to that state.
• Child on child sexual abuse assessments are only sequenced as supplemental with the same or similar allegations.
• A child death allegedly due to maltreatment occurring during an active investigation requires an immediate call to the Hotline and must not be added as a new maltreatment to the existing intake.
• A child death report must not be merged with any other intake alleging maltreatment that did not cause the death.

Calls Not Handled as Additional or Supplemental Intakes - 65C-29.002(7)(e)3.
• One intake is institutional and the other is in a family setting.
• One intake has a child victim and the other an adult victim.
• One intake is on abuse, neglect or abandonment and the second is a special condition referral.
Maltreatment Versus Special Conditions

65C-30.001(81) - Maltreatment - a specific type of injury or harm, as incorporated by the Child Maltreatment Index, used as an inclusive description for all forms of maltreatment. The reporter’s statement to the Hotline of a suspected specific harm/threatened harm is referenced in the report as a maltreatment.

Must be by a parent/legal custodian or caregiver

65C-30.001(132) - Special Condition Referrals:

- Requests accepted by the Hotline that require a response to assess the need for services
- Are not willful maltreatment but may result in allegations of maltreatment and/or the need to shelter a child upon response and/or Hotline contact if maltreatment exists.

During the response to these referrals you must assess significant danger as determined by the following factors:

- child’s age
- child’s medical condition, behavioral, mental or emotional problems, developmental disability, or physical handicap, particularly related to the child’s ability to self protect
- severity and frequency of the occurrence
- parent/caregiver’s physical, mental or emotional abilities
- dynamics of the relationship between the parent/caregiver and the child
- previous history of maltreatment
- current stressors or crises in the home
- presence of other supporting persons in the home

They include the following situations:

- **Caregiver(s) Unavailable**
  - Situations in which the parent or caregiver has been incarcerated, hospitalized, or died and immediate plans must be made for the children’s care.
  - Also includes situations where children are unable or unwilling to provide information about their caregiver or custodian.
  - Must assess for the presence of maltreatment

- **Foster Care Referral**
  - Concerns about the care being provided in a licensed foster home, group home or emergency shelter that are not allegations of maltreatment
  - In assessing these cases, must consider the following:
    - Law enforcement involvement
    - Age of child
    - History of similar incidents
• **Child on Child Sexual Abuse**
  • Calls alleging sexual behavior between children, when the aggressor child is 12 years or younger occurring without consent, without equality, or as a result of coercion.
  • **65C-30.001(18) - Child exhibiting sexually inappropriate behavior:** child having demonstrated some action found under the terms and definitions of an alleged juvenile sexual offender, but without an established pattern of behavior sufficient to define the child as an alleged juvenile sexual offender
  • **65C-30.001(19) - Child on Child sexual abuse** refers to any sexual behavior between children 12-years or younger, occurring without consent, without equality or as a result of coercion

• **39.01(7): Alleged juvenile sexual offender:**
  • Child 12-years of age or younger who is alleged to have committed a violation of sexual battery, prostitution, lewdness, indecent exposure, child abuse, sexual performance by a child, or obscenity; or
  • Child alleged to have committed any violation of law or delinquent act involving juvenile sexual abuse.

• **Juvenile sexual abuse:** any sexual behavior occurring without consent, without equality, or as a result of coercion.
  • Coercion: The exploitation of authority or the use of bribes, threats of force, or intimidation to gain cooperation or compliance.
  • Equality: Two participants operating with the same level of power in a relationship, neither being controlled nor coerced by the other.
  • Consent: An agreement, including all of the following:
    • understanding of what is proposed based on age, maturity, developmental level, functioning, and experience;
    • knowledge of societal standards for what is being proposed;
    • awareness of potential consequences and alternative;
    • assumption that agreement or disagreement will be accepted equally;
    • voluntary decision; or
    • mental competence.
  • Juvenile sexual offender behavior ranges from non-contact sexual behavior such as making obscene phone calls, exhibitionism, voyeurism, and the showing or taking of lewd photographs to varying degrees of direct sexual contact, such as frottage, fondling, digital penetration, rape, fellatio, sodomy and various other sexually aggressive acts.
• **39.01(14):** Child who has exhibited inappropriate sexual behavior: 12-years of age or younger and who has been found by the department or the court to have committed an inappropriate sexual act on himself or herself or another individual.

• **Chapter 39.701** - requirements of the responses to child-on-child sexual abuse cases.
  - Must consider the behaviors of the alleged juvenile sexual offender or aggressor child

• Parent Needs Assistance - situations that do not meet the criteria for a maltreatment report, but the family may need services. The intent is to prevent future maltreatment by helping families or individuals through a family and/or community-centered approach before maltreatment occurs.
  - Must consider:
    - Is caregiver looking for help to prevent maltreatment in the present situation?
    - Parent/caregiver has physical or mental conditions necessitating assistance with children, especially if caregiver is self-referring
    - Age of the child, and ability to self-protect
    - History of seeking services

• **Prevention Referrals** - situations that do not meet criteria for an intake, but the victims or their family may need services to prevent future maltreatment. In these situations, information can be sent directly to the appropriate circuit as a “Prevention Referral”.
  - These referrals allow the agency to assess if a child or family needs services to prevent a future intake that will require investigation.
### INTAKE REPORT

**Intake Name:** JENSEN, CLYDE  
**Intake Number:** 2007-000989-01  
**County:** Broward

**Date and Time Intake Received:** 01/23/2007 1:00PM  
**Program Type:** Child Intake - Initial  
**Investigative Sub-Type:** In-Home  
**Provider Name:** N/A

**Worker Safety Concerns:**  
- Yes: X  
- No: 

**Prior Involvement:**  
- No: X  
- Yes: 

**Law Enforcement Notified:**  
- No: X  
- Yes: 

**Response Time:** 24 Hours  
**Name – Worker:** DELRAY, WILLIAM  
**Name – Supervisor:** LAUDERDALE, MAY

### I. Family Information

- **Name – Family:** JENSEN, CLYDE  
- **Telephone Number – Home:** (954)888-0100  
- **Address – Street:** 1865 Riverdale Lane  
- **City:** Ft. Lauderdale  
- **State:** FL  
- **Zip Code:** 33311

**Primary Language:**  
- English: Yes  
- X No

**Interpreter Needed:**  
- Yes: X  
- No: 

**Directions to House:**  
1865 Riverdale Lane, Ft. Lauderdale is the home address for all participants

### A. Participants

<table>
<thead>
<tr>
<th>Name</th>
<th>ID Number</th>
<th>Role</th>
<th>Gender</th>
<th>DOB</th>
<th>Ethnicity</th>
<th>Race</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>JENSEN, BARBARA</td>
<td>374096811</td>
<td>AP</td>
<td>Female</td>
<td>01/22/1983</td>
<td>Unable to Determine</td>
<td>White</td>
<td></td>
</tr>
<tr>
<td>JENSEN, CLYDE</td>
<td>854687309</td>
<td>V-IN</td>
<td>Male</td>
<td>09/23/2005</td>
<td>Unable to Determine</td>
<td>White</td>
<td></td>
</tr>
<tr>
<td>JENSEN, JEAN</td>
<td>3649658059</td>
<td>V</td>
<td>Female</td>
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<td>THOMAS, GWEN</td>
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<td>V</td>
<td>Female</td>
<td>01/01/2000</td>
<td>Unable to Determine</td>
<td>White</td>
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</tbody>
</table>
A person who knowingly or willfully makes public or discloses to any unauthorized person any confidential information contained in the central abuse hotline is subject to the penalty provisions of § 39.206.

<table>
<thead>
<tr>
<th>Name</th>
<th>Type</th>
<th>Address</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>JENSEN, BARBARA</td>
<td>Primary Residence</td>
<td>1865 Riverdale Lane Ft. Lauderdale, FL 33311</td>
<td>(954)889-0100</td>
</tr>
<tr>
<td>THOMAS, LEROY</td>
<td>Primary Residence</td>
<td>1865 Riverdale Lane Ft. Lauderdale, FL 33311</td>
<td>(954)889-0100</td>
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<tr>
<td>JENSEN, CLYDE</td>
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<td>1865 Riverdale Lane Ft. Lauderdale, FL 33311</td>
<td>(954)889-0100</td>
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<tr>
<td>JENSEN, JEAN</td>
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<tr>
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<td>JENSEN, JEAN</td>
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<tr>
<td>THOMAS, LEROY</td>
<td>Paramour – Parent/Caregiver</td>
<td>JENSEN, CLYDE</td>
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<tr>
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<td>Paramour – Parent/Caregiver</td>
<td>JENSEN, JEAN</td>
</tr>
<tr>
<td>THOMAS, LEROY</td>
<td>Father - Biological</td>
<td>THOMAS, GWEN</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Alleged Maltreatment</th>
<th>Maltreatment Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>JENSEN, CLYDE</td>
<td>Inadequate Supervision</td>
</tr>
<tr>
<td>JENSEN, CLYDE</td>
<td>Substance Misuse</td>
</tr>
<tr>
<td>JENSEN, JEAN</td>
<td>Inadequate Supervision</td>
</tr>
<tr>
<td>JENSEN, JEAN</td>
<td>Substance Misuse</td>
</tr>
<tr>
<td>THOMAS, GWEN</td>
<td>Inadequate Supervision</td>
</tr>
<tr>
<td>THOMAS, GWEN</td>
<td>Substance Misuse</td>
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<table>
<thead>
<tr>
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<th>Address – Street</th>
<th>Apt.</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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</thead>
<tbody>
<tr>
<td>1865 Riverdale Lane</td>
<td>Ft. Lauderdale</td>
<td>FL</td>
<td>33311</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

II. Narratives

A. Allegation Narrative

The other day the children were left home alone for several hours from around 3:30pm until Barbara and Leroy returned home drunk sometime after four o’clock yesterday morning. The children were hungry and had been wearing the same clothes for three days. This is not the first time this has happened. Last year child protective services found all the children at home alone. They had not seen or heard from their mother for two days.
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**REPORTER NARRATIVE**

**B. Narrative for Worker Safety Concerns**

---

### III. Agency Response

#### A. Probationary Worker Recommendation

<table>
<thead>
<tr>
<th>Decision</th>
<th>Date/Time Decision Made</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explain</td>
<td></td>
<td></td>
</tr>
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</table>

#### B. Worker/Supervisor Decision

<table>
<thead>
<tr>
<th>Decision</th>
<th>Date/Time Decision Made</th>
<th>Reason</th>
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</thead>
<tbody>
<tr>
<td>Screen In</td>
<td>01/23/2007 1:30pm</td>
<td>Screen In-Accepted for Services/Investigation</td>
</tr>
<tr>
<td>Explain</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### IV. CI Unit Documentation

- **First Call Attempted Date/Time**: 01/23/2007 2:00 PM
- **Completed Call Date/Time**: 01/23/2007 2:00 PM
- **Call Log**

- **Called Out By**: ALLEN, GLORIA
- **Called To**: LAMB, MARY

- **Name – Worker**: DELRAY, WILLIAM
- **Name – Reporter**: John Smith
- **Reporter Caller ID (954) 555-9088**
- **Reporter Requests Contact**
  - X Yes
  - No
- **Report Method**: Telephone
- **Home Phone (954) 555-9088**
- **Work Phone**
- **Other Phone**

**Reporter Narrative**

Reporter is a neighbor. This is not the first time that the children have been left unsupervised.

**Source Information**

---

**Background Summary**

- **Summary**: FCIC, NONE DJJ, NONE DOC, NONE Sexual Predator. NONE

---
### INTAKE REPORT

<table>
<thead>
<tr>
<th>Intake Name</th>
<th>Intake Number</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>BELL, GEORGIA</td>
<td>2010-000889-01</td>
<td>Orange</td>
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<table>
<thead>
<tr>
<th>Date and Time Intake Received</th>
<th>Program Type</th>
<th>Investigative Sub-</th>
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<tr>
<td>02/01/2010 11:00AM</td>
<td>Child Intake – Initial</td>
<td>In-Home</td>
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<table>
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<tr>
<th>Worker Safety Concerns</th>
<th>Prior Involvement</th>
<th>Law Enforcement Notified</th>
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</thead>
<tbody>
<tr>
<td>Yes X No</td>
<td>Yes No</td>
<td>Yes No</td>
</tr>
</tbody>
</table>

**Response Time**

- **24 Hours**
- **Name – Worker:** THOMAS, RONALD
- **Name – Supervisor:** DAVIS, MICHELLE

### I. Family Information

- **Name – Family:** BELL, GEORGIA
- **Telephone Number – Home:** (407)889-0100
- **Address – Street:** 1357 North Lincoln Road
- **Unit Designator:** City
- **City:** Orlando
- **State:** FL
- **Zip Code:** 32801

**Primary Language:**

- **Interpreter Needed:** Yes X No

**Directions to House:**

1357 North Lincoln Road, Orlando is the home address for all participants.

---

### A. Participants

<table>
<thead>
<tr>
<th>Name</th>
<th>ID Number</th>
<th>Role</th>
<th>Gender</th>
<th>DOB</th>
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<tbody>
<tr>
<td>BELL, TIMOTHY</td>
<td>012734923</td>
<td>V</td>
<td>Male</td>
<td>09/23/2001</td>
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<tr>
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<table>
<thead>
<tr>
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<th>ID Number</th>
<th>Role</th>
<th>Gender</th>
<th>DOB</th>
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<tbody>
<tr>
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<td>Female</td>
<td>01/01/2003</td>
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<table>
<thead>
<tr>
<th>Name</th>
<th>ID Number</th>
<th>Role</th>
<th>Gender</th>
<th>DOB</th>
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</thead>
<tbody>
<tr>
<td>BELL, GRACE</td>
<td>936458932</td>
<td>AP</td>
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<td>08/14/1983</td>
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<td>Ethnicity</td>
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<td>Yes X No</td>
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</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>ID Number</th>
<th>Role</th>
<th>Gender</th>
<th>DOB</th>
</tr>
</thead>
<tbody>
<tr>
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<td>05/22/1983</td>
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</tr>
<tr>
<td>Ethnicity</td>
<td>Unable to Determine</td>
<td>White</td>
<td>Yes X No</td>
<td></td>
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</table>
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<thead>
<tr>
<th>AP</th>
<th>CH</th>
<th>HM</th>
<th>NM</th>
<th>PC</th>
<th>RN</th>
<th>SO</th>
<th>V</th>
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<tbody>
<tr>
<td>= Alleged Perpetrator</td>
<td>Child In Home</td>
<td>Household Member</td>
<td>Non-Household Member</td>
<td>Parent/Caregiver</td>
<td>Report Name</td>
<td>Significant Other</td>
<td>Victim</td>
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### B. Address and Phone Information

<table>
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<tr>
<th>Name</th>
<th>Type</th>
<th>Address</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>BELL, TIMOTHY</td>
<td>Primary Residence</td>
<td>1357 North Lincoln Road, Orlando, FL 32801</td>
<td>(407)889-0100</td>
</tr>
<tr>
<td>BELL, GEORGIA</td>
<td>Primary Residence</td>
<td>1357 North Lincoln Road, Orlando, FL 32801</td>
<td>(407)889-0100</td>
</tr>
<tr>
<td>BELL, MARY</td>
<td>Primary Residence</td>
<td>1357 North Lincoln Road, Orlando, FL 32801</td>
<td>(407)889-0100</td>
</tr>
<tr>
<td>BELL, GRACE</td>
<td>Primary Residence</td>
<td>1357 North Lincoln Road, Orlando, FL 32801</td>
<td>(407)889-0100</td>
</tr>
<tr>
<td>BELL, SAM</td>
<td>Primary Residence</td>
<td>1357 North Lincoln Road, Orlando, FL 32801</td>
<td>(407)889-0100</td>
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### C. Relationships

<table>
<thead>
<tr>
<th>Subject</th>
<th>Relationship</th>
<th>Subject</th>
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<tr>
<td>BELL, GRACE</td>
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<td>BELL, TIMOTHY</td>
</tr>
<tr>
<td>BELL, GRACE</td>
<td>Mother</td>
<td>BELL, GEORGIA</td>
</tr>
<tr>
<td>BELL, GRACE</td>
<td>Mother</td>
<td>BELL, MARY</td>
</tr>
<tr>
<td>BELL, SAM</td>
<td>Father</td>
<td>BELL, TIMOTHY</td>
</tr>
<tr>
<td>BELL, SAM</td>
<td>Father</td>
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</tr>
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<td>Father</td>
<td>BELL, MARY</td>
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### D. Alleged Maltreatment

<table>
<thead>
<tr>
<th>Alleged Victim</th>
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<tbody>
<tr>
<td>BELL, TIMOTHY</td>
<td>Physical Injury</td>
</tr>
<tr>
<td>BELL, TIMOTHY</td>
<td>Family Violence Threatens Child</td>
</tr>
<tr>
<td>BELL, GEORGIA</td>
<td>Family Violence Threatens Child</td>
</tr>
<tr>
<td>BELL, MARY</td>
<td>Family Violence Threatens Child</td>
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### E. Location of Incident

<table>
<thead>
<tr>
<th>Address – Street</th>
<th>Apt.</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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<tbody>
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<td>1357 North Lincoln Road</td>
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<td>32801</td>
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<table>
<thead>
<tr>
<th>Telephone Number – Home</th>
<th>Telephone Number – Work</th>
<th>Telephone Number - Cell</th>
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</thead>
<tbody>
<tr>
<td>(407)889-0100</td>
<td></td>
<td></td>
</tr>
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</table>

### II. Narratives

#### A. Allegation Narrative

Timothy has bruises on his arms and legs. He stated that his parents were fighting last night and he was hit several times while trying to stop the fighting. This is not the first time that Timothy and his siblings were injured during fights between the parents.
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### B. Narrative for Worker Safety Concerns

**III. Agency Response**

<table>
<thead>
<tr>
<th>A. Probationary Worker Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decision</td>
</tr>
<tr>
<td>Explain</td>
</tr>
</tbody>
</table>

**B. Worker/Supervisor Decision**

| Decision | Date/Time Decision Made | Reason |
| Screen In | Screen In – Accepted for Services/Investigation |
| Explain |

**IV. CI Unit Documentation**

<table>
<thead>
<tr>
<th>First Call Attempted Date/Time</th>
<th>Completed Call Date/Time</th>
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<tbody>
<tr>
<td>02/01/2010 12:00 PM</td>
<td>02/01/2010 12:00 PM</td>
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**Call Log**

<table>
<thead>
<tr>
<th>Called Out By</th>
<th>Called To</th>
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</thead>
<tbody>
<tr>
<td>HOWARD, PETER</td>
<td>HALL, DANIEL</td>
</tr>
</tbody>
</table>

**REPORTER NARRATIVE**

Name—Worker
Thomas, Ronald

Name—Reporter
Aaron Carter

Reporter Type
Teacher

Reporter Caller ID
407-555-6709

Reporter Requests Contact
Report Method
X Yes No

Home Phone
Phone
(4075585546)

Work Phone

Other

The reporter is a teacher at Kennedy Elementary School.

Source Information

Background Summary

Summary - FCIC.NONE DJJ.NONE DOC.NONE Sexual Predator. NONE Summary - FCIC.NONE DJJ.NONE DOC. NONE Sexual Predator. NONE
Reading an Intake: Bell Investigation

- Read the Bell intake, Participant Guide 18-21.
- Answer the questions individually.
- Compare answers in your small group.

The Intake Report

1. Are there priors and/or providers for this family?
2. When was this intake received at the hotline?
3. What is the response time for the intake?
4. Who received the call at the hotline?
5. Who is the reporter and what is this person’s address?
6. Can you use the caller ID #?
7. What is this person’s relationship with the family?
8. What additional information can you find about the reporter?
9. What is the main concern of the reporter?
10. What has this person observed?
11. Did this person try to do anything about the alleged maltreatment?
12. Who are the alleged victim(s) and how old are they?
13. What immediate safety concerns can you identify?
14. What is the alleged maltreatment(s) for each child?
15. Who are the other people involved in this situation?
16. What are their relationships to the family?
17. What are the initial roles of these people?
Child Maltreatment Index-Activity

Part I: The Child Maltreatment Index

- Use the Child Maltreatment Index to identify the specific type of maltreatment that are alleged in the scenarios.

<table>
<thead>
<tr>
<th>Maltreatment</th>
<th>Special Conditions</th>
</tr>
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<tbody>
<tr>
<td>Burns</td>
<td>Substance Misuse</td>
</tr>
<tr>
<td>Bone Fracture</td>
<td>Inadequate Supervision</td>
</tr>
<tr>
<td>Internal Injuries</td>
<td>Abandonment</td>
</tr>
<tr>
<td>Asphyxiation</td>
<td>Environmental Hazards</td>
</tr>
<tr>
<td>Physical Injury</td>
<td>Malnutrition/Dehydration</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>Failure to Thrive</td>
</tr>
<tr>
<td>Bizarre Punishment</td>
<td>Medical Neglect</td>
</tr>
<tr>
<td>Mental Injury</td>
<td>Family Violence Threatens Child</td>
</tr>
<tr>
<td>Threatened Harm</td>
<td>Failure to Protect</td>
</tr>
<tr>
<td>Human Trafficking</td>
<td>Death</td>
</tr>
</tbody>
</table>

Scenario 1:
The children, ages 4 and 6, are suspected to be at risk, on those occasions when their mother leaves them in the care of her mother, Mildred. Mildred is an amputee who is dependent on a wheelchair. She currently has a broken arm and is described as being unable to provide safe and adequate supervision for her grandchildren. The children are aware that they can leave the residence and wander anywhere in the neighborhood without being found and returned because of their grandmother’s physical limitations. They have been cautioned previously but continue with this arrangement.

Maltreatments/Special Conditions:

Scenario 2:
Mary tested positive for cocaine at the time of delivery today. The drug screen on the baby is pending. The baby is doing fine. APGARS were 5 and 9 and she was delivered by C-Section. Mother received prenatal care through the clinic and also a private physician.

Maltreatments/Special Conditions:
Scenario 3:
The single mother, Lorine, passed away last night. Although no one was ever involved when Lorine and her daughter lived in poverty, suddenly there are relatives and friends “coming out of the woodwork” wanting custody of her child, Fannie. The whereabouts of the father are unknown and there is no name and/or signature on the birth certificate regarding the biological father.

Maltreatments/Special Conditions:

Scenario 4:
The mother and her children live in a condemned apartment building; apt. 3. No one else actually lives in the building. The mother is said to have no visible means of income. The children cannot stay awake during the day and are obviously not getting sufficient sleep at night. The older son has to urinate frequently and has a history of pus coming from penis. The mother has failed to get him medically checked. The younger son is showing some of the same signs and smells strongly of urine. The children are not clean. Michelle has ringworm on her face and the mother put shoe polish on it to try to cover it up, instead of obtaining medical treatment.

Maltreatments/Special Conditions:

Scenario 5:
The parents advise that their 14-year-old child refuses to go to school or to abide by the parents’ rules. They are unable to control his behavior and are worried that he will get harmed when he is “running the streets” instead of going to school. They want help in getting him to listen and to behave.

Maltreatments/Special Conditions:

Scenario 6:
It is alleged that a young girl, approximately 9-years of age is residing with the Gutierrez family. She is forced to live in the garage and does not attend school. Allegedly, this girl “works” for the family and is forced to clean, and do wash for 16 hours per day.

Maltreatments/Special Conditions:
Module 2: Family Dynamics in Child Maltreatment

The Parent's Predisposition to Abuse Their Child

Research indicates that a high percentage of parents who maltreat their children can relate and describe a history of maltreatment in their own lives.

This can create a predisposition to maltreat one's own children, for the following reasons:

- The parent has **low self-esteem**.
  - Feels unloved, uncared for, somehow bad, the "black sheep" of the family, unworthy, abandoned, and depressed.
- The parent cannot trust or depend upon others to meet their needs to care about them.
  - Expects rejection and pain in relationships.
  - Often isolates him/herself to avoid further pain.
- Parents are often **preoccupied** with finding ways to get their own needs met.
  - Turning to their children to meet their needs creates the classic "role reversal", in which the child assumes adult behaviors which nurture the parent.
  - Neglectful parents may engage in impulsive or selfish behaviors, which can be explained as a similar lack of empathy for the needs of the child and a preoccupation with themselves and meeting their own needs.
- The abusive parent looks to the **child to validate the parent's self-esteem**.
  - Abusive parents believe their children have the power to measure their worth.
  - If the child appears grateful for the parent's care, is happy, pleasant to be around, and responsive, this confirms that the parent is a "good parent" and the child "loves him".
  - If the child is unresponsive, oppositional, or unhappy, the parent often interprets this as a devastating personal failure and rejection.
- The parent's lack of trust contributes to **conflict and inconsistency in interpersonal relationships**.
  - Because of this conflict, sources of support and help which might otherwise be available are not.
  - The parent is extremely **vulnerable to being hurt** by other people. They expect to be attacked.
- Many abusive parents have **poor emotional control**.
  - They may carry a residue of anger from childhood.
  - With low frustration tolerance and deep feelings of insecurity, they experience even minor events as major assaults to an already fragile self-esteem, and at times, their rage may become uncontrollable and be expressed in violent behavior against the child.
• They appear to **fear authority**, yet behave authoritatively.
  • This may be an attempt to assume and retain control in an "uncontrollable" world.

• Both abusive and neglectful parents may exhibit a pervasive **lack of empathy and understanding** of their children.
  • Caretaking is often performed mechanically and at the parent's convenience, without any warmth, sensitivity, and empathetic action in response to the perceived needs of the child.
  
• In situations of abuse, the parent's inability to empathize is exhibited in distorted and unrealistic expectations for children's behavior.
  • Abusive parents tend to see a normal child's dependence, rebelliousness, distress, and autonomy as direct evidence of their inability to parent, or confirmation that their child does not really care about them.

• In situations of neglect, especially where the parent is apathetic and emotionally void or distant, the parent appears to not have the ability to provide emotional nurturance, and is largely unaware that the child needs such nurturance and attention.

• Some parents who have been raised with violence make the assumption that violence is "natural". Violent attention is construed as attention, which is preferred to indifference.

• Both abuse and neglect may occur in families in which parents are mentally ill, mentally challenged, or emotionally disturbed.
  • The percentage of abusive or neglectful parents with disorders of this type is relatively small.
  • The psychotic parent's lack of contact with reality, pervasive thought disorder, hallucinations, and delusions creates very abnormal parenting.
  • Mentally challenged parents may have very little knowledge of proper parenting methods, poor skills, and very limited judgment. As a result of their deficits in both cognitive and social skills, parents who are mentally retarded may both abuse and neglect their children.

**The Child is Seen as "Different" or "Unworthy"**

• Children are more prone to abuse if they cannot meet the abusive parent's expectations for "good" or "right" behavior.
  • Although the characteristics that make the child "good" or "different" are often in the eyes of the beholder, certain characteristics place children at higher risk.

• Some children are more **difficult to care** for due to personality traits and temperament.
  • Being stubborn, rebellious, extremely energetic, easily distressed or temperamental, distractible, withdrawn and self-absorbed, or challenging places a child at a greater risk of maltreatment.
• Children who are hyperactive, mentally challenged, emotionally disturbed, developmentally disabled, premature, or have chronic illnesses or medical conditions, are at higher risk.
  • These conditions may reinforce the parent's belief that the child is somehow "defective" or less than adequate.
• It is typical to find children in a family treated differently, with one child the target of most of the abuse.
• In situations of neglect, the quality of care provided to all the children is more consistent.
  • It is less likely that a neglectful parent will selectively provide a high quality of care for some of his/her children and neglect others.
• Children are at **higher risk of maltreatment during certain developmental periods**, particularly infancy.
  • Infants require constant care and attention to meet even their most basic needs, therefore, they are easily neglected by parents who provide marginal care.
  • The stress experienced by an abusive parent may erupt in violence against the child.
• Toilet training can create power struggles and conflicts, particularly when the child is stubborn, oppositional, and fails to comply with the parent's toileting demands.
  • Many abusive parents view toileting accidents or autonomy on the child's part as "willful" noncompliance, or "doing it just to spite me."
  • Inflicted injuries to the genitals and dunking burns on the buttocks in toddlers are common punishments for toileting accidents.

**Stress and Crisis in the Family**
• In situations of chronic abuse, there may be long periods of time between abusive events.
• The precipitation of an abusive event is often related to excessive stress or a family crisis.
  • Abusive parents are more vulnerable to emotional stress, resulting in a high level of frustration and self-criticism which often "trigger" abuse.
  • There is a high correlation between situational stress, lack of coping resources, and neglect of children.

**The Absence of Supports**
• The parent's inability to trust other people, the expectation of attack and criticism, and a sense of shame about perceived failures together lead to "self-imposed isolation," which is an unwillingness to reach out to other people for help.
• This may be exhibited both in fear of other people, or in an attitude that, "This is nobody's business. We handle our own problems in this family." This isolation prevents families from accessing needed sources of support to help in coping with stress situations.

2011 Florida Child Abuse Death Review Summary
- Detailed review of the facts and circumstances surrounding cases of child maltreatment.
- Limited to child death investigations that have verified findings.
- In 2010, 2,282 children lost their lives, of those deaths 507 were reported to the Florida Abuse Hotline.
- 155 verified child abuse deaths occurred in 2010. Of which the committee received 136 during the review period (January – November 14, 2011).
- The Child Abuse Death Review Committee’s findings show the presence of substance abuse in 64% of the 174 perpetrator/caretakers responsible for the child death cases reviewed.

Key Recommendations

Continue and Enhance Statewide Public Awareness and Education Efforts - 
There is a need to continue and enhance researched-based statewide public awareness campaigns to educate the public on strategies and actions that work to prevent child abuse and neglect and child deaths from occurring.

Review All Child Deaths - Amend s. 383.402 (1), F. S., to expand the State Child Abuse Death Review Committee’s authority to review all child deaths in two phases – Amending this statute will allow Florida to have a better understanding of why children die in Florida.
- Phase I - expand the State’s child abuse death review process to include the review of all child deaths reported to the Florida Abuse Hotline.
- Phase II - expand the State’s child abuse death review process to include the review of all child deaths.

Amend the statutory due date of the State Committee’s annual report to March 31st – Amending the statute will allow the State Committee additional time to review reports closed during November and December and to conduct a more thorough review of the deaths.

Invest in Successful Prevention Programs to Prevent Child Abuse and Neglect - The 2012 Florida Legislature should maintain the 2011-12 funding level for Healthy Families Florida and other successful prevention programs that improve the health, safety and well-being of Florida’s children to avoid the costly short-term and long-term consequences of child abuse and neglect.
There will be additional recommendations included this report that are more specific to the types of maltreatment deaths reviewed in 2011.

Please see completed Death Review Annual Report December 2010 for complete list of all priority issues and recommendations.
FLORIDA 2010 CHILD DEATH STATISTICS
The State Committee reviewed 136 child abuse and neglect deaths that occurred in 2010.
- 51 (37.5%) were from abuse
- 85 (62.5%) were from neglect
136 infant/child deaths reviewed during 2010.
- 161 (84%) of the children were 5 and under.

Abuse Vs. Neglect  PPT17 &18

- 79 (58%) Accidental
- 49 (36%) Homicides
- 41 (84%) were under 5 years of age
- 22 (45%) were less than 1 year of age
- 4 (3%) Undetermined
- 3 (2%) Natural
- 1 (1%) Suicide

Age of Child PPT19
- 52 (38%) were <1
- 50 (37%) were 1-2
- 17 (13%) were 3-5
- 4 (3%) were 6-8
- 7 (5%) were 9-12
- 5 (4%) were 13-15
There were 119 (88%) of the children age five and under.

**Gender of Child PPT20**
- 92 (70%) were male children
- 44 (30%) were female children

**Race/Ethnicity of Child PPT21**
- 62 (46%) were White
- 39 (29%) were Black
- 11 (8%) were Hispanic
- 10 (7%) were Multi-racial
- 9 (7%) were Haitian
- 3 (2%) were Asian Pacific
- 2 (1%) were Middle Eastern
Perpetrator/Caretaker Characteristics
The total number of identifiable perpetrator/caretakers responsible for the 136 child deaths was 174 (more than one perpetrator can be responsible for a death.) Two of the 136 deaths involved an unknown perpetrator/caretaker(s).

Age of Perpetrator/Caretaker PPT23
- 10 (6%) were under the age of 19
- 41 (24%) were 20-24
- 47 (27%) were 25-29
- 41 (24%) were 30-40
- 35 (20%) were > 41

The majority of the perpetrator/caretakers (56%) were under the age of 30.
Gender of Perpetrator/Caretaker PPT24
- 94 (54%) were females
- 80 (46%) were males

Race of Perpetrator/Caretaker PPT25
- 107 (62%) were White
- 62 (36%) were Black
- 5 (3%) were Other
**Relationship of Perpetrator/Caretaker to Child PPT26**

- 76 (44%) were Mothers/Stepmothers
- 60 (34%) were Fathers/Stepfathers
- 12 (7%) were Other Relatives**
- 8 (5%) were Other non-relatives
- 5 (3%) were Day care workers
  - Four were licensed facilities
  - One was an unlicensed home day care
- 3 (2%) were Male and Female Paramours
- 1 (0.5%) was a Foster Mother

**Other relatives included grandparents, aunts, great grandparents, and other relatives.**

**Top Five Perpetrator/Caretaker Risk Factors PPT27-28**

**Prior Abuse or Neglect History PPT29-31**

- In 95 (70%) of the 2010 child death cases reviewed, the child did not have any prior involvement with DCF.
- In 41 (30%) of the 2010 child death cases reviewed, the child had prior involvement with DCF.
PREVENTABILITY

Preventable Deaths
The State Committee is charged with the responsibility of determining whether the child’s death was preventable, based on the information provided, using the following categories:

Definitely preventable by caretaker or system or both
The information provided demonstrates clearly that steps or actions could have been taken that would have prevented the death from occurring. A system can be agencies such as DOH, DCF, Community Based Care, Healthy Families, Healthy Start, Law Enforcement, the Judicial system, or relatives, to name a few.

Deaths resulting from homicidal violence are classified as “not preventable” unless the information provided clearly demonstrates that actions taken by the community or an individual other than the perpetrator/caretaker could definitely have prevented the death or could possibly have prevented the death.

Possibly preventable by caretaker or system or both
There is insufficient information to determine if the death was preventable.

Not preventable by caretaker or system
No current amount of medical, educational, social or technological resources could prevent the death from occurring.
Preventability PPT32

- 76 (56%) were definitely preventable by caretaker
- 19 (14%) were definitely preventable by caretaker and system
- 17 (13%) were not preventable
- 8 (6%) were definitely preventable by caretaker and possibly system
- 8 (6%) were possibly preventable by caretaker
- 6 (4%) were definitely preventable by system
- 2 (1%) were undetermined

Neglect Deaths

Eighty-five (62.5%) child deaths were from neglect, the following are the specific maltreatments related to those deaths. PPT33

- 42 (49%) Drowning
- 21 (25%) Unsafe sleep
- 9 (11%) Vehicle
- 6 (7%) Drug toxicity deaths
- 3 (4%) Other neglect deaths
- 2 (2%) Medical neglect
- 1 (1%) Firearm
- 1 (1%) Fire
In 2010, the number of drowning deaths in Florida among children less than five years old increased from the year before, following a 15% decrease from 2007-2009. The DCF hotline received 91 cases of child death drowning during 2010. Forty-two were verified for abuse/neglect and submitted to the state committee for review. Between 2004 and 2008, Florida had the 3rd highest overall drowning death rate in the nation and the highest unintentional drowning rate for children 0-4 years old; with a rate of 6.3 per 100,000 population. The top five counties statewide for unintentional pool drowning deaths among ages 0-4 for 2009-2010 were as follows:

Hillsborough - 10
Broward - 9
Orange - 8
Pinellas - 7
Miami-Dade – 6

There were a total of 42 drowning deaths. Inadequate supervision was found in all drowning deaths.

- 29 (69%) were in pools
- 10 (24%) were in other bodies of water
- 3 (7%) were in bathtubs

Risk Factors
- 18 had criminal history
• 16 had substance abuse history
• 14 had prior history
• 12 had domestic violence history

CHILD CHARACTERISTICS

Age of Children

• 5 (12%) were between ages 0-12 months
• 9 (21%) were between ages 13 months to 23 months
• 23 (55%) were between ages 2 to 3 years
• 5 (12%) were between ages 4 to 6 years

Gender of Children

• 30 (71%) were males
• 12 (29%) were females
Race/Ethnicity of Children
- 21 (50%) were White
- 8 (19%) were Black
- 8 (19%) were Haitian
- 2 (5%) were Multi-racial
- 2 (5%) were Middle Eastern
- 1 (2%) was Asian

PERPETRATOR/CARETAKER CHARACTERISTICS
Fifty-one perpetrators/caretakers were identified in the drowning deaths

Age of Perpetrator/Caretaker
- 25 (49%) were between the ages of 18-29 years
- 12 (24%) were between the ages of 30-38 years
- 9 (18%) were between ages of 40-48 years
- 5 (10%) were between ages of 53-72 years

Gender of Perpetrator/Caretaker
- 27 (53%) were females
- 24 (47%) were males
Relationship of Perpetrator/Caretaker to Child

- 22 (43%) were fathers/stepfathers
- 21 (41%) were mothers
- 5 (10%) were grandparents
- 2 (4%) were non-relatives
- 1 (2%) was an aunt
Factors to consider in Drowning/Inadequate Supervision

Was the pool in a safe condition? Was the pool murky water or unkempt?
Were there layers of protection i.e., locks on doors that are out of reach of the child, pool alarm, pool fence?
Were the locks/layers of safety being used?
How did the child access the water, pool?
Was the child physically capable of unlocking doors, opening sliding doors?
Was this the child's residence or relative, friend, vacationing home, etc?
Was the caregiver under the influence of drugs (prescribed or otherwise)/alcohol?
Is there a criminal history of drugs/alcohol?
Is there evidence of alcohol or drug/paraphernalia observed?
Has the child gotten into the pool area alone before?
Does the parent have developmental impairment?
Does the child have any delays or impairment i.e. autism?
Are there DCF priors of inadequate supervision and or substance misuse?
Collateral contacts of neighbors on supervision issues in past-unreported?
If the parent was sleeping, had they been diagnosed as depressed and taking medication past or present? Note what time it is they are sleeping?
Were the parents doing shift work?
Was the caretaker on the computer– for what amount of time?
What was the activity of the parent when child went missing?
What is the time of event?
How long does caretaker say they were missing?
Who was designated to watch the child? Especially in cases of parties, BBQ's.
Has code enforcement been involved?
Is this a rented home or owned?
Did caretaker know how to swim?
Did caretaker know CPR?
SLEEP ENVIRONMENT RELATED DEATHS PPT43-47

Issues of unsafe sleep practices have been recognized as a major priority by the State Committee and by many of Florida’s state agencies and organizations. The State Committee, along with several of its members, supported the DOH’s review/analysis of Florida’s Sudden Unexpected Infant Deaths (SUID). The purpose of this review/analysis was to measure the impact of SUID in Florida, to assess the quality of SUID investigations at the local level and to estimate the impact of unsafe sleep practices on SUID. In addition, several of the State Committee members actively participated in the review/analysis along with their other job-related duties. Committee member involvement included being primary reviewers as well as serving on the advisory committee. The findings from the review/analysis are forthcoming and will be critical to both the State Committee and the DOH in advancing their efforts to identify, improve surveillance of, and reduce SUID and sleep-related deaths: which are responsible for 200 to 300 infant deaths each year in Florida.

There were 21 unsafe sleep-related child deaths
- 14 (67%) were co-sleeping related
- 7 (33%) were due to unsafe sleep environments

Overall Risk Factors
- 18 had substance abuse history
- 18 had criminal history
- 18 had prior history
- 9 had domestic violence history
CHILD CHARACTERISTICS

Age of Children

- 15 (71%) were between 0 and 3 months
- 4 (19%) were between 3 and 6 months
- 2 (10%) were between 6 and 9 months

Gender of Children

- 15 (71%) were males
- 6 (29%) were females

Race/Ethnicity of Children

- 12 (57%) were White
- 4 (19%) were Hispanic
- 3 (14%) were Black
- 2 (10%) were Multi-racial

PERPETRATOR/CARETAKER CHARACTERISTICS

Twenty-eight perpetrator/caretakers were identified in the 21 infant sleep-related deaths.

Age of Perpetrator/Caretaker

- 18 (64%) were between 19-25
- 4 (14%) were between 26-30
- 4 (14%) were between 31-35
- 1 (4%) was 36 years
- 1 (4%) was 46 years
Gender of Perpetrator/Caretaker
- 19 (68%) were females
- 9 (32%) were males

Relationship of Perpetrator/Caretaker to Child
- 18 (64%) were mothers
- 9 (32%) were fathers
- 1 (4%) was a foster mother

Factors to consider on unsafe sleeping related cases
Is this the normal residence for the child?
What was the condition of the home?
Was the parent under the influence of drugs/alcohol?
Is there evidence of alcohol or drug/paraphernalia observed?
Is there a DCF or criminal history of drugs and/or alcohol?
Age of parent?
Were parents working different shifts, rather than daycare?
What type of sleep surface was the child on? Was it a shared sleep surface? If so with whom and how many? Height, weight, age, relationship, etc.
Was there a crib/bassinet for the child, if so was it being used?
Did they have appropriate bedding for the child?
If the crib was used were there unsafe items in the crib i.e. blankets, clothes, toys?
Were the parents advised of the danger in placing the child on the stomach to sleep and/or co-sleeping and if so, by who?
If a blanket or covering was used over the child's face, how much did it weigh and type of material?
Were they bottle propping, and what was used to hold bottle, blanket etc?
Was the bed in poor condition i.e. no board underneath to keep it hard and flat?
Was the child sleeping in a car seat? Note the position of the head.
What was the location of the car seat?
When was the last time they checked on the child?
When was the last time they fed the child?
Has there been a SIDS death in the family in the past?
Ask how many children they have had, not how many do they have?
Was the child recently sick and, if so, was the child on medication?
Document the type of medication and dose given.
Safe Sleeping
Developed by Healthy Families Florida
Facts:

- Babies are safest when sleeping on their backs in a crib (meeting safety standards) with a firm mattress.
- Each year in the United States, more than 4,500 infants die suddenly of no obvious cause. These deaths are called Sudden Unexpected Infant Deaths or SUIDs.
- Suffocation and strangulation in bed is the leading cause of injury-related death for infants under age 1.
- Infant deaths due to suffocation, strangulation and Sudden Infant Death Syndrome (SIDS) are highest among infants 1 to 3 months of age.
- The risk for suffocation among infants who sleep in adult beds is 40 times higher than the risk for suffocation in cribs.
- Babies laid down to sleep without a pacifier in their mouth are more than twice as likely to die of SIDS.
- Soft bedding or lying on or next to an adult or child can lead to suffocation. This could also cause overheating which increases the risk of SIDS.
- The risk of SIDS is 3 times higher for mothers who smoke while pregnant and 2-3 times higher for babies living in smokers’ households. After pregnancy, the risk rises depending on the number of smokers in the household and the number of cigarettes smoked by each person.
- The SIDS rate has been declining significantly since the early 1990s. However, Centers for Disease Control (CDC) research has found that the decline in SIDS since 1999 can be explained by increases in other SUID rates (e.g., deaths attributed to someone rolling over on top of the infant, suffocation and wedging).
- Babies that are placed on their stomachs to sleep when they are used to sleeping on their backs are 18 times more likely to die of SIDS.
- Bottle propping (such as using a pillow or something else to “prop” a bottle for feeding) or allowing a baby to bottle-feed alone can cause choking or suffocation.
Safe Sleeping
Developed by Healthy Families Florida

Tips:
- Babies should never sleep with an adult or another child.
- Babies should sleep alone, on their back, on a firm, flat surface.
- The safest place a baby can sleep is in a crib, bassinet, Pack ‘n’ Play or cradle located in the same room as the caregiver.
- Cover the mattress with a tightly fitted sheet that tucks well under the mattress pad.
- Babies should never sleep in an adult bed, on a couch, pillow, chair, bean bag, air mattress, waterbed or any other piece of furniture not made for babies.
- Do not put anything in the baby's bed. Pillows, quilts, comforters, sheepskin, stuffed animals, bumper pads and other soft products are not safe for sleeping babies. Use a sleeper or sleep sack, instead of a blanket.
- Always take off a bib before the baby goes to sleep.
- Babies should sleep on their backs during naps and at night until age 1, unless the baby's doctor says another position is better.
- Babies learn to sleep in the position they are placed from birth. It is important for the baby to start sleeping on their back. This may be hard at first, but parents should not give up. Babies will learn to sleep on their backs!
- Parents should talk about safe sleeping with everyone that takes care of their baby.
- Babies should always sleep in an area with no smoke.
  - Offer a pacifier until the baby is one-year-old using the following steps:
  - The pacifier should be used when placing the baby down to sleep and should not be put back in the baby's mouth after the baby falls asleep.
  - If the baby does not want the pacifier, do not force it.
  - If breastfeeding, do not use a pacifier until the baby is one-month-old.
- Hold the baby when feeding, since propping a bottle can cause the baby to choke and possibly die.
Asphyxiation/Suffocation/Unsafe Sleep Environment

Developed by Healthy Families Florida

Unsafe sleep practices and environments place infants at an increased risk of dying from accidental suffocation or positional asphyxiation.

Babies are safest when sleeping on their backs on a firm mattress in a crib meeting current safety standards.

Do not have a child share a sleep surface with an adult or another child. Sharing an adult bed with an obese adult, an adult under the influence of alcohol or drugs (legal or illegal) and/or an adult who is exhausted increases the risk of suffocation. Being placed in an adult bed can cause compression or overlay by the adult or child they are sharing a sleep surface with; suffocation from becoming entangled or face down in loose bedding; or suffocation from entrapment by being wedged in couch cushions or between the bed and wall. Being placed in a bed that is broken, has items the child may come in contact with that would prohibit breathing, or hazardous items that could endanger the child, i.e. plastic bags, toys, blankets, pillows. Waterbeds, bean bags, and car seats can also pose a risk to children. Propping bottles in the child’s mouth by using blankets, towels or other soft objects also poses a risk.

Asphyxiation

Unconsciousness or death from suffocation or interference of oxygen or blood as a result of actors or omissions.

Suffocation

To impede respiration by choking, wedging against something, smothering, or other mechanical means: to be unable to breathe as a result of acts or omissions.

Sudden Infant Death

“The sudden death of an infant under one year of age that remains unexplained after a thorough case investigation including performance of a complete autopsy, examination of the death scene, and review of the clinical history.” By definition SIDS can be diagnosed ONLY after a thorough examination of the death scene, a review of the clinical history, and performance of an autopsy fail to find an explanation for the death.

Sudden Unexplained Infant Death

The sudden and unexpected death of an infant due to a variety of natural or unnatural causes.
Vehicle crashes are the most under-reported child neglect deaths. Although there was no Florida data on children who die in vehicle crashes in which the driver was impaired, according to the National Highway Traffic Safety Administration (NHTSA) report, in 2009 (the most recent data), a total of 1,314 children age 14 and younger were killed in motor vehicle traffic crashes. Of those 1,314 fatalities, 181 (14%) occurred in alcohol-impaired driving crashes. Out of those 181 deaths, 92 (51%) were occupants of a vehicle with a driver who had a blood-alcohol (BAC) level of .08 or higher. For further information on the report see http://www.nhtsa.gov.

These vehicle-related child deaths are often viewed as a traffic fatality and not as a child neglect death. There is a lack of training for law enforcement officers on mandatory reporting of child neglect deaths that occur when the parent/caregiver is driving under the influence of alcohol. There were six children in Florida that died as a result of being left in a vehicle. Of those, four were verified during the review period. Florida is second in the nation for these types of child deaths.

Nine children died from vehicle-related deaths
- 4 (44%) were left in vehicles
- 4 (44%) were either driven or backed over
- 1 (11%) was killed in a vehicle crash

Overall Risk Factors
- 5 had substance abuse history
- 3 had prior history
- 3 had domestic violence history
- 3 had criminal history
CHILD CHARACTERISTICS

Age of Children
- 1 (11%) was 4 months
- 5 (56%) were between the ages of 1-2
- 2 (22%) were between the ages of 3-4
- 1 (11%) was 8 years old

Gender of Children
- 5 (56%) were males
- 4 (44%) were females

Race/Ethnicity of Children
- 5 (56%) were Black
- 2 (22%) were White
- 1 (11%) was Asian
- 1 (11%) was Hispanic

PERPETRATOR/CARETAKER CHARACTERISTICS

Ten perpetrator/caretakers were indentified in the vehicle-related deaths.

Age of Perpetrator/Caretaker
- 5 (50%) were between the ages of 20-25
- 2 (20%) were between the ages of 30-35
- 3 (30%) were between the ages of 35-40
Gender of Perpetrator/Caretaker
- 8 (80%) were females
- 2 (20%) were males

Relationship of Perpetrator/Caretaker to Child
- 6 (60%) were mothers
- 2 (20%) were fathers
- 1 (10%) was a day care employee
- 1 (10%) was an aunt
Factors to consider on Traffic related cases
Was caretaker under influence or impaired?
Was child restrained appropriately?
Was this a result of criminal activity - i.e. fleeing from LEO?
Are there prior traffic violations? To include citations, reckless driving?
Did any family members know of previous substance abuse/impairment and driving by the parent/caregiver?
Did anyone see the perpetrator drive off?
Any past history of substance abuse treatment?
Any criminal history of drug related offences?

Kids left in cars
Was there a change in routine?
Who normally takes child?
Type of vehicle and visibility.
Was there a car seat?
Was this intentional - being used as the babysitter?
What was temperature of child, temperature outside, and temperature in the car?
Were they under influence of drugs/alcohol?

Kids backed up or run over
Who was supposed to be watching child?
Were they under influence of drugs/alcohol?
What type of event, i.e. birthday party etc?
Type of vehicle and visibility?
Prior history with DCF, supervision, drugs-alcohol?
DRUG TOXICITY RELATED DEATHS PPT53-56

About seven million people abuse prescription drugs, including painkillers, according to the 2010 National Survey on Drug Use and Health. Centers for Disease Control and Prevention (CDC) deaths in Florida attributed to prescription overdose increased by 84.2 % from 2003 to 2009. Data from the Florida MEC highlight a continuing and disturbing trend in prescription misuse and abuse. The State Committee has recognized that substance abuse is one of the leading risk factors present in both abuse and neglect deaths each year. For the past four years, the State Committee has recommended that law enforcement agencies and DCF should perform field drug testing of caregivers, when indicated, as part of their protocols for the investigation of the unexpected deaths of infants and children.

Six children died as a result of drug toxicity

- 4 (67%) were teen drug overdose deaths
- 1 (17%) was a premature drug exposed new born
- 1 (17%) was an accidental drug overdose due to inadequate supervision

Overall Risk Factors

- 6 had substance abuse history
- 5 had prior history with DCF
- 4 had criminal history
- 3 had domestic violence history
CHILD CHARACTERISTICS

Age of Children

- 4 (67%) were between ages 13-17 years
- 1 (17%) was 2 years old
- 1 (17%) was 4 hours old

Gender of Children

- 4 (67%) were females
- 2 (33%) were males

Race/Ethnicity of Children

- 3 (50%) were White
- 3 (50%) were Black

PERPETRATOR/CARETAKER CHARACTERISTICS

There were nine perpetrator/caretakers identified in the drug toxicity related deaths.

Age of Perpetrator/Caretaker

- 2 (22%) were between 20-25
- 2 (22%) were between 25-30
- 2 (22%) were between 35-40
- 3 (33%) were between 41-46

Race of Perpetrator/Caretaker

- 6 (67%) were White
- 3 (33%) were Black
Gender of Perpetrator/Caretaker

- 7 (78%) were females
- 2 (22%) were males

Relationship of Perpetrator/Caretaker to Child

- 5 (56%) were mothers
- 2 (22%) were other non-relatives
- 1 (11%) was a father
- 1 (11%) was a grandmother

Five cases of prescription medications were noted to be of concern.

Factors to consider on Poisoning related cases

Log types of medications in home at time, dosage and milligrams, number of pills left in container.

Is the amount left appropriate to the prescribed dose?
Take a photo of the pills. What was the reason given for being prescribed the medication?
Were they in a locked container?
Were household members under any treatment- i.e. methadone clinic?
Names of prescribing physicians?
Were the physicians aware of the different prescriptions?
Was caretaker under the influence?
Do they have criminal offenses or arrest history related to drug use?
Are there DCF priors of inadequate supervision, and or drugs involved?

Overdose or Suicide, especially the teens

If the child intentionally took the medication or drugs and died of an overdose, was caretaker
aware of drug misuse?
If yes, did they seek treatment for child?
Was anyone aware of child’s drug use? Friends, relatives etc.
Was the child under DJJ or history with DJJ?
Was the school aware of problems or issues?

OTHER NEGLECT RELATED DEATHS PPT57

Three children died and the contributory factor was inadequate supervision.

- 2 (67%) died from dog mauling
- 1 (33%) died from inhaling a balloon

Overall Risk Factors

- 2 had substance abuse history
- 2 had prior abuse history
- 1 had criminal history

CHILD CHARACTERISTICS

Age of Children

- 1 (33%) was 7 days
- 1 (33%) was 2 years
- 1 (33%) was 3 years

Gender of Children

- 2 (67%) were males
- 1 (33%) was female
Race/ Ethnicity of Children

- 2 (67%) were White
- 1 (33%) was Black

PERPETRATOR/CARETAKER CHARACTERISTICS

Four perpetrator/caretakers were identified in the other neglect related deaths.

Age of Perpetrator/Caretaker

- 2 (50%) were between 30-33 years
- 1 (25%) was 47 years
- 1 (25%) was 16 years

Race of Perpetrator/Caretaker

- 2 (50%) were White
- 2 (50%) were Black

Gender of Perpetrator/Caretaker

- 3 (75%) were females
- 1 (25%) was male

Relationship of Perpetrator/Caretaker to Child

- 3 (75%) were mothers
- 1 (25%) was a father

Remaining Neglect Verified Neglect Deaths PPT58
MEDICAL NEGLECT RELATED DEATHS

Medical neglect is the refusal or failure on the part of the person responsible for the child's care to seek, obtain, and/or maintain services for necessary medical, dental, or mental health care, or withholding medically indicated treatment from disabled infants with life-threatening conditions. Medical neglect means that even minimal health care is not being obtained for a child. This lack of health care can lead to serious harm and even death.

Two children died from medical neglect

- 1 died from ketoacidosis due to type 1 diabetes
- 1 died from hanging

Overall Risk Factors

- 2 had prior abuse history
- 1 had substance abuse history
- 1 had criminal history
- 1 had domestic violence history

CHILD CHARACTERISTICS

Age of Children

- 1 was 11 years
- 1 was 12 years

Gender of Children

- Both children were females

Race/ Ethnicity of Children

- 1 was White
- 1 was Black

PERPETRATOR/CARETAKER CHARACTERISTICS

Three perpetrator/caretakers were identified in the medical neglect related deaths.

Age of Perpetrator/Caretaker

- 1 (33%) was 40 years
- 1 (33%) was 36 years
- 1 (33%) was of unknown age
Race of Perpetrator/Caretaker
• 2 (67%) were White
• 1 (33%) was Black

Gender Perpetrator/Caretaker
• All three were female

Relationship of the Perpetrator/Caretaker
• 2 were mothers
• 1 was a grandmother

FIREARM RELATED DEATHS

Florida’s Child Access Prevention Law is one of only three such state laws allowing felony prosecution of violators and this appears to have significantly reduced unintentional firearm deaths of children. Recent surveys indicate that 33 to 40 percent of U.S. households have a firearm. Caregivers, family members or others must remember that firearms must be secured, preferably with gunlocks, to ensure that they cannot be accidentally discharged. Florida law already requires individuals to ensure that firearms are secured and kept in locations away from children.

One child died from a gunshot wound to the head

Overall Risk Factors
• 1 had substance abuse history
• 1 had prior history

CHILD CHARACTERISTICS

Age of Child
• was 2 years

Gender of Child
• was male

Race/ Ethnicity of Child
• was White

PERPETRATOR/CARETAKER CHARACTERISTICS

One caretaker was responsible for the firearm related death.
Age of Perpetrator/Caretaker

- was 57 years

Race of Perpetrator/Caretaker

- was White

Gender of Perpetrator/Caretaker

- was female

Relationship of Perpetrator/Caretaker to Child

- was a great grandmother

**FIRE RELATED DEATHS**

The high cost of home heating fuels and utilities has caused many Americans to search for alternate sources of home heating. The use of wood burning stoves is growing and space heaters are selling rapidly, or coming out of storage. Fireplaces are burning wood and man-made logs. All of these methods of heating may be acceptable, but can present a danger to children. Parents/caregivers must remain diligent in supervising their children around fire related hazards to prevent possible injury or death. Children playing with fire cause injuries and deaths each year. Preschoolers and kindergartners often start these fires, usually by playing with matches and lighters, and are the most likely to die in fires.

One child died of complications from a thermal burn

**Overall Risk Factors**

- 1 had substance abuse history
- 1 had prior history
- 1 had criminal history

**CHILD CHARACTERISTICS**

Age of Child

- was seven months

Gender of Child

- was male
Race/Ethnicity of Child

- was Black

PERPETRATOR/CARETAKER CHARACTERISTICS

One perpetrator was responsible for this thermal burn death.

Age of Perpetrator/Caretaker

- was 37 years

Race of Perpetrator/Caretaker

- was Black

Gender of Perpetrator/Caretaker

- was male

Relationship of Perpetrator/Caretaker

- was a father

Physical Abuse Maltreatment Deaths \textit{PPT59-66}

Physical abuse is the most visible form of child abuse. Abuse is defined in s. 39.01(2), F.S., as “…any willful act or threatened act that results in any physical, mental, or sexual injury or harm that causes or is likely to cause the child's physical, mental, or emotional health to be significantly impaired. Abuse of a child includes acts or omissions…”

This section will provide an analysis of the child deaths from three categories of physical abuse: intentional injury, murder/suicides and out-of-hospital births. Perpetrator/caretaker risk factors discovered by the State Committee during the death reviews are also presented.

The State Committee found that a majority of the mothers were not responsible for the actual abuse, but may have been aware and often were not held accountable or charged criminally.

There were a total of 51 (37.5\%) children who died as a result of physical abuse.

- (78\%) died as a result of intentional injury
  - 20 had evidence of prior trauma
- 9 (18\%) died as a result of a murder/suicide
  - 4 killed by the stepfather were siblings
  - 2 killed by the father were siblings
- 2 (4\%) died as a result of newborn abandoned babies
Overall Risk Factors

- 36 had criminal history
- 24 had domestic violence history
- 23 had substance abuse history
- 29 had prior history

CHILD CHARACTERISTICS

Age of Children

- 24 (47%) were <1
- 13 (25%) were ages 1-2
- 5 (10%) were ages 3-4
- 4 (8%) were ages 6-10
- 5 (10%) were ages 11-15
Gender of Children

- 34 (67%) were males
- 17 (33%) were females

Race/Ethnicity of Children

- 20 (39%) were White
- 17 (33%) were Black
- 6 (12%) were Hispanic
- 6 (12%) were Multi-racial
- 1 (2%) was Haitian
- 1 (2%) was Asian
PERPETRATOR/CARETAKER CHARACTERISTICS

A total of 67 perpetrator/caretakers were identified in the physical abuse related deaths and two child deaths had unidentified perpetrator/caretaker(s).

- 3 also killed the mothers
- 2 also attempted to kill the mothers

Age of Perpetrator/Caretaker

- 38 (57%) were between the ages of 18-29
- 17 (25%) were between the ages of 30-40
- 10 (15%) were between the ages of 41-52
- 2 (3%) were between the ages of 67-72 years

Gender of Perpetrator/Caretaker

- 39 (58%) were males
- 28 (42%) were females

Relationship of Perpetrator/Caretaker to Child

- 24 (36%) were fathers/stepfathers
Intentional Physical Injury Perpetrator/Caretaker Characteristics

This does not include the murder/suicides or the abandoned newborns.

Of the 40 deaths attributed to intentional physical injury:

Age of Male Perpetrator/Caretaker

- 19 (68%) were between ages 19-29
- 7 (25%) were between ages of 30-40
- 2 (7%) were between ages 43-45 years

Relationship of Male Perpetrator/Caretaker to Child

- 11 (39%) were male paramours
- 11 (39%) were fathers
- 3 (11%) were other non-relatives
- 2 (7%) were stepfathers
- 1 (4%) was a grandfather

Age of Female Perpetrator/Caretaker

- 5 (63%) were between ages 18-29
- 2 (25%) were between ages 30-40
- 1 (13%) was 52 years

Relationship of Female Perpetrator/Caretaker to Child

- 4 (50%) were mothers
• 1 (13%) was a licensed day care worker
• 1 (13%) was an unlicensed home care provider
• 1 (13%) was a female paramour
• 1 (13%) was an other non-relative

Non-offending Caregiver/Parent

Is defined as a parent or caregiver who was residing in the household but was not aware of the abuse.

Secondary Perpetrator/Caretaker

Is defined as caregivers who were residing in the household or who were aware of injuries and who negligently failed to protect a child in his or her care from inflicted physical, mental, or sexual injury caused by the acts of others. The characteristics of the secondary perpetrator/caretakers are identified below.

Age of Secondary Perpetrator/Caretaker

• 9 (60%) were between the ages of 19-29
• 5 (33%) were between the ages of 30-40
• 1 (7%) was 67 years

Gender of Secondary Perpetrator/Caretaker

• 13 (87%) were females
• 2 (13%) were males

Relationship of Secondary Perpetrator/Caretaker to Child

• 12 (80%) were mothers
• 2 (13%) were fathers
• 1 (7%) was a grandmother
Factors to consider on intentional physical injury cases

Who called 911?
Was it delayed? Did alleged perpetrator call someone else before calling 911?
Check cell phone and text records.
Did they drive to hospital? If yes, what is the distance- how long would it take for EMS to arrive? Initial statement, child stopped breathing, found unresponsive, sick, accidentally dropped or fell on child?
Where was mom, at work?
What type of work does mom do?
Did alleged perpetrator have employment, or was he/she full time caretaker?
Were they working in shifts?
Were finances for day care an issue?
How long had mom known alleged perpetrator?
What was motivating factor- crying, toilet training, illness?
What was the activity of the alleged perpetrator right before the crying started?
Did alleged perpetrator have a DV history, criminal history?
Did alleged perpetrator have substance abuse history, to include charges?
Was alleged perpetrator on probation past or current?
Was mom aware of abuse or suspect?
Has she seen any previous bruises while in alleged perpetrator's care, or child fearful?
What was her reason for alleged perpetrator watching child, no day care, cannot afford, work schedule?
Has she been a victim of DV in this situation or in past?

Factors to consider on Murder/suicide cases

Is there a history of DV?
Have there been any injunctions?
Has alleged perpetrator been referred to batterer's classes or attended?
Has alleged perpetrator threatened to anyone the intent to kill the kids?
Is there a custody issue?
Did alleged perpetrator have criminal history?
What is most apparent motive? Custody, retaliation, finances, mental illness, drugs?
If mental illness, has there been treatment?
Was there mental health history, on medication for depression or mental health disorder?
Look for or obtain any mental health records.
Factors to consider on abandoned babies

Location found.
Was mother identified?
Did mother have criminal history?
Did she have mental health issues?
Did she have substance abuse history?
Did she have other children? If yes, had they been removed? Why?
Did she deny she was pregnant, if so to whom?
What was the motivating factor- finances, culture, youth, issues with father, unwanted child?
Was she aware of services, safe haven, prenatal care, counseling etc?

Factors to consider on all cases

Were the caretakers on methadone treatment?
- Were they drug tested before given medication?
- When was medication last given?
- How often do they obtain medication and how long have they been on this treatment?
- Are they getting any other counseling with the methadone treatment?

Gang related activity

- Are the parents or family members involved in gang activity, resulting in shootings and homicides in and around the home where children are present?

Obtaining pediatric records on children 2 and under

Have there been economic changes, job loss, housing loss and day care changes, due to financial changes?

When children are in the hospital document mom's interaction with child, how often she visits, her demeanor, etc.?

Does dad come to the hospital, what is his interaction, demeanor?

Referring the cases to CPT for a medical opinion and getting their findings
- especially good for substance exposed premature babies who die, inadequate supervision issues related to unsafe sleep, drowning.
# Home Safety Checklist

Participant Name: ____________________ Date: ____________________

Please check the appropriate interval:

- Initial: Within 3 months of enrollment
- 4-6 months old: getting ready to crawl
- 9 to 12 months old: increased mobility
- 24-months-old
- Annually, after 24 months old
- New Home

Circle the appropriate answers based on your observations.

**Home Safety** - Ask the participant(s) if they would like to walk around their home with you to assess the safety of the home (bathroom, kitchen, bedroom, etc.) by answering the questions below.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>3.</td>
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<td>5.</td>
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<td>6.</td>
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<td>14.</td>
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<td>16.</td>
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<td>18.</td>
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<td>19.</td>
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<td>No</td>
<td>N/A</td>
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<tr>
<td>20.</td>
<td>Yes</td>
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<td>N/A</td>
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</tbody>
</table>

- Are electrical cords intact and away from the reach of children?
- Are electrical appliances away from a filled tub, sink or running water?
- Are painted surfaces (walls and furniture free from chalking, flaking and peeling, which could indicate the presence of lead-based paint)?
- Are all exterior doors, including pet doors if applicable, childproofed (latches, high locks or alarms, etc.)?
- Are all stairways and floor space for walking clear from obstruction and in a non-slippery condition?
- Is there railing protecting all stairways and elevated landings (top and bottom of stairs)?
- If there are railing slats greater than 2 and 3/8 inches apart, are they covered with a piece of wood or hard plastic?
- Is there a safe place for the child to sleep?
- If there is a crib, are the gaps between the slats on the crib 2 and 3/8 inches or less?
- If there is a child under 1 year of age, is the sleeping area free of soft bedding (including bumper pads), pillows, blankets and stuffed animals?
- If there is a crib, does the crib sheet and mattress fit tightly to avoid entrapment and suffocation?
- Are all houseplants out of reach of children?
- Are all ashtrays out of the reach of children?
- Are emergency numbers readily accessible?
- Are knives and other sharp objects out of the reach of children or in a childproofed drawer?
- Are plastic bags out of the reach of children?
- Are sharp edges and corners covered (i.e. fireplaces, tables, etc.)?
- Are there safety plugs in all unused electrical outlets?
- Are hair dryers and curling irons out of the reach of children?
- Are the iron and ironing board out of the reach of children?
<table>
<thead>
<tr>
<th>No.</th>
<th>Yes/No</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Yes</td>
<td>Are all chemicals/cleaning supplies stored in original containers? (Some examples of dangerous products include paint thinner, antifreeze, gasoline, turpentine, bleach, insect spray, fertilizer, poison.)</td>
</tr>
<tr>
<td>22</td>
<td>Yes</td>
<td>Are all chemicals/cleaning supplies stored out of the reach of children or in a childproofed cabinet?</td>
</tr>
<tr>
<td>23</td>
<td>Yes</td>
<td>Are all vitamins, over the counter and prescription medication stored out of the reach of children or in a childproofed drawer/cabinet?</td>
</tr>
<tr>
<td>24</td>
<td>Yes</td>
<td>Are all alcoholic beverages stored out of the reach of children or in a childproofed cabinet?</td>
</tr>
<tr>
<td>25</td>
<td>Yes</td>
<td>Are cosmetics stored out of the reach of children or in a childproofed drawer/cabinet?</td>
</tr>
<tr>
<td>26</td>
<td>Yes</td>
<td>Are curtain and blind cords kept out of the reach of children?</td>
</tr>
<tr>
<td>27</td>
<td>Yes</td>
<td>If residence is not on the ground floor, is furniture that a child could climb on away from windows, or are there window guards installed?</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>Guns/Weapons Safety - if applicable, verify the location and method of storage.</td>
</tr>
<tr>
<td>28</td>
<td>Yes</td>
<td>Are all guns and ammunition stored/locked out of sight and reach of children?</td>
</tr>
<tr>
<td>29</td>
<td>Yes</td>
<td>Are guns and ammunition stored separately?</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>Fire Safety - Ask participant(s) to show you the smoke alarm(s) and unrestricted exits.</td>
</tr>
<tr>
<td>30</td>
<td>Yes</td>
<td>Are smoke alarm(s) in working order and located on every floor?</td>
</tr>
<tr>
<td>31</td>
<td>Yes</td>
<td>Are space heaters in good repair and are they at least 4 feet from clothing, curtains/drapes or any flammable material?</td>
</tr>
<tr>
<td>32</td>
<td>Yes</td>
<td>Are there two unrestricted exits (windows or doors) that can be used in case of fire?</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>Water Safety - if applicable, ask participant(s) to show you all areas with water (pool, hot tub, retention pond and/or fountain). Measurements are based on current Florida Building Code 424.2.17.</td>
</tr>
<tr>
<td>33</td>
<td>Yes</td>
<td>If there is an in-ground pool, is there at least a 4-foot barrier with gaps of no more than 4 inches?</td>
</tr>
<tr>
<td>34</td>
<td>Yes</td>
<td>If there is an in-ground pool, is there two inches or less between the ground and the bottom of the pool barrier?</td>
</tr>
<tr>
<td>35</td>
<td>Yes</td>
<td>If there is a door from the house that leads into an area with water, is there an exit alarm or a lock located at least 54 inches above the floor?</td>
</tr>
<tr>
<td>36</td>
<td>Yes</td>
<td>If there is a barrier around the pool, are large objects outside of the barrier (such as tables, chairs, or ladders) far enough away from the barrier to prevent children from using them to climb over the barrier and into the pool?</td>
</tr>
<tr>
<td>37</td>
<td>Yes</td>
<td>If there is a gate into the area with water, is there a latch on the gate that closes automatically? Is the latch located on the side with the water? Is the latch located at least 54 inches above the bottom of the gate?</td>
</tr>
<tr>
<td>38</td>
<td>Yes</td>
<td>If there is a window that is accessible to the area with water, is there an exit alarm and/or is the base of the window at least 48 inches from the interior floor (can be 42 inches if there is a cabinet beneath a screened or protected pass-through window)?</td>
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<td>39.</td>
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<td>41.</td>
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<tr>
<td>42.</td>
<td>Yes</td>
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</tbody>
</table>

Safety concerns resolved during the visit:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Plans for follow-up:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Participant Signature: ___________________________ Date: ________________

Home Visitor Signature: __________________________ Date: ________________
Warning Signs of Maltreatment
You must look for warning signs or symptoms of maltreatment on an ongoing basis. Certain family factors might influence the occurrence of maltreatment while behaviors exhibited by parents may serve as a clue that abuse is already occurring.

Situational/Environmental Clues
- Obtain details of exactly what happened in the hours prior to the injury or allegation in the intake.
- Ask when the caretaker(s) first noticed that the child was injured.
- Observe and record clues in the home environment.
- Find out who was home and who was taking care of the child.
- Interview anyone who witnessed the event if injury occurred.

Physical Clues: How to Check the Injury
- Refer to the Child Maltreatment Index.
- Consider the location of the injury on the child's body.
- Look at the skin, which may be the first identifiable location for abuse and the most accessible location for non-health professionals to inspect for trauma.
- Check other areas of the child's body, not just the area of the injury.
- Consider the shape and appearance of the marks or other injuries.

Child/Caregiver Behaviors
Interview parents separately and look for the following behaviors:
- shows inappropriate concern given the nature and severity of the child's condition or injury
- is extremely compliant/cooperative (This behavior might be an indicator of abuse when considered along with other factors. “If I say what they want to hear, they'll go away.”)
- exhibits explosive or threatening behavior when discussing possible maltreatment
- accuses the other parent or a child in the household
- contradicts the story of the other parent
- describes a minor accident, yet major injuries have occurred
- dates the injury differently from the clinical dating
- describes behavior impossible for the child's development
- explains the injury by being evasive or vague
- alleges that the injury is self-inflicted or that someone else inflicted it
- delays in seeking medical care for the child

Parent’s Family History Factors
- Record the parents (caretakers) experiences as children.
- Do they have a history of maltreatment?
- Did their parents have substance abuse problems?
Abnormal Family Dynamics
- domestic violence
- substance abuse
- previous involvement with child protective services
- divorce or separation

Social Stressors
- Identify social stressors in the family such as poverty, unemployment, trouble with the law, or family conflicts.

Societal Values
- Look for societal values that might foster acceptance of maltreatment:
  - acceptance of violence as a way of life
  - conviction that parents have the right to treat children as they please
  - Decide if the family desires to avoid outside involvement in family life.

Critical Indicators of Abuse
- delay in seeking medical attention for injuries
- history of repeated, suspicious injuries
- frequent injuries
- multiple bruises and injuries in different stages of healing
- bruises and injuries in inaccessible places
- injuries inconsistent with adult explanation
Module 3: Physical Abuse

Examples of Child Abuse Critical Indicators

Injuries and Evidence
- numerous alleged “accidental” injuries
- escalating injuries
- injuries inconsistent with explanation
- frequent change of hospitals or physician
- professional medical opinion contrary to facts
- delay in seeking medical treatment

Child Vulnerability
- 5 years and younger
- prior intakes/investigations
- limited access to or contact with child by outside world

Target Child
- no observable signs of bonding with target child
- flat or depressed affect
- lack of peer relationships
- subjected to unusual forms of discipline
- only discipline used is physical
- exhibits behaviors indicative of abuse and neglect
- secretive about injuries
Parent/Caretaker Characteristics

- sociopathic personality (overly charming, extremely cooperative, externalizing role in abuse or other problems, “not my fault”, smooth talker)
- appears to make extreme progress (always pleasing, completes/appears to complete assignments quickly, gives the right answers all the time)
- tells you what you want to hear
- violent and aggressive behavior (domestic violence reports, other police reports, charges involving violence, etc.)
- unrealistic expectations of child
- alienated from family; no family support network
- isolation, lack of social contact (friends, activities)

Parent/Caretaker History

- maltreatment as a child
- alcohol or other substance abuse
- mental illness
- frequent moves
- job instability
- criminal history

Parent/Caretaker Relationship

- boyfriends drifting in and out of the home
- relationship takes precedence over child’s needs (adults’ needs first)
- imbalance of power
- domestic violence
- no clear identification of roles
- open hostility and/or negative perceptions

Physical Environment

- environment poses safety risks (electrical or fire hazards, weapons)
- sleeping area for child is inappropriate
- child is removed from others during common activities - eating, sleeping, etc.
- home is physically isolated (e.g., far out in the country)
- unsecured swimming pools - drowning is the leading cause of neglect deaths (i.e., inadequate supervision) annually in Florida
  - You must be aware of drowning risk factors when there are bodies of water or a pool on the premises or close by the home and must include these factors in any safety plans, etc. that are developed with the family.
Factors to consider on Drowning/Inadequate Supervision

- Was the pool in safe condition? Was the pool water murky or unkempt?
- Were there layers of protection, i.e., locks on doors that are out of reach of the child, pool alarm, pool fence?
- How did the child get access to the pool?
- Were the locks/layers of safety being used?
- Was this the child’s residence or relative, friend, vacationing home, etc.?
- Was the caregiver under the influence of drugs (prescribed or otherwise)/alcohol?
- Is there a criminal history or DCF history of drugs/alcohol?
- Is there evidence of alcohol or drug/paraphernalia observed?
- Has the child gotten into the pool area alone before?
- Does the parent have developmental impairment?
- Does child have any delays or impairment, i.e., autism?
- Are there priors of inadequate supervision and/or substance misuse?
- Collateral contacts of neighbors on supervision issues in past - unreported?
- If the parent was sleeping, had they been diagnosed as depressed and taking medication, past or present?
- Who was designated to watch the child? If a child, what is relationship and how old is the child?
- Has code enforcement been involved?
- Did caretaker know how to swim?
- Did the child know how to swim?
- Did caretaker know CPR?
Adult Behaviors Indicative of Child Abuse

Adult behaviors that may indicate abuse of a child:

- calls a child offensive names or chronically ridicules them
- performs willfully malicious/violent acts directed toward a child's possessions, pets, or environment
- uses crude, brutal, or severely misguided actions in the attempt to gain submission or enforce maximum control to modify a child's behavior
- has unrealistic expectations which are inappropriate to the child's developmental level
- has a need to always be in charge; always critical
- totally rejects a child or has obvious preference for one child over another
- has distant, shallow, or superficial relationships with family members, or are isolated from society
- is extremely disappointed regarding their baby's gender
- fails to bond with infant
- suffers from acute tension, encounters chronic crises, or is easily frustrated
- has poor impulse control
- often blames the child for problems
- provides inaccurate, illogical, or conflicting explanations for a child's injury
- exposes a child to repeated violent, brutal, or intimidating acts or statements
- leaves a child in a hostile or dangerous situation
- fails to protect a child from inflicted injury
- abuses substance to the degree that they are unable to provide adequate care
- beats or corporally punishes a child so that it leaves or it is likely to leave an injury
- kicks, scratches, or punches a child
- hits or slaps an infant
- pulls a child's hair
- over medicates or poisons a child
- ties a child's limbs together or to an object
Behavioral & Emotional Indicators of Physical Abuse

There are many variables that affect the child's response to maltreatment, and the effects of maltreatment on the child's development. They will also determine the behavioral indicators of maltreatment in children.

- **The age of the child** when the maltreatment begins.
  - The younger the child when first abused, the more likely the child will have serious developmental problems from the maltreatment.

- **The length of time the child is maltreated.**
  - The greater the period of time the child is maltreated, the more severe the developmental outcomes will be.

- **The frequency of the maltreatment.**
  - The more often the child is abused, the more pervasive the effects will be.

- **The nature of the child's relationship with the abuser.**
  - The closer the relationship of the abuser to the child, the more likely the child will be negatively affected. Abuse by a parent has the most serious consequences.

- **The type of maltreatment.**
  - The more severe the pain and the greater the injury inflicted on the child, the more negative the psychological, as well as physical, outcomes will be.

- **The availability to the child of support.**
  - The presence of other, non-abusing adults who can provide proper care and nurturance, either in the home or easily available to the child, can partially mediate the negative effects of abuse.

- **Constitutional factors.**
  - The child's basic personality and temperament can affect the outcomes of abusive treatment.
  - Some children are more resilient than others and have unusual coping strengths. Other children are more vulnerable.

- Young children who have been **abused severely and at an early age**
  - May display pervasive indicators of developmental delay and abnormal developmental patterns.
  - The child may be **remote, withdrawn**, lacking in curiosity, compliant, and detached; the child may not relate to other people.
  - The child may whine, whimper, or cry, with **no expectation that they will be comforted**.
  - The child may not look to adults for help.

- A state of **"frozen watchfulness"** has been noted in severely abused children.
  - They remain emotionally withdrawn and uninvolved, but watch carefully to what is going on around them.
  - They may exhibit discomfort with or **fear of physical contact**.
Severely abused children may **appear to be autistic.**

- Many do not relate in normal ways to the people and objects in their environment.
- Most seriously abused infants show serious delays in all areas of development.

The child may display a forlorn **clinging dependency**, but may be lacking in healthy attachment to any adult, and appear unable to attach in healthy ways.

The child may appear **depressed**, or display flat affect and **lack of emotion**. They may not:

- cry or respond when in pain or when injured, and show no enjoyment.
- smile or play.

Pre-school aged children who have been abused may display the following characteristics. They may:

- be **timid, easily frightened.**
- duck, cringe, flinch, withdraw, attempt to get out of the way, or otherwise exhibit fear of the parent.

The child may be very **eager to please**, may crave affection, and may show indiscriminate attachment by becoming affectionate with anyone, including strangers.

Early signs of **role reversal** may be present. The child may:

- **try hard to meet the parent’s needs.**
- **also demonstrate a clingy attachment and verbalize love for the abusing parent.**

The abused adolescent may show behavior problems:

- Lying, stealing, acting out, and other aggressive behaviors
- Use of alcohol or drugs
- Truancy, including repeatedly running away and refusing to go home
- Generalized difficulty in entering into and sustaining interpersonal relationships
Signs of Physical Abuse
Refer to the Child Maltreatment Index for a description of the injury, and other guidelines to consider when assessing if an injury is accidental or willfully inflicted.

The following key points list injuries by category and possible methods of inflicting this type of injury or the object used. Relevant handouts are listed next to the injury category.

Use the “Abuse or Not” job aid to compare medical conditions that might resemble certain types of abuse and to evaluate the caregiver’s explanation for the injury.

Bruises, Welts
- Caused by pinching or hitting the child with a hand or with an object

Estimating the age of a bruise by its color cannot be done with any precision:
- A bruise with any yellow must be older than 18 hours.
- Red, blue, and purple or black may occur anytime from 1 hour of bruising to resolution.
- Red has no bearing on the age of the bruise because it is present in bruises no matter what age.
- Bruises of identical age and cause on the same person may not appear as the same color and may not change at the same rate.
- Bruises do go through an evolution of color: initially - red, violet, or black and perhaps blue; successive colors - brown, green, and yellow.
- Color of bruises is affected by the depth and location of the bruises, surrounding light and skin color.

Location of Bruises
- Non-intentional bruise sites: knees, shins, forehead, and elbows.
- Neither the ears nor the buttocks are frequently injured in accidents.
- Intra-oral bruising should invoke suspicions of abuse.
- Patterned bruises usually result from inflicted trauma and reflect the shape of the injuring object.

Pinch Bruises
- Pinch bruises often have a symmetrical pattern, such as on each earlobe.
- Shaken infants may show bruises on each arm where the offender grasped the arms.

Loop Marks
- Whipping the child with a looped cord such as an electrical cord leaves a loop mark.
- No disease or accident looks like a loop mark.

Belt Marks
- Bruises and lacerations often clearly show the object used to abuse the child.
Ligature Bruises
- May be a bruise or a burn
- Might be caused by ropes tied around the child's ankles or neck

Slap Marks
- Fingers may leave bruises on the face.
- Loose tissue with little bony structure underneath bruises most easily and retains bruises for the longest period of time.
  - eyelids, genitals
- Bruises vary in appearance based on the weight of the child and the skin color.

Mongolian Spots
- Most common in African American and American Indian babies
- Birthmarks that may be mistaken for abuse
  - grayish blue, clearly defined spots on the buttocks and back, but also found on the extremities

Genital Bruises
- Most caregivers of children who have non-intentional injuries to the genitals will seek immediate medical treatment for the child and often provide a detailed, unsolicited explanation for the injury.
- If a caregiver delays seeking treatment for a child with a genital injury, carefully assess the situation.
- May be caused by pinching a boy's penis to punish him for touching himself.
- Grooves on the penis could indicate that a string or rubber band was used to tie off the penis in an effort to prevent the child from wetting the bed.
- Bruises in the inner thigh or genital area may indicate sexual abuse.

Cuts, Punctures, Bites

Lacerations
- Occur on soft tissue areas such as abdomen, throat, buttocks, thighs.
- Injuries to buttocks, lower back, thighs are usually caused by whipping.
- Some areas of the body are normally protected by being inside or covered by other body parts (insides of arms and legs); it would be difficult to fall and injure these areas.
  - Lacerations of the ear, nose, and throat do not tend to occur accidentally and should arouse suspicion.
  - A torn frenulum of the upper lip can be considered a sign of abuse.

Bites
- Bite marks may be inflicted by humans or animals - refer to handout.
- Torn flesh is usually a dog bite and compressed flesh is usually a human bite.
- Adult bite marks are a sign of serious danger to a child - uncontrolled aggression.
- Human bites appear as distinctive oval to horseshoe-shaped marks in which tooth impressions appear as bruises facing each other.
Child Protection Team/Law Enforcement Exams

- A forensic odontologist (dentist) or forensic pathologist must evaluate the size, contour, and color(s) of the bite mark.
- Since each individual has a characteristic bite pattern, a forensic odontologist or forensic pathologist may be able to match molds (casts) of a suspected abuser's teeth with molds of the bite itself, if there is sufficient tissue damage to produce a meaningful mold.
- If the wound is fresh, swabbing may recover the offender's saliva for DNA evidence.
- If the distance between the center of the canine teeth is greater than 3 cm, the bite is most likely from an adult.
- Victim's teeth must be examined and measured to exclude the possibility of a self-inflicted bite.

Burns/Scalds (Burns: Severity and Types)

- Burns account for 10% to 15% of child abuse cases.
- Burns from hot water are the most common, whether non-intentional or abusive.
- Accidental burns tend to be asymmetrical in distribution.
- A burn covering 20% or more of the body is severe regardless of child’s age.
- A burn covering 65% or more can be fatal, even when it is a first-degree burn.
- Medical conditions mistaken for burns are scalded skin syndrome - caused by staph bacteria - and impetigo.

Immersion Burns

- Burns inflicted by immersion have a “water-line” or sharp demarcation border between burned and not burned tissue.
- The absence of splash marks must be documented; perfectly even burns are very suspicious.

Doughnut Hole Burn

- Caused when a child is forced into a bathtub.
- Parts of the body, usually the buttocks, rest on the bottom of the tub; because the buttocks are in contact with the cool tub instead of the hot water, they will not burn creating a patch of unburned skin in the center of the burn - like a doughnut hole.
Dunking Burn
- Caused by dunking the child into scalding water to punish for wetting the bed
- Hands and feet not burned since the child is held and dunked
- No splash marks since child is held and can't splash while struggling to get out of the hot water
- Distinct line between the burned and unburned skin; often called parallel lines; child held but not forced to the bottom of a tub or pot on the stove

Stocking Burns/Glove Burns
- Caused by immersing the child’s hands or feet in hot water or holding the hands and feet under very hot running water
- Usually shows a clear line between burned and unburned skin
- Have similar burns on hands and feet

Splash Burns
- Splash burns are caused by offender throwing hot liquid on the child.
- Non-intentional splash burns are usually on the head or top of chest and run downward; caused by child reaching upward to grab a pot handle.
- Liquids thrown at a child hit at a horizontal angle, are concentrated on the child’s face or chest, and run toward the back of the body.
- Splash burns on the back or buttocks are highly suspicious; children seldom receive burns from tipping over hot pots and then turning their back to the pots.

Cigarette Burns
- Usually appear on the trunk, external genitalia, or extremities (palms of the hands or soles of the feet)
- Usually symmetrical in shape, whereas impetigo blisters are irregular; impetigo can be tested for signs of the streptococcal bacteria
- Easier to detect because there are multiple burns in various stages of healing

Chemical Burns
- Household products can burn.
- Some parents force children to drink lye derivatives (toilet bowl cleaner, detergents, or oils) causing chemical burns of the mouth and throat, vomiting, esophageal damage and subsequent narrowing of the esophagus.

Dislocation
- A bone is displaced from the socket or joint.
- A fracture near a joint that is dislocated is called a dislocation fracture.
Bone Fractures
- Fractures account for about 20% of abusive injuries.
- About 77% of abusive fractures involve the extremities—the arms and legs.
- 90% of all abusive fractures in children 2 years or younger include the ribs.
- Fractures are usually inflicted in non-ambulatory children

Common Types of Fractures

Metaphyseal Fracture
- Can only occur from a jerking force applied to the extremities
- Involves a chip of the growing end of a bone being pulled off by a ligament
- Can be caused by shaking or swinging a child by the arms or legs

Spiral Fracture
- Diagonal fracture usually caused by an extremity being twisted
- Common in children due to growing, soft bones
- Can occur very easily in small children by their own twisting of a leg or ankle

Chip and Bucket Handle Fractures
- These do not normally result from accidental injuries.
- A chip fracture is a small piece of bone flaked from the major part of the bone.

Periosteal Elevation
- Periosteum is new tissue which forms a sheath over the bones of infants.
- This tissue is highly vascular, so it contains many blood vessels.
- Injury occurs when an infant’s extremities are twisted or shaken and the periosteum separates from the hard bone beneath; blood can form between the periosteum and the bone because the periosteum bleeds easily.
- This injury is more like an internal injury; no cast is worn and there are no external signs of a fracture.

Rib Fractures
- A baby with rib fractures can exhibit signs of respiratory distress, a cold, or lung disease for the fractures can interfere with breathing.
- Injury can be caused by a caregiver squeezing the baby to forcefully quiet it.
- Call CPT if the baby is coughing or having trouble breathing; check the child's medical history.

Bone Scans
- Shows multiple, old healed injuries more clearly than x-rays
- Should be done if abuse is suspected
Internal Injuries

- Injuries to internal organs are caused by blows to the abdomen or squeezing.
- Significant violent force is required to cause a life-threatening abdominal injury.
- A small percentage of children receive internal injuries from abuse.
- The mortality rate in abusive abdominal injuries is 40% to 50%.
- If suspected, get the child medical treatment immediately or the child may die.

Signs of Internal Injury:

- Any pain in the stomach, chest, or any internal area
- Visible bruising of the chest or abdomen
- Distended, swollen abdomen
- Tense abdominal muscles
- Labored breathing
- Severe, pinching pain in the chest while breathing
- Nausea or vomiting

Skull Fracture, Brain or Spinal Cord Damage, Intra-Cranial Hemorrhage

- Serious life-threatening injuries do not result from a child falling from a bed or crib.

Skull Fracture

- The skull of a very young child is soft and vulnerable.
- Since the skull bones aren't completely formed, there are places where the bones don't meet (fontanelles).
- Any pressure from brain swelling or blood can separate these soft tissues.
- An infant's brain floats in a larger pool of fluid than the adult's brain, making the brain more likely to “swish” around.

Subdural Hematoma

- Blood vessels in the space between the brain and the skull are easily damaged, and once damaged, they release blood into the space between the skull and the brain putting pressure on the brain.
Abusive Head Trauma (Shaken Baby Syndrome)
- Describes a child who has been held by the shoulders or arms and shaken back and forth with great force so that the child's head hits a surface with each backward stroke.
- Adult may hold the child upside down by his feet and shake him up and down.
- Child's brain literally sloshes due to rapid acceleration and deceleration of shaking by offender.
- Delay in getting treatment often causes the child to become comatose and infants often die.
- Many shaken infants who survive have permanent brain damage and may be paralyzed, developmentally delayed, or may develop cerebral palsy.
- There is often an absence of externally visible injuries.

Signs:
- Subdural hematoma
- Retinal hemorrhage - pressure builds up in the blood vessels of the head
- Metaphyseal lesions - fractures in the growing part of bones

Subgaleal Hematoma
- In this type of brain injury, the scalp actually separates from the skull.
- It is caused by offenders who jerk or twist a child's hair as punishment.
- Girls who wear pigtails are vulnerable to this type of abuse.
- A sign of this abuse is a bald spot where the hair has been pulled out.
- Other scalp injuries can be caused by neglect if the child lies on its back for long periods.

Asphyxiation, Suffocation, Drowning
- In 2009 there were 59 drowning cases reviewed by the Child Death Review Committee.
- During 2009, 42 children died as a result of suffocation due to an unsafe sleep

Excessive Corporal Punishment
Beatings (Battered Child Syndrome)
- A “battered child” is a child who has been chronically abused. This abuse may go undetected by doctors
Signs of a Battered Child:
- Unsuspected fractures “accidentally” discovered in the course of an examination, sometimes a routine examination
- Injuries out of proportion with history provided, or with child’s age; fractures in non-walking babies are suspicious
- Multiple fractures, often symmetrical (appear on both arms or both sides of the body)
- Skeletal trauma combined with other types of injuries, such as burns
- Subdural hematoma
- Failure to thrive
  - the child may appear malnourished, underweight, or have unhealthy-looking skin.

Other Physical Injury

Munchausen Syndrome by Proxy (“Identifying Munchausen’s Syndrome by Proxy”)
- Usually committed by mothers: the parent simulates or lies about child’s medical conditions, resulting in the child being submitted to painful and frightening medical tests and hospital stays.

Abrasions (Including Rope or Rug Burns)
- Blinding/Eye Damage
- Blows to the eyes can result in dislocated lens and later, cataracts.
- Blows to the front or back of the head can also result in “bilaterial black eyes”; massive swelling of the eyelids is indicative of abuse.
- Subconjunctival hemorrhage is an injury to the eye caused by direct trauma as a child who is hit in the face.
  - can be the result of birthing trauma
  - are observed in the eye but are not related to the retinal hemorrhage (brain injury)

Injury to Teeth and Jaws, Mouth and Lips
- A strong blow is required to completely dislodge a tooth from its socket.
- Injuries to the maxilla, or upper jaw, are rarely seen in accidents.
- Fractured mandibles, or lower jaws are common in accidents.
- Forced feeding of infants causes bruised lips or a severed frenulum (folds of skin that connect the lip to the gums and the tongue to the floor of the mouth).
- A torn frenulum of the upper lip and intra-oral bruising are highly suspicious signs of physical abuse.
**Damage to Ears/Hearing**
- Blows to the ears or pinching/twisting of the ears can result in bruised pinna, or the outer ear.

**Hair Pulling**
- Signs of this abuse are irregular patches of missing hair, with broken hair visible.
- No completely bald areas are visible.
- (Areata) Alopecia is a disorder in which hair falls out in patches and can look similar to hair that is pulled out.

**Most Life-Threatening Abuse (Robert Reece’s “Recognition of Non-accidental Injury” 1985)**
- Any abuse resulting in head injuries, particularly sub-dural hematomas
- Internal injuries
- Burns, both non-intentional and abusive—one of the most common causes of death in children; most likely burned in the bathroom, and are at risk during toilet training
- Poisoning - about 17% of children who are poisoned die
- Deadly weapon injury

**Poisoning**
- Most childhood poisonings are not intentional. However, some parents punish their children by poisoning them.
  - Salt poisoning: forcing a child to swallow salt as a punishment for bed-wetting; causes hypomatremia or excess sodium in the blood causing dehydration, seizures, and vomiting.
  - Water: forcing a child to ingest water as a punishment for involuntary urination; leads to hypomatremia or inadequate sodium in the blood causing convulsions, confusion, lethargy, and coma.
  - Laxatives: causes diarrhea, which can lead to severe dehydration, fever, and bloody stools.
  - Sedatives: symptoms include lethargy and coma.
  - Pepper: ingesting black pepper can clog the throat and lungs, causing apnea or stopped breathing; can damage the mucous membranes of the mouth and stomach.
## Abuse or Not?

### Bruise

<table>
<thead>
<tr>
<th>Is it Non-intentional?</th>
<th>Steps to Confirm</th>
</tr>
</thead>
</table>
| Non-intentional Falls  | • Check for location of bruises; bruises on knees, shins, forehead, or elbows are usually non-intentional.  
                           • Check for bruises on the forehead; bruises to the forehead often drain through soft tissues to give appearance of black eyes 24-72 hours afterwards, usually confirmed with history and bruise is not tender.  
                           • Check to see if bruises are on a single surface or clustered; usually one bruise on a single surface is caused accidentally.  
                           • Correlate non-intentional incident with developmental age and motor skills of child.  
                           • Check for discrepancies between the bruise and the history provided by the caregiver. |

<table>
<thead>
<tr>
<th>Is it a Medical Condition?</th>
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</tr>
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</table>
| Hemophilia                | • Have medical tests done to check bleeding function: prothrombin (PT), partial prothrombin (PTT), bleeding time, platelet count, and complete blood count (CBC).  
                              • Have histopathologic examination by physician.  
                              • Find out if spots were present at birth.  
                              • Spots are flat, non-tender but more blue/green than true bruises.  
                              • Check history.  
                              • Check history.  
                              • Check history; 90% are detected within the first month of life. |
| Leukemia                  | None             |
| Idiopathic thrombocytopenic purpura | None             |
| Mongolian spots           | None             |
| Maculae cerulea          | None             |
| Salmon patches           | None             |
| Hemangiomas (“strawberry marks”) | None             |

### Bite Mark

<table>
<thead>
<tr>
<th>Is it Non-intentional?</th>
<th>Steps to Confirm</th>
</tr>
</thead>
</table>
|                       | • Check to see if flesh is torn or just compressed; torn flesh is usually a dog bite, and compressed flesh is usually a human bite.  
                           • Measure the distance between the center of the canine teeth, the third tooth on each side; if it is greater than three centimeters, the bite is most likely from an adult.  
                           • Check for discrepancies between the injury and the history provided by the caregiver. |

<table>
<thead>
<tr>
<th>Is it a Medical Condition?</th>
<th>Steps to Confirm</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
## Hair Loss

**Is it Non-intentional?**

None

**Steps to Confirm**

None

**Is it a Medical Condition?**

Trichotillomania  
Tineacapitis (ringworm)  
Idiopathic (e.g., alopecia areata)  
Nutritional deficiencies

- Check to see if loss of hair is in a localized spot.
- Varying bald spots may be indicative of abuse.
- Localized spot is usually on back of the head.
- A child will be at least 3 years old for this condition to occur.
- Check for scaly skin.
- Fungal culture of scalp by physician.
- Check history.

## Burns

**Is it Non-intentional?**

Spilling of a hot liquid

- Check location of splash burns; non-intentional burns are most likely to occur on the front of the head, neck, trunk, and arms. It is usually possible to estimate the direction from which the liquid came and the position of the body.
- Check for discrepancies between the burn and the history provided by the caregiver.

**Steps to Confirm**

None

**Is it a Medical Condition?**

None

**Steps to confirm**

Brushing against a cigarette

- Check location of burns; usually non-intentional if found on child’s face, arms or trunk.
- Check shape of burn; usually non-intentional if burn is more elongated than round, with a higher degree of intensity on one side.
- Check for discrepancies between the burn and the history provided by the caregiver.

## Impetigo

**Is it a Medical Condition?**

Steps to confirm.

**Steps to confirm.**

- Suspicious blisters are generally cultured by a physician for streptococcal infections that may be found with impetigo and treated with antibiotics.
- Examine lesions: impetigo lesions have various shapes and sizes, cigarette burns are symmetrical.
## Burns (continued)

<table>
<thead>
<tr>
<th>Is it Non-intentional?</th>
<th>Steps to Confirm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falling into a hot bath</td>
<td>Check for clear lines of demarcation; non-intentional burns have no clear line separating burned and unburned skin. Check deepness of burn; non-intentional burns are not as deep as forced burns because an unrestrained child will rarely be unable to remove himself or herself from the burning environment. Check to see if perineum and feet are burned, but not the hands; it is impossible for a child to non-intentionally fall into a tub without hands going into water. Check for doughnut hole, parallel lines, and flexion burns; these burns may be indicative of abuse. Check for discrepancies between the burn and the history provided by the caregiver.</td>
</tr>
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<thead>
<tr>
<th>Is it a Medical Condition?</th>
<th>Steps to Confirm</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Staph Scalded Skin Syndrome (SSSS)</td>
<td>• Ask about symptoms of fever, malaise, and sore throat. • Check for mouth and nose crusting. • Ask about onset of medical condition.</td>
</tr>
<tr>
<td>• Toxic Epidermal Necrolysis (TEN)</td>
<td></td>
</tr>
<tr>
<td>Coming into contact with a burning object</td>
<td>• Check location of burn; some areas of the body are clearly more difficult for a child to self-inflict burn. • Check pattern of burn; an irregular burn will be left when a young child who moves away from a burning object reflexively. • Check deepness of burn; non-intentional burns are usually deep on one edge of the burn. • Check margins of burn; non-intentional burns usually do not have crisp overall margins. • Check for discrepancies between the burn and the history provided by the caregiver.</td>
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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Varicella (chickenpox)</td>
<td>• Check history. • Consult with physician.</td>
</tr>
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</table>
## Fracture

<table>
<thead>
<tr>
<th>Is It Non-intentional?</th>
<th>Steps to Confirm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth trauma (fractured clavicles most common)</td>
<td>Consult with physician to decide cause of fracture.</td>
</tr>
<tr>
<td>Little league elbow</td>
<td>(Refer to Types of Fractures in your PG for a description of the different types of fractures.)</td>
</tr>
<tr>
<td>Nurse-maid elbow</td>
<td>Check for discrepancies between the fracture and the history provided by the caregiver.</td>
</tr>
<tr>
<td>Fractures from passive exercises for therapeutic reasons</td>
<td></td>
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</tbody>
</table>

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<thead>
<tr>
<th>Is it a Medical Condition?</th>
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</thead>
<tbody>
<tr>
<td>Congenital syphilis</td>
<td>A physician can use radiology to decide if a fracture exists and also to gain insight into how it was produced.</td>
</tr>
<tr>
<td>Infantile cortical hyperostosis (Caffey’s disease)</td>
<td>Obtain pediatric radiologist if possible.</td>
</tr>
<tr>
<td>Leukemia</td>
<td>It is critical to tell radiologist that child abuse is suspected.</td>
</tr>
<tr>
<td>Menkes’ kinky hair syndrome</td>
<td>X ray is fine for screening.</td>
</tr>
<tr>
<td>Osteogenesis imperfecta</td>
<td>A bone scan can be used to reveal old, healed fractures caused by suspected abuse.</td>
</tr>
<tr>
<td>Osteomyelitis</td>
<td></td>
</tr>
<tr>
<td>Rickets</td>
<td></td>
</tr>
<tr>
<td>Scurvy</td>
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</table>

## Head Injury

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Birth trauma causing effusion, cephalohematoma, diffuse cerebral edema, infarction, cerebral contusions, posttraumatic hypopituitarism</td>
<td>Check onset of injury; injuries from birth traumas should become apparent shortly after birth.</td>
</tr>
<tr>
<td>Insect bite on head (usually forehead)</td>
<td>Check for discrepancies between the injury and the history provided by the caregiver; subdural hematomas found in an infant or toddler without adequate explanation of trauma may be indicative of abuse.</td>
</tr>
</tbody>
</table>

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<thead>
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<tbody>
<tr>
<td>Infectious meningitis</td>
<td>Check compatibility between the history and physical findings.</td>
</tr>
<tr>
<td></td>
<td>Consider child’s developmental maturity.</td>
</tr>
</tbody>
</table>
### Eye Injury

<table>
<thead>
<tr>
<th>Is it Non-Intentional?</th>
<th>Steps to Confirm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemical burns</td>
<td>• Check for discrepancies between the injury and the history provided by the caregiver.</td>
</tr>
<tr>
<td>Nonintentional foreign body to the eye (e.g., sticks, sand, or paper edge)</td>
<td></td>
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</table>

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Conjunctival hemorrhaging during birth</td>
<td>• Conjunctival hemorrhaging during birth usually disappears by one month.</td>
</tr>
<tr>
<td>Allergic conditions (“allergic shiners”).</td>
<td>• Check history</td>
</tr>
</tbody>
</table>

### Ear Injury

<table>
<thead>
<tr>
<th>Is it Non-intentional?</th>
<th>Is it a Medical Condition?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury from inserting cotton swab</td>
<td>• Check if laceration is of the external auditory meatus; this injury can occur only by inserting a pointed object into the ear.</td>
</tr>
<tr>
<td></td>
<td>• Check for discrepancies between the injury and the history provided by the caregiver.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is it a Medical Condition?</th>
<th>Steps to Confirm</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

### Nasal Injury

<table>
<thead>
<tr>
<th>Is it Non-intentional?</th>
<th>Steps to Confirm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury from inserting foreign bodies into the nose</td>
<td>• Check to see if foreign bodies are found in more than one site; if found only in nose, this is common in the normally developing child.</td>
</tr>
<tr>
<td></td>
<td>• Check for discrepancies between the injury and the history provided by the caregiver.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is it a Medical Condition?</th>
<th>Steps to Confirm</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
### Tooth Injury

<table>
<thead>
<tr>
<th>Is it Non-intentional?</th>
<th>Steps to Confirm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-intentional falls. Striking the mouth with a hard instrument.</td>
<td>• Check to see if any teeth are loosened; any loosening of the teeth must be immediately examined by a dentist to decide severity.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is it a Medical Condition?</th>
<th>Steps to Confirm</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

### Poisoning

<table>
<thead>
<tr>
<th>Is it Non-intentional?</th>
<th>Steps to Confirm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Giving toxic doses of vitamins and minerals to cure illness Feeding a baby improperly diluted formula Non-intentional ingesting of medicines, household cleaners, etc.</td>
<td>• Check with parent about cause of poisoning; non-intentional poisoning may be a form of neglect that can be treated with education and support.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is it a Medical Condition?</th>
<th>Steps to Confirm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endocrine</td>
<td>• Consult with physician.</td>
</tr>
</tbody>
</table>

## Burns: Severity and Types

<table>
<thead>
<tr>
<th>Degree</th>
<th>Appearance at Time of Injury</th>
<th>Appearance Two Weeks Later</th>
</tr>
</thead>
</table>
| First-Degree Burn | • A superficial burn of minimal depth.  
• Characterized by redness, hyperemia (redness which disappears under pressure), tenderness and swelling.  
• Can be serious if it covers a large percentage of body area, i.e. sunburn | • No scar                           |
| Second-degree burn | • Burn extending through the outermost layer of skin and into the next layer.  
• Usually not severe enough to interfere with skin after injury, so no scar tissue develops.  
• Characterized by weeping blisters on the skin’s surface, with increased sensitivity to touch. | • If no infection occurs, no scar remains.  
• If infection occurs, surgery may be required. |
| Third-degree burn | • Entire thickness of the skin is burned, including the hair follicles.  
• Area looks white or charred and is not sensitive to touch or a pin prick.  
• These injuries require hospitalization and often require skin grafting. | These burns heal with scarring, creating a change in color and a “parchment” type of skin. |

## Rule of Nines

<table>
<thead>
<tr>
<th>Percentage of Body Burn</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 10%</td>
<td>Under two years of age</td>
</tr>
<tr>
<td>Over 15%</td>
<td>Between two and twelve years of age</td>
</tr>
<tr>
<td>Over 20%</td>
<td>Any Age</td>
</tr>
<tr>
<td>Over 65%</td>
<td>Any age, sometimes fatal, even when only first degree</td>
</tr>
<tr>
<td>Any portion of the face hand or genitalia</td>
<td>Any age</td>
</tr>
</tbody>
</table>

Burns are considered severe when they cover the following percentages of the body in correlation with certain age groups. Physicians use the "Rule of Nines" to indicate the body surface covered by the burn. They explain the amount of surface area burned in percentages, rather than measuring the exact size of the burn. First-degree burns are not included in this measurement. Note that a burn that may cover only a small area of an adult could cover an appreciably larger area of an infant's body.

<table>
<thead>
<tr>
<th>Type of Burn</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burns by objects</td>
<td>• Objects include irons, stove burners, heater grates, radiators, electric hot plates, and hair dryers.</td>
</tr>
<tr>
<td></td>
<td>• Objects such as combs, keys, knives, or cigarette lighters can be heated and “branded” into the skin.</td>
</tr>
<tr>
<td></td>
<td>• During summer months, second and third-degree burns can be caused by vinyl upholstery, seat belts, infant backpack carriers, or seatbelt buckles.</td>
</tr>
<tr>
<td>Chemical burns</td>
<td>• Household items such as acidic cleaners cause chemical burns.</td>
</tr>
<tr>
<td></td>
<td>• Burning process continues as long as the substance is in contact with the skin.</td>
</tr>
<tr>
<td>Cigarette burns</td>
<td>• They measure about 1 cm in diameter.</td>
</tr>
<tr>
<td></td>
<td>• They are often found on the trunk, external genitalia and extremities, such as the palms of the hands and the soles of the feet.</td>
</tr>
<tr>
<td></td>
<td>• The presentation ranges from blisters to deep wounds.</td>
</tr>
<tr>
<td>Electric burns</td>
<td>• The conduction of current through the saliva of a child causes electric burns.</td>
</tr>
<tr>
<td></td>
<td>• The child may be sucking or mouthing a plug or biting a live electric cord.</td>
</tr>
<tr>
<td></td>
<td>• Burns at the corners of the mouth are common.</td>
</tr>
<tr>
<td>Immersion burns</td>
<td>• Immersing a child into high-temperature water produces immersion burns.</td>
</tr>
<tr>
<td></td>
<td>• Forms of immersion burns include stocking or glove, doughnut hole, parallel lines, and flexion burns.</td>
</tr>
<tr>
<td>Splash burns</td>
<td>• Hot liquid either thrown or poured produces splash burns.</td>
</tr>
<tr>
<td></td>
<td>• They are less severe than immersion burns; liquid runs off the skin before it has a chance to incur deep damage.</td>
</tr>
<tr>
<td></td>
<td>• The deepest burn is usually the area in contact with the main mass of fluid.</td>
</tr>
<tr>
<td></td>
<td>• Often the burn pattern is an “arrowhead” configuration.</td>
</tr>
</tbody>
</table>

Abusive Head Trauma (Shaken Baby Syndrome)

The American Academy of Pediatrics wants doctors to stop using the term "shaken baby syndrome" in favor of something more scientific.

The country's largest pediatricians' group recommends "abusive head trauma," calling it a more comprehensive diagnosis for brain, skull and spinal injuries associated with shaking and other head injuries inflicted on infants.

It is considered a serious form of child maltreatment and most often involves children younger than 2 years, but may be seen in children up to 5 years old.

A shaken baby requires emergency medical attention.

Causes

Abusive Head Trauma can occur from as little as 5 seconds of violent shaking.

Injuries are most likely to happen when there is both acceleration (from shaking) and deceleration (from the head hitting something).

Even hitting a soft object, such as a mattress or pillow, may be enough to injure newborns and small infants.

The result is a type of whiplash since the child's brain is soft, neck muscles and ligaments are weak and not fully developed, and a child’s head is large and heavy in proportion to the body.

Abusive Head Trauma does not result from gentle bouncing, playful swinging or tossing the child in the air, or jogging with the child.

It is also very unlikely to occur from accidents like falling off chairs or down stairs or accidentally being dropped from a caregiver's arms. Short falls may cause other types of head injuries.

Possible Results

Violent shaking of a baby can cause bleeding inside the brain which may lead to:

- Death
- Brain damage
- Mental retardation
- Blindness
- Paralysis
- Seizures
- Developmental delays
Signs and Symptoms of Abusive Head Trauma

There are usually no outward physical signs of trauma such as bruising, bleeding, or swelling. In some cases, the condition can be difficult to diagnose and may not be identified during an office visit.

- Extreme irritability or constant crying
- Stiffness
- Sleeping more than usual
- Unable to wake up/loss of consciousness
- Seizures
- Dilated pupils or blood spots in the eyes
- Poor sucking or swallowing
- Decreased appetite
- Vomiting
- Difficulty breathing
- Pale or bluish skin
Battered Child Syndrome

The term “battered child syndrome” (BCS) describes the condition of a child who has been seriously abused over time.

Some children with this syndrome go undetected by doctors.

The abuse may be confused with a bone disease such as scurvy or osteogenesisimperfecta.

Usually the child is three years old or younger, often an infant.

The signs of this syndrome include:

- unsuspected fractures “accidentally” discovered in the course of an examination, sometimes a routine examination
- injuries inconsistent with the history provided or with the child’s age
- multiple fractures, often symmetrical. This means the fractures may appear on both arms or both sides of the body. Any fractures in non-walking babies are suspicious
- multiple injuries in various stages of healing
- skeletal trauma combined with other types of injuries, such as burns
- subdural hematoma
- failure to thrive (appearing malnourished and underweight or having unhealthy-looking skin)
Is This Explanation Plausible?

1. A 6-year-old girl has missing hair-bald patch. The mother reports, "Linda got her hair caught in the car door when Danny, her 9-year-old brother, slammed the door shut."
   - Steps to confirm
   - Persons in home to question
   - Questions to ask
   - Environmental observations to document
   - Other methods and clues to consider
   - Outside persons to question
   - What to photograph

2. A 3-year-old girl has both palms of her hands burned. The grandmother states, "Tasha reached up and grabbed the hot burner on the stove."
   - Steps to confirm
   - Persons in home to question
   - Questions to ask
   - Environmental observations to document
   - Other methods and clues to consider
   - Outside persons to question
   - What to photograph
3. A 3-year-old boy has burns on the inside of his throat. There are no visible signs of a burn on the outside. The father states, “Wayne sucked on the spout of the teapot that was on the kitchen table.”

- Steps to confirm
- Persons in home to question
- Questions to ask
- Environmental observations to document
- Other methods and clues to consider
- Outside persons to question
- What to photograph

4. A 12-year-old boy has purple and blue discoloration under both eyes. His eyes are swollen. A.C. said, “I don’t know what happened. My eyes weren’t black last night. This morning I noticed that both of my eyes were black and blue.”

- Steps to confirm
- Persons in home to question
- Questions to ask
- Environmental observations to document
- Other methods and clues to consider
- Outside persons to question
5. A 9-month-old girl has a spiral fracture on her right leg. Her mother said, "Charlene woke up from her nap crying. When I went into her room, her leg was caught between the side rails in the crib."
   - Steps to confirm
   - Persons in home to question
   - Questions to ask
   - Environmental observations to document
   - Other methods and clues to consider
   - Outside persons to question
   - What to photograph

6. An 8-year-old girl has rectangular, brownish-yellow bruises across her buttocks. Her mother said, "We weren't home when Kathy was playing with her friend next door. Kathy told us that she fell out of the tree house and hit the ladder."
   - Steps to confirm
   - Persons in home to question
   - Questions to ask
   - Environmental observations to document
   - Other methods and clues to consider
   - Outside persons to question
   - What to photograph
7. A 4-year-old girl has bite marks on the outside of her upper arm. Her father said, "Amy often bites herself when she gets angry or frustrated."
   - Steps to confirm
   - Persons in home to question
   - Questions to ask
   - Environmental observations to document
   - Other methods and clues to consider
   - Outside persons to question
   - What to photograph

8. Four-year-old twin boys have ligature marks on both wrists. Their stepfather said, "George and Jim love to play 'cowboy' and tie each other up ever since we started taking them to rodeos."
   - Steps to confirm
   - Persons in home to question
   - Questions to ask
   - Environmental observations to document
   - Other methods and clues to consider
   - Outside persons to question
   - What to photograph
Signs of Abuse: 3 Scenarios

- Read the scenarios on the following pages and use any PGs that are relevant to complete the activity tasks.
- List physical signs of maltreatment in the space provided below.
- Compare the injuries to the history given.
- Be ready to share the signs and answers to the discussion questions with the group.
- Present your group’s answers to the class.

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Signs:</td>
<td>Physical Signs:</td>
<td>Physical Signs:</td>
<td></td>
</tr>
</tbody>
</table>

Answer the following questions about your scenario:

1. Was the injury abuse or accidental?

2. How did you decide if the injury was abusive or accidental?

3. What information must be documented in the file?

4. What other professionals must be notified to verify the abuse or accidental injury?
Scenario One: “Daniel”
Daniel was brought to the emergency room by his mother and a neighbor who heard him crying hysterically.
The neighbor had knocked on the door of the home and found his mother, Adella, home. Adella told the neighbor that Daniel, age three, pulled the ironing board over and was hit by the falling, hot iron. The neighbor offered to drive Adella and Daniel to the hospital.
Daniel was very dizzy, sleepy, and appeared confused. The nurse lifted Daniel's shirt and saw the clear imprint of an iron on Daniel's upper back. The skin was red and blistered, and the burn had not been treated in any way. The physician who examined Daniel was concerned and talked with Adella. Adella said Daniel wandered into the living room while Adella was changing clothes to go to work. She said she heard the ironing board fall over, but did not become concerned because Daniel was “always into something.” Adella said she thought he was crying because he was “having a tantrum” and she ignored him. Adella said she had a lot of trouble getting Daniel to settle down for his nap when she was getting ready to leave for work. The physician admitted Daniel because he continued to be sleepy and was increasingly unresponsive. Further examination showed that Daniel had a small bruise on his forehead. Adella said Daniel rolled off the couch when he was watching television last night.

Scenario Two: “Melanie”
Melanie, age three and a half, was brought to the local walk-in clinic by her father, Lenny, and his girlfriend, Renee, because Melanie had a sore ear. The doctor examined Melanie and found she had otitis media — a common ear infection in young children. In Melanie’s case the disease had progressed so far that she was in extreme pain and the doctor found her fussy and uncooperative during the examination. Lenny told the doctor that Melanie was “damn hard to control” and was “always whining about something.” As the doctor continued her examination, she noticed bruises around Melanie's mouth with no injury to her teeth or frenulum of the mouth. She also found old, healing burns encircling Melanie's wrists. As she turned Melanie's left wrist over to examine it further, Melanie cried out in pain. (cont.)
The doctor ordered X-rays of Melanie’s arm, revealing a compression fracture.
Lenny said he did not know why Melanie would have a fracture, and said he was not aware of her falling or having any other accident.
Lenny said the bruises on Melanie’s mouth and wrists were due to a “skin disease.”

**Scenario Three: “Matti”**

Matti, three and a half years old, was brought to the emergency room by her foster mother, Jane, due to burns on her feet.
The nurse who examined Matti questioned Jane, who said she did not know how Matti’s feet were burned.
Jane said she had treated the burns with petroleum jelly but they were not getting better.
The doctor noted that both feet were burned on the tops and bottoms, with a fairly clear line between unburned and burned skin at Matti’s ankles.
The burns were second-degree burns and appeared to be over a week old.
The doctor reported the case because of the severity of the injury and the foster mother’s delay in getting treatment.
Jane told you that the burns appeared after she bathed Matti the previous evening.
She said she had found Matti playing dress up with Jane’s clothes and makeup, and that Matti had poured powder on her feet.
Jane said she tested Matti’s bath water and it seemed comfortable to her.
Jane reported that Matti did not make any outcry while in the bath, but that Jane noticed her feet were burned later in the evening.
Jane said she thought petroleum jelly would be enough to “cure the burn.”
You interviewed Matti, who told a very similar story. The only difference was that Matti said the incident happened “a long time ago.”
Module 4: Sexual Abuse

Scared Silent

The video *Scared Silent: Exposing and Ending Child Abuse* may evoke strong feelings as it shows a family torn apart after the abuse is exposed and describes the horrible damage caused by sexual abuse.

**As You View the Video**

1. How were the offender, non-offending parent, and the victim affected by the abuse?
2. What were their feelings and some of the causes of those feelings?
3. What were the long-term effects of the abuse and how did the child cope with these effects?

**Questions for Discussion**

1. How did the daughter describe her father?
2. What sexually stimulated the father?
3. How did the father see his daughter?
4. Why wasn’t force necessary on the part of the father to commit sexual abuse?
5. Why did the mother ignore the signs and symptoms of sexual abuse in her daughter?
6. What do you think the father meant when he said “part of the grooming”? What grooming behavior did the father do?
7. Why did it take the daughter so long to disclose the sexual abuse?
8. What prompted the daughter to disclose the abuse?
9. How did the father's history of sexual abuse contribute to his abusing his daughters?
10. What was the impact of the disclosure on the family?
11. Why was the daughter surprised at her mother's reaction?
12. What do you think is the typical reaction from others to the disclosure of abuse?
Sexual Abuse Defined

Sexual Battery:

Definition:
- Oral, anal, or vaginal penetration by, or union with, the sexual organ of another, or
- Anal or vaginal penetration of another by any other object.
  - An act done for a bona fide medical purpose is not considered sexual battery.
- Includes acts commonly known as oral sex (cunnilingus, fellatio), coition, coitus, and copulation.

Incest:
- Includes sexual battery or sexual intercourse by a relative of lineal consanguinity (blood relatives: parent or grandparent or adult brother, sister, uncle, aunt, nephew, or niece) while responsible for the child's welfare.

Sexual Molestation:
- Sexual conduct with a child when such contact, touching or interaction is used for the arousal or gratification of sexual needs for desires of the abuser. This includes:
  - intentional or inappropriate touching of the genitals or intimate parts, including the breasts, genital area, groin, inner thighs, and buttocks, or the clothing covering them, of the child by the abuser
  - encouraging, forcing, or permitting the child to inappropriately touch the same parts of the abuser's body
  - A child who is exhibiting sexual acting-out behavior beyond his or her age or developmental or emotional level. There is a wide variety of behaviors commonly observed in sexually abused children.
- Sexual molestation does NOT include:
  - touching which may reasonably be construed to be a normal parental responsibility (such as cleaning a child who is not able to do so alone or at all)
  - a normal interaction with, or affection for, a child
  - touching that is intended for valid medical purposes
**Sexual Exploitation:**
- Sexual use of a victim for sexual arousal, gratification, advantage, or profit. Includes, but is not limited to:
  - indecent solicitation of a child, or explicit verbal enticement
  - allowing a child to participate in pornography
  - exposing sexual organs to a child for the purpose of sexual arousal or gratification of the caretaker responsible, aggression toward the child, degradation of the child, or other similar purpose
  - intentionally perpetrating a sexual act in the presence of a child for the purpose of sexual arousal or gratification of the caretaker responsible, aggression toward the child, degradation of the child, or other similar purpose
  - self-masturbation in the child's presence
  - allowing, encouraging, or forcing a child to solicit for, or engage in, prostitution

**Factors to consider:**
- The inappropriate action or situation must be directly attributable to the action of the parent or other person responsible for the child's care.
- The parent may not have physically undertaken the activity but was aware of it or condoned it.

**Sexual Abuse-Other Child:**
- Past sexual abuse of another child when there is reasonable cause to believe that the reported child is at risk.
Sexual Abuse: F.S. 39.01(67)

“Sexual abuse of a child” means one or more of the following acts:

- Any penetration, however slight, of the vagina or anal opening of one person by the penis of another person, with or without semen emission.
- Any sexual contact between the genitals or anal opening of one person and the mouth or tongue of another person.
- Any intrusion by one person into the genitals or anal opening of another person, including the use of any object for this purpose, except that it does not include any act intended for a valid medical purpose.
- The intentional touching of the genitals or intimate parts, including the breasts, genital area, groin, inner thighs, and buttocks, or the clothing covering them, of either the child or the perpetrator, except that this does not include any act:
  - which may reasonably construed to be a normal caregiver responsibility, any interaction with, or affection for a child; or
  - intended for a valid medical purpose.
- The intentional masturbation of the perpetrator's genitals in the presence of a child.
- The intentional exposure of the perpetrator's genitals in the presence of a child, or any other sexual act intentionally perpetrated in the presence of a child, if such exposure or sexual act is for the purpose of sexual arousal or gratification, aggression, degradation, or other similar purpose.
- The sexual exploitation of a child, which includes allowing, encouraging, or forcing a child to:
  - solicit for or engage in prostitution; or
  - engage in a sexual performance, as defined by chapter 827.

Other Statutes and Operating Procedures Related to Sexual Abuse

F.S. 39.2012(f) Juvenile Sexual Offender
F.S. 39.302 Institutional Child Abuse, Abandonment, Neglect
F.S. 39.303(2)(c) Child Protection Team
F.S. 39.3035(1)(c) Child Advocacy Centers
F.S. 39.304(1) Photos, Medical Exams, X-Rays
F.S. 39.305 Intervention and Treatment in Sexual Abuse Cases-Model Plan
F.S. 39.307 Reports of Child on Child Sexual Abuse
F.S. 39.806(1)(g) Child Sexual Abuse-Ground for TPR
65C-28.004(10) Placement of Children Who are Victims of Sexual Abuse
65C-29.007 Child on Child Sexual Abuse
CFOP 175-20 CPT and Sexual Abuse Treatment Programs
The Phases of Child Sexual Abuse

Phase I: Engagement

THE PERPETRATOR:
Almost always in the child’s own family
- Generally someone who is known to the child, and who has ready access.
- Almost always someone in the child's own family who has access and opportunity by being a part of the immediate or extended family.
  - May include close family friends, or
  - Other persons with frequent contact with the child.

Position of power and authority over the child
- Most often involves an adult in a legitimate position of power/authority over the child.
  - The misuse & exploitation of an accepted power relationship of the adult over the child.
- The power and authority of the adult convey to the child that the proposed behavior is acceptable and sanctioned.
  - Often the perpetrator presents the activity to the child as a game, or something that is special or fun.
  - At times, rewards or bribes are offered.
  - Engaging in an activity with a known and favored adult is often sufficient incentive for the child to participate.

Opportunity
- Opportunity to engage in sexual activity is essential
  - Equated with privacy - perpetrator and child need to be alone with each other. While these circumstances may be accidental the first time, the perpetrator can be expected to then watch for or create such opportunities.

Phase II: Sexual Interaction
- Over a period of time, the perpetrator will engage the child in sexual activity.
- The typical pattern of progression is from less to more intimate sexual activity.
- The engagement phase does encompass a progression of sexual activity
  - exposure to fondling to some form of penetration is very predictable.
  - expect a similar progression of sexual activity in most intra-family cases.

Phase III: Secrecy

Essential & enables repetition
- Primary task for the perpetrator (after sexual behavior has taken place) is to impose secrecy.
  - Eliminates accountability.
  - Perpetrator does not wish to be caught and held responsible.
Enables repetition of the behavior.
- Perpetrator engages in sexual activity with a child to meet his/her own needs, and is generally powerfully motivated to continue the behavior. Secrecy, therefore, is essential.

Encouraged with rewards
- Perpetrators may offer and provide rewards to the child for keeping the secret.
  - In addition to tangible rewards, the child may value and enjoy the interaction.
  - Perpetrator may be known and valued to the child and the interaction may be pleasurable on several levels, including
    - enhancement of the child's self-esteem
    - feeling important to another person
    - being special in a grown-up fashion
    - pleasurable sexual stimulation

Enforced with threats
- Some perpetrators use threats to enforce secrecy.
  - Threats of anger by a third party
    - "If you tell mommy, she'll be awfully mad!"
  - Threats of separation
    - "I may be sent to jail.", or "If you tell anyone, you'll be sent away."
  - Threats of violence against oneself or the child
    - "If you tell, I'll kill myself.", or "I'll hurt you or kill you if you tell anyone."

Secrecy phase often lasts for months or years
- Often lasts for months or years, especially in interfamilial sexual abuse.
- It is very likely the incident of sexual behavior that occurred at the time the case came to attention is not likely the first incident of sexual activity for that child.
- Many situations of child sexual abuse remain secret forever.

Phase IV: Disclosure

Two types of disclosure in child sexual abuse: Accidental & Purposeful.

ACCIDENTAL DISCLOSURE: Secret is revealed accidentally due to external circumstances.
Key Factor: None of the participants decided to tell the secret.
- Sexual abuse can be revealed in one of several ways:
  - observation by a third party;
  - identification of physical injury to the child by an outsider;
  - sexually transmitted disease in children who are too young to be expected to be involved in sexual activity;
  - pregnancy; or precocious sexual activity initiated by a child.
- In situations where the disclosure is accidental, none of the participants are prepared for the secret to be revealed. As a result, most often precipitates a crisis.
PURPOSEFUL DISCLOSURE:
One of the participants (most often the child) decides to tell an outsider about the abuse.

- Older children may disclose in an attempt to escape or modify the family situation.
- Children, however, may have their own reasons for wanting to modify the family situation.
  - For example, an adolescent girl may disclose in order to attain the freedom to form peer relationships, to date, to socialize outside the family, activities that are often not permitted by incestuous fathers who control their daughter's social activities as a way of assuring their own needs are met.
- You must determine the underlying reasons for a child's disclosure of abuse.
  - The child who discloses sexual abuse may have completely unrealistic expectations of the person who received the information.
  - Unless you take the time to find out why the child told, and attempt to modify the child's expectations, if they are unrealistic, the child is likely to recant the story as soon as the threat of outside interference is identified.
- In situations of planned disclosure you can meet with the child and:
  - in a calm and playful manner, proceed with fact finding
  - give the child the opportunity to express his/her concerns
  - together determine alternatives for disclosure to the family and subsequent interaction.

Family Members’ Reactions to Disclosure
Family members' reactions to disclosure are variable.

Perpetrators
- Are likely to react with alarm.
  - Child sexual abuse is a crime, with possible criminal penalties.
  - Feared loss of social status in the community, as well as his/her job, or family.
- Can also be expected to:
  - react defensively to disclosure with self-protection as the primary goal.
  - react with hostility toward the child.
  - exploit his/her power position to the fullest in order to:
    - control the child and other family members
    - undermine the credibility of the allegation.

Child’s Parents – If Not the Perpetrator
The child's parents are more likely to react in a more protective fashion toward the child when a child has been sexually abused by someone other than a parent.
- There may be conflicting loyalties (e.g., child was abused by extended family members)
- May experience guilt about their own failure to protect the child
- May wish to deny or cover up their own culpability
- May be reluctant to address the issue of the child's premature introduction to sexuality and the negative impact of the sexual abuse on the child.

For above reasons, may refuse to cooperate and handle the allegations with denial.
**Child's Mother**

In situations of intra-family sexual abuse the child's mother may:

- Initially react by expressing concern for the child & fully cooperate in activities to help the child.
  - Not all mothers can be expected to react in this way
  - Not all mothers can sustain a posture of protection and concern without considerable support and encouragement from others.
- Have already been aware of the sexual abuse
- Have been previously told about the sexual abuse, but failed to believe the child or to stop the activity.
  - If either is true, may react to disclosure with guilt and a desire to protect herself.

A common problem for the mother is having to choose between protecting the child or the perpetrator.

- If the perpetrator provides economic support, social status, or emotional support, the choice may be very difficult.
- If the perpetrator has been violent or abusive toward the mother in the past, she may fear physical retribution.

Under these pressures, It is not unusual for mothers to:

- abandon responsibility
- avoid decision making
- withdraw from the activities following disclosure

Thereby affording more opportunity for the perpetrator to exert control over the family's response.

**Siblings**

Siblings may react defensively to disclosure:

- Fear disruption of family life, the unknown, and of separation.
- May be forced to choose between the perpetrator and the victim.
- May themselves have been previously victimized
- May have participated in the abuse or "set up" the victim.

**Support and Concern for the Victim**

In sum: All family members can be expected to react to disclosure of child sexual abuse by considering "How will this affect me?"

- Only persons with considerable ego strength and security can sustain a posture of protection and concern toward the victim.
- All others require enormous support & some pressure to maintain a victim-oriented response.
- In some cases, family members will not be able to react with support or concern for the victim, regardless of the circumstances.
Phase V: The Suppression Phase

In most cases, there is a period of suppression following disclosure.

Family May Try to Suppress Publicity, Information, and Intervention

- May extend to denial of the significance of disturbances suffered by the child victim in order to discourage further intervention by "outsiders".
- At times, the parents prefer to "forget" about the sexual incident.

Perpetrator May Exploit Power Position and Pressure the Child and Family

- In situations of interfamilial sexual abuse, suppression is likely to be intense.
- The perpetrator can be expected to further exploit his/her power position by pressuring the child and any other family members who appear to be cooperating with outside authority figures.
- Sometimes the suppression is limited to verbal pressure calculated to induce feelings of guilt in the child for his/her part in the disclosure.
- Other family members may join in the process and "gang up" on the child.

Perpetrator Uses Verbal Abuse or Threats to Pressure Child to Recant

- Sometimes the suppression phase is characterized by verbal pressure that is abusive or threatening.
- The aim of the verbal abuse or threats is to pressure the child to recant or stop complying with the intervention process.
- In some cases, children and compliant family members may be subjected to physical abuse as part of the suppression phase.

Perpetrator Undermines the Credibility of the Child

The primary aim of the perpetrator during the suppression phase, regardless of the type of pressure used is to undermine the credibility of the child and the allegation of sexual abuse.

- One obvious result may be for the child to withdraw the complaint or falsely declare the complaint a lie.
- When the child withstands pressure to withdraw the complaint, the suppression phase may be characterized by various attempts to undermine the child's credibility.
- Other family members may describe the child as a pathological liar, or as mentally disturbed or "crazy."
- The child may feel isolated and ostracized, and give in and withdraw the complaint, or simply stop cooperating with those who are trying to assist.
NCSBY Fact Sheet
Sexual Development and
Sexual Behavior Problems in Children Ages 2-12

This Fact Sheet provides basic information about sexual development and problematic sexual behavior in children ages 2-12. This information is important for parents and professionals who work with or provide services to children such as teachers, physicians, child welfare personnel, daycare providers, and mental health professionals. Understanding children’s typical sexual development, knowledge, and behavior is necessary to accurately identify sexual behavior problems in children. Guidelines to distinguish typical sexual behaviors from problematic sexual behaviors are described below.

Research on sexual behavior of children ages 2 to 12 has documented that:

- sexual responses are present from birth;  
- a wide range of sexual behaviors for this age range are normal and non-problematic;  
- increasing numbers of school age children are being identified with inappropriate or aggressive sexual behavior; it is not clear if this increase reflects an increase in the actual number of cases or an increase in identification and reporting;  
- several treatment interventions have been found to be effective in reducing problematic sexual behavior in children, such as cognitive behavioral group treatment; and  
- sexual development and behavior are influenced by social, familial, and cultural factors, as well as genetics and biology.

Typical sexual knowledge of children age 2 to 6 years old:
- understand that boys and girls have different private parts;  
- know labels for sexual body parts, but use slang words such as weenie for penis; and  
- have limited information about pregnancy and childbirth.

Typical sexual knowledge of children ages 7 to 12 years old:
- learn the correct names for the genitals but use slang terms;  
- have increased knowledge about masturbation, intercourse, and pregnancy; and  
- understand the physical aspects of puberty by age 10.
**COMMON SEXUAL BEHAVIORS**

<table>
<thead>
<tr>
<th>AGES 2-6</th>
<th>AGES 7-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not have a strong sense of modesty, enjoys own nudity</td>
<td>Sexual play with children they know, such as playing “doctor”</td>
</tr>
<tr>
<td>Use elimination words with peers</td>
<td>Interested in sexual content in media (TV, movies, radio)</td>
</tr>
<tr>
<td>May explore body differences between girls and boys</td>
<td>Touch own genitals at home, in private</td>
</tr>
<tr>
<td>Curious about sexual and genital parts</td>
<td>Look at nude pictures</td>
</tr>
<tr>
<td>Touch their private parts, even in public</td>
<td>Interested in the opposite sex</td>
</tr>
<tr>
<td>Exhibit sex play with peers and siblings; playing “doctor”</td>
<td>Shy about undressing</td>
</tr>
<tr>
<td>Experience pleasure from touching their genitals</td>
<td>Shy around strange men</td>
</tr>
</tbody>
</table>

### Common vs. Infrequent Sexual Behaviors in Children

In the last decade, research has described typical sexual behaviors in boys and girls ages 2-12. The table below lists sexual behaviors that are commonly observed or reported by parents of pre-school and school age children.

**INFREQUENT SEXUAL BEHAVIORS AGES 2 - 12**

- Puts mouth on sex parts
- Puts objects in rectum or vagina
- Masturbates with objects
- Touches others’ sex parts after being told not to
  - Touches adults’ sex parts
- Asks to engage in sex acts
- Imitates intercourse
- Undresses other people
- Asks to watch sexually explicit television
- Makes sexual sounds

Research has also described infrequent and uncommon sexual behaviors in boys and girls ages 2-12. The table below lists sexual behaviors that are reported by parents of pre-school and school age children to be infrequent or highly unusual.
Sexual Play vs. Problematic Sexual Behavior

Professionals in the field have developed a continuum of sexual behaviors that range from common sexual play to problematic sexual behavior. These are described below.

**Sexual play**
- is exploratory and spontaneous;
- occurs intermittently and by mutual agreement;
- occurs with children of similar age, size, or developmental level, such as siblings, cousins, or peers;
- is not associated with high levels of fear, anger, or anxiety;
- decreases when told by caregivers to stop; and
- can be controlled by increased supervision.

**Problematic sexual behavior**
- is a frequent, repeated behavior, such as compulsive masturbation;

  Example: A six-year-old repeatedly masturbates at school or in other public places.

- occurs between children who do not know each other well;

  Example: An eight-year-old girl shows her private parts to a new child during an after school program.

- occurs with high frequency and interferes with normal childhood activities;

  Example: A seven-year-old girl has been removed from the soccer team because she continues to touch other children’s private parts.

- is between children of different ages, size, and development level;

  Example: An eleven-year-old boy is “playing doctor” with a three-year-old girl.

- is aggressive, forced, or coerced;

  Example: A ten-year-old threatens his six-year-old cousin and makes him touch his penis.

- does not decrease after the child is told to stop the behavior;

  Example: A nine-year-old child continues to engage other children in mutual touching after being told the behavior is not allowed and having consequences, such as being grounded.

- causes harm to the child or others.

  Example: A child causes physical injury, such as bruising, redness, or abrasions on themselves or another child, or causes another child to be highly upset or fearful.
Children With Sexual Behavior Problems

Children with sexual behavior problems (SBPs) are children 12 years and under who demonstrate developmentally inappropriate or aggressive sexual behavior. This definition includes self-focused sexual behavior, such as frequent public masturbation, and intrusive or aggressive sexual behavior towards others that may include coercion or force. Although the term “sexual” is used, the children’s intentions and motivations for these behaviors may be unrelated to sexual gratification.

Some children who have been sexually abused have inappropriate sexual behaviors and others have aggressive or highly problematic sexual behavior. However, it should be noted that the majority of children who have been sexually abused do not have subsequent inappropriate or aggressive sexual behaviors.

Although only a small number of children develop problematic sexual behavior, professionals and parents may have concerns about (1) whether the behavior is problematic, (2) whether a child should be referred for mental health services, and (3) when an incident should be reported to the proper authorities.

Suggestions for professionals and parents are listed below:

• Do not overreact as most sexual behaviors in children are within the typical or expected range.
• Inappropriate or problematic sexual behavior in children is not a clear indicator that a child has been sexually abused.
• Most children will stop the behavior if they are told the rules, mildly restricted, well supervised, and praised for appropriate behavior.
• If the sexual behavior is problematic as defined above, referral for mental health services is recommended.
• It is important to remember that children with problematic sexual behavior are significantly different from adolescent and adult sex offenders.
• A report to Child Protective Services (CPS) and/or law enforcement may be required by law for certain behaviors such as aggressive or forced sexual behavior.

Additional information about adolescent sex offenders and children with sexual behavior problems is available from the National Center on Sexual Behavior of Youth, www.ncsby.org.
Reference:

Opinions in this document are those of the authors and do not necessarily represent the official positions or policies of the US. Department of Justice/Office of Juvenile Justice and Delinquency Prevention.

The University of Oklahoma is an equal opportunity institution.

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Physical & Behavioral Indicators of Sexual Abuse

The indicators of sexual abuse vary in children of different ages.

- Sexual abuse includes a wide range of behaviors and activities, some of which have no physical signs.
  - Kissing
  - Fondling
  - Genital exposure
  - Observation of adult sexual activity by a child

- When a child has been physically involved in sexual activity, there maybe physical indicators or injury.
  - May be validated through a medical examination by a physician trained in sexual abuse.
  - Several physical indicators common in sexually abused young children
  - Depending upon how recent and how extensive the sexual activity, there may be no clear physical evidence

Physical Injury to the Genitals

- Injuries include bruising, cuts or lacerations, bite marks, stretched rectum or vagina, fissures in the rectum, or swelling and redness of genital tissues.
- These injuries may have been caused by penetration of the vagina or rectum with fingers, an adult penis, or other objects.
- Injuries to the genitals in older infants and toddlers may be the result of physical punishment for toileting accidents.

Sexually Transmitted Diseases

- The presence of sexually transmitted diseases, including herpes on the genitals, gonorrhea, syphilis, venereal warts, or Chlamydia, strongly suggests sexual exposure.
- The presence of monilia (yeast infection) in a female child or adolescent may not necessarily be the result of sexual abuse.
- Yeast infections may occur from having taken systemic antibiotics, or from excessive douching.
- A yeast infection in a preadolescent child, however, warrants a medical examination and further investigation.

Suspicious Stains, Blood, or Semen on the Child’s Underwear, Clothing, or Body

- The presence of blood or semen strongly suggests sexual exposure and all evidence must be collected by law enforcement.
Bladder or Urinary Tract Infection
- This includes pain when urinating, blood and pus in the urine, and high frequency urination.
- Urinary tract infections are common in sexually active women.
- They are uncommon in children, unless the child has a physical abnormality of the urinary system such as children with spina bifida, who often have chronic urinary tract infections as a result of neurological dysfunction.
- Any urinary tract infection in a child must be medically evaluated for the possibility of sexual abuse.

Painful Bowel Movements or Retention of Feces
- Might indicate that the rectum has been penetrated. Chronic constipation may also cause painful bowel movements and retention of feces by a child.

Early, Unexplained Pregnancy
- Particularly in a child whose history and behavior does not suggest sexual activity with peers.

Behavioral Indicators of Sexual Abuse

Verbal Disclosure
- When a child discloses sexual involvement, or that an adult has done "bad things" to them, this disclosure must always be taken seriously.
- If a child's disclosure is handled improperly, the child may be unwilling to talk about the abuse again.
- The child is often hesitant to disclose due to threatened consequences imposed by the perpetrator.
  - Disclosure may only be hinted at (e.g., "I don't want to go home." or "I don't like my dad anymore.")

Precocious Sexual Knowledge and Inappropriate Sexual Behavior
You must have a basic knowledge of appropriate sexual knowledge/behavior in children of different ages in order to recognize when a child possesses sexual knowledge or engages in sexual behavior that is not typical for his or her age.
- Behaviors that often indicate unusual sexual involvement include:
  - Seductive behavior toward adults of the opposite sex
    - (generally female children toward adult men)
  - Sexual acting out in pre-adolescent and adolescent children
    - including promiscuity or blatantly provocative dress
  - Excessive masturbation (again, beyond what is age appropriate)
  - Enticing other children into sexual play
    - (beyond normal curiosity and visual or tactile exploration, such as the "doctor" games and mutual disrobing often engaged in by younger children)
• Involving other children, either of the same or opposite sex, in more extensive sexual behavior.
  • Adolescent male perpetrators are themselves very often victims of sexual abuse.
• Creating and playing out sexual scenarios with toys or dolls
  • The "child" doll presses her face into the "daddy" doll's groin and says "he likes this;" or the "daddy" doll puts his hand under the "child" doll's skirt and rubs her.
• Specific fears of males or females
  • Adolescent fear of sex (beyond normal adolescent ambivalence and anxiety)
• Some children wear extra layers of clothing, or clothing that is inappropriate for the weather:
  • An apparent symbolic attempt to hide, or to protect their bodies.
• The child may hide clothing that is stained, bloodied, or otherwise soiled as a result of sexual activity.
• A sexually abused child may have difficulty with, or appear to lack interest in participating in normal physical activities.
  • Indicators: difficulty sitting in a chair, sitting awkwardly, or squirming, having difficulty walking, staying seated and choosing not to become involved in games or sports.
  • Indicators may be the result of pain or discomfort in the genital area.

Generalized Indicators of Emotional Distress are Prevalent

NOTE: These indicators are also prevalent in other maltreated children and are not direct indicators of sexual abuse:
• Fears and phobias (of the dark, of school, going out, going home, being left alone, or free floating anxiety)
• Aggressive behaviors, tantrums, behavioral acting out, running away from home, fighting
• Withdrawal from social relationships, secrecy, isolation, and a prevailing lack of trust in relationships. This is often mistaken for independent activity.
• Low self-esteem, poor body image, perceives oneself in a negative way with a distorted sense of one's own body
• Regression in young children; enuresis, encopresis, thumb sucking, baby talk, clinging behaviors
Sexual Abuse

Identifying the Signs:

Angela

Angela, age 7, was placed in a newly approved foster home 8 months ago because her father sexually abused her.

The abuse had been going on for 3 years before Angela disclosed the abuse to a friend who, in turn, reported it to a teacher.

Angela was quiet and withdrawn during the early weeks of placement.

A month after placement, the foster mother reported observing Angela in her room reenacting what appeared to be intercourse with a doll.

The foster mother also reported she had found Angela masturbating at least 6 times during the last two weeks and Angela continued to masturbate even when her foster mother walked into the room.

You visit the home to assure the foster parents that Angela’s behavior was typical for a child who had been sexually abused.

During this visit, you notice Angela seemed extremely friendly with her foster father.

The child followed him all over the house and when he sat down, she tried to get into his lap.

For the most part, Angela ignored the foster mother and responded in a hostile tone when the foster mother addressed her.

You contacted Angela’s school and learned that Angela did not get along well with peers.

Although bright, her grades were slipping.

Angela’s teacher said that Angela’s one great love was swimming and that she was part of a group of children who stayed after school to swim in the high school swimming pool instead of going to day care.

The teacher reported that lately Angela had “become bashful” about putting on her bathing suit and sometimes cried for several minutes before changing.

Soon after Angela learned her father was convicted of sexual molestation, she accused her foster father of sexually molesting her.

She gave details about how her foster father would help her get ready for bed and tuck her in each night with a forceful kiss on her mouth.

Angela also stated that he liked lots of “bear hugs” and would pat her bottom. When asked if she ever told the foster mother, Angela stated her foster mother was “mean and would never believe me.”

Angela was removed immediately from the home and an investigation began.

The foster father denied all allegations. Angela was given a medical exam which revealed that she had a thick discharge and vaginal irritation.
Alphonzo

Mrs. Walker is very proud of Alphonzo because he is becoming very independent lately. For example, he wants to make his own cereal in the morning and he won't let Mrs. Walker walk with him into his preschool classroom anymore.

Lately, he wants to give himself his bath and won't let Mrs. Walker in the bathroom at all.

Mrs. Walker says that she has been monitoring Alphonzo's bowel movements since he had severe diarrhea 3 months ago.

Lately, he complains of diarrhea and hurries into the bathroom but when she checks, his bowel movements appear normal.

Mrs. Walker is concerned because sometimes when she reaches out to hug Alphonzo, he pulls away from her.

Mrs. Walker doesn't know if this is normal or not. Alphonzo seems to be talking less and less. For example, this morning Mrs. Walker noticed Alphonzo playing with his trucks.

She said: “I like the red truck, Alphonzo. Which one is your favorite?” Alphonzo yelled, “Truck bang buszsch.” Alphonzo has always been such a serious little boy, but lately he just won't talk to anyone.

He must be going through a shy stage.

Still, Mrs. Walker feels there is something very wrong with Alphonzo.

Maria

Maria, 10 years old, told her best friend that her mother's boyfriend, Marcello, repeatedly forced her to fondle him when her mother was baby-sitting for the next-door neighbor.

Maria encourages her mother to baby-sit because it gives her money to take Maria out for dinner at McDonald's.

Maria is a very articulate child. She tells her friend she's “coping fine with the situation” and that “adults often have problems relating to children.”

Maria is very worried about her mother because she is working so many hours and Marcello won't help at all.

Maria does the family's laundry, cleans, and even writes checks for the monthly bills for her mother to sign. Maria microwaves frozen dinners for Marcello unless he orders pizza.

She also runs her mother's bath for her late at night when her mother returns home from work.

Maria's teachers think Maria is a very polite. She is well-behaved and shows no signs of aggression. They do think Maria is overly sexual. She wears tight clothes and make-up and seems to be flirting with boys her own age as well as with teachers.

This morning a bad thing happened to Maria - she suddenly became very dizzy in school. The school nurse called to ask Maria's mother to take her to the doctor for a complete examination.

The doctor found that Maria has a gonococcal infection of the throat. Maria's mother told the doctor Maria was taking antibiotics for a middle ear infection.
The doctor also said Maria's dizziness is the result of not having eaten for almost 24 hours. Maria forgot to eat breakfast or lunch and didn't realize how hungry she was.

The doctor also commented on some old and new scratches on Maria's stomach and thighs. Maria said a dog jumped up on her and scratched her.

Now it's 5:00 and Maria is scared because she felt like the doctor was staring at her.

She decided to talk to her friend. But after she told her friend what happened, her friend said she was going to tell her mother.

Maria told her that she was just joking - she just saw a TV movie about a kid who had that happen to her.

What Maria doesn't know is that her friend's mother wouldn't have believed the story.

Many of the mothers in Maria's neighborhood don't like their daughters hanging around with Maria because she is so flirtatious.

Maria's friend's mother commented just the other day that Maria was “looking to get pregnant.” If Maria's friend had told her mother what Maria said, her mother would have responded that Maria clearly asked for it.
Module 5: Is it Mental Injury

10 Myths about Verbal Abuse

1. Sticks and stones break bones but words don’t hurt.
   - In some cases, words can hurt more than a stick or stone ever could.
   - It is often not just about the words hurled abusively but also about who is the abuser.
   - If it is a parent that a child needs to trust and depend on for love and support, the result can be an experience of abandonment and betrayal.

2. Verbal abuse is no big deal - it doesn’t hurt.
   - Abuse leaves children doubting their own feelings.
   - Part of the pain and damage has to do with the way in which it threatens to invalidate the reality of the victim.
   - Verbal abuse is damaging to the victim’s mental health and self-esteem and self-worth.

3. The target (victim) of the abuse deserved it.
   - Each and every adult is responsible for managing his or her own feelings.
   - Verbal abusers try to hold the victim responsible for what they feel, then they want to get the victim or pay the victim back for it.
   - How the verbal abuser feels is NOT the child’s responsibility.

4. It is the victim’s fault for disagreeing with the abuser.
   - There is nothing that the victim does that warrants or justifies verbal abuse.
   - Verbal abuse is an aggression and an emotional violation.

5. The target of the abuse made the abuser mad.
   - Abusers notoriously think that their poor choices and inability to take responsibility for their choices is someone else’s fault.
   - It is the abusers’ responsibility.

6. Verbal abuse is less impacting than physical abuse.
   - Verbal abuse is an element of emotional abuse.
   - Verbal abuse is emotional battering.
   - Verbal abusers bruise the child emotionally, in a way that hurts as much, if not more, than actual physical bruises.
7. **Verbal abuse only involves name-calling or yelling.**
   - Verbal abuse is more than name-calling or yelling and screaming.
   - It is using words to intimidate or control.
   - It involves threats, put-downs, and/or making fun of someone.
   - Verbal abuse is any language used to demean, criticize, tear-down, make fun of, embarrass or otherwise intimidate or control another person.

8. **Verbal abuse is not as bad as hitting someone.**
   - Verbal abuse is as painful and debilitating emotionally, if not more so than physical abuse.
   - As victims of physical abuse “walk on egg shells” and try not to upset the abuser, the same is true for the victim of verbal abuse.
   - Many victims of both physical and verbal abuse stated that the physical bruises heal a significant amount faster than the emotional bruises.

9. **The abuser doesn’t really mean it, can’t help it, and really loves the child.**
   - Verbal abuse often has its roots in a legacy of abuse experienced in dysfunctional families.
   - It also has its roots in many of the experiences of those who have personality disorders.
   - When confronted verbal abusers say and believe that they did not mean what they said and that they said it because they were angry, tired, felt pushed, were being bugged, felt criticized, etc.
   - They may not recognize that how they are using their words, and/or the volume at which they are yelling and screaming, and/or the hate and/or malice with which they are raging is even a problem.
   - Verbal abuse is abuse, no love. It is meant. It is chosen. It is not safe.
   - Verbal abuse can be a red flag as it can escalate to other forms of abuse.

10. **It is the child’s fault due to their behavior and failure to change.**
    - Verbal abusers often tell their victims that if they would just change this or that - if the victim would change - everything would be fine and they would not have to use their violent verbiage.
Is it Mental Injury?

Definition:

F.S. 39.01(42) defines mental injury as...

...an injury to the intellectual or psychological capacity of a child as evidenced by a discernible and substantial impairment in the ability to function within the normal range of performance and behavior.

Is It Mental Injury?

- The law requires a direct cause and effect relationship between parental behavior and harm to the child.

- Courts make rulings based on expert testimony about the child's mental and emotional well-being.
  - Harm to the child must be demonstrated in the form of significant impairment in the child's functioning
  - Professional evaluation must be obtained to prove significant impairment.
  - The suffering causes, or will cause, continuing difficulties in the child’s ability to think, reason, and relate to others and has sufficient indicators and substantial, observable symptoms.
  - There must be identifiable parental behavior that could cause harm. This parental behavior must be established through substantial, observable action or lack of action on the part of the caregiver.
  - A causal link between the parental behavior and the harm to the child must be established.
  - A direct link must be shown.
Indicators of Mental Injury

General Behavioral Indicators

- Habit disorders
  - such as poor eye contact, sucking, biting, rocking, enuresis, or eating and other food-related disorders
- Conduct disorders, including withdrawal and anti-social behavior
- Neurotic traits
  - such as sleeping disorders, inhibition of play, compulsiveness, hysteria, obsession, phobias, and hypochondria
- Suspicious, untrusting, pessimistic, depressed, anxious, preoccupied behavior
- Inappropriate adult behavior or inappropriate infantile behavior
- Developmental lags in mental and emotional growth
- Suicide attempts
- Poor self-image
- Running away
- Adaptive behavior in an attempt to respond to family’s inconsistent interactions or expectations
- Nervous tic, persistent stuttering, or speech disorder
- Subservient role in the home
- Developmental lag in decision-making
- Hesitant to participate in discussions
- Overriding worry about pleasing authority figure
- Anger/hostility when not feeling in control

General Physical Indicators

- Hair missing because of pulling
- Nails bitten
- Body posture/facial expressions are withdrawn
- Hives
- Nervous tics
- Overweight
- Depression - low self-worth, low self-esteem
- Thoughts and/or acts of suicide
- Rebelliousness
- Self-inflicted injuries
Caregiver Behaviors

• Have a need to always be in charge; can never let go, always critical
• Practice the abuse daily, ongoing and continuous
• Have distant, shallow, or superficial relationship with family members
• Deny themselves fulfillment of emotional needs
• Are usually isolated from society
• Totally reject the child
• Make any positive interaction between the child and themselves inconsistent and unpredictable
• Program the child for failure
• Impose unrealistic expectations on the child
• Refuse to make allowances for the child’s individuality
Case Scenario - Margaret
- Review the PG, “Indicators of Mental Injury.”
- Read the case scenario Margaret.
- Using the PG list the child and caregiver indicators that you find in the scenario.
- Discuss them in your groups and record group responses to the questions that follow the scenario.
- Share answers with the class.

Margaret Scenario
Margaret was reported by a family friend to be a victim of mental injury because the friend felt Margaret is being “abused.”

The friend reported that Margaret, who is 11 years old, is treated differently from her three siblings.
She is not allowed to eat with the family, nor is she included in family social outings.
She is also not permitted to participate in any social activities outside the home.

You interview Margaret, and the descriptions of her treatment agreed with the allegations.
Margaret said she deserved this treatment because, “I’m a trouble-maker. I can’t control myself. They have to watch me all the time or I’ll go crazy and hurt someone.”

Margaret’s teacher said Margaret is a good student but has few friends. The teacher also said Margaret is sensitive and cries when she makes mistakes.

You conduct a family interview. Margaret’s parents describe Margaret as “a problem child, one of those kids you have to watch all the time.”

Neither parent spoke to Margaret or made eye contact with her throughout the interview. Even Margaret’s youngest sibling, a five-year-old girl, described Margaret as “bad.”

Activity Questions
1. What did you observe that might indicate mental injury? List child and caregiver behaviors.

2. Is there a direct link between the caregiver’s actions or lack of actions and the child’s suffering?

3. What else must you do to support your observations?
Types of Mental Injury

- A repeated pattern or extreme incidents of the conditions described here constitute psychological maltreatment.
- Such conditions convey the message that the child is worthless, flawed, unloved, endangered, or only valuable when meeting someone else's needs.

Spurning (Hostile Rejecting/Degrading)

- Includes verbal and non-verbal caregiver acts that reject and degrade a child.
- Belittling, degrading and other nonphysical forms of overtly hostile or rejecting treatment
- Shaming and/or ridiculing the child for showing normal emotions such as affection, grief, or sorrow
- Consistently singling out one child to criticize and punish
  - ex: to perform most of the household chores, or to receive fewer rewards
  - Humiliating in public

Terrorizing

Includes caregiver behaviors that threaten or are likely to physically hurt, kill, abandon, or place the child or child's loved ones/objects in recognizable dangerous situations.

- Placing a child in:
  - unpredictable or chaotic circumstances
  - recognizable dangerous situations
- Setting rigid or unrealistic expectations with threat of loss, harm, or danger if they are not met.
- Threatening or perpetrating violence against:
  - the child
  - a child's loved ones or objects

Exploiting/Corrupting

Includes caregiver acts that encourage the child to develop inappropriate behaviors (self-destructive, anti-social, criminal, deviant or other maladaptive behaviors).

- Modeling, permitting, or encouraging:
  - Antisocial behavior
    - (e.g., prostitution, performance in pornographic media, initiation of criminal activities, substance abuse, violence to or corruption of others)
  - Developmentally inappropriate behavior
    - (e.g., parentification, infantalization, living the parent's unfulfilled dreams)
- Encouraging or coercing abandonment of developmentally appropriate autonomy through extreme over involvement, intrusiveness, and/or dominance (e.g., allowing little/no opportunity/support for child's views, feelings, and wishes; micromanaging child's life)
- Restricting or interfering with cognitive development
Isolating
Includes caregiver acts that consistently deny child opportunities to meet needs for interacting/communicating with peers or adults inside/outside home.

- Confining the child or placing unreasonable limitations on the child’s freedom of movement within his/her environment
- Placing unreasonable limitations or restrictions on social interactions with peers or adults in the community

Denying Emotional Responsiveness (Ignoring)
Includes caregiver acts that ignore the child’s attempts and needs to interact (failing to express affection, caring, and love for the child) and showing no emotion in interactions with the child.

- Detached and uninvolved through either incapacity or lack of motivation
- Interacting only when absolutely necessary
- Failing to express affection, caring, and love for the child

Mental Health, Medical and Educational Neglect
Include unwarranted caregiver acts that ignore, refuse to allow, or fail to provide the necessary treatment for the mental health, medical, and educational problems or needs of the child.

- Ignoring the need for, failing or refusing to allow or provide treatment for serious:
  - emotional/behavioral problems or needs of the child
  - physical health problems or needs of the child
  - educational problems or needs of the child
## Mental Injury: Examples of Caretaker Behavior by Age of Child

<table>
<thead>
<tr>
<th></th>
<th>Rejecting</th>
<th>Terrorizing</th>
<th>Ignoring</th>
<th>Isolating</th>
<th>Corrupting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infant</strong></td>
<td>Refuses to accept child’s primary attachment.</td>
<td>Consistently violates child’s ability to handle new situations and uncertainty.</td>
<td>Fails to respond to infant’s social behaviors which form the basis for attachment.</td>
<td>Denies the child social interactions with others.</td>
<td>Reinforces bizarre habits or creates addictions.</td>
</tr>
<tr>
<td></td>
<td>Behaviors: Refuses to return smiles, punishes child for vocalizations, abandons baby.</td>
<td>Behaviors: Teasing/scaring infants by throwing them up in the air, reacting in unpredictable ways to infant’s cries.</td>
<td>Behaviors: Mechanical care-giving without affection, fails to make eye contact with infant.</td>
<td>Behaviors: Refuses to allow relatives and family friends to visit the infant, leaves the infant unsupervised for long periods of time.</td>
<td>Behaviors: Creates drug dependencies, reinforces sexual behaviors.</td>
</tr>
<tr>
<td><strong>Toddler</strong></td>
<td>Actively excludes from family activities.</td>
<td>Using extreme measures to punish the child.</td>
<td>Pattern of apathetic treatment and lack of awareness of the child’s needs.</td>
<td>Teaches the child to avoid social contact beyond the caretaker/child interaction.</td>
<td>Gives inappropriate reinforcement for anti-social behaviors.</td>
</tr>
<tr>
<td></td>
<td>Behaviors: Refuses to allow child to hug them, treats the child differently from siblings; pushes child away</td>
<td>Behaviors: Verbal threats of mysterious harm (attacks by monsters), leaves child in the dark, alternating rage with warmth</td>
<td>Behaviors: Doesn’t speak with child at meals, leaves child alone for long periods, does not respond to requests for help.</td>
<td>Behaviors: Punishes child for making social overtures to other children, rewards child for withdrawing from social contacts.</td>
<td>Behaviors: Rewards child for aggressive acts toward animals or other children, &quot;brainwashes&quot; child into racism</td>
</tr>
</tbody>
</table>
## Mental Injury: Examples of Caretaker Behavior by Age of Child

<table>
<thead>
<tr>
<th>SCHOOL CHILD</th>
<th>Rejecting</th>
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<th>Isolating</th>
<th>Corrupting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistently communicates to child that they are inferior/bad. Behaviors: Uses labels such as “bad child”, “dummy”, always tells children they are responsible for family problems.</td>
<td>Places child in “double binds” or places inconsistent or frightening demands on child. Behaviors: Sets up unrealistic expectations and criticizes the child for not meeting them, forces children to choose between parents, teases the child, plays cruel games.</td>
<td>Fails to protect the child from threats while aware of the child's need for help. Behaviors: Fails to protect the child from assault by other family members, shows no interest in child's education or life outside the home.</td>
<td>Attempts to remove the child from social relationships with peers. Behaviors: Refuses to allow other children to visit the home, keeps the child from engaging in after school activities.</td>
<td>Rewards child for anti-social or illegal acts, exposes child to poor role models. Behaviors: Exposes the child to pornography, rewards the child for stealing.</td>
<td></td>
</tr>
<tr>
<td>SCHOOL AGE CHILD</td>
<td>Rejecting</td>
<td>Terrorizing</td>
<td>Ignoring</td>
<td>Isolating</td>
<td>Corrupting</td>
</tr>
<tr>
<td>Refuses to acknowledge the changes in child as they grow up, attacks child's self-esteem. Behaviors: Treats an adolescent like a young child, excessive criticism, verbal humiliation.</td>
<td>Threatens to or actually subjects child to public humiliation Behaviors: Threatens to reveal embarrassing facts to the child's friends, forces the child into degrading punishments.</td>
<td>Gives up parenting role and shows no interest in the child. Behaviors: Says “this child is hopeless, I give up” &amp; means it, refuses to listen to child's discussion of their lives &amp; activities, focuses on other relationships at the exclusion of children.</td>
<td>Over-controlling the child's social interactions, restricting the child's freedom to an extreme degree. Behaviors: Punishes child for engaging in normal social activities (dating), accuses child of lying/doing drugs, etc., whenever they leave home, refuses to allow engaging in social activities.</td>
<td>Involves child in illegal or immoral behavior, encourages child to be part of this lifestyle at the expense of the child. Behaviors: Involves child in prostitution, encourages child to hit or verbally abuse siblings, encourages drug use.</td>
<td></td>
</tr>
</tbody>
</table>
In-Home Safety Assessment

Signs of Present Danger

1. Family’s whereabouts are unknown, or there is reason to believe that the family is about to flee or refuse/limit access to child(ren).

2. There are household environmental hazards AND the child may be in immediate danger of harm as a result.

3. The parent, caregiver or other household member(s) is responsible for the death or serious injury of another child.

4. The parent, caregiver or household member(s) have a history of violence or display current violent behaviors (e.g. battery, domestic violence, intimidation) and the child may be in danger of harm as a result.

5. The parent, caregiver or household member(s) has a criminal history (regardless of disposition) or engages in dangerous criminal activities that may impact child safety and/or present(s) a potential threat of harm to the child (e.g. drug manufacture and distribution, trafficking or sale of illegal drugs or weapons, prostitution).

6. The caregiver describes child(ren) in predominantly negative terms or has unrealistic expectations.

7. Caregiver or other person having access to the child has made a credible threat or expresses a credible belief that his or her actions may result in harm or danger of harm to the child.

8. The parent or caregiver has not met or is unable to meet the child’s immediate needs for food, clothing, shelter, medical, behavioral or mental health care, or protection from harm.

9. The parent or caregiver(s)’ apparent mental, physical or developmental condition, or drug or alcohol use affects their ability to adequately care for the child(ren).

10. The parent or caregiver(s)’ age affects their ability to adequately care for he child(ren) (e.g. excessively young or elderly).

11. There is a pattern of continuing, escalating and/or increasing frequency of incidents, either reported or unreported (e.g. child discloses ongoing abuse or chronic In-Home violence for which no abuse or law enforcement reports were made).

12. There is evidence of physical or sexual abuse and the possible responsible person is Unknown.

13. Person(s) biologically unrelated to alleged child victim(s) is visiting or part of the household.
14. The actual injury, neglect, or threatened harm is serious or severe. If yes, at least one of the following must be selected:

- Child Death
- Inflicted Burn
- Crack house or similar environment
- Bruises on any child less than 6 months
- Extensive body bruising, especially involving the head or torso
- Sexual abuse or exploitation
- Bizarre punishment/confine\ment

- Inflicted Facture
- Head trauma
- Blunt abdominal injury
- Multiple bit marks
- Failure to thrive
- Other

15. Medical attention was required as a result of the actual injury, neglect or threatened harm (indicate if and when medical attention was received).

16. Other signs of present danger

**Child Vulnerability**

17. Child is five years or younger or nonverbal.

18. Child has developmental, physical, emotional or medical conditions that increase his or her vulnerability.

19. Child exhibits behavior(s) that may be indicative of abuse or neglect. If yes, at least one of the following must be selected:

- Enuretic and/or encopretic
- Uses drugs/alcohol
- First setting
- Age inappropriate sexual behavior/knowledge
- Suicidal thoughts/threats
- Expresses fear of caregiver(s) and/or others living in or frequenting the home
- Excessive school absenteeism

- Physical harm to self
- Physical aggression/threats
- Runs away from home
- Sexual aggressor
- Other
20. Child has limited community visibility and others cannot observe the condition of the child.
21. Other signs of child vulnerability

**Protective Capacities**

22. There are prior intakes involving any of the subjects in the current intake, regardless of finding(s).
23. The parent or caregiver(s) has previously had children in agency custody or out-of-home care as a result of maltreatment, and/or has had parental rights terminated or has considered relinquishment of the child(ren).
24. The parent or caregiver(s) is unable or unwilling to protect the child(ren) from the possible responsible person who continues to have access and/or proximity to the child(ren).
25. Parent or caregiver(s) demonstrate(s) ability and willingness to meet child's basic needs and resources are sufficient to meet basic needs (e.g. housing, income, access to medical care, food, shelter, utilities).
26. The parent or caregiver(s) communicates with or acts toward the child(ren) in a constructive manner free of verbal/mental abuse.
27. Has a relationship with spouse/partner that supports their ability to protect and nurture the child(ren).
28. Has demonstrated adequate comprehension and problem solving skills.
29. The parent or caregiver(s) has a childhood history free from abuse or neglect.
30. Appropriate supports are adequate and immediately available (e.g. extended family, friends, neighbors, community).
31. The parent or caregiver(s) has demonstrated a willingness and ability to follow through with current or prior actions, referrals and/or services.
32. Other protective capacities or lack of protective capacities.
Family Assessment

Cultural
- Cultural factors affect family strengths, needs, and protective capacities
- Communication/language factors impact intervention

Environmental
- Behaviors of any household member which may affect the level of well-being to the child(ren)
- Stressors that impact family's ability to manage.

Safety
- Is there an Active Safety Plan?
  - Are there any signs of present danger, threats of harm, protective capacities or child vulnerability concerns that would suggest the need for an initial or updated Family Assessment?

Emerging Dangers
- Are danger-related risk dynamics (substance abuse, mental illness, violence, perception of the child, domestic violence) escalating in intensity or frequency?
- Are protective capacities diminishing?
- Are intakes increasing in severity?
- Are family stressors increasing?
- Are more people becoming involved, either as a victim or subject of the intake?
- Are different types of maltreatment reports being received?
- Is family stability diminishing?
- Are there any other emerging dangers?

Child

Permanency/Placement factors
- Is this child in an out of home placement?

Well-Being/Health Factors
- Child's diet and nutrition are consistent with health maintenance
- Child receives regular preventative health care
- Child's current medical maintenance and treatment are consistent with medical conditions and/or symptoms
- Child's needs for dental care and preventative maintenance are being met

Well-Being/Behavioral Health Factors
- Child demonstrates coping and problem solving skills, resiliency, and sense of identity
- Child demonstrates developmentally mental/behavioral health functioning

Well-Being/Education Factors
- Child's academic performance, including attendance
- Child's cognitive/intellectual development, including developmental delays
- Does the child meet the criteria for the Rilya Wilson Act?

Well-Being/Social Factor
• Child displays age-appropriate interpersonal skills
• Child maintains social connections to family, peers or others
• Child has no ungovernable behavior, illegal behavior, or gang affiliation

**Vulnerability/Fragility factors**
• Child has no arrests, law enforcement or Juvenile Justice involvement
• Child’s age and level of functioning enables self-protection
• Child is free of substance use, and/or exposure (including in utero)
• Child has no medical, mental or physical conditions that increase vulnerability

**Vulnerability/Behavior factors**
• Child displays behaviors or conditions that may be indicative of a need for specialized assessment or treatment

**Vulnerability/Adjustment factors**
• Child is effectively coping with the impact of maltreatment
• Child is positively adjusting to current placement/living arrangement
• Child feels safe and secure in current placement/living arrangement

**Adult**

**Functioning/Health factors**
• Individual is free from any physical health conditions that may impact the family, ability to parent or protective capacities
• Manages own physical health maintenance and treatment, consistent with medical needs

**Functioning/Behavioral Health factors**
• Individual is free from any behavioral/mental health issues that may impact the family, ability to parent or protective capacities
• Manages own behavioral/mental health maintenance and treatment, consistent with identified needs
• Individual is free from any substance abuse issues that may impact the family

**Functioning/Intellectual factors**
• Cognitive/intellectual functioning impacts the family, ability to parent, and protective capacities

**Functioning/Communication factors**
• Has ability to read and write in their primary language
• Effectively communicates to obtain service needs

**History/Abuse factors**
• Has a history free of abuse or neglect either as a child or as an adult
• Has a history free of perpetrating abuse or engaging in abusive or neglectful behavior
History/Criminal factors
- Has a history free of illegal activity, arrests or law enforcement involvement
- Has a history free of crimes of violence, sex offenses, or drug/alcohol related offenses

History/Financial factors
- Has a history of stable, legal financial resources sufficient to meet basic needs
- Has current legal financial resources sufficient to meet basic needs

Relationships/Domestic Violence factors
- Has a history free of being a victim of domestic abuse
- Has a history free of perpetrating domestic abuse
- Has a history free of physical, and/or emotional aggression towards others
- Balance of power with other household members does not impact ability to protect a child

Relationships/Dynamics factors
- Has a history of stable relationships
- Able to resolve relationship conflicts in a positive manner
- Involved in a current relationship?
- Current relationship is stable and does not negatively impact protective capacity
- Able to engage in joint decision making within current relationship

Relationships/Support Networks factors
- Has ability to develop and maintain supportive relationships
- Has a positive support network outside the home

Parenting/Protective Capacities factors
- Understands and can identify harmful situations
- Motivated to protect the child
- Motivated and willing to comply with restrictions on access to child
- Attached to child and meets child’s need for attachment
- Able to meet child’s needs for food/nutrition, hygiene, shelter, and education; and supervises the child’s activities

Parenting/Expectations of Child factors
- Sets age and developmentally appropriate standards and expectations for child's behavior and responds to child consistent with those standards
- Develops strategies to set and enforce limits, manages child's behavior, and encourages development of child’s self-control
- Utilizes age and developmentally appropriate discipline techniques consistent with behavior

Parenting/Participation factors
- Has a realistic understanding of intervention and needed services
- Recognizes seriousness of the maltreatment
- Willing and able to participate in offered services
- Demonstrates follow through with case commitments
- Demonstrates behavior change from service participation
Module 6: Substance Abuse

Facts About Methamphetamine

What is meth?
- Stimulant
- White, odorless
- Bitter tasting
- Crystalline powder
- Easily dissolves in water or alcohol
- Made of highly volatile, toxic substances

Slang terms for meth
- Meth
  - Speed
  - Meth
  - Crystal
  - Crank
- Crystallized meth - more powerful form - smokable
  - Ice
  - Crystal
  - Glass
  - Tweak
  - Tina

How is meth used?
- Snorted
- Injected
- Smoked in a pipe

What are the effects of meth?
- Increases arousal in the central nervous system
- Lower doses
  - Boosts alertness and blocks hunger and fatigue
- Higher doses
  - Causes exhilaration and euphoria
- Very high doses
  - Agitation, paranoia, bizarre behavior
- Psychological effect
  - Anxiety
  - Emotional swings
  - Paranoid delusions
  - Hallucinations
  - Violence
  - Self-destruction
• Side effects
  • Short term memory loss
  • Wild rages
  • Mood swings
  • Hyperactivity
  • Irritability
  • Visual hallucinations
  • Aggression
  • Suspiciousness
  • Stroke
  • Sweating
  • Long periods of sleep
  • Weight loss, malnutrition
  • Itching
  • Welts on the skin
  • Involuntary body movements
  • Paranoid delusions
  • Hallucinations

**Signs of a meth lab**
• Frequent visitors at all times of the day or night
• Activity in the house is usually at odd hours or late at night
• Occupants appear
  • Unemployed, yet seem to have plenty of money and pay bills with ease
  • Watch cars suspiciously when they pass by
  • Display a paranoid or odd behavior
  • Go outside to smoke cigarettes
  • Places garbage for pick up in another neighbor's collection area
• Extensive security at the home or signs that indicate “Private Property” or “Beware of Dog”, fences, large shrubs, bushes and trees
• Windows blackened or curtains always drawn
• Chemical odors coming from the house or garbage
• Garbage contains numerous bottles, containers, and materials used to make meth
• Coffee filters, bed sheets or other material stained from filtering red phosphorus or other chemicals
• Evidence of chemical or waste dumping
  • Burn pits
  • Dead spots in yard

**Common chemicals used to make meth**
• Alcohol (isopropyl or rubbing)
• Brake cleaner - toluene
• Engine starter - ether
• Drain cleaner - sulfuric acid
• Matches/road flares - red phosphorus
• Salt
• Teat dip or flakes/crystal - iodine
• Batteries - lithium
• Gun scrubber - trichloroethane
• Cutting agent - MSM
• Gasoline additives - sodium metal, methanol/alcohol
• Farm fertilizer - muriatic acid, anhydrous ammonia
• Lye - sodium hydroxide
• Cold tablets - pseudoephedrine; ephedrine
• Acetone
• Cat litter

**Typical equipment used to make meth**
• Pyrex or corning dishes
• Jugs/bottles
• Paper towels
• Coffee filters
• Thermometer
• Cheesecloth
• Funnels
• Blenders
• Rubber tubing/gloves
• Pail/buckets
• Gas cans
• Tape/clamps
• Internet documented/notes
• Aluminum foil
• “How to” books
• Propane cylinders (20 pound)
• Hotplates
• Plastic storage containers
• Ice chests
• Measuring cups
• Towels/bed sheets, laboratory beakers/glassware

**Dangers of a meth lab**
• Toxic and potentially explosive
• Fires
• Exposure to potent chemicals
• Enter the central nervous system by
  • Touching
  • Breathing
  • Ingestion
• Accidental injection
• Neural damage
• Effect kidneys
• Burns or irritation to the skin, eyes and nose
Stages of Substance Abuse

Phase 1: Experimentation/Social Use
- This phase is the first introduction to chemicals.
- Use is usually occasional, social and voluntary.
- There are no negative consequences such as pain to self or others.
- The effect is reliable and the person can return to normal.
- The user learns:
  - that chemicals can provide a temporary mood swing in the direction of euphoria.
  - that chemicals provide this positive mood swing every time they are used.
  - to trust the chemical and its effects.
  - to control the degree of the mood swing by regulating the quantity of the chemical intake.
  - substance may "solve" a problem.

Phase 2: Seeking the Mood Swing/Regular Use
- Users apply what was learned in phase 1 to their social, cultural, and life situation:
  - adjust their scheduling and lifestyle to allow for use
  - use the chemical at appropriate times and places
  - develop self-imposed rules about the use of the chemical and adhere to them
- Adult users may suffer physical pain from an occasional overuse of chemical, but little emotional pain.
- Adolescent users may experience more pain due to creation of "double life."
- Social users remain in this phase, continuing to control the times, quantities, and outcome of all chemicals using experience.
- Victims of chemical dependency progress to phase 3.

Phase 3: Harmful Abuse
- The substance abuser increases the risk of becoming a child abuser.
- Periodic loss of control over chemical use occurs. The user can no longer predict the outcome once chemical use begins.
- Episodes result in behavior that violates the user's value system and creates or intensifies emotional pain.
- The user rationalizes the behavior and hides feelings. The loss of insight becomes a growing delusion.
- Because the user's feelings about himself (or herself) remain unidentified and unresolved, he or she experiences growing chronic emotional distress.
• Anticipation and preoccupation with the use of the chemical grows:
  • Lifestyle begins to change and revolve around the chemical.
  • Specific times for chemical use are established and rigidly held.
  • Self-imposed rules developed in phase 2 are regularly broken.
  • Tolerance to the chemical increases causing the victim to develop more ingenious ways to get, use, and keep the chemical.
  • The user begins to project self-hatred onto others.
  • The user's whole life deteriorates as health, spirituality, emotional stability, and interpersonal relationships become adversely affected.
  • First suicidal thoughts occur.

**Phase 4: Dependency Addiction**

• A medical condition involving serious physical and psychological changes.
• Chemicals are needed to feel “normal.” They are used to survive rather than to feel euphoric.
• Blackouts occur more frequently.
• Tolerance built in phase 3 breaks.
• Physical addiction can occur.
• Paranoid-like thinking is present.
• Geographic escapes are made.
• The substance abuser loses the desire to live.
Alcoholism: Addiction and Recovery
Checking for Substance Abuse

Look for signs of substance abuse. They may be in the person's personal appearance or in something you see around the home.

Look for each of the following and make notes about anything you see that is unusual. In some cases, it may be important to observe the individual and family over time, to look for changes from what is usual for them.

**Money**
- Sources of income
- Current expenditures
- Debt

**Mood/Feelings**
- Inconsistent with the situation
- Confusion
- Helplessness
- Frustration
- Paranoia
- Suspiciousness
- Manipulation
- Resistance
- Isolation

**Children**
- Not well fed, inappropriately clothed
- Pattern of school absence
- Behavioral problems
- Compliance with any medical needs
- Immunization
- Pattern of parent/child interaction
- What the child says when the parent is not around

**Clues in the Home**
- Absent/spoiled food
- No electricity, water, or phone (where they should be affordable)
- Absent appliances (possibly pawned)
- Diminished responsibility

**Communications**
- Level of eye contact (be conscious of culture)
- Expression is difficult and awkward
- Mismatch between what the person says and does
- Defensiveness, evasiveness, or argumentativeness (especially in recovery)
- Rationalizations
**Substance Dependent Newborn Indicators**

- Irritability
- Tremors or jitteriness
- Prolonged or high pitched crying
- Increased or decreased muscle tone
- Alternating periods of lethargy and irritability
- Frantic sucking of hands
- Uncoordinated sucking
- Seizures
- Fever
- Sweating
- Diarrhea
- Excessive vomiting
- Unusual or rapid eye movements
- Disturbances in sleep patterns
- Premature birth and associated complications
- Low birth weight
- Failure to thrive
- Fetal Alcohol Syndrome
- Fetal Alcohol effects
Identifying the Stages of Substance Abuse

For each scenario, identify the substance abuse stage being depicted and the indicators that support your choice.

**Susan Jackson** has been given medication to help her sleep in the past week but has been unable to sleep for the last 3 nights. When questioned, Ms. Jackson reveals that she has consumed alcohol heavily for several years.

Stage:
Indicators:

**Carolyn Bond** is a 16-year-old child in foster care. She was an honor roll student last semester. Since she has started to hang out with a different crowd, her grades have dropped significantly. Last weekend the foster mother found a marijuana cigarette in her book bag.

Stage:
Indicators:

**Jim Nesbitt** has been using cocaine for the last 3 years. At first he snorted it infrequently with his friends at work parties. Now he craves its effects and recently solicited the name of a drug dealer. His increased use has led to arguments with his wife. After making his first crack purchase, the mortgage check bounced.

Stage:
Indicators:

**Cheryl Jones** is a single parent being investigated for lack of supervision when she left her 18-month-old at home alone asleep in his crib. She explained that she had only been gone for a short while and never left him at night more than 1 hour. She explained that he never wakes up once asleep. She stated that she had only been able to purchase a six-pack the day before because she had not cashed her check. So she had gone back to the liquor store to get a 12-pack while they were on sale. She said she was depressed because she lost her job today after being late on three occasions. She said she was having a hard time getting moving in the mornings.

Stage:
Indicators:

**The Marshalls** have begun the process of adopting a child. In conducting the home study, you ask the family about history of substance use. Both parents state they drink a glass of wine with their dinner most evenings.

Stage:
Indicators:
**Signs and Symptoms of Child and Adolescent Substance Abuse**

**Family**
- Changing attitudes toward rules and regulations
- Estrangement from the family
- Lack of participation in family activities
- Isolation, staying in room much of the time while at home or staying out more
- Breaking curfew, sneaking out at night
- Stealing items from the home: money, pills, alcohol, etc.
- Lying, blaming others for troubles
- Arguing with parents, siblings
- Burning incense

**Friends/Social Life**
- Change in quality of peer relationships
- Change in friends and social activities
- Loss of friends
- Child’s peers uncomfortable in your home
- Parents have little or no information about friends, do not know them
- Phone conversations become extremely private, seem strange, occur at odd hours
- Drug-oriented interests (e.g., graffiti on notebooks, drug messages in yearbook)
- Secretiveness, vagueness about social activities
- Lies about whereabouts
- Has new possessions, gives or receives gifts
- Language changes

**Legal**
- Thefts, assaults, arrests, DUI’s
- Speeding, reckless driving, auto accidents
School
- Makes lower grades
- Skips classes or entire days
- Changes classes, drops academic classes
- Sleeps in class
- Arrives late
- Shows disrespect of teachers
- Gets suspended, expelled
- Loses motivation, loses self-discipline
- Drops out of activities, clubs, sports
- Shows no interest in and does not attend school functions

Personal Health
- Subtle change in personality
- Mood swings, hostile, irritable, self-righteous
- Impairment of judgment and/or capacity to reason or think clearly
- Depression
- Feelings of loneliness
- Weight loss or gain
- Dilated pupils, red eyes, uses eye drops or sunglasses
- Erratic sleeping, sleep disturbances, has trouble getting up in the morning, hard to arouse
- Erratic eating habits
- Deep, persistent cough
- Smoking
- Blackouts, short-term memory loss, forgetful
- Hangovers, flashbacks
- Sloppy in dress, appearance; changes style of dress
- Frequent colds, impaired ability to fight infections
- Paranoia
Behavioral Indicators of Substance Abuse

Child Indicators

- Assumes roles within the family as a means of survival
  - **Enabler**: covers up for the abusing parent
  - **Hero**: overachiever, does well in school, tries to make family proud due to feelings of inadequacy
  - **Scapegoat**: gets into trouble to take the focus off the parent
  - **Lost child**: withdrawn, quiet, neglected, not noticed
  - **Mascot**: class clown, social butterfly, provides humor for the family
- Not well fed
- Inappropriately clothed
- Poor hygiene
- Poor school attendance
- Behavioral problems
- Medical needs unattended
- No immunizations
- Poor or non-existent pattern of parent/child interaction
- Seeks immediate attention from counselor
- Inappropriate knowledge of drugs
- Parentified behavior; mimics adult behavior
- Play patterns are not age-appropriate
- Loss of interest in food

Caregiver Indicators

- Poor judgment (inaction, impulsive actions, reduced options)
- Poor self-esteem
- History of childhood abuse
- Attendance at work is erratic
- Poor self-care or hygiene
- Bills not paid
- Deterioration in functioning
- Neglected or unclean house
Personal Appearance
- Body odor
- Cuts and bruises
- Abscesses
- Nasal problems
- Dental decay
- Gum problems
- Skin pallor, dusksiness
- Burned fingers, hands, clothes
- Tardive Dyskinesia (uncontrollable movements, licking of lips, chewing mouth)
- Change in appearance
- Blood spatters

Paraphernalia
- Crushed cans with holes
- Aluminum foil
- Lighters and propane torches
- Razor blades and mirrors
- Straws
- Rolling papers/roach clips
- Needles
- Drug pipes and “bongs”
- Small vials and baggies
- Loose tobacco in ashtray
- Baking soda boxes (to make crack)

Behaviors
- Preference for dark surroundings, wearing sunglasses
- Strange odor
- Reversed clothing
- Abnormal visitor patterns
- Unattended medical problem
- Lack of prenatal care
- Unreasonable fears
- Slurred speech
- Over-compliance
- Criminal activity: DUI, prostitution, drug charges, shoplifting, forgery, larceny, robbery, breaking and entering, burglary, probation/parole violations, assault, child abuse/neglect
Substance Abuse Statistics

- Most studies find that between one-third and two-thirds of children involved with the child welfare system, parental substance abuse is a contributing factor. [http://www.aspe.hhs.gov/hsp/subabuse99/chap4.htm](http://www.aspe.hhs.gov/hsp/subabuse99/chap4.htm)
- Neglect is the major reason that children are removed from a home in which adults have drug or alcohol problems. [http://www.aspe.hhs.gov/hsp/subabuse99/chap4.htm](http://www.aspe.hhs.gov/hsp/subabuse99/chap4.htm)
- Histories of parents abusing alcohol or drugs reveal that typically both parents were raised with a lack of parental nurturing and often grew up in disruptive homes. [www.childabuse.com](http://www.childabuse.com)
- Research has shown that when alcohol and/or drugs are a problem and the children are being abused or neglected, both of these problems must be treated simultaneously in order to ensure a child’s safety. [www.childabuse.com](http://www.childabuse.com)
- Ending drug treatment does not guarantee safety of the child, very little can be done to improve parenting skills until the drug and/or alcohol abuse is treated. [www.childabuse.com](http://www.childabuse.com)
- Many adolescents are at risk for abusing substances, either by parental example or by behavior they have already developed. [www.health.org/nacoa](http://www.health.org/nacoa)
- Children of alcoholics (COAs) are four times more likely than non-COAs to develop alcoholism [www.health.org/nacoa](http://www.health.org/nacoa).
- Early adolescence (age 11-15 years or 6th-10th grades) is the period when people are most likely to try smoking for the first time. US Department of Health and Human Services, Center for Disease Control and Prevention, 2000. 30% of tobacco experiments became established for smokers [www.ama-assn.org](http://www.ama-assn.org).
- Three out of four juvenile offenders in delinquency treatment admit to problems with alcohol or drug use. [www.djj.state.fl.us/statsnreasearch/keytrends.html](http://www.djj.state.fl.us/statsnreasearch/keytrends.html).
Categories of Risk Factors

Factors that Put an Individual at Risk for Becoming a Substance Abuser

Community and School Factors
- economic and social deprivation
- crowded living conditions
- low neighborhood attachment
- unconcerned neighbors
- community norms that facilitate drug use/abuse
- availability of tobacco, alcohol, or drugs
- high level of crime and delinquency
- lack of clear, enforced policies
- school transitions
- academic failure
- lack of student involvement
- little commitment to the schools

Family Factors
- lack of monitoring or supervision
- lack of caring; abandonment
- inconsistent or severe discipline
- permissive parental attitudes toward alcohol or other drug abuse
- low or unclear expectations for children’s success
- history of alcohol or other drug abuse
- poor role modeling

Individual and Peer Factors (Psychosocial Factors)
- alienation and rebelliousness
- antisocial behavior
- insensitivity to punishment
- easy and frequent lying
- favorable attitudes toward drug use
- susceptibility to peer influence
- friends who use tobacco, alcohol, or drugs
- need for immediate gratification

NOTE: Not every child growing up with one or more risk factors will abuse substances, but these factors may increase the likelihood of abuse.
Mental Health Disorders

- Some common serious mental disorders associated with chronic drug abuse:
  - Schizophrenia
  - Bipolar disorder
  - Manic depression
  - Attention deficit hyperactivity disorder (ADHD)
  - Generalized anxiety disorder
  - Obsessive-compulsive disorder
  - Post-traumatic stress disorder
  - Panic disorder
  - Antisocial personality disorder

Disorders With Increased Risk of Drug Abuse

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antisocial personality disorder</td>
<td>15.5%</td>
</tr>
<tr>
<td>Manic Episode</td>
<td>14.5%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>10.1%</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>4.3%</td>
</tr>
<tr>
<td>Major depressive episode</td>
<td>4.1%</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder</td>
<td>3.4%</td>
</tr>
</tbody>
</table>

Which occurs first - drug abuse or serious mental illness?

- Some people suffering from serious mental disorders (often undiagnosed) take drugs to alleviate their symptoms.
  - Individuals with schizophrenia sometimes use marijuana to mitigate the negative symptoms, combat auditory hallucinations and paranoid delusions.
- In other cases, mental disorders are caused by drug abuse.
  - Ecstasy produces long-term deficits in serotonin function leading to mental disorders such as depression and anxiety.
- Chronic substance abuse and serious mental disorders may exist completely independently of one another.
- Experts estimate that at least 60% of people battling one of these conditions are battling both.
- When there is a biological or genetic vulnerability to any type of mental health problem, substance use often triggers the onset of that problem. The substance abuse does not cause the mental health problem, but it may cause the condition to manifest.

NOTE: Not every child growing up with one or more risk factors will abuse substances, but these factors may increase the likelihood of abuse.
Module 7: Neglect

Behavioral & Emotional Indicators of Neglect

Behavioral and emotional indicators of neglected children can alert you to the presence of neglect in a family when there are no clear physical indicators of illness or injury.

- **Developmental delays:** A large percentage of neglected children are developmentally delayed in all domains. The degree of delay is determined by comparing the child's developmental level with expected developmental achievements for the child's chronological age. Neglected children may display from mild to serious delays in physical/motor development, cognitive ability and school achievement, social skill and interpersonal relationships, and emotional development. Severely neglected children may become mentally challenged as a result.

- **Unresponsiveness:** Neglected children are often characterized as unresponsive, placid, apathetic, dull, lacking curiosity and uninterested in their surroundings. They do not approach other people, or exhibit a normal degree of exuberance in their interactions. They may not play, or they may play half-heartedly. In cases of serious neglect, the child may exhibit signs of depression.

- **Hunger/Fatigue:** The child may appear to be hungry or always tired. Some older children who are inadequately fed use their own resources by scrounging for, or stealing, food.

- **Out of Control Behavior:** The child may be "out of control" due to an absence of limits from adult caretakers. They may exhibit a variety of behavior problems, anxiety, and other signs of emotional distress. A false bravado may be seen.

- **School Failure:** School failure may be an indicator of neglect, particularly when combined with an inability to concentrate, falling asleep in class, and a lack of interest in the school environment. School failure by itself cannot be considered the result of neglect, but can support a diagnosis of neglect when other indicators are present.

- **Physical Signs of Stress and Anxiety:** The child may show physical signs of stress and anxiety, including physical illness and regressive behaviors.

- **Aggression:** The child may be aggressive with other children, have temper tantrums, may be "touchy."

- **School age child shows many of the same characteristics as the pre-school child:** Their problems in relationships and their developmental delays are more pronounced the longer they have been maltreated.

- **The child assumes the "adult" role in their relationship with the parent:** The child is often a "little helper", who cares for the parent, demonstrates excessive concern when the parent is distressed, is unusually compliant.

- **Difficulty in Relating:** to other children and to adults. He may be manipulative, or withdrawn and distant. He may have angry, aggressive outbursts and temper tantrums.

- **Symptoms of Chronic Anxiety:** Child may appear to be "hyperactive," including having an unusually short attention span, an inability to concentrate. They often do not do well in school, and may appear to be "preoccupied."

- **Fear of the parents:** The child may demonstrate a fear of the parents or, in some cases, an absence of fear or concern in the face of parental or adult authority.

- **Unnecessary Clothing:** Some children wear unseasonable or unnecessary clothing, in an apparent attempt to hide themselves or their injuries.
Three Families
The Davis Family
The Davis family had been an open case for 3 months. The hotline received a call alleging that the Davis children, ages 2, 6, and 7, were left alone in their apartment for several hours. The reporter stated that Ms. Davis repeatedly leaves the children unattended while she is out partying all night. After the investigation, the children were found to be at risk and services were initiated.

You conduct a family assessment and decide that Ms. Davis, age 22, has a long history of inconsistent childcare. She often provided adequate care for weeks at a time, but then would leave the children for long periods of time, neglecting to meet even basic needs. An aunt confirmed that Ms. Davis has a drinking problem since adolescence and that previously she has left the children with the aunt and disappeared for weeks at a time. You work with Ms. Davis to develop a safety plan; she is to leave the children with friends when she goes out. For several weeks, things seem to be going well. Ms. Davis kept her appointments with you, and the house was always very clean when you visited.

You recently attempt to reach Ms. Davis for an appointment. When you get no response, you become concerned and go to the home. Seven-year-old Leanna answers the door and tells you her mother isn't home. You ask Leanna to bring the other children to the door so you can see that they are OK. Leanna says the baby is sick and has been crying all morning. She also says there is no food and they are hungry. You assess the situation to be an emergency and phone for police support to enable you to enter the home.

When you and the officer enter the home, you find the house in complete disarray. Half-empty beer cans and dirty plates with rotting food litter the living room. The temperature in the house is about 50 degrees and the 2 year-old was feverish and cranky. Leanna takes you to the kitchen where you watch her pull a chair to the stove and begin to light the gas burners. The top of the stove was littered with burnt matches. You take the children to their bedroom where you witness even more disarray. The bed sheets are soaked with urine and there are dried feces on the floor. You find dry and warm clothes for the children and call the agency to request PI involvement and an emergency shelter placement for the children. As you are waiting for a call back, Ms. Davis walks in disheveled, smelling strongly of alcohol. She is initially belligerent and angry and yells at you for entering her home when she wasn't there. When she sees the police officer, she begins to cry and apologize. She says that she only left the children for a few minutes to run to the store, but then her car broke down and she was stranded. You firmly explain that her story did not explain why she had left her children alone for 17 hours. You then ask for a relative or non-relative who can care for the children temporarily rather than place them in shelter care.
The Mitchell Family:

The hotline receives a call alleging the following: Damian, age 9, came to school 2 days in a row complaining of a sore tooth. On the first day, Mrs. Mitchell was called about Damian. She told the school that Damian was fine and that he was just looking for an excuse to leave school. On the second day, a Friday, when the school called, Mrs. Mitchell went to the school to pick up Damian, and said she was taking him to the dentist. Damian returned to school the following Monday and stated that his tooth still hurt and that his mother had not taken him to the dentist. Damian stated that his tooth didn't bother him much over the weekend because his mother gave him Nyquil three times a day so he would sleep. He said his mother had given him Tylenol that morning but it wasn't helping. The school nurse noted that there was some swelling around Damian's jaw and he was running a slight fever of 100 degrees. Damian also said that he was very hungry and the only thing he had had to eat all weekend was a pizza his dad brought Saturday night.

You go to see Mrs. Mitchell that afternoon. It takes several minutes for her to come to the door. Her appearance is very disheveled and she had obviously been crying. Mrs. Mitchell is irate and only reluctantly lets you into the apartment. The apartment is in complete disarray. There is a stench of rotting garbage, which Mrs. Mitchell attributes to Damian not taking out the trash the way he's supposed to. When you inquire about Damian, Mrs. Mitchell replies that he is sleeping. You tell her he still needs to be seen and interviewed before leaving. When asked if she had given Damian Nyquil, Mrs. Mitchell replied, “It helps him sleep and keeps his tooth from hurting. Besides, I can’t afford to take him to the dentist, so what else can I do to shut him up?”

The refrigerator contained very little food. The cupboards were almost completely bare with only some plastic utensils and six boxes of macaroni and cheese. Mrs. Mitchell said that her husband brings food on the weekends when he comes home from his job 4 hours away. She commented, “That is if he hasn’t spent his money on beer before he gets home.” She said she was planning on pawning her stereo to buy food this week because all her husband had brought over the weekend was a pizza and the boxes of macaroni and cheese.

Physical Indicators:

Environmental Indicators:

Child's behavioral Indicators:

Caregiver's Behavioral indicators:
The Marquez Family

A call came into the hotline from a woman stating Jorge and Alicia were neglecting their 8-month-old daughter, Lucia. The caller contended that the Marquez parents went on vacation leaving Lucia with Jorge’s older daughter, Jasmine. According to the reports, Jasmine is 16 and not mature enough to care for an 8-month-old for such a long period of time. She also added that the 16 year old told several people that Lucia was out of formula on the third day after the Marquez parents left town.

On the first visit to the Marquez’s home, you find Lucia and Jasmine home alone. Lucia seems very content, though she did have quite a bit of crust around her nose from a cold. She was also not dressed warmly enough for the weather, although the house was very warm. Lucia was obviously attached to Jasmine and Jasmine was very affectionate with Lucia. The parents were not home, but you did find out that the week of vacation turned out to be 5 days and the neighbor was aware of the situation and available to assist Jasmine if needed.

On the second visit, you find Alicia and Jasmine home with Lucia. Lucia appeared rather dirty with food all over her face and hands. Her hands and lower legs were quite dirty and you conclude that it was because the kitchen floor was particularly dirty. Jasmine interacted quite a bit with Lucia who seemed to enjoy the game of “peek-a-boo” Jasmine was playing with her. Alicia tried to pick Lucia up, and Lucia began to cry. Jasmine took Lucia, and she immediately quieted down. Alicia shrugged and said, “She loves her big sister I guess.”

The house was somewhat untidy and there were stacks of newspapers all over the living room. You also observe roaches crawling all over the newspapers. Jasmine nervously apologized for the messy house and said that she told her dad she was planning on cleaning up as soon as Lucia went down for a nap.

Physical Indicators:

Environmental Indicators:

Child’s behavioral Indicators:

Caregiver’s Behavioral indicators:
Neglect Indicators Checklist

Lack of Supervision

Physical Indicators
- dirty clothes
- poor hygiene
- burns from cooking for themselves

Environmental Indicators
- locks on the outside of interior doors
- dirty house
- unsafe conditions, hazardous house
- not enough food in the house
- TV on and doors open
- neighborhood kids “hang out”
- no answer at door, but there is evidence someone is home
- small child spends excessive amounts of time in crib or playpen
- children are left alone and are responsible for activities not consistent with age

Child’s Behavioral Indicators
- exhibits anger
- seems fearful
- either overeats or is hungry
- relate different stories about who is watching them
- looks at parent before answering question
- does not attend school regularly
- easily distracted and seems nervous
- experiences delays in speech or motor development
- excessively shy or, conversely, excessively demanding of attention

Caregiver Behavioral Indicators
- seems apathetic
- gives conflicting stories about whereabouts of children
- makes statements like “she can take care of herself”
- seems unconcerned about appearance of house or children
- shows immaturity and bad judgment
- lacks planning and organizational skills
- offers excuses to minimize the situation (e.g. “I was only gone 5 minutes.” or “This is the first time this has happened.”)
Environmental Neglect

Physical Indicators
- chemical burns or heat burns
- inappropriate dress
- low weight/height
- skin diseases/head lice/scabies
- anemia
- sunken/hollow eyes
- excessively dirty; foul body odor
- poor quality food dominates the diet
- residue of fecal material in genital area or underwear of child
- severe diaper rash
- runny noses that have become excessively crusty
- untreated scrapes or infections

Environmental Indicators
- broken glass or missing doors
- chipping paint that may contain lead
- missing windows/screens a child could fall out of
- abandoned appliances in which a child could be trapped
- exposed garbage
- child has no place to sleep or bed is unacceptably unclean
- lack of heat (in central and north Florida)
- rotten, moldy, or insect infested food
- human or animal feces which threaten the health of the child
- alcohol/harmful substances accessible to the child
- stagnant water in the sink, shower or bath indicating unsanitary plumbing conditions
- rodent or insect infestation
- lack of access to clean water

Child’s Behavioral Indicators
- delinquency/stealing
- unwillingness to bring peers home
- delays in speech or presence of speech impediment
- begging or stealing food
- delays in motor development
- excessively shy or excessively demanding of attention
- withdrawn/angry
Caregiver behavioral Indicators (environmental neglect continued)

- depression/apathy
- immaturity and bad judgment
- lack of planning and organizational skills
- no concern about appearance of house or children
- alcohol or substance abuse
- has a sense of being overwhelmed
- feeling of isolation, helplessness

Lack of Health Care: Medical Neglect

Physical Indicators

- has a medical condition (verified by a qualified health professional) which needs attention
- condition has worsened from lack of health care, or qualified health professional states condition will worsen without care
- is developmentally delayed
- has rotten teeth
- has open sores, infection

Environmental Indicators

- no medical records available
- little food in the refrigerator
- lack of prescribed home health equipment
- unfilled prescriptions (though there are resources to do so)
- no preventative care (immunizations, checkups)
- standards of cleanliness not followed
- no wheelchair ramp for wheelchair-bound child

Child’s Behavioral Indicators

- excessive crying
- listlessness
- no smiles or animation
- statements of pain or lack of care
- symptoms of illness or disability requiring medical care

Caregiver Behavioral Indicators

- doesn’t make or keep doctor appointments
- unable to demonstrate proper use of medical equipment
- doesn’t properly use or maintain prescribed medications
- ignores symptoms of serious medical problems
- lacks concern for the physical well-being of the child
does not take child to a health care professional despite symptoms of health problem

**Degrees of Neglect**

1. The children in the home do not have any medical condition that could benefit from medical treatment; however, none of the children have seen a dentist in three years.

2. The children have so few clothes that they are prevented from doing necessary activities (school, playing outdoors).

3. The children do not wash or bathe regularly. Hair is visibly dirty, and children may wear the same dirty clothes for 3 days.

4. All essential appliances are in working order; however, the furniture is in need of repairs. Quantity of house ware items such as linens and dishware is insufficient for the family’s size.

5. Trash and junk piled up in all living areas - especially in the four-year-old’s bedroom. Home smells of rotting food/urine/feces.

6. There are many hazardous conditions in the home (peeling lead paint, broken windows, cleaning substances within reach of children); however, the children, ages 5 and 8, have not sustained injuries as a result of the hazardous conditions.

7. Two-year-old child was found wandering in the neighborhood on more than one occasion. At the time of the visit, the caregiver does not know whereabouts of the child.

8. The family has been without heat or electricity for several days, and they have no resources to turn the utilities back on.

9. The home is untidy, dusty, the carpet smells of mildew. A few roaches are seen in the kitchen area, and the sink is full of dirty dishes.
The Gavin Family

- Read the Gavin Scenario and list at least four indicators that suggest the presence of chronic neglect in this family.

Gavin Scenario

The Gavin family is not new to the agency. On this occasion a call was received alleging that the children were begging for food.

The Gavin family home is unkempt and dirty. The sagging couch was piled high with mixed loads of dirty and clean unfolded laundry.

The front window has a large piece of cardboard covering the broken out pane. The greasy kitchen table holds remnants of food: an open loaf of bread, soggy cereal in bowls, and an opened can of potted meat that looks rancid.

Ms. Gavin is a divorced woman in her mid-thirties and the mother of seven children.

She is obese, weighing close to three hundred pounds, and by her own admission she seldom leaves the sofa.

From her position on the couch, she talks on the telephone (mostly fending off bill collectors) and yells at the children when they cross her path.

Ms. Gavin was the first-born child of a 16 year old mother who eventually had four children. At about the age of 5, Ms. Gavin was placed in care after having been given up by her mother.

She stayed institutionalized until the age of 10 when she was placed in a number of successive foster care homes.

At the age of 16, she returned home to her mother for one year until she became pregnant with her oldest daughter, Joy, and moved out on her own.

Joy is currently being raised by Ms. Gavin’s mother and Ms. Gavin has had no contact with either Joy or her mother in over two years.

At the age of 18, Ms. Gavin began working in a poultry processing plant where she met “John” whom she had a relationship with for 12 years but never married because “he had a wife someplace else.”

John is the father of the other six children, but seldom comes around anymore according to Ms. Gavin.

Ms. Gavin expects the 11 year old daughter, Jennie, to take care of all the other children.

Jennie is older and larger than any of the other fourth graders in her school and is frequently absent.
Her mother allows this and expects Jennie to cook and clean when Ms. Gavin is not present. Lately, Jennie has been leaving the house pretending to go to school and has been found wandering the city on two occasions.

The 7 year old, Jimmy, also often stays home from school, but Ms. Gavin says she does not mind because he is her “little man around the house.” However, she also says that she is concerned because he is failing in school and has no friends.

Both Jennie and Jimmy have a speech impairment that makes it difficult to understand them and for which they are receiving special services at school.

The four preschoolers spend most of their day watching TV and squabbling. They seldom go outside. The children all bear the scars of a woman who cannot communicate joy, interest, or love. Yet she clings to them tightly and says “they are my whole life.”
Chronic vs. Situational Neglect

Crisis/Situational

Parents fundamentally able to cope but temporarily overwhelmed
- Major crisis, or series of crises
- History of adequate child care
- Regular employment
- Sufficient income and skills
- Emotional support from friends and relatives
- Average problem-solving abilities
- Generally good physical health, minimal use of illegal substances, & essentially no illegal activity
- Adequate education and housing that allow for individual space and organization of belongings
- Intimacy is non-sexualized
- Acceptance of differences in opinion
- Understanding and acceptance of their respective roles
- Generally good mental health
- Likely to be cooperative with genuinely supportive child protection personnel
- Likely to regain ability to solve problems themselves when crisis has passed

Chronic

Parents with continual and serious child-rearing difficulties
- Constantly in stressful situation or crisis
- Little parenting knowledge
- Limited education/vocational opportunities and skills
- Poverty
- Extreme social isolation
- Little support from relatives or friends
- Poor problem-solving skills; blame others
- Ill health, substance abuse, drug dealing, legal problems, handicap
- Overcrowded or run-down housing
- Prostitution, abuse between adults
- Chronic mental illness
- Parental history involves neglect as a child
- Distrustful of professional helpers
- New crises constantly arise even as old crises are resolved
# Common Effects of Child Neglect

## Infants
The effects of neglect in infancy are likely to result in failure to thrive which can lead to death of the child. Other effects:
- lack of attachment to mother
- impaired brain, motor, and physical development
- malnutrition, significant health problems
- development of anxious, insecure attachments in other relationships
- insecurity limits ability to explore environment
- development of feelings of incompetence

## Toddlers
- extremely withdrawn and passive
- engage in random, undisciplined activity
- impaired brain, motor, and physical development
- deficits in coping skills - displays frustration, anger, and noncompliance
- attention/affection need sought indiscriminately from other adults
- malnutrition, significant health problems

## Kindergarten/School-aged Children
- lack of attachment
- significant health problems
- delayed or impaired speech
- developmental delays
- violent acts
- severely withdrawn
- inability to concentrate
- serious learning deficits and delays
- low self-esteem
- curiosity blunted, almost nonexistent

## Adolescents
- low self-esteem
- poor school attendance
- work and learn below average levels
- high risk for delinquent behavior
- high risk for “ungovernable” behavior (e.g., truancy, running away, substance use/abuse)
Module 8: Domestic Violence

Domestic Violence Myths & Facts

- Determine if each statement is a MYTH or a FACT.
- Write M (myth) of F (fact) in the blank.
  1. Men of all socioeconomic classes and races abuse women.
  2. The level of violence in battering escalates over time.
  3. Batterers are out of control.
  4. Alcohol or drug abuse causes battering.
  5. Men who batter cannot cope with stress or express anger properly.
  6. Battered women are codependent.
  7. Battered women often try to placate, accommodate and please their abusers
  8. Historically, battered women have been misdiagnosed as mentally unbalanced or unstable.
  9. Battered women often do not volunteer information about the abuse.
 10. Women assaulted by their husbands usually confide in a friend or law enforcement officer about the abuse.
 11. Battering is a relationship problem best dealt with in couples counseling.
 12. Violence against women is consistent across all racial and ethnic groups
 13. Most families involved in child fatalities are two-person caretaker situations where a majority of the perpetrators are the mothers.
 14. Many children exposed to adult domestic violence also exhibit behavioral, emotional, and cognitive problems.
 15. Exposure to violence in the home does not impact a child's use of violence in the community.
 16. Battered mothers are twice as likely to maltreat their children as mother's who are not battered.
What is Domestic Violence?
Domestic violence is “a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners.” (Ganley & Schechter, 1995)

Domestic Violence Defined:

s. 741.28, F. S.: any assault, battery, or criminal offense resulting in physical injury or death of one family or household member by another who is or was residing in the residence.

Family or Household Member Defined:

s. 741.28, F.S. spouses, former spouses, persons related by blood or marriage, persons who are presently residing together as if a family or who have resided together in the past as if a family, and persons who are parents of a child in common regardless if they have been married. With the exception of persons who have a child in common, the family or household members must be currently residing or have in the past resided together in the same single dwelling unit.

Statistics (compiled by American Academy of Pediatrics):

Note: The majority of injuries in this study were to the head, face, and eyes. Child abuse and wife abuse are linked (1995 Harvard School of Public Health, Injury Control Center):

• Studies indicate that 30% to 59% of mothers of children reported for child abuse also are battered.
• In homes where domestic violence occurs, the children are at increased risk of physical abuse or neglect.
• From 3.3 to 10 million children are estimated to witness parental violence annually.
• Studies indicate that 40-60% of child abuse victims have witnessed the abuse of their mothers.
• Witnessing the battering of their mothers may be as traumatic to children as being a direct victim of abuse; both result in similar psychosocial and developmental effects.
• The demonstrated co-existence of spouse and child abuse, including the impact of children witnessing domestic violence, prompts a strong argument for an interdisciplinary approach to the victims of domestic violence by professionals.
• Children who witness domestic violence often continue the cycle of abuse as they become adults.
• Children who live in violent households are at risk for physical injury while witnessing the family violence (1996 study, Children’s Hospital of Philadelphia, University of Pennsylvania School of Medicine).
• Children may become injured while being held by parents and/or during attempts to intervene in fights.
## Types of Domestic Violence and Associated Behaviors

<table>
<thead>
<tr>
<th>Physical Assaults</th>
<th>Sexual Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Hitting/punching/slapping</td>
<td>- Pressured sex or coerced sex</td>
</tr>
<tr>
<td>- Kicking</td>
<td>- Forced sex/marital rape</td>
</tr>
<tr>
<td>- Biting</td>
<td>- Physical attacks on the victim’s genitals or breasts</td>
</tr>
<tr>
<td>- Assaults with weapons</td>
<td>- Withholding sex</td>
</tr>
<tr>
<td>- Choking</td>
<td>- Insisting on sex immediately after beating</td>
</tr>
<tr>
<td>- Throwing things at victim</td>
<td>- Threatening violence if victim does not consent to sex</td>
</tr>
<tr>
<td>- Shoving against the wall</td>
<td>- Exploitation</td>
</tr>
<tr>
<td>- Throwing victim downstairs</td>
<td>- Sodomy</td>
</tr>
<tr>
<td>- Head banging</td>
<td>- Forced sex with others</td>
</tr>
<tr>
<td>- Shooting</td>
<td>- Having the children watch</td>
</tr>
<tr>
<td>- Burning on stove, or with kerosene, acid, or cigarettes</td>
<td>- Sexual mutilation</td>
</tr>
<tr>
<td>- Mutilation</td>
<td>- Forcing victim to perform scenes from pornographic material</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emotional/Psychological Assaults</th>
<th>Economic Coercion</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Threatening violence against the victim, others, or self</td>
<td>- Withholding information about finances</td>
</tr>
<tr>
<td>- Acts of violence against self or people other than victim</td>
<td>- Lying about finances</td>
</tr>
<tr>
<td>- Attacks against property/pets</td>
<td>- Withholding money for basic necessities from victim</td>
</tr>
<tr>
<td>- Stalking</td>
<td><strong>Use of children to control victim</strong></td>
</tr>
<tr>
<td>- Other intimidating acts</td>
<td>- Using the children to spy on the victim</td>
</tr>
<tr>
<td>- Emotional abuse, humiliation, degradation</td>
<td>- Forcing the children to assault the victim</td>
</tr>
<tr>
<td>- Isolating the victim</td>
<td>- Making children watch the degradation/abuse of the victim</td>
</tr>
<tr>
<td>- Threatening to kill the victim, children or others</td>
<td>- Using the children as pawns</td>
</tr>
<tr>
<td>- Name Calling</td>
<td>- Physically assaulting or threatening to assault children in order to control the victim.</td>
</tr>
<tr>
<td>- Accusing the victim of having sex with other partners</td>
<td><strong>Adapted from Families in the Crossfire (Tallahassee, FL; Florida Dept. of Health and Rehabilitative Services, 1994 training packet) and Domestic Violence, A National Curriculum for Child Protective Services by Anne Ganley and Susan Schechter (San Francisco: Family Violence Prevention, 1995)</strong></td>
</tr>
<tr>
<td>- Constantly monitoring the victim's activities</td>
<td></td>
</tr>
<tr>
<td>- Damaging prized possessions</td>
<td></td>
</tr>
</tbody>
</table>
Indicators of Domestic Violence

When conducting assessments and interacting with families, disclosure of any of the following behaviors could indicate that domestic violence is occurring:

- “Accidents” have occurred during pregnancy.
- Victim
  - offers inconsistent explanations for observed bruises, fractures, or multiple injuries in various stages of healing;
  - substantially delays seeking needed medical treatment for herself;
  - has a history of repeated accidents and emergency room visits, often at different hospitals;
  - admits to being sad, lethargic, depressed and admits having suicidal thoughts;
  - reports psychosomatic and emotional complaints: chest pain, choking sensation, hyperventilation, sleep or eating disorders;
  - is embarrassed and/or evasive when questioned about injury or abuse;
  - exhibits anxiety and fear in the presence of her partner;
  - often apologizes for her partner’s behavior.
- Alleged batterer
  - speaks for victim during an interview and strongly resents having her interviewed separately;
  - describes victim as “clumsy,” “crazy,” “incompetent,” “stupid,” etc.;
  - is overly solicitous of and condescending to victim;
  - admits to violence but minimizes frequency and severity. Blames partner for provoking violence and/or refuses to accept responsibility for it;
  - holds rigidly to traditional sex roles, expecting or demanding that the victim serve him;
  - exhibits a “Dr. Jekyll & Mr. Hyde” personality;
  - exhibits extreme jealousy.

Adapted from Depanfilis and Brooks, Child Maltreatment and Woman Abuse (1989), and Holder
Domestic Violence and Childhood Trauma
The connection between trauma in childhood and domestic violence later in life is presented in the video Domestic Violence and Childhood Trauma.
As you view the video focus on the three Stories by Brenda, Tammy, and Jamie and answer the questions:

Brenda

? What were some of the initial feelings of Brenda and her family when they found out about Brenda's sister getting shot by her husband?
   Brenda:
   Brenda's husband:
   Brenda's second sister:

? What realization about domestic violence do you think Brenda had after her second sister made the comment she did.

Tammy

? What did Tammy do that is often common in an abused victim's choice of partners who has not received counseling?

? Why do you think nobody knew about Tammy's second abusive relationship?

Jamie

? What were Jamie's thoughts about her abusive relationship?

? Why did Jamie continuously leave and go back to her abusive relationship?

Childhood Trauma
How is the child effected when exposed to rage, anger, and domestic violence?

? How do you think a child who is exposed to Domestic Violence is affected as an adult?
Domestic Violence Risk/Danger Assessment

If an intake is accepted containing DV allegations a Risk/Danger Assessment must be completed to assist in assessing the immediate and ongoing risk of danger to the child and adult.

- The purpose of performing a domestic violence risk/danger assessment with the family is to gather critical information regarding the:
  - nature and extent of the domestic violence;
  - impact of the domestic violence on adult and child victims;
  - risk to and the protective factors of the alleged victim and children;
  - help-seeking and survival strategies of the alleged victim;
  - alleged perpetrators level of dangerousness;
  - safety and service needs of the family members;
  - availability of practical community resources and services
- Risk/Danger Assessments must be included and updated throughout the case at every phase of the child protection process.

The greatest risk to the victim and child's safety is usually at the time of intervention or separation from the abuser.

The following practice recommendations will assist during the assessment with the alleged victim, the child and the perpetrator:

**Adult Victim**

- Interview the alleged victim alone;
- Develop trust by creating a climate of safety;
- Provide safe alternatives and access to domestic violence resources;
- Avoid “victim-blaming” questions or statements.
  - “What did you do to make your partner so mad?”
  - “Why don't you just leave?”
- Conduct the assessment with sensitivity and in a non-threatening manner.
- Suggested questions to begin the assessment include:
  - Could you tell me about your relationship with your partner?
  - All couples argue. How do you and your partner argue?
  - Has there been a time when you felt afraid of your partner? If so, can you tell me what happened?
**Child**
- Create a safe, supportive age-appropriate atmosphere;
- Validate the child’s feelings;
- Promote safe and healthy coping skills and responses to domestic violence
- Begin direct inquiry regarding domestic violence with a general statement:
  - Sometimes when moms and dads fight, they get angry. Sometimes too angry, and they may yell or even hit each other. I know fights can be scary. I want to ask you a few questions about when your parents fight. Would that be o.k.?

**Alleged Perpetrator**
- Plan for personal safety
- Perpetrators routinely deny, minimize, or blame the victim for their violent behaviors, so use third party reports
  - police/criminal records
  - civil protection records
  - hospital records
- Obtain information about the alleged abuser’s behaviors and the degree to which he or she accepts responsibility.
- Engage the alleged abuser in an assessment that is respectful and structured.
  - In a low key tone, “I need to speak with you about your family; everybody gets a chance to talk about what’s going on.”
Plans for Safety: While the Batterer is still in the Home

- The Adult Victim Should:
  - Try to hide or remove all guns and ammunition from the home.
  - Consider going to a predetermined, safe place outside the home if battering seems imminent.

- If victim cannot leave, she should:
  - Avoid areas where weapons might be available (as much as possible).
    - kitchen, bathrooms, or rooms where sharp objects or other dangerous items are found (chemicals, fire, hot water)
  - Show children how to call the police when the battering starts.
  - Make plans with friends and neighbors nearby - if they hear fighting they should call the police.
  - Work out a signal so that neighbors will know that she needs the police
    - code words, lights flashed, curtains raised, etc.
  - Keep a phone in a safe area so that he cannot break or cut the lines.
    - obtain a cellular if possible

- Victim should keep a diary that lists the following:
  - All incidents of violence, including dates, times, and descriptions of the incidents
  - Threats made before, during, and after the incident
  - Injuries
  - If the police were involved, a record of the name and badge number of the officers, their response, and the report or case number
  - Any medical treatment - a record of the name of the doctor or hospital, the treatment received, and whether or not photographs were taken

- Victim should keep copies of all medical and police reports and copies of any photographs which were taken. This information must be kept in a safe place where the batterer will not have access to it.
  - Open her own bank account at a bank that the batterer does not use.
  - Have a plan that outlines where she will go if she has to leave the home suddenly.
  - This plan should include the number for the local shelter or domestic violence hotline, as well as a list of other emergency numbers.
Plans for Safety: When the Adult Victim and Children Must Leave

- The adult victim should keep the following with her at all times:
  - Emergency phone numbers (police, domestic violence hotline, shelter, friends)
  - Change to make calls
  - Keys to the car (always park the car in such a way that it cannot be blocked in)
- Keep a bag packed and include the following:
  - A change of clothes for herself and the children
  - Spare keys to the house, car, office, safety deposit box, etc.
  - Medications and spare glasses
  - Jewelry, items of sentimental value, and extra cash
- Keep the bag in a safe place outside the house, where it can be retrieved quickly. If it must be kept in the house, she should keep it in a place that she can get to it quickly.
- The adult victim should keep important documents in a safe place:
  - In a safe deposit box that the batterer does not know about
  - With a person who can store them and from whom she can get them quickly
  - In one easily retrieved file box (if they must be kept in the house)
- Important documents to gather:
  - Identification - birth certificates for the children and herself
  - Social Security cards, driver's license, registration and auto insurance card, welfare, Medicaid, food stamp identification, passports, green cards, and work permits.
  - School and medical records, vaccination records for the children
  - Prescriptions for required medications and glasses; medical reports and documents recording any prior abuse of the children and the adult victim.
  - Legal papers - divorce, custody and restraining orders; police reports of prior abuse; lease/rental agreement/house deed; insurance papers, and wills
  - Financial documents - money, bankbooks, credit, and ATM cards; recent tax returns, pay stubs, statements from banks, brokerage firms and other proof of income and assets
  - Address book and diary of previous abuse

Caution: Joint cards can be reported stolen by the batterer and can be canceled. He can also use receipts from the cards to track her movements.

Adapted from a plan by Marilyn Brown. For nonprofit use only.
Plans for Safety: After Leaving

- If the adult victim has an injunction for protection, she should also keep it with her at all times. In addition, she should keep the number of the agency that enforces the injunction.
- If she stays in the home she shared with the battered, she should:
  - change the locks on all doors, including patio and garage doors
  - have the alarm access codes changed and remove all previous codes
  - have the lock changed on her car if the batterer has keys to it
  - consider installing steel doors, alarm systems, outside lighting and other security features
- The adult victim should inform her neighbors that she has left an abusive relationship and has a protective order (injunction) against the batterer. She should ask them to call the police if they see him near you or your home.
- She should inform her employer and/or coworkers that she has an injunction against the battered. She should ask them to call the police if he is seen near her or her workplace.
- If the batterer harasses her at work with calls, she should arrange to have calls screened and the harassment documented.
- If her employer has security guards, she should ask to be walked to her car when leaving work.
- If she rents or leases her home or apartment and the batterer is named on the lease, ask the landlord to remove his name from the agreement.
- If she has custody of the children and does not want the batterer to pick them up at school, she should inform the school of the situation and specify in writing who is allowed to pick up the children.
- If the batterer has visitation rights with the children, she should arrange for the children to be picked up and dropped off at a location other than her home or have other people present when he picks up and drops the children off.
- If the batterer talks or harasses her, she should inform the police and the court that issued the injunction for protection.
- She should avoid using the same bank, supermarket, dry cleaner, or other services that the batterer uses.
- If she decides to move to escape the harassment or stalking by the batterer, she should remember that it is relatively easy for a detective to locate people unless the person has made major changes and expended great effort to make themselves difficult to find. She should discuss her plans with a local battered women’s program and/or an attorney to insure that the batterer will not be able to easily locate her.

Adapted from a plan by Marilyn Brown. For nonprofit use only.
Slide 1

MALTREATMENTS

Slide 2

Module 1: The Hotline & Child Maltreatment Index

Objectives
- Describe Abuse Hotline procedures & reporting requirements.
- Name & analyze specific elements of an Hotline Intake.
- Identify the uses, benefits, organization and information in Child Maltreatment Index.

Slide 3

Abuse Hotline & Reporting Requirements
- What are the criteria for accepting an intake of child maltreatment?
- What other kinds of intakes are received by the Florida Abuse Hotline?
- Which occupations are required to provide their names when reporting abuse/neglect?
- What are the responsibilities of the Hotline & the Region?
Slide 4

**Abuse Hotline & Reporting Requirements**

- When you are working a case, when is a call to the Hotline required?
- When are you **NOT** required to call the Hotline?
- How do Hotline counselors decide which calls meet the intake acceptance criteria?

---

Slide 5

**Abuse Hotline & Reporting Requirements**

- F.S.39.201(7): Calls & reports of 3 or more unaccepted reports on a single child must be reviewed.
- Unaccepted reports to the hotline by identified relatives must be analyzed by a component of quality assurance program.
- Identifies harassment-type situations; and situations that warrant investigation due to the frequency/variety of calls/reports.

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Slide 6

**Florida Abuse Hotline**

- Receives all incoming intakes/referrals, 24 hours/day, 7 days/week (Phone, TDD, Mail, Email & Fax)
- Seeks all information about alleged maltreatment
- Gathers data regarding subjects of the intake
- Uses Child Maltreatment Index to decide if allegation constitutes maltreatment
Slide 7

Abuse Hotline (continued)

- Determines priority level of investigation
- Notifies regions/units of intakes
- Checks for priors, current intakes & previous service referrals
- Completes criminal background checks on named subjects
- Checks family’s involvement with other DCF programs

Slide 8

Penalties Related to Reporting

- Knowingly or willfully fail to report or prevent another person from reporting - First degree misdemeanor
- Failure to report known or suspected abuse while living in the same household as the victim - Third degree felony
- Any person 18 or older can be charged
- Exception: Domestic violence situation or other mitigating circumstances 39.205(2)

Slide 9

Mandatory Referrals to CPT

- Injuries to the head, bruises to the neck or head, burns, or fractures in a child of any age
- Bruises anywhere on a child five years or under
- Any report alleging sexual abuse
- Reported medical neglect of a child
- Family’s has had one child die as a result of suspected abuse, abandonment, or neglect & sibling or other child remains in their home
- Physically transmitted disease to a prepubescent child
- Child has symptoms of serious emotional problems
**Slide 10**

**F.S. 39.303(1)(a)-(j)**

**CPT Services Include:**

- Medical diagnosis & evaluation services
- Telephone consultations (emergencies & other situations)
- Case staffings, case service coordination & assistance
- Psychological & psychiatric evaluation
- Expert medical, psychological & related professional testimony

**Slide 11**

**CPT Services**

- Training services
- Educational & community awareness
- Family psycho-social interviews
- Specialized clinical interviews
- Forensic interviews

**Slide 12**

**When are face-to-face medicals NOT required?**

A child is examined by another physician or medical professional and the CPT medical director finds that further medical evaluation is unnecessary.

You conduct a safety assessment and find, with your supervisor's approval, that there are no indications of injuries as described in 39.303(2)(a)-(h).

The CPT medical director finds that a medical evaluation is not necessary.
Slide 13

<table>
<thead>
<tr>
<th>Four Most Crucial Steps in the Investigative Process</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1:</strong> Assess the nature &amp; severity of reported injury or harm to a child.</td>
</tr>
<tr>
<td><strong>Step 2:</strong> Assess the substantial likelihood of immediate injury or harm to a child.</td>
</tr>
<tr>
<td><strong>Step 3:</strong> Assess the probability of further harm.</td>
</tr>
<tr>
<td><strong>Step 4:</strong> Determine the finding of child maltreatment based on evidence.</td>
</tr>
</tbody>
</table>

Slide 14

<table>
<thead>
<tr>
<th>Child Maltreatment Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describes and defines specific maltreatments and special condition referrals</td>
</tr>
<tr>
<td>Guidelines for needed evidence &amp; documentation to determine the finding</td>
</tr>
<tr>
<td>Excluding factors to consider when deciding if maltreatment occurred</td>
</tr>
<tr>
<td>Injuries - with no evidence supporting a cause of abuse or neglect must have a finding of “no indicators”</td>
</tr>
</tbody>
</table>

Slide 15

<table>
<thead>
<tr>
<th>Module 2: The Dynamics of Child Maltreatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objectives</strong></td>
</tr>
<tr>
<td>• Identify the contributing dynamics to child maltreatment in families.</td>
</tr>
<tr>
<td>• Describe ways to look further into situations to identify the warning signs of maltreatment.</td>
</tr>
<tr>
<td>• Describe the Decision-Making Model.</td>
</tr>
</tbody>
</table>
Slide 16

Dynamics
What is a dynamic?

List examples of dynamics that may be present in families who might abuse/neglect their children.

Slide 17

Abuse vs. Neglect

2010

<table>
<thead>
<tr>
<th></th>
<th>Abuse</th>
<th>Neglect</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>37</td>
<td>63</td>
</tr>
</tbody>
</table>

Slide 18

Classification of Child Deaths

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Count</th>
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<tbody>
<tr>
<td>Accident</td>
<td>120</td>
<td>79</td>
</tr>
<tr>
<td>Homicide</td>
<td>10</td>
<td>49</td>
</tr>
<tr>
<td>Undetermined</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Natural</td>
<td>31</td>
<td>1</td>
</tr>
<tr>
<td>Suicide</td>
<td>10</td>
<td>0</td>
</tr>
</tbody>
</table>
Slide 19

**Maltreatment Statistics**

Total Percentage of 136 Children

- <1: 37%
- 1-2 y: 17%
- 3-5 y: 3%
- 6-8 y: 5%
- 9-12 y: 4%
- 13-15 y: 1%
- 16-18 y: 0%

Slide 20

**Gender of Child**

- Male: 50
- Female: 50

Slide 21

**Race of Child**

- White: 62
- Black: 39
- Hispanic: 11
- Multi-Racial: 10
- Haitian: 9
- Asian Pacific: 3
- American Indian: 2
- Other: 0

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Core 108_MAL_PG_July 2013 (Core 107 MAL)
PowerPoint Slides
Slide 31

Household Member with DCF Priors

- Stepparent
- Caretaker
- Paramour
- Sibling
- Parent

Total Cases with Priors (n=139)

Slide 32

Preventability

- Undetermined
- Definitely preventable by the system
- Definitely preventable by caretaker and possibly system
- Not preventable
- Definitely preventable by caretaker
- Definitely preventable by system
- Definitely preventable by caretaker and system

Slide 33

Neglect Deaths

Total for 2010
Slide 34

Drowning Deaths Top 5 Counties

- Hillsborough
- Broward
- Orange
- Pinellas
- Miami-Dade

Slide 35

Location of Drowning Deaths

- Pools
- Other bodies of water
- Bathtubs

Slide 36

Risk Factors in Drowning Deaths

- Criminal History
- Substance Abuse History
- DCF Priors
- Domestic Violence History
**Slide 37**

Age of Children in Drowning Deaths

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-12 months</td>
<td>4</td>
</tr>
<tr>
<td>13 to 23 months</td>
<td>10</td>
</tr>
<tr>
<td>2-3 years</td>
<td>5</td>
</tr>
<tr>
<td>4-6 years</td>
<td>3</td>
</tr>
</tbody>
</table>

**Slide 38**

Gender of Drowning Victim

- Females: 17 (40%)
- Males: 25 (60%)

**Slide 39**

Race/Ethnicity of Child

- Asian: 2
- Middle Eastern: 1
- Multi-racial: 3
- Haitian: 1
- Black: 6
- White: 10

- Male: 23 (55%)
- Female: 19 (45%)
Slide 40

Age of Perpetrator

- 18-29
- 30-38
- 40-48
- 53-72

Total Perpetrators in Drowning Deaths (n=51)

Slide 41

Gender of Perpetrator in Drowning Deaths

- Female (45.1%)
- Male (54.9%)

Slide 42

Relationship of the Caretaker Responsible in Drowning Deaths

- Mother
- Father/StepFather
- Grandparents
- Non-relatives
- Aunt
Slide 46

Total Perpetrators in Sleep-related Deaths (n=28)

Age of Perpetrator

19-25
26-30
31-35
36
46

Slide 47

Total Perpetrators (n=28)

Relationship of the Caretaker Responsible in Sleep-related Deaths

Mother
Father
Foster mother

Slide 48

Vehicle Deaths

Vehicle Deaths

Killed in Vehicle Crash
Driven or Backed over
Left in Vehicle
Slide 49

Risk Factors in Vehicle Related Deaths

- Criminal History
- Substance Abuse History
- DCF Priors
- Domestic Violence History

Slide 50

Age of Children in Vehicle Related Deaths

- 4 months
- 1-2 years
- 3-4 years
- 8 years old

Slide 51

Total Perpetrators in Vehicle Related Deaths

- Age of Perpetrator
  - 20-25
  - 30-35
  - 35-40
Slide 52

Relationship of the Caretaker Responsible in Vehicle related Deaths

Mother
Father
Daycare Employee
Aunt

Slide 53

Drug Toxicity Deaths

Accidental Drug Overdose due to Inadequate Supervision
Premature Drug Exposed Newborn
Teen Drug Overdose

13-17 years old
4 hours old
2 years old

Slide 54

Risk Factors in Drug Toxicity Deaths

Criminal History
Substance Abuse History
DCF Priors
Domestic Violence History
Slide 55

**Age of Perpetrator**

- **Total Perpetrators in Drug Related Deaths (n=9)**
  - Age of Perpetrator
    - 20-25
    - 25-30
    - 35-40
    - 41-46

Slide 56

**Relationship of the Caretaker Responsible in Drug Toxicity Deaths**

- **Total Perpetrators (n=9)**
  - Relationship of the Caretaker Responsible in Drug Toxicity Deaths
    - Mother
    - Father
    - Other Non-relatives
    - Grandmother

Slide 57

**Other Neglect Deaths (n=3)**

- **Other Neglect Deaths**
  - Inhaling a balloon
  - Dog Mauling
Slide 58

Remaining Verified Neglect Deaths (n=4)

- Fire (Thermal Burn)
- Gun Shot Wound
- Medical Neglect

Slide 59

Physical Abuse Deaths (n=51)

- Intentional Injury
- Murder/Suicide
- Newborn Abandoned Babies

Slide 60

Risk Factors in Physical Abuse Deaths

- Criminal History
- Substance Abuse History
- DCF Priors
- Domestic Violence History
Slide 64

Age of Caregiver Responsible for Physical Abuse Deaths

- 18-29
- 30-40
- 41-52
- 67-72

Total Perpetrators in Physical Abuse Deaths (n=67)

- 18-29: 10
- 30-40: 15
- 41-52: 20
- 67-72: 10

Slide 65

Gender of Physical Abuse Perpetrator

- Parents: 60%
- Other: 40%

Slide 66

Relationship of the Caretaker Responsible (Physical Abuse)

- Mother/Stepmother: 40%
- Father/Stepfather: 20%
- Other Relatives: 15%
- Other Non-relatives: 15%
- Daycare workers: 5%
- Paramours: 5%
Slide 67

**What is an indicator?**

- What is an indicator as applied to child maltreatment?
- Are indicators always obvious?
- If not, what kinds are more subtle?

Slide 68

**How child maltreatment indicators relate to the decision-making process**

- Probe further when indicators are present to assess the immediate & long-term risk to each child.
- Indicators may help identify needs that are not being met.
- A thorough investigation or assessment helps you decide the appropriate disposition and services needed.
- Weigh indicators against risk factors & protective factors when making child safety decisions.
- An indicator helps you find the root causes for the maltreatment.
- A finding of "not substantiated" means there is credible evidence that the harm was caused by a caretaker's abuse or neglect.

Slide 69

**Decision-Making Model**

- Gather Document Assess
- Child Safety Decision
Slide 70

**Making Decisions**

- The Decision-Making model is applicable to all program areas.
- Careful assessment of all the information you gather & receive helps you decide which actions ensure child safety and evaluate progress to permanency.
- The Decision-Making model is applied continuously throughout the case flow process.

Slide 71

**Module 3: Physical Abuse**

- Identify physical abuse indicators.
- Link the identified indicators with investigative decision-making.
- Decide what evidence/information to gather and document to assess if maltreatment has occurred.
- Identify indicators of Abusive Head Trauma.

Slide 72

**Examples of Critical Indicators**

- Injuries & Evidence
  - Numerous alleged “accidental” injuries
  - Escalating injuries
  - Injuries inconsistent with explanation
  - Frequent change of hospitals or physicians
  - Professional medical opinion contrary to facts
  - Delay in seeking medical treatment
Examples (continued)

Child Vulnerability
- 5 years or younger
- Prior intakes
- Limited access or contact with outside world

Examples (continued)

Target Child
- No observable signs of bonding
- Flat or depressed affect
- Lack of peer relationships
- Subjected to unusual forms of discipline
- Only discipline used is physical
- Exhibits behaviors indicative of abuse or neglect
- Secretive about injuries

Examples (continued)

Parent/Caretaker Characteristics
- Overly charming, extremely cooperative
- Appears to make extreme progress
- Tells you what you want to hear
- Violent and aggressive behavior
- Unrealistic expectations of child
- Alienated from family; no family support network
- Isolation, lacks social contacts
Examples (continued)

Parent/Caretaker History
- Maltreated as a child
- Alcohol or other substance abuse
- Mental illness
- Frequent moves
- Job instability
- Criminal history

Examples (continued)

Parent/Caretaker Relationship
- Boyfriends drift in and out of home
- Relationship takes precedence over child's needs
- Imbalance of power
- Domestic violence
- No clear identification of roles
- Open hostility or negative perceptions

Examples (continued)

Physical Environment
- Environment - poses safety risks
- Unsecured swimming pools/bodies of water
- Child's sleeping area - inappropriate
- Child - removed from others during common activities
- Home - physically isolated
**Slide 79**

**Adult Behaviors**
- Calls child offensive names, chronically ridicules them
- Commits malicious or violent acts toward child's possessions, pets, environment
- Uses crude, brutal, or severely misguided actions to gain submission or control to influence child's behavior
- Unrealistic expectations inappropriate to child's developmental level
- Always needs to be in charge; always critical
- Rejects child or has obvious preference for one child over another
- Distant, shallow, or superficial relationships with family members, or isolated from society

**Slide 80**

**Adult Behaviors (continued)**
- Extremely disappointed regarding their baby's gender
- Fails to bond with infant
- Suffers from acute tension, has chronic crises, or is easily frustrated
- Poor impulse control
- Blames the child for problems
- Gives inaccurate, illogical, or conflicting explanations for a child's injury
- Exposes child to repeated violent, brutal or intimidating acts or statements
- Leaves child in hostile or dangerous situation

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**Adult Behaviors (continued)**
- Fails to protect child from inflicted injury
- Abuses substances to the degree that adequate care is not provided
- Beats or corporally punishes child so that it leaves (or is likely to leave) an injury
- Kicks, scratches, or punches child
- Hits or slaps and infant
- Pulls child's hair
- Over medicates or poisons child
- Ties child's limbs together or to an object
Variables Affecting Child’s Response to Maltreatment

- Child’s Age
- Length of time the child has been maltreated
- Frequency of the maltreatment
- Nature of the child’s relationship with the abuser
- Type of maltreatment
- Availability of support
- Constitutional factors

Emotional Indicators

- Developmental delay and abnormal developmental patterns
- Remote, withdrawn
- No expectation they will be comforted
- "Frozen watchfulness"
- Fear of physical contact
- Appears to be autistic
- Clinging dependency
- Depressed, lack of emotion
- Preschool children: easily frightened; eager to please; role reversal
- Adolescents: lying; stealing; use of alcohol/drugs; running away

Estimating the Age of Bruises

- Cannot base solely on color with precision
- Obtain CPT medical examination
  - Yellow bruising is at least 18 hours old
  - Red, blue, purple, or black may occur anytime between 1 hour and resolution
  - Red is present no matter what the age
  - Bruises of identical age and cause may not be the same color or heal at the same rate
  - Color is affected by depth, location, light, and skin color
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**Normal Bruising**

Possibly normal bruising on the lower legs of a very active toddler

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**Suspicious Bruises**

Multiple areas

**Soft tissue areas**

- Abdomen
- Throat or mouth
- Buttocks, thighs

**Normally protected areas**

- Sides
- Insides of arms and legs
- Genitals

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**Patterns of Abusive Bruises**

Figure 6: Marks from objects.
Spankings that leave bruises are considered to be abuse.

Multiple injuries to back and legs, with blunt trauma bruises to buttocks and parallel bruises across back caused by a beaded belt.

“Garroting” Marks on Neck
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Gag Tie Marks on Mouth

Slide 95

ENCIRCLEMENT TIE MARKS ON ANKLES (Bilateral)

Slide 96

Bruise from Forceful Slap
Slide 97

Bruising to the ear can be from pinching, pulling, "boxing the ears" or from slapping on the side of the head.

Can be easily missed

Slide 98

Double black eyes, indicative of 2 fist blows to eyes - resulting in possible severe and permanent injury
Injuries to the inside of a child’s mouth can be caused by putting a hand over their mouth in an attempt to quiet or suffocate the child.

Hand-Slap Bruises to Buttocks
Identify Children at High Risk for Future Injury
Slide 103

Mongolian Spots

Mongolian Blue Spots are flat, brownish with wavy borders and irregular shapes, common among people of Asian, East Indian, African, and Latino heritage. They may be seen in about 10% of Caucasians to over 90% of African Americans. They commonly appear at birth or shortly after birth and may look like bruises.

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Examples of Mongolian Spots

- The green triangle indicates the so-called “hot spot” of Mongolian spots. Most common spots appear in this area.
- Common Mongolian spots: Will disappear within 10 years.
- Deep blue Mongolian spots: All deep blue spots are ectopic and may become persistent Mongolian spots which remain until adulthood.
- Ectopic Mongolian spots: All spots are thin and will disappear in within a few years.

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Mongolian Spots

Core 107_MAL_PG_July 2013 (Core 107 MAL) 35
PowerPoint Slides
Severe bruising to child's abdomen and genitals, caused by fist blows, resulting in possible life threatening injuries.
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Young girl with bruising to inner thigh and genitals which may be indicative of sexual abuse.

Slide 110

This child was not yet walking and had no teeth; therefore injury was found to be inflicted.

Slide 111

Child punched in mouth, forcing lower teeth to cut lower lip.
Slide 112

Frenulum torn and ulcerated

Slide 113

“Tattoo” puncture marks on feet caused by kitchen fork stabbing

Slide 114

Adult Bite Bruises
Identify Children at High Risk for Future Injury
Slide 115

Human bite: 4 incisors and short canines leaving elliptical or oval arch.

Dog bite: 4 incisors and short canines leaving elliptical or oval arch.

Slide 116

Three deep bite marks on child’s back.

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Burns Severity & Type
- Burns account for 10% to 15% of child abuse cases.
- Hot water burns are most common, whether accidental or abusive.
- Accidental burns tend to be asymmetrical.
- Burns covering 20% or more is severe regardless of child’s age.
- Burns covering 65% or more can be fatal even if 1st degree.
- Medical conditions mistaken for burns are scalded skin syndrome (staph) and impetigo.
Slide 118

Severity of Burns

Degree
- 1st Degree – Minimal depth, not tender
- 2nd Degree – Extends through the top layer of skin, blistered
- 3rd Degree – White, not sensitive to touch

Percentage of Body Covered

Body Part Affected
- Face
- Hands
- Genitals

Age of Child

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Patterns of Abusive Burns


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Figure 11. Marks from burns

Core 108_MAL_PG_July 2013 (Core 107 MAL)  40
PowerPoint Slides
Slide 127

“splash burn” to back – in this case accidental

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Cigarette burns on child’s hands

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Cigar and cigarette burns on child’s hands and arms
Iron Burns Often Result from Negligent Supervision

Module 3: Physical Abuse

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**Slide 136**

Infant with burns on back and arms caused by being held against a space heater.

**Slide 137**

"Coining Marks" – medical ritual of rapidly rubbing coin over area of concern - Practiced by Asian Cultures.

**Slide 138**

"Cupping" another form of medical treatment used for chest congestion.
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Module 3: Physical Abuse

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**Bone Fractures**
- Fractures account for about 20% of abusive injuries
- About 77% of fractures involve extremities
- 90% of abusive fractures in children 2 years or younger include the ribs
- Fractures are usually inflicted in non-ambulatory children

Slide 141

**Skeletal Survey**
- Sometimes called a Kempe Series for the author of the original "Battered Child" article
- X-rays of skull, ribs, long bones, spine, hands and feet to check for unsuspected fractures
- Most likely to be helpful in children under two years old
Internal Injuries

Injuries to the internal organs are caused by blows or squeezing to the abdomen.

Significant violent force is required to cause a life-threatening abdominal injury.

A small percentage of children receive internal injuries from abuse.

The mortality rate in abusive abdominal injuries is 40%-50%.

Get the child medical treatment immediately or the child may die.

Signs of Internal Injuries

- Pain in stomach, chest, or other internal area
- Visible bruising to abdomen or chest
- Distended, swollen abdomen
- Tense abdominal muscles
- Labored breathing
- Severe, pinching pain in chest while breathing
- Nausea and vomiting

Other Physical Injury

- Asphyxiation, Suffocation, Drowning
- Munchausen Syndrome by Proxy
- Blinding/ Eye damage
- Injuries to teeth, jaws, mouth, and lips
- Damage to ears/ hearing
- Hair pulling
Slide 145

**Most Life-Threatening Abuse**

- Head injuries
  - Subdural hematoma
  - Whiplash Shaken Infant Syndrome
  - Battered Child Syndrome
- Internal injuries
- Burns
- Poisoning

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**Abusive Head Trauma**

Serious brain injury that occurs when a frustrated caregiver "shakes" an infant, usually to stop them from crying.

Is a form of child abuse.

Some parents, siblings, & caregivers who would never hit a baby think shaking a baby is okay.

Shaking a baby can cause serious injuries or death.

Usually no outward physical signs

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**"Whiplash Shaken Infant Syndrome"**

Serious, often fatal injuries caused by violent shaking of a very young child.

Shaken infants - do not often show visible signs of external trauma.

Generally seen in children 2 years of age or younger - most common in children less than 6 months of age.

Three main signs:
- Subdural hematoma
- Retinal hemorrhage
- Metaphyseal lesions
Head Injuries: Abusive Head Trauma

"Shaken Baby Syndrome"

Common form of life-threatening child abuse

Account for about 35% of abuse fatalities in Florida

Survivors often left with permanent handicaps

The Classic “Shaken Baby”

Battered Child Syndrome

A child who has been seriously abused over time

Usually three years of age or younger

Signs:

• Fractures “accidentally” discovered during routine exam
• Inconsistent with history provided or with the child’s age
• Multiple injuries in various stages of healing
• Failure to thrive
Slide 151

Battered Child
Various bruises, burns and scars in various stages of healing

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Critical Indicators of Physical Abuse
- Frequent injuries
- Multiple bruises and injuries
- Bruises and injuries in inaccessible places
- Injuries in different stages of healing
- Injuries inconsistent with adult explanation

Slide 153

Investigative Techniques
- Always investigate, even if the explanation seems plausible.
- Check other areas of the child's body, not just the area of the injury.
- Interview all subjects of the intake individually.
- Check for and analyze all prior case histories and intakes.
- Refer the child to CPT.
- Notify Law Enforcement/SAO within mandated timeframes.
- Interview all persons in the environment who may have information.
- Gather information from school personnel and family physicians.
Investigative Techniques (continued)

- Get the child's version of what happened.
- Always probe deeper with each piece of information you gather.
- Each answer you receive is only one piece of the puzzle; it should spark another question or clue to investigate.
- Always ask to see the physical source of the injury: iron, stove, burner, rope, etc.
- Visit the site of the "accident.
- Ask if physical environment and explanation for how the injury occurred match.
- Visit and observe entire home environment for clues, especially child’s bedroom.
- Take photographs.

Module 4: Sexual Abuse

Objectives

- Describe the dynamics of child sexual abuse using the five phases.
- Describe the physical, behavioral, and emotional signs of child sexual abuse.

Sexual Abuse Statistics

- 1 out of every 4 women are sexually molested by an adult before age 18.
- For men, 1 out of 10.
- Child molesters are predominantly men.
- Only 1 out of 15 cases of child sexual abuse is reported to law enforcement.
Slide 157

Sexual Abuse Statistics

- Victims under age 12
  - Strangers: 1%
  - Family Member: 7%
  - Acquaintances: 86%

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Phases of Child Sexual Abuse

- Phase 1: Engagement
- Phase 2: Sexual Interaction
- Phase 3: Secrecy
- Phase 4: Disclosure
- Phase 5: Suppression

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Types of Disclosure

- Accidental disclosure: victim reveals by chance rather than deliberately
- Purposeful disclosure: victim makes a conscious decision to tell an outsider
Module 5: Mental Injury

Objectives
- Define mental injury.
- Identify the indicators of mental injury.
- Describe the types of mental injury.

Mental Injury F.S. 39.01(42)
Mental Injury: any injury to the intellectual or psychological capacity of a child as evidenced by a discernible and substantial impairment in the ability to function within the normal range of performance and behavior.

The Child Maltreatment Matrix
The impairment may be in the emotional, affective, cognitive, physical, or behavioral functioning of the child. Damage can be present and observable, or can be forecast as highly probable for the near future.
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Emotional Abuse

Pattern of behavior attacking a child's emotional development and sense of self-worth. Includes:

- Excessive, aggressive or unreasonable demands placing expectations on a child beyond their capacity
- Failure to provide psychological nurturing necessary for a child's psychological growth and development – providing no love, support or guidance


Slide 164

Mental Abuse

Behavior that undermines a person's independent thought in order to control how they view and respond to situations. (SASC)

Slide 165

Observable Indicators in Children

- Rocks, sucks items/body parts, bites self
- Inappropriately aggressive
- Destructive to others
- Suffers from sleep, speech disorders
- Restricts play activities or experiences
- Demonstrates compulsions, obsessions, phobias, hysterical outbursts
Behavioral Indicators in Children

- Negative statements about self
- Shy, passive, compliant
- Lags in physical, mental and emotional development
- Self destructive behavior
- Highly aggressive
- Cruel to others
- Overly demanding

Family or Parental Indicators

- Blames or puts down child
- Cold and rejecting
- Indifferent to child's problems or welfare
- Withholds affection
- Preferential treatment when there are multiple children

Signs in Adulthood

Adults emotionally abused as children are:

- More likely to experience mental health problems and difficulties in relationships
- Exhibit a range of complex psychological and psychosocial problems (Glaser 2002)
- Problems forming personal, professional and romantic relationships
- Easily misinterpret other people's behaviors and social cues
- Misapply rules that governed their abusive relationships with their parent to everyday social situations (Oberlander et al., 2006)
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Cycle of Violence

- Tension Build-Up
- Removal/Honeymoon
- Explosion

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Mental Injury

- Emotional Neglect
- Psychological Abuse

Mental injury is often accompanied by or embedded in other forms of child maltreatment.

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Types of Mental Injury

- Spurning (hostile rejecting/degrading)
- Terrorizing
- Exploiting/corrupting
- Isolating
- Denying emotional responsiveness (ignoring)
- Mental health, medical and educational neglect
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Module 6: Substance Abuse

**OBJECTIVES**

- Define substance abuse & related terms.
- Define “disease” as related to substance abuse & describe its characteristics.
- Recognize the progression/stages of substance abuse.
- Describe behavioral indicators of substance abuse.
- Define & identify risk factors.
- Describe the protective factors.

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Substance Abuse Statistics

- Approximately 18 million persons abuse or are addicted to alcohol.
- 12 million persons abuse tranquilizers & other psychotropic drugs.
- 5.5 million get high on marijuana more than once a week.

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Substance Abuse Statistics

- At least 7 million are addicted to cocaine or crack.
- Up to 1 million individuals use heroin.
- 2% of population over 12 (460,000) people use methamphetamine.
  Higher rate than heroin.
  Half the rate of cocaine.
Slide 175

Definitions

Substance: Any chemical that modifies the function of living tissues, resulting in physiological or behavioral change.

Substance Use: The desired effects of a drug can be realized with minimal hazard, whether or not used therapeutically, legally, or as prescribed by a physician.

Substance Abuse: Drugs taken or administered at a dose that greatly increases their hazard potential, whether used therapeutically, legally, or as prescribed by a physician.

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Addiction

A disease with its own psychopathology characterized by compulsion, loss of control, continued use in spite of adverse consequences.

Addiction is progressive, potentially fatal if untreated, & incurable but remissible through abstinence and recovery.

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Characteristics of a Disease

Primary

- Not a secondary symptom of something else

Progressive

- Progressively worsens
- Victim becomes physically, spiritually, emotionally, & psychologically ill

Chronic

- No cure
- Recovery must be based on abstinence from mood altering chemicals

Fatal

- Can only be arrested
- If it is not arrested, person will die from it
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Elements of Disease

- Cause
- Effect
- Symptoms
- Course of Action
- Predictable Outcome

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Symptoms Associated with Stages

- First, people drink for relief
- Second, social problems (e.g., job loss, family problems) become identified
- In late stages, there is physical deterioration
- Death usually occurs in 15 to 20 years
- Recovery rates are 60 to 70 percent if treated in the middle stage

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Stages of Substance Abuse

- Stage 1: Experimentation & social use
- Stage 2: Seeking the mood swing
- Stage 3: Harmful abuse
- Stage 4: Dependency addiction
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Substance Abuse:
A risk factor is...

- an attitude, belief, behavior, situation, and/or action that may put an individual, group, organization, or community at risk for experiencing drug use and its effects.

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Categories of Risk Factors

- Family
- Community/School
- Individual/Peer/Psychosocial
- Mental Health Disorders

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Family Risk Factors

- Family Management Practices
  - The way parents manage the family may increase the possibility of alcohol and drug abuse among the children.

- Family History of Alcohol & Drug Abuse
  - If a parent has a history of alcoholism or other drug abuse, the children are more likely to become substance abusers.

- Condoning Alcohol & Other Drug Abuse
  - The message that alcohol and drug abuse are acceptable increases the likelihood that substance abuse will occur.

- Parents who drink, smoke, and abuse other substances, set an example for their children.
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**Family Bonding**

- Strong relationship between parents and children
- Children feel safe, loved, and supported

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**Protective Factors in Parents**

- Consistent praise/low criticism
- Clear expectations/high expectations
- Stress management
- Quality time/sharing responsibilities
- Supportive adult relationships/extended family

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**Protective Factors in Children**

- Relationship with a caring, adult role model
- Opportunities to contribute or be a resource
- Success in work, play, and relationships
  - Self-esteem
  - Self-discipline
  - Problem-solving skills
  - Sense of humor
- Healthy expectations and positive outlook
Module 7: Neglect

OBJECTIVES

• Define neglect.
• Identify the types of neglect as defined in the Child Maltreatment Index.
• Identify indicators for each type of neglect.
• Recognize indicators of neglect that represent a risk for significant impairment.
• Distinguish between chronic & situational neglect.
• Describe the effects of neglect on toddlers, early school-aged children, & adolescents.
• Define failure to thrive.

Chapter 39.01(44)(a)-(b)
States that neglect occurs when a child is:

- deprived of, or allowed to be deprived of, necessary food, clothing, shelter, or medical treatment
- permitted to live in an environment when such deprivation or environment causes the child’s physical, mental, or emotional health to be significantly impaired or to be in danger of being significantly impaired

“Neglect of a child includes acts or omissions”
Circumstances NOT considered neglect:

If caused primarily by financial inability unless actual services for relief have been offered and rejected

Parent or legal guardian legitimately practicing his religious beliefs under a recognized church or religious organization who thereby does not provide specific medical treatment for a child must not, for that reason alone, be considered a negligent parent or legal custodian.

The Court can...

Order the following services to be provided, when the health of the child requires:

- Medical services from a licensed physician, dentist, optometrist, podiatrist, or other qualified health care provider;
- Treatment by an accredited practitioner who relies solely on spiritual means for healing under the tenets and practices of a well-organized church or religious organization

Types of neglect recognized by the Child Maltreatment Index

- Bizarre Punishment (Institutions)
- Mental Injury
- Substance Misuse
- Inadequate Supervision
- Abandonment
- Environmental Hazards
- Malnutrition/Dehydration
- Failure to Thrive
- Medical Neglect
- Failure to Protect
- Death due to Neglect
Slide 193

**The Four Indicator Classifications**

- Physical
- Environmental
- Child's Behavioral
- Caregiver's Behavioral

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**Chronic Neglect**

Chronically neglectful families often suffer from pervasive character problems due to their own severely emotionally impoverished childhood.

Chronic neglectful families are often caught in a "cycle" of neglect:

- Large families with many children and limited financial support
- Socially isolated
- Very little extended family support or network of friends in the community

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**Factors**

- Child's Age
- Child's Personality
- Availability of Support
- Frequency
- Length of Time Neglected

Many factors influence the degree of damage in a child.
A Child Suffers from Failure to Thrive when...

- Weight or height is below the 5th percentile of the population on a standard weight/height curve (some experts recommend 3rd percentile)
- Actual weight is 20% or more below the ideal weight for height
- Weight gain is significantly slower than normal
- Triceps skin-fold thickness (total body fat measurement) is below 15th percentile for the population

*Schmitt & Mauro, 1989

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Intervention

- Essential early intervention
- Collaborate with medical personnel
- If child remains in the home, intensive family support is necessary, plus continuous monitoring of the infant, possibly on a daily basis.
- Decision criteria for leaving an infant in the home (or not):
  - Severity of the infant's condition
  - Caregiver's openness to intervention
  - Active safety plan that includes relative, neighbor, or friend who can help care for the infant

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Module 8: Domestic Violence

Objectives

- Identify indicators of domestic violence.
- Recognize the relationship between domestic violence and child abuse.
- Relate domestic violence behavior to neglect of a child.
Domestic violence:
“any assault, battery, sexual assault, sexual battery, or any criminal offense resulting in physical injury or death of one family or household member by another who is or was residing in the same single dwelling unit.”

Domestic violence is...
"a pattern of assultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partner" (Ganley & Schechter, 1995)

Key Points:
- Pattern of assault and coercion
- Many forms of abuse
- Affects people in all types of intimate relationships

Physical Abuse:
The most obvious form of domestic violence is physical abuse.

Batterers are aware that visible physical evidence could draw the wrong kind of attention, so they selectively hit the victim in areas hidden from sight.

Batterers might:
- Pull the victim's hair
- Bang the victim's head against the wall
- Shake the victim violently

Serious internal or neurological injury might occur.
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Emotional/Psychological Abuse

Can be the impetus behind physical abuse or the victim's fear of physical harm.

Batterer may make covert threats. Batterer may intimidate victim by threatening to take the children

Dining hours behind emotional abuse are the victim's belief that

Directional abuse is also the result of greater fear than physical abuse.

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Sexual Abuse

Any attempt to force a partner to act against his or her will.

Vulnerability is punishable by law (Florida).

Sexual battering: a wide range of behaviors including:

- Pressured sex when the victim does not want sex
- Coerced sex through manipulation or threats
- Violent sex
- Victims may be forced to perform acts they do not like:
  - Sex with third parties
  - Painful sex
  - Acts which are offensive to them

Victims may comply to avoid punishment or may be punished for resisting.

Sexual abuse is profound and may be difficult for the victim to discuss.

Some victims are unsure that the sexual abuse is really abuse, and, for others, it is the ultimate betrayal.

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Sexual Abuse (continued)

Victims may be forced to have sex at inappropriate times:

- when they don't want it
- in front of the children
- when they're asleep

Victims may comply to avoid punishment or may be punished for resisting.

Sexual abuse is profound and may be difficult for the victim to discuss.

Some victims are unsure that the sexual abuse is really abuse, and, for others, it is the ultimate betrayal.
**Economic Coercion**

Batterers attempt to control the adult victim by controlling the family finances.

- The batterer may require the victim to keep all records and handle all financial transactions while granting limited permission to pay bills.
- Batterers will often hide all financial information from the victim.

Adapted from Shccepter & Ganley, 1995

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**Use of Children to Control Adult Victim**

- Use children to spy on the victim
- Force children to assault the victim
- Make children watch the degradation/abuse of victim
- Use children as pawns
- Physically assault or threaten to assault children in order to control the victim

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**Child Abuse Related to Domestic Violence**

- Strike child who tries to intervene
- Force child to witness or participate in beatings
- Threaten to beat a child who discloses
- Hit the child with objects intended to strike the adult victim
Children & Domestic Violence

Children experience fear from witnessing family violence that changes them for life.

Domestic violence can be a factor in child abuse deaths.

Research & data indicate that abuse begins with spouse battering that escalates to include the children.

Overlap between households with both domestic violence & child abuse ranges from 40 to 60%.[1]

The risk of child abuse is 1500% greater in homes where there is domestic violence.[2]

When there is an “indication” of domestic violence there are concerns of possible child maltreatment.