CHAPTER 5 – CHILD MALTREATMENT

First Nations and Inuit Health Branch (FNIHB) Pediatric Clinical Practice Guidelines for Nurses in Primary Care.
The content of this chapter has been reviewed August 2010.

Table of contents

DEFINITIONS OF TYPES OF CHILD MALTREATMENT[1]

Broadly defined, child maltreatment and child abuse refers to any intentional harm, or threat of harm, inflicted upon a child by an older person. It may involve physical, sexual or emotional abuse, neglect or failure to provide the necessities of life and includes the physical abuse of a pregnant woman. As a health care provider, one must be alert to the possibility of abuse during each client encounter. Provincially legislated child protection Acts may provide specific definitions of abuse or neglect (for example, *The Child and Family Services Act of Manitoba* and the related professional protocol or *The B.C. Handbook for Action on Child Abuse and Neglect (2007)*.

PHYSICAL ABUSE OF CHILDREN[2,3]

An act or an omission by a parent, caregiver or other person that results in, or can result in, physical injury to a child. Such acts include inflicting blows that cause bruising, striking a child with a fist or instrument, and kicking, biting, burning, beating, throwing or shaking a child. It can be due to physical punishment and/or over discipline. An omission is the failure to prevent a potentially injurious act (for example, failure to use a child safety seat regardless of whether or not the child is harmed).

SEXUAL ABUSE OF CHILDREN

"Any sexual exploitation of a child whether consented to or not. Sexual activity between children may constitute sexual abuse if the difference in age or power between them is significant".[1] The law in Canada differentiates between exploitative and non-exploitative sexual activity with, and between, children. Exploitative sexual activity includes prostitution, pornography, situations where there is a relationship of trust, authority, dependency or any situation that is otherwise exploitative to a young person.[2] The age of consent for exploitative sexual activity is 18 years. Children under 18 are protected from all exploitative sexual activity. With regards to non-exploitative sexual activity, in 2008, Canada raised the age of consent to 16 years. The law includes a close-in-age exception which permits 14 and 15 year olds to engage in consensual, non-exploitative sexual activity with a partner less than 5 years older than themselves. The law also includes a close-in-age exception which permits 12 and 13 year olds to engage in consensual, non-exploitative sexual activity with a partner less than 2 years older than themselves (for example, a 12 year old can consent to sex with a 14 year old, but not a 15 year old). Lastly, children under 12 years of age are not able to consent to sexual activity with anyone.[3,4]

EMOTIONAL ABUSE OF CHILDREN[5,6,7,8]

"Repeated emotional attacks or omissions that cause, or could cause, serious emotional injury. This would include the behavior of parents or guardians who persistently do not take an interest in their children."[9] Such acts or omissions may include an unwillingness or inability to provide care, control, nurturance, security, love, emotional support, affection or stimulation or exposure of the child to violence. Rejecting, isolating, terrorizing, ignoring, corrupting, confining, verbally assaulting (including threats, humiliation, ridicule) or the excessive pressuring of a child are categories of emotional abuse when the behaviours are repeated. Examples include locking a child in a closet, or yelling at a child.

NEGLECT OF CHILDREN[10,11,12,13]

A non-deliberate failure of the parent(s) or caregiver to provide for a child's basic physical, emotional, developmental, psychological, medical and educational needs that results in, or may result in, harm. This can include noncompliance with health care recommendations, a delay in seeking medical care, inadequate food, inadequate supervision, inadequate protection from environmental hazards, abandonment, withholding love or affection, lack of nurturing, inadequate hygiene, not meeting educational needs, exposure of the child to domestic violence or failure to provide developmentally appropriate stimulation or play.

Inadequate nutrition and lack of social interaction contribute to poor weight gain, developmental delays and abnormal behaviours. This neglect can cause failure to thrive in children or infants *(see "Failure to Thrive" in the pediatric chapter 17, "Hematology, Endocrinology, Metabolism and Immunology")*.

SPECIFIC TYPES OF CHILD MALTREATMENT

MUNCHAUSEN SYNDROME BY PROXY[14]

An injury of the child by deliberate poisoning or physical means or any interference with medical care so that the child presents unwell or with multiple life-threatening scenarios. Results in multiple and increasingly frequent medical investigations and interventions. For example, a child may present with unexplained electrolyte disturbances or with positive toxicology tests without a history of ingestion. The caregiver benefits psychologically.

ABUSIVE HEAD TRAUMA[15,16,17,18]

Previously referred to as Shaken Baby Syndrome, it is a form of traumatic brain injury that occurs when an infant or young child is violently shaken or is a result of an impact or a combination of the two. It should be considered a differential diagnosis in any child with an altered level of responsiveness that is not due to an obvious likely cause (for example, meningitis or injury from a collision or fall).

GENERAL

- Children <1 year are most at risk
- A baby's demands for attention, such as crying, can become a trigger for a frustrated parent or caregiver
- Occurs most in infants and young children, but can occur in older children
- Child often presents with non-specific clinical features and no history of trauma
- In milder cases, the child may present with symptoms similar to a viral illness
- Most children with abusive head trauma have at least one neurologic abnormality
- Assess for suspected abusive head trauma, particularly if they have a severe head injury reportedly from a short fall or minor trauma

PHYSICAL FINDINGS

May include some or all of the following:

- Intracranial hemorrhages
- Retinal hemorrhages
- Brain injury
- Skull fractures
- Rib fractures
- Long bone fractures
- Other fractures
- Bruises, lacerations or other signs of external trauma (their absence is common in abusive head trauma)
- Lethargy
- Decreased feeding
- Full or bulging anterior fontanel
- Irritability
- Headache
- Vomiting
- Respiratory distress
- Apnea
- Seizures
- Altered level of consciousness
- Downward gaze preference

COMPLICATIONS[19]

- Developmental delay
- Seizures
- Mental retardation
- Paralysis
- Blindness
- Death

APPROPRIATE CONSULTATION

Consultation with a physician is essential early on in any case of suspected abusive head trauma.

SITUATIONS IN WHICH CHILD MALTREATMENT OCCURS[20,21]

The occurrence of child maltreatment usually depends on the interplay of three components: a high-risk caregiver, a high-risk child and a crisis.

High-risk caregivers vary depending on the type of abuse.

Risk indicators for committing physical abuse include low socioeconomic status, male sex, young maternal age, large family, single parent family, spousal violence, caregiver's experience of physical abuse in childhood, few social supports, maternal psychiatric impairment, low maternal educational level, lack of attendance of prenatal classes, substance abuse, low religious attendance, unplanned pregnancy and negative parental attitude toward pregnancy.

Risk indicators for sexual abuse include living in a family with no natural parent, growing up in a family with poor marital relations between parents, low maternal age, parental death, presence of a stepfather and poor child-parent relationships.

Risk indicators for neglect include parental sociopathic behaviour and substance abuse.

A high-risk child is one who has special needs or who is perceived as undesirable for a variety of reasons (for example, prematurity, colic, physical or emotional challenges, the result of an unplanned or unwanted pregnancy, demanding child, delayed bowel/bladder control during toilet training). Only one child in a family may be abused.

Children between 15 and 17 years or less than 5 years old are more at risk for physical abuse.

Sexual abuse is more common towards females, particularly between 10 and 12 years of age.

Children abusing substances should be routinely screened for past abuse.

A crisis is an event, major or minor, within the abuser's life that precipitates an abusive event.

CONSEQUENCES OF CHILD MALTREATMENT ON CHILDREN[22]

- Cognitive, social and emotional impairment
- Physical disabilities
- Association with psychiatric disorders including depression, personality disorders, anxiety, substance abuse, suicidal behavior, criminal behavior

HISTORY AND PHYSICAL EXAMINATION FOR SUSPECTED CHILD MALTREATMENT

GENERAL HISTORY[23,24,25,26]

- If possible, interview the caretaker and child (if age appropriate) by themselves. A child's accounts of abuse must be considered credible, particularly if they can provide details pertaining to the event(s).
- Document exact statements of caregiver(s) and children in quotations.
- Allow the parent to lead the interview.
- Ask non-leading and open-ended questions.

Think about:

- Possibility of maltreatment with all injuries

While taking the history, look for and document:

- Inconsistencies or discrepancies in the history (for example, no history on mechanism, partial history, history changes, or child's history differing from that of the caregiver's)
- History incompatible with the presenting problem/injury
- Story does not make sense given age and development of child
- Unwitnessed injury
- Injury attributed to child's sibling
- New or old injury with inadequate, evolving or no explanation
- Delays in seeking medical attention after an injury
- Past record of repeated or unusual injuries
- Element of neglect or inappropriate supervision
- Unrealistic caregiver expectations of child
- Child avoiding questions
- Child reporting self-inflicted injury

Ask about:

- Name(s), telephone number(s) and address(es) of the person(s) responsible for the care, including the name(s) and address(es) of the alleged offender(s).
- Dates and times of incidents
- Exact mechanism and circumstance of injury
- Names of individuals who saw injury occur and/or was with the child at the time
- Location of other people when it happened
- Child's health status until the injury happened
- Unexplained, symptomatic injury in a child who was well when last seen by the caregiver
- What was done immediately after the injury; was medical care sought
- History of the same by another perpetrator
- How often it has happened
- Child's developmental abilities and motor skills
- Menstrual and sexual activity history
- Prior trauma or medical procedures in affected area
- History of abuse or child protection agency involvement
- Family history of conditions that account for easy bruising or bone fragility (for example, von Willebrand disease, osteogenesis imperfecta)
- Family tree (siblings, numbers of parental partners)
- Current living situation and who lives there
- Emotional abuse
- Neglect
- Any changes in child's normal eating, sleeping, toileting or behavioural patterns
- Problems at school, runaway attempts, suicide attempts
- Excessive masturbation or sexualized activities
- Inappropriate play for age
- Anger, rage, suicidal ideation, depression, anxiety
- Substance abuse
- Domestic violence
- Withdrawal from family or peers

GENERAL PHYSICAL ASSESSMENT

- General appearance, including appropriate dress for weather
- Height, weight and head circumference, if appropriate (look at growth pattern)
- Vital signs as appropriate
- Behaviour of child (for example, normal developmental milestones, appropriate for age, any wariness of physical contact)
- Behaviour of caregiver (for example, apathy, lack of concern, bizarre behaviours or overreaction to the child's actions)
- Interaction between family members, particularly child's response to caregiver and vice versa
- Child's personal hygiene and cleanliness of clothing
- Injuries (use body diagrams to illustrate site of injuries)
- Full physical assessment, in particular looking for indicators as described below

PHYSICAL ABUSE[27,28,29,30]

INDICATORS

Head and Central Nervous System (CNS) Injuries

- Torn fraenulum
- Dental injuries (for example, fractured teeth, puncture lesions of lips, or bruises on lips or gums)
- Bilateral black eyes
- Traumatic hair loss
- Trauma to ear
- Diffuse/severe CNS injury
- Retinal hemorrhage
- Abusive head trauma injuries *(see "Abusive Head Trauma")*

Skin Injuries

- Human bite – note size of arc
- Unexplained bruises, burns and welts, especially if on multiple body surfaces (bilateral or symmetric)
- Different types of injuries co-existing (for example, bruises, burns, fractures on body)
- Severe bruising or the presence of multiple scars
- Injuries at various stages of healing/ages; note that the colour of bruises does not accurately reflect age or onset of injury
- More than 15 cutaneous lesions from trauma if over 9 months old (more than 3 if non-mobile)
- Bruises or burns in areas of the body not normally injured during play (for example, axilla, neck, ears, cheeks, jaws, trunk, abdomen, lumbar back, thighs, genitalia, buttocks). Forearm lesions may be the result of a child's attempt to protect themselves
- Bruises in infants not crawling
- Bruises in recognizable pattern (for example, belt marks, fingerprints, knuckles, hands)
- Burn in recognizable pattern (for example, a knife or a cigarette)
- Burn in circumferential immersion pattern of glove/stocking areas or donut shape without splash burns
- Multiple burns
- Burns in places normally protected by clothing
- Burns covering a larger area

For pictures demonstrating characteristic lesions due to abuse, *see Cutaneous Signs of Physical Abuse in Children* at http://www.stacommunications.com/journals/cme/2002/07-July/i.pdf.

Bone Injuries

- Decreased range of motion, tenderness, swelling, redness or bruising may be associated with a fracture
- Reluctance to use an extremity
- Unexplained fractures (for example, rib fracture without major trauma; femur or humerus fracture in children < 1 year; spiral fracture in long bone of nonambulating child; metaphyseal fractures; multiple/complex skull fractures; fractures of sternum, scapula or spinous processes)
- Any fractures in the first year of life
- Bilateral acute long-bone fractures
- Multiple fractures of varied ages

Genitourinary/Gastrointestinal Injuries

- Chronic abdominal or perineal pain
- Abdominal distension, rigidity, guarding and/or decreased bowel sounds
- Recurrent vomiting and/or diarrhea

DIFFERENTIAL DIAGNOSES[31]

- Accidental injury (for example, fall, unrestrained child in motor vehicle collision, bicycle accident,
- Burns (usually uneven and not severe, and/or with a splash pattern)
- Dermatologic condition (for example, impetigo, contact dermatitis)
- Mongolian spots
- Henoch Schonlein purpura
- Infections
- Hematologic disorders
- Animal bite
- Sepsis
- Osteogenesis imperfecta

SEXUAL ABUSE[32,33,34]

INDICATORS

Often those who are sexually abused have normal anogentialia, particularly to the untrained eye.

Specific

- Bruises or lacerations of genitalia, particularly of hymen at 6 o'clock position
- Vaginal or penile discharge
- Sexually transmitted infections (STIs)
- Vaginal bleeding
- Swelling in anogenital area
- Pregnancy (if child is unable to give consent by the criteria in the *Sexual Abuse* definition section)

Less Specific

- Difficulty walking
- Pain, rash or itching in genital area
- Injury to genitalia or rectum
- Recurrent urinary tract infections (dysuria)
- Recurrent vomiting and/or diarrhea
- Enuresis or encopresis
- Chronic abdominal and/or perineal pain
- Headache
- Vague symptoms like fatigue
- Behavioural symptoms: sexualized behaviour in play, delinquent behaviour, self-destructive behaviour, runaway behavior, excessive masturbation, substance abuse, sleep disturbances, hyperactivity
- Depression, anger, or suicide attempt
- Eating disorders

DIFFERENTIAL DIAGNOSES

- Accidental or self-inflicted injury
- Urethral prolapse
- Pruritus due to pinworms
- Constipation or diarrhea causing anal fissures or infection
- Vaginitis from harsh soaps or laundry detergents
- Prolonged contact with sand or chlorine
- Lichen sclerosus et atrophicus
- Labial adhesions

EMOTIONAL ABUSE[35]

INDICATORS

- Failure to thrive (in some infants)
- Behavioural disturbances
- Developmental lags
- Emotional disturbances (anxiety, depression, agitation, fearfulness)
- Social withdrawal
- Running away from home
- Drug or alcohol abuse
- Eating disorders

DIFFERENTIAL DIAGNOSES

- Failure to thrive due to underlying medical problem (for example, drug addiction in utero)
- Parental cognitive, psychological or economic limitations
- Psychopathology from other causes

NEGLECT[36,37]

INDICATORS

- Unattended medical needs
- Poor hygiene
- Abandonment
- Nonorganic failure to thrive
- Developmental delays
- Starvation or dehydration
- Severe, untreated dental caries
- School truancy (unexcused absences from school or bullying)
- Injuries due to lack of supervision
- Caregiver admitting to domestic violence in front of the child

DIFFERENTIAL DIAGNOSES

- Failure to thrive due to underlying medical problem; for example, drug addiction in utero
- Neglect from poverty, mental retardation or mental illness

MANAGEMENT OF CHILD MALTREATMENT[38,39,40]

The steps in managing a case of suspected abuse are as follows:

1. Suspect abuse in situations where there is not a definite diagnosis, or where there are inconsistencies.
2. Obtain detailed history according to *General History*.
3. In cases of sexual assault, consult with a physician by telephone before proceeding with examination and cultures. If sexual abuse took place within 72 hours of presentation for care, one will likely need to collect evidence by completion of a sexual assault evidence kit. Discuss the need to complete it with another health care provider.
4. Conduct a general *Physical Assessment* as described above.
5. If feasible and prior to reporting suspected abuse to provincial child welfare services, attempt to obtain a written consent from the parent or guardian or child him/herself (if old enough to understand to what he/she is consenting to and if able to appreciate the consequences of giving or refusing consent) to release the relevant information. *Refer to Appendix A for a sample release of information form*. If consent cannot be obtained, medical information can only be released to the provincial child welfare authorities. To release information to anyone other than provincial child welfare authorities, a written consent, describing the party requiring the information, must be obtained.
6. When notifying provincial child and welfare services, do so as soon as possible following the suspicion of maltreatment; maltreatment does not have to be confirmed prior to reporting. Include the information described in "*Reporting Maltreatment*". Caregivers should be made aware, in an empathetic, supportive and nonaccusatory manner, that you will be reporting the suspicion. They can be told that it is necessary to report as the first concern is for the safety and well-being of the child and it is legally required when abuse is suspected. They should also be informed that an investigation may be conducted.
7. During the initial assessment, consult the child-protection authorities regarding a location for safe placement of the child. Find out which restrictions, if any, have been placed on the custodial rights to the child and visitation. Only if custodial rights of the parent/guardian or primary caregiver have been removed should the child not be released to that caregiver. This is a critical part of the management.
8. Maintain a helpful, non-judgmental approach with the parents/guardian or primary caregiver. As they will be under a great deal of stress, try to demonstrate compassion and respect and offer them the appropriate resources and support.
9. Do not discuss possible mechanisms of injury with the caregiver(s). State simply that the injuries are a result of trauma. A suggestion can negatively influence the outcome or process of investigation.
10. Treat medical issues as a result of the maltreatment locally or send child to a hospital.

11. If a sexual assault has occurred, discuss prophylaxis for STIs, HIV and hepatitis B with a physician. For a female of childbearing age, discuss emergency contraception with a physician. Also consider psychological counseling.

REPORTING MALTREATMENT[41,42]

As written above, if feasible and prior to reporting suspected abuse to provincial child welfare services, Health Canada employees should attempt to obtain a written consent from the parent or guardian or child him/herself (if old enough to understand to what he/she is consenting to and if able to appreciate the consequences of giving or refusing consent) to release the relevant information. *Refer to Appendix A for a sample release of information form.*

In the absence of consent from the parent, guardian or child, provide only the following information, if known, when reporting the situation to provincial or local child welfare authorities:

- Provider's name, position and telephone number. Note: all disclosed information is to be documented in the client's chart, including provider's identification through signature and professional status
- Complete child's demographic data, including name, age, date of birth, sex and address
- For any children residing in the household, provide the number of children and their ages
- Name(s), telephone number(s) and address(es) of the person(s) responsible for the care, including the name(s) and address(es) of alleged offender. Consider reporting the age of the alleged offender as an element of the risk assessment
- Time of injury in relation to seeking care
- Names of witnesses able to provide direct observations (corroborating evidence)
- History of child's injury from the caregiver (guardian or accompanying person) and child. If possible, include any discrepancies reported to various caregivers or by different people. Use quotations as much as possible
- Information on the situation(s) including all physical and behavioral indicators observed, Include the nature, time and setting (for example, school, day care) of the maltreatment or abuse. Provide details of the child's injuries in clear, non-medical terms. The nature and possible cause of each injury is presented individually
- Aspects of the family social history directly relevant to the suspicion of abuse
- Diagram of child's injuries and whether or not photographs were taken
- The reasons why abuse is suspected and any immediate concerns about the child's safety

Where the information above is disclosed to child welfare authorities without the consent of the child, parent or guardian, the Access to Information and Privacy (ATIP) Coordinator must be informed of the release as soon as possible.

If child welfare authorities request any additional information not listed above, the Health Canada employee must attempt to obtain an approval of the ATIP Coordinator prior to disclosing the additional information.

The ATIP Coordinator's office can be reached weekdays during business hours at:

telephone: (613) 954-9165
email: atip-aiprp@hc-sc.gc.ca

If the ATIP Coordinator cannot be reached for authorization, the additional information requested by the child welfare authorities may only be disclosed if the situation satisfies the following two elements:

1) The event is defined as an emergency, that is: an immediate urgent and critical situation of a temporary nature, regardless of its cause, which may seriously endanger or threaten the lives, health or safety of individuals; and

2) A reasonable person would need to agree that an *immediate* release of the ADDITIONAL personal information was necessary.

Documentation to reflect the decision to disclose will be required. Additionally, as soon as possible, Health Canada officials must contact the ATIP coordinator to inform him/her of the disclosure; to inform him/her of the information disclosed; and to provide the reasoning for the disclosure of any additional information not listed above.

Non-FNIH providers, employed by band councils or First Nation health authorities, need to comply with the provincial legislation and possible First Nation by-laws on child maltreatment already in place. All providers should be aware of their respective provincial policy on child abuse and maltreatment.

DOCUMENTING CHILD MALTREATMENT[43,44,45,46]

Include the following information in the medical documentation, in addition to that in the "*Reporting Maltreatment"* section:

- Detailed description of the injury
- Detailed description of the history and physical findings
- Measurements and drawings where appropriate
- Colour, size, shape, texture, location, and level of discomfort or pain (if old enough, pain scales may be useful) related to lesions and bruises
- Dates, times and names of caregiver(s) interviewed
- Child and parent's behaviour
- Details of any explanations provided
- History of previous injuries or accidents
- Developmental history
- Procedures performed (for example, fundoscopic exam)
- Diagnosis (for example, suspected child abuse)
- Whether a child abuse/neglect report was made and any known results
- Final disposition of the child

LEGAL ASPECTS

Provincial/territorial legislation makes the reporting of actual and suspected child abuse mandatory across Canada with the exception of the Yukon where a person "may" report. When a person believes a child is in need of protection, there is a duty under provincial/territorial legislation to report the matter to the proper child welfare authorities

Health Canada requires its health care employees to report suspected child maltreatment to child welfare authorities. Reporting suspicions of child abuse based on information attained while working for Health Canada will require the release of personal information and must comply with Health Canada's obligation to protect personal information under the federal Privacy Act and the Canadian Charter of Rights and Freedoms.

When reporting suspected child maltreatment to child welfare authorities, Health Canada employees must provide information in accordance with the "*Reporting Maltreatment"* section.

CHILD MALTREATMENT PREVENTION STRATEGIES[47,48,49,50]

- Monthly home visits by nurses from prenatal period through infancy (until child's second birthday) for disadvantaged families, targeting first time mothers with one or more of the following: age less than 19 years, single parent status and low socioeconomic status.
- Ensure children are coming regularly for well child examinations and look for any signs of abuse or difficulty in the child-caregiver relationship.
- Educate parents and caregivers that physical discipline (for example, spanking) and verbal abuse are not acceptable forms of discipline.
- Educate parents, caregivers and prenatal clients to never shake or toss a baby. Tell them that the most common trigger to do so is the child's crying. Encourage them to seek help if the baby's demands create anger or frustration. Also, encourage them to use caution in allowing caregivers who have difficulty controlling their anger to care for their child(ren), even for a short period of time.
- Educate children about "good" and "bad" touch and that if someone touches them in a "bad" way, it is wrong and should be reported to their parent/caregiver or teacher.
- Do not screen parents for potential for child maltreatment due to the high false positive rate and the potential for mislabelling individuals.
- Educate parents and caregivers about believing all disclosures of abuse by children and seeking help.

APPENDIX A

HEALTH CANADA CONSENT FORM

EXAMPLE

TO BE COMPLETED BY MINOR CHILD OR PARENT/GUARDIAN/SUBSTITUTE DECISION MAKER/ PERSON HAVING A LEGALLY RECOGNIZED AUTHORITY TO ACT ON BEHALF OF THE MINOR CHILD.

I, _____ (name of the minor child or authorized person):

- Understand that Health Canada's health care provider has taken into consideration my (or the child named above's) best interests and, in their professional judgment, suspects that I am (or the child named above is) being or may be abused or maltreated and am/is or may be in need of protection.
- Understand that the Child Welfare Authority (or Children's Aid Society) has the responsibility to protect children and investigate allegations of child abuse or maltreatment.
- Understand that my (or the child named above's) personal health information will be used by the Child Welfare Authority (or Children's Aid Society) to determine whether I am (or the child named above is) in need of protection.
- Give my consent to Health Canada to share personal health information about me (or the child named above) with the Child Welfare Authority (or Children's Aid Society) in _____ (province/territory).
- Understand that Health Canada will only share personal health information about me (or the child named above) with the Child Welfare Authority (or Children's Aid Society) that is directly relevant to abuse and maltreatment suspected by Health Canada's health care provider for the purpose of protecting my health and safety.
- Understand that the personal information is protected under the *Privacy Act*. I am aware that every individual has a right to access the personal information about himself or herself and that the information may only be used or disclosed within the conditions set out in that Act.
- Understand that I may withdraw or amend my consent in writing at any time by contacting _____ (name, position, Health Canada address and phone number).
- Understand that should I not give consent to the disclosure of information, Health Canada may still have the authority to share my (or the child named above's) personal health information with the Child Welfare Authority (or Children's Aid Society) as authorized under the *Privacy Act*.
- Have read the above statements, understand the content of this Consent Form and chose to give my consent voluntarily.

Name (print): _____ Signature:_____

Date: _____

If this Consent Form is signed by a Parent/Guardian/Substitute Decision Maker/authorized person, please specify the relationship to the minor child.

Name (print): _____ Signature:_____

Relationship: _____ Date:_____

SOURCES

Internet addresses are valid as of August 2010.

BOOKS AND MONOGRAMS

Behrman R.E., Kliegman, R., Jenson, H.B. (1999). *Nelson's Essentials of Pediatrics* (16th ed.). Philadelphia, PA: W.B. Saunders.

Berkowitz, C. D. (2008). *Berkowitz's pediatrics: A primary care approach* (3rd ed.). United States: American Academy of Pediatrics.

Dipchand, A., & Friedman, J. (Eds.). (2009). *The Hospital for Sick Children: Handbook of pediatrics (11th ed.)*. Toronto, ON: Saunders Elsevier.

Hazinski, M. F. (Sr. Ed.). (2002). *PALS Provider Manual*. Dallas, TX: American Heart Association.

Indian and Northern Health Services. (1994, February, 4). National Child Abuse Protocol: Addressing legal issues for the health care team. Health Canada, Nursing Division, Medical Services: Ottawa.

Rudolph, C.D., et al. (2003). *Rudolph's Pediatrics* (21st ed.). McGraw-Hill.

Ryan-Wenger, N. A. (Ed.). (2007). *Core curriculum for primary care pediatric nurse practitioners*. St. Louis: Mosby Elsevier.

Strange, G.R. (Ed.). (1998). *APLS – The Pediatric Emergency Medicine Course Manual* (3rd ed.). Elk Grove Village, IL: American College of Emergency Physicians and American Academy of Pediatrics .

INTERNET GUIDELINES

Block, R.W., Krebs, N.F., Committee on Child Abuse and Neglect, & Committee on Nutrition. (2005). Failure to thrive as a manifestation of child neglect. *Pediatrics, 116*, 1234-1237. Available at: http://pediatrics.aappublications.org/cgi/reprint/116/5/1234

Canadian Paediatric Society. (2007). *Multidisciplinary guidelines on the identification, investigation and management of suspected abusive head trauma*. Ottawa, ON: Author. Available at http://www.cps.ca/english/statements/PP/AHT.pdf

Christian, C., & Endom, E.E. (2009, May 27). *Evaluation and diagnosis of inflicted head injury in infants and children*. UpToDate Online 17.2. Available at http://www.uptodate.com

Endom, E.E. (2009, February 10). *Physical abuse in children: Epidemiology and clinical manifestations*. UpToDate Online 17.2. Available at: http://www.uptodate.com

Endom, E.E. (2009, January 21). *Child neglect and emotional abuse*. UpToDate Online 17.2. Available at: http://www.uptodate.com

Endom, E.E. (2009, February 10). *Child abuse: Social and medicolegal issues*. UpToDate Online 17.2. Available at: http://www.uptodate.com

Endom, E.E. (2009, June 8). *Physical abuse in children: Diagnostic evaluation and management*. UpToDate Online 17.2. Available at: http://www.uptodate.com

Labbe, J. (2002). Cutaneous signs of physical abuse in children. *Canadian Journal of CME, 7*, 83-92. Available at: http://www.stacommunications.com/journals/pdfs/cme/julycme/i.pdf

MacMillan, H. L. (2000). Preventive health care, 2000 update: Prevention of child maltreatment. *Canadian Medical Association Journal, 163(*11), 1451-1458. Available at: http://www.cmaj.ca/cgi/reprint/163/11/1451

MacMillan, H.L., MacMillan, J.H., & Offord, D.R. (1994). Primary prevention of child maltreatment (pp. 320-332). In *Canadian Task Force on the Periodic Health Examination: Canadian guide to preventative health care*. Ottawa, ON: Health Canada. Available at: http://www.ctfphc.org/Full_Text/Ch29full.htm

Public Health Agency of Canada. (2002). *Joint statement on shaken baby syndrome*. Available at: http://www.phac-aspc.gc.ca/dca-dea/publications/jointstatement_web-eng.php

ENDNOTES

1 Endom, E.E. (2010, January). *Physical abuse in children: Epidemiology and clinical manifestations*. UpToDate Online 18.1. Available at: http://www.uptodate.com; Definition section.

2 Ryan-Wenger, N.A. (Ed.). (2007). *Core curriculum for primary care pediatric nurse practitioners*. St. Louis: Mosby Elsevier; p. 269.

3 Indian and Northern Health Services. (1994, February, 4). *National Child Abuse Protocol: Addressing legal issues for the health care team*. Health Canada, Nursing Division, Medical Services: Ottawa; p. 6.

4 Indian and Northern Health Services. (1994, February, 4). *National Child Abuse Protocol: Addressing legal issues for the health care team*. Health Canada, Nursing Division, Medical Services: Ottawa; p. 6.

5 Department of Justice. (2006, June). Age of Protection Legislation. Available at: http://www.justice.gc.ca/eng/news-nouv/nr-cp/2006/doc_31832.html

6 Public Works and Government Services Canada. (2008, February 28). Statutes of Canada 2008: Chapter 6: Bill C-2. Available at: http://www2.parl.gc.ca/HousePublications/Publication.aspx?Docid=3320180&file=4; section 13, subsection 150.1.

7 Bellemare, S. (2008). Age of consent for sexual activity in Canada. Pediatrics and Child Health, 13(6), 475. Available at: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2532909

8 Ryan-Wenger, N.A. (Ed.). (2007). *Core curriculum for primary care pediatric nurse practitioners*. St. Louis: Mosby Elsevier; p. 270.

9 Endom, E.E. (2009, January 21). *Child neglect and emotional abuse*. UpToDate Online 17.2. Available at: http://www.uptodate.com; Emotional Abuse section.

10 Ryan-Wenger, N.A. (Ed.). (2007). *Core curriculum for primary care pediatric nurse practitioners*. St. Louis: Mosby Elsevier; p. 270.

11 Indian and Northern Health Services. (1994, February, 4). *National Child Abuse Protocol: Addressing legal issues for the health care team*. Health Canada, Nursing Division, Medical Services: Ottawa; p. 6.

12 Indian and Northern Health Services. (1994, February, 4). *National Child Abuse Protocol: Addressing legal issues for the health care team*. Health Canada, Nursing Division, Medical Services: Ottawa; p. 6.

13 Block, R.W., Krebs, N.F., Committee on Child Abuse and Neglect, & Committee on Nutrition. (2005). Failure to thrive as a manifestation of child neglect. *Pediatrics, 116,* 1234-1237. Available at: http://pediatrics.aappublications.org/cgi/reprint/116/5/1234

14 Endom, E.E. (2009, January). *Child neglect and emotional abuse*. UpToDate Online 17.2. Available at: http://www.uptodate.com; Child Neglect section.

15 Ryan-Wenger, N.A. (Ed.). (2007). *Core curriculum for primary care pediatric nurse practitioners*. St. Louis: Mosby Elsevier; p. 269.

16 Indian and Northern Health Services. (1994, February, 4). *National Child Abuse Protocol: Addressing legal issues for the health care team*. Health Canada, Nursing Division, Medical Services: Ottawa; p. 7.

17 Ryan-Wenger, N. A. (Ed.). (2007). *Core curriculum for primary care pediatric nurse practitioners*. St. Louis: Mosby Elsevier; p. 277.

18 Canadian Paediatric Society. (2007). *Multidisciplinary guidelines on the identification, investigation and management of suspected abusive head trauma*. Ottawa, ON: Author. Available at http://www.cps.ca/english/statements/PP/AHT.pdf; p. 5-11.

19 Christian, C., & Endom, E.E. (2009, May 27). *Evaluation and diagnosis of inflicted head injury in infants and children*. UpToDate Online 17.2. Available at http://www.uptodate.com

20 Public Health Agency of Canada. (2002). *Joint statement on shaken baby syndrome*. Available at http://www.phac-aspc.gc.ca/dca-dea/publications/jointstatement_web-eng.php

21 Dipchand, A., & Friedman, J. (Eds.). (2009). *The Hospital for Sick Children: Handbook of pediatrics (11th ed.)*. Toronto, ON: Saunders Elsevier; p. 182.

22 Ryan-Wenger, N. A. (Ed.). (2007). *Core curriculum for primary care pediatric nurse practitioners*. St. Louis: Mosby Elsevier; p. 276-277.

23 MacMillan, H.L., MacMillan, J.H., & Offord, D.R. (1994). Primary prevention of child maltreatment (p. 320-332). In *Canadian Task Force on the Periodic Health Examination: Canadian guide to preventative health care*. Ottawa, ON: Health Canada. Available at http://www.ctfphc.org/Full_Text/Ch29full.htm; Risk Indicators section.

24 MacMillan, H.L. (2000). Preventive health care, 2000 update: Prevention of child maltreatment. *Canadian Medical Association Journal, 163(*11), 1451-1456. Available at http://www.cmaj.ca/cgi/reprint/163/11/1451

25 MacMillan, H.L., MacMillan, J.H., & Offord, D.R. (1994). Primary prevention of child maltreatment (pp. 320-332). In *Canadian Task Force on the Periodic Health Examination: Canadian guide to preventative health care*. Ottawa, ON: Health Canada. Available at http://www.ctfphc.org/Full_Text/Ch29full.htm; Burden of Suffering section.

26 Canadian Paediatric Society. (2007). *Multidisciplinary guidelines on the identification, investigation and management of suspected abusive head trauma*. Ottawa, ON: Author. Available at http://www.cps.ca/english/statements/PP/AHT.pdf; p. 1-9.

27 Hazinski, M. F. (Sr. Ed.). (2002). *PALS Provider Manual*. Dallas, TX: American Heart Association; p. 179, 272.

28 Dipchand, A., & Friedman, J. (Eds.). (2009). *The Hospital for Sick Children: Handbook of pediatrics (11th ed.)*. Toronto, ON: Saunders Elsevier; p. 180-183.

29 Ryan-Wenger, N. A. (Ed.). (2007). *Core curriculum for primary care pediatric nurse practitioners*. St. Louis: Mosby Elsevier; p. 272-273.

30 Labbe, J. (2002). Cutaneous signs of physical abuse in children. *Canadian Journal of CME, 7,* 83-92. Available at http://www.stacommunications.com/journals/pdfs/cme/julycme/i.pdf

31 Endom, E. E. (2009, June). *Child neglect and emotional abuse*. UpToDate Online 17.2. Available at http://www.uptodate.com; Physical Examination section.

32 Dipchand, A., & Friedman, J. (Eds.). (2009). *The Hospital for Sick Children: Handbook of pediatrics (11th ed.)*. Toronto, ON: Saunders Elsevier; p. 181-183.

33 Ryan-Wenger, N. A. (Ed.). (2007). *Core curriculum for primary care pediatric nurse practitioners*. St. Louis: Mosby Elsevier; p. 273-279.

34 Ryan-Wenger, N. A. (Ed.). (2007). *Core curriculum for primary care pediatric nurse practitioners*. St. Louis: Mosby Elsevier; p. 274-278.

35 Dipchand, A., & Friedman, J. (Eds.). (2009). *The Hospital for Sick Children: Handbook of pediatrics (11th ed.)*. Toronto, ON: Saunders Elsevier; p. 183-184.

36 Ryan-Wenger, N. A. (Ed.). (2007). *Core curriculum for primary care pediatric nurse practitioners*. St. Louis: Mosby Elsevier; p. 278-280.

37 Berkowitz, C. D. (2008). *Berkowitz's pediatrics: A primary care approach* (3rd ed.). United States: American Academy of Pediatrics; p. 711-715.

38 Endom, E. E. (2009, January). *Child neglect and emotional abuse*. UpToDate Online 17.2. Available at http://www.uptodate.com; Emotional Abuse section

39 Berkowitz, C. D. (2008). *Berkowitz's pediatrics: A primary care approach* (3rd ed.). United States: American Academy of Pediatrics; p. 717-720.

40 Endom, E. E. (2009, January). *Child neglect and emotional abuse*. UpToDate Online 17.2. Available at http://www.uptodate.com; Child Neglect section.

41 Canadian Paediatric Society. (2007). *Multidisciplinary guidelines on the identification, investigation and management of suspected abusive head trauma*. Ottawa, ON: Author. Available at http://www.cps.ca/english/statements/PP/AHT.pdf

42 Endom, E. E. (2009, February 10). *Child neglect and emotional abuse*. UpToDate Online 17.2. Available at http://www.uptodate.com; Child Neglect section.

43 Indian and Northern Health Services. (1994, February, 4). *National Child Abuse Protocol: Addressing legal issues for the health care team*. Health Canada, Nursing Division, Medical Services: Ottawa; p. 8.

44 Kelly R. (2010) Children's Aid Society of Ottawa-Carleton. Personal discussion regarding Reporting Maltreatment. April 14, 2010.

45 Finkelhor, D., Hotaling, G., Lewis, I.A., & Smith, C. (1990). Sexual Abuse in a National Survey of Adult Men and Women: Prevalence, Characteristics, and Risk Factors. *Child Abuse and Neglect* vol.14 p. 21.

46 Berkowitz, C.D. (2008). *Berkowitz's pediatrics: A primary care approach* (3rd ed.). United States: American Academy of Pediatrics; p. 707-721.

47 Canadian Paediatric Society. (2007). *Multidisciplinary guidelines on the identification, investigation and management of suspected abusive head trauma*. Ottawa, ON: Author. Available at http://www.cps.ca/english/statements/PP/AHT.pdf; p. 4-11.

48 Dipchand, A., & Friedman, J. (Eds.). (2009). *The Hospital for Sick Children: Handbook of pediatrics (11th ed.)*. Toronto, ON: Saunders Elsevier; p. 180-184.

49 Endom, E.E. (2009, February). *Child neglect and emotional abuse*. UpToDate Online 17.2. Available at http://www.uptodate.com; Reporting Suspected Abuse section.

50 Ryan-Wenger, N.A. (Ed.). (2007). *Core curriculum for primary care pediatric nurse practitioners*. St. Louis: Mosby Elsevier; p. 282.

51 Public Health Agency of Canada. (2002). *Joint statement on shaken baby syndrome*. Available at http://www.phac-aspc.gc.ca/dca-dea/publications/jointstatement_web-eng.php

52 MacMillan, H.L. (2000). Preventive health care, 2000 update: Prevention of child maltreatment. *Canadian Medical Association Journal, 163*(11), 1451-1456. Available at http://www.cmaj.ca/cgi/reprint/163/11/1451