25th Annual Downstate Conference on Child Abuse

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Workshop F1

CHILDHOOD INJURIES: Abusive or Not?

Speaker:
L. Shaw, MD MSSW
Child Protection Division, St. Louis University School of Medicine
(314) 268 2700 ext. 3274

The following are excerpted from: RECOGNIZING WHEN A CHILD'S INJURY OR ILLNESS IS CAUSED BY ABUSE, Portable Guide to Investigating Child Abuse, OJJDP, NCJ 243908, July 2014

Increased **RISK** of child physical abuse is associated with:

- intimate partner violence, criminal activity, mental illness, substance abuse, inappropriate expectations of children, punitive childrearing habits;
- premature babies and children with physical, developmental or behavioral difficulties;
- triggers such as crying, toilet training accidents, and a child's "misbehaviors"

Red flags for **INJURIES**:

- those in non-mobile kids, especially infants; those on protected surfaces of body; multiple injuries and those with varied stages of healing; those with patterned mark(s); those which supervision should have prevented; those with a non-plausible or no explanation; those with delay in seeking medical care

Injury **ASSESSMENT**:

- Is the injury caused by a medical condition or a normal variant/natural phenomenon? e.g., Mongolian spots/birthmarks; impetigo (not a cigarette burn); bleeding problem (hemophilia or Von Willebrand disease), rashes; bone or collagen disorders (like osteogenesis imperfecta)

SKIN INJURIES:

- BRUISES suggesting abuse: On any non-cruising child; on areas not over bony prominences: on ears, face, abdomen, buttocks, back, upper arms, thighs, hands and feet; in clusters/ over large areas; patterned, symmetric or on both sides of body.

BEWARE!! No one can precisely date bruises!!

- BURNS suggesting abuse: CONTACT burns which reflect the size and shape of the object which burned child; SCALD burns with sharp margins and of uniform depth; on both sides of body; which spare creases or areas of body (e.g. from drawing up legs).

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FRACTURES:

- Most ABUSIVE fractures occur in infants and young toddlers. Household falls and accidents produce the most common accidental fractures=skull, clavicle, forearm, toddler's (lower leg bone).
- Medical conditions causing fractures are RARE, e.g., osteogenesis imperfecta or vitamin D deficiency rickets.
- DATING of fractures is imprecise, so only a range is usually reasonable to expect.
- Fractures suggesting ABUSE: In a non-mobile child; with no explanation for or inconsistency between type/severity of fracture and its explanation; when other evidence of abuse/neglect is present; when medical care was delayed; metaphyseal fractures at ends of arms and leg bones (bucket handle, chips, classic metaphyseal lesions); rib fractures; complex, depressed skull fractures.

HEAD INJURIES (significant):

- Suggestive Symptoms: vomiting, seizures, stupor and coma-- or irritable, without energy, poor appetite.
- ACCIDENTAL—explained by high-speed auto collision or fall from several stories, NOT by short falls, falls down stairs or usual play.
- ((Other considerations: Bleeding disorders, metabolic conditions (glutaric aciduria type 1), structural abnormalities, meningitis/encephalitis, birth trauma—note these are not from Portable Guide))
- ABUSIVE HEAD TRAUMA (AHT), no longer called Shaken Baby Syndrome:
    - Bleeding into scalp or around eyes, with or without hair loss from hair pulling
    - Subdural (or subarachanoid) hematoma without external injury from shaking or whiplashing;
    - Subdural, subarachanoid, or epidural hemorrhage from skull fracture, perhaps with bruising or swelling of scalp.
    - (Serious AHT involves injury of the BRAIN TISSUE itself. Retinal hemorrhages may be seen, as well as rib and/ or metaphyseal fractures.)

ABDOMINAL INJURIES:

- ACCIDENTAL: usually from long fall, motor vehicle accident, contact sport or bicycle accident
- ABUSIVE: More often in younger kids (toddlers/preschoolers). Delayed presentation for medical care after punching, kicking, and/or striking with object, in conjunction with false or misleading history
- Damage to liver, spleen, pancreas, stomach and/or intestines, often without bruising of belly

KEY TIMELINE QUESTIONS around an Injury:

- When was child last known to be well/acting normally, without an injury?
- What is child's age and developmental status (skills)?
- Does child have a medical condition/chronic illness/take medications?
- When was child last seen for medical care?
- When did the caregiver(s) first realize there was a problem and how?
- If an incident occurred, where was that?
- Who witnessed that incident? (or heard something?)
- How did the child respond to what happened?
- What treatments were given—what was done?
- How did the child's symptoms progress since then?
- When and how was the decision made to seek medical care?

PLEASE REMEMBER:

Almost never does an injury by itself indicate ABUSE. The history of how the injury occurred is vital when determining if abuse occurred. A comprehensive assessment by a TEAM of knowledgeable professionals is the best approach to reaching an accurate determination of child abuse.

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