

Recognition and Reporting of Child Abuse

Part 3: Consult Series



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Recognition and Reporting of Child Abuse

Part Three – Consult Series

To participate in this module, you must read the three Child Abuse Consult documents that follow:

- Child Abuse Reporting
- Definition of Child Abuse
- Signs and Symptoms of Child Abuse

You are encouraged to also review the additional resources referenced in the materials via the live links provided within the documents.

When you have completed the review of this module, return to the main activity page. Complete the assessment to earn credit for the required training and claim CME.



Child Abuse Reporting

Updated Sept. 30, 2016

This is general legal information and is not intended as legal advice. The law can change and is subject to differing interpretations. Physicians should consult their attorney if they need legal guidance on a specific situation. Nothing in this information should be construed as defining a standard of care.

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Physicians have a mandatory obligation to report suspected child abuse under [Pennsylvania’s Child Protective Services Law](#) (CPSL).¹ This PAMED *Quick Consult* summarizes physician’s mandatory reporting obligation and related responsibilities, including [changes enacted in 2013 and 2014](#) to address concerns with the adequacy of protections for abused children in Pennsylvania. Key changes in the law impacting physicians include:

- The new definition of child abuse is more specific and has been expanded.
- Physicians must report suspected child abuse identified in certain circumstances outside their professional capacity.
- Physicians no longer can fulfill their reporting obligation simply by making a report to their supervisor or other designated person in their workplace.

- The penalties for failing to make a mandatory report are increased.
- Physicians have a mandatory child abuse recognition and reporting training requirement as a condition of licensure.

Child welfare system²

The principal goals of the public child welfare system are to assure the safety, permanency, and well-being of children. This includes assuring that children are protected from abuse and neglect.

Pennsylvania's public child welfare system is county-administered and state-supervised. Each [county Children and Youth Agency \(CYA\)](#) is responsible for delivering services to prevent and address child abuse and neglect. The state [Department of Human Services \(DHS\)](#), formally known as the Department of Public Welfare (DPW), oversees the child welfare system and provides technical assistance through [the Office of Children Youth and Families](#).

Child welfare services are provided in Pennsylvania in two types of situations:

- **Child protective services** – These services are provided in child abuse cases, that is when the abuse constitutes child abuse as defined in the law. Services may include counseling, classes to strengthen parenting skills, self-help groups, emergency medical services, and placement outside the home as a last resort. .
- **General protective services** – Essentially the same services are available to protect children in certain other situations that do not rise to the level of child abuse. Examples include inadequate shelter, hygiene concerns, inappropriate discipline, inadequate supervision, truancy, and other issues that threaten a child's opportunity for healthy growth and development.

Definition of child abuse

Generally speaking, the following types of conduct (action or failure to act), when intentional, knowing, or reckless, constitutes child abuse if the victim is a child (any person under 18):³

- Causing or creating a reasonable likelihood of bodily injury or death
- Causing or substantially contributing to serious mental injury
- Causing or increasing a likelihood of sexual abuse or exploitation
- Committing any of a list of specified acts
- Causing serious physical neglect, including failure to provide essential medical care
- Engaging in Munchausen by proxy behavior

Of note, the new law lowers the threshold for physical abuse. The old definition set the threshold as *serious* physical injury, which meant causing *severe* pain or *significantly* impairing the child's physical functioning. The new definition lowers the threshold to bodily injury. Bodily injury is defined as causing *substantial* pain or *any* impairment in physical condition. Also, the new definition identifies culpable conduct that is per se child abuse; that is, intentionally, knowingly, or recklessly engaging in this conduct – in and of itself – constitutes child abuse, regardless of whether an injury results. Examples include kicking, biting, throwing, burning, stabbing, or cutting a child in a manner that endangers the child and forcefully shaking or slapping an infant.

The law classifies certain persons as “perpetrators.” Generally, perpetrators are limited to parents, spouses and paramours of a parent (present or former), persons responsible for the child’s welfare (14 or older for actions; 18 or older for failure to act), residents of the same household (14 or older for actions; 18 or older for failure to act), certain close adult relatives (only actions); and individuals having direct contact with children as an employee of child care services, a school, or through a program, activity, or service (14 or older; actions only). However, child abuse by other persons – for example, a stranger the child encounters in a park – is reportable. Physicians should report suspected child abuse, when required, regardless of whether the person who is responsible for the abuse meets the definition of perpetrator.

Mandated reporters

All of the following persons are now mandated reporters if they are an adult (18 or older):⁴

- Physician or other person who is licensed or certified to practice any health-related field by the Department of State
- Medical examiner, coroner, or funeral director
- Employee of a health care facility or provider licensed by the Department of Health who is engaged in the admission, examination, care, or treatment of individuals
- School employee
- Employee of a childcare service who has direct contact with children in the course of employment
- Clergyman, priest, rabbi, minister, Christian Science practitioner, religious healer, or spiritual leader of any regularly established church or other religious organization
- Individual paid or unpaid, who, on the basis of the individual's role as an integral part of a regularly scheduled program, activity, or service, is a person responsible for the child's welfare or has direct contact with children
- Employee of a social services agency who has direct contact with children in the course of employment
- Peace officer or law enforcement official
- Emergency medical services provider certified by the Department of Health
- Employee of a public library who has direct contact with children in the course of employment.
- Individual who provides a program, activity, or service to an agency, institution, organization, or other entity, including a school or regularly established religious organization, that is responsible for the care, supervision, guidance, or control of children and has direct contact with children
- Individual supervised or managed by a person listed above who has direct contact with children in the course of employment.
- Foster parent
- Attorney affiliated with an agency, institution, organization, or other entity, including a school or regularly established religious organization, that is responsible for the care, supervision, guidance, or control of children

- Adult who is responsible for the welfare of a child with an intellectual disability or chronic psychiatric disability and provides services in a DHS supervised or licensed family living home, community home for individuals with intellectual disabilities, or host home for children

Of note, mandated reporters are no longer limited to persons who, in the course of their work — that is employment, occupation, or practice of a profession – come into contact with children. All physicians with a Pennsylvania license are mandated reporters, regardless of how frequently they come into contact with children as patients. This includes even specialists that have few child patients, retired physicians with an active-retired license, and residents and fellows with a graduate license. Physician practices should keep in mind that unlicensed office staff also are mandated reporters if they have routine interaction with children in the course of their employment. For example, medical assistants as well as the front desk staff may qualify as mandated reporters.

Reporting requirement

Physicians and other mandated reporters are now required to make a child abuse report if they have reasonable cause to suspect child abuse under any of the following circumstances:⁵

- **Contact with child** – The mandated reporter comes in contact with the child in the course of the reporter’s employment, occupation, or practice of a profession or through a regularly scheduled activity, program, or service
- **Responsibility for child** – The mandated reporter is directly responsible for the care, supervision, guidance, or training of the child, or is affiliated with an agency, institution, organization, school, regularly established church or religious organization, or other entity that is directly responsible for the care, supervision, guidance, or training of the child
- **Notice of identified victim** – A person makes a specific disclosure to the mandated reporter that an identifiable child is the victim of child abuse
- **Confession by abuser** – An individual 14 years of age or older makes a specific disclosure to the mandated reporter that the individual has committed child abuse

This is an expansion from prior law. Of note, physicians are required to make a child abuse report in certain circumstances, even though they learn of the suspected abuse outside of work and regardless of whether the child is a patient of the physician or the facility or practice where the physician works. For example, if a physician obtains a reasonable suspicion that a child has been abused from information told to the physician at a social gathering after work, the physician must make a report. Also, physicians must report when they have a reasonable suspicion that a person who is 14 or older, including a patient, committed child abuse if the person specifically disclosed the abuse to the physician. As discussed below, the reporting mandate over-rides patient confidentiality obligations.

The reporting requirement applies even if the mandated reporter does not know the identity of the abuser.⁶ For example, if a physician reasonably suspects that a child is the victim of sexual abuse, a report is required even if the physician cannot identify who committed the abuse.

The CPSL also provides for permissive child abuse reports. Any person who has reasonable cause to suspect that a child is the victim of child abuse is encouraged to report.⁷

Basis for reasonable suspicion

Pennsylvania's Child Welfare Resource Center, operated by the University of Pittsburgh, recommends that mandated reporters (and those considering a permissive report) evaluate the following:⁸

- **Circumstances** – What do you know about the facts of the incident or pattern of events? Consider who, what, how, and when.
- **Observations** – Are any indicators of abuse or “red flags” present? Consider the behavior and demeanor of both the child and the adult. Think about whether there are other behaviors or observations important to notice.
- **Familiarity** – Consider the knowledge you have about the individuals, the family situation, relevant history or similar prior incidents.
- **Feelings** – Think about your feelings and personal biases and consider how they influence your conclusions and actions.

Mandated reporters, including physicians, are not expected to be experts in child abuse; their role is not to validate suspected abuse before reporting. The trigger for reporting is “reasonable cause to suspect” child abuse. This requires more than a gut feeling or guess based upon intuition rather than known facts. At the same time, a reasonable suspicion does not require a high degree of medical certainty or even a belief that the child's injuries more likely than not resulted from child abuse. David Turkewitz, MD, an expert in child abuse who provides recognition and reporting training to physicians advises: “If, when reviewing the history, physical examination, and the results of any laboratory and imaging tests, you conclude that abuse reasonably fits in the differential diagnosis, then you must report.”

Although the law's definition of child abuse includes a number of exclusions, physicians should not consider the exclusions when determining whether to report. These are exclusions to the *definition* of child abuse, not the *obligation to report* suspected child abuse. For example, a parent's failure to consent to essential medical care may, depending on the circumstances, rise to the level of child abuse. The definition of child abuse includes an exclusion for when parents are acting pursuant to bona fide religious beliefs. However, the county CYA makes the determination as to whether the exclusion applies. In other words, physicians should not consider a parent's religious beliefs when determining whether a report of suspected child abuse is required for failure to provide essential medical care.

Signs and symptoms of abuse

The American Academy of Pediatrics recommends that physicians should consider abuse in *any* child from *any* family in these situations:⁹

- Multiple injuries to multiple organ systems
- Denial of trauma in child with significant injury
- History inconsistent with injury
- History incompatible with child's development
- History that changes over time
- Unexpected and unexplained delay in seeking treatment

Dr. Turkewitz cautions that physicians “will never reach a reasonable suspicion threshold if they have preconceived notions that child abuse is rare or doesn’t occur unless there are risk factors such as poverty.” He emphasizes that “reporting suspected child abuse is a critical protection for children, as the consequence of missed child abuse typically is further abuse and sometimes even death of the child.” PAMED’s *Quick Consult on Signs and Symptoms of Child Abuse* further outlines signs and symptoms of child abuse. PAMED also has a child abuse recognition and reporting training program that includes case studies to aid understanding of when there is reasonable cause to suspect child abuse. These resources and more are available at www.pamedsoc.org/childabuselaws.

Procedures for making report

Mandated reporters must follow these procedures when making a child abuse report:

- **Immediate report** – An immediate report must be made to the DHS (formerly DPW) either orally by [telephone](#) or via a new electronic [Child Welfare Portal](#).¹⁰
 - **Oral telephone report** – The procedures for oral reports are unchanged. Oral child abuse reports must be made via [ChildLine](#) at (800) 932-0313, a statewide toll-free number that is staffed 24 hours a day, seven days a week.
 - **Electronic report** – Physicians and other mandated reporters also may now make their immediate report through DHS’s new electronic [Child Welfare Portal](#).¹¹
- **Follow-up written report within 48 hours** – If the immediate report is made orally (versus electronically), a written report must be submitted within 48 hours to DHS or the county CYA assigned to the case on DHS’s [written report form](#).¹²

The new law requires a mandated reporter to personally make the report; language allowing compliance by “causing the report to be made” was eliminated.¹³ The new law also eliminated the option that allowed staff of an institution, school, facility, or agency to hand-off the reporting responsibility by informing the head person or that person’s designee for making reports. These mandated reporters must personally make an immediate report to DHS and then (after their report to DHS) immediately report to the head person or that person’s designee for cooperating with the CYA investigation.¹⁴ As in the past, the CPSL does not require more than one report from an institution, school, facility or agency.¹⁵

Content of report

Mandated written reports of suspected child abuse, including electronic reports, must include the following information, to the extent available:¹⁶

- Identification of child, child’s parents, any other person responsible for child’s welfare, and suspected perpetrator, including:
 - Name
 - Social security number, gender, and birthdate
 - Address, county, and telephone number
- Names and relationships of other persons in child’s family household
- Location and date of suspected abuse
- Description of child’s injuries and condition and why reporter suspects abuse, including evidence of prior abuse to child, sibling, or suspected perpetrator

- Actions taken by reporter, CYA, law enforcement, school officials, and others, including:
 - Medical examination, photographs, medical tests and X-rays
 - Hospital admission
 - Emergency custody
 - Notification to coroner and law enforcement
- Child risk factors, including:
 - Physical, mental, or behavioral factors
 - Need for immediate medical attention
 - Level of pain
 - Fearful, suicidal, or withdrawn appearance
- Family risk factors, including:
 - Characteristics of caregiver/suspected perpetrator
 - Extent of suspected perpetrator's access to child
 - Substance abuse in household
 - History of violence or severe emotional problems
 - Environmental (health and safety) condition of home
 - Risk from CYA involvement
 - Weapons in home
- Name, address, telephone number of reporter

Required related reports

Depending on the circumstances, a mandated reporter of suspected child abuse may need to make one or more related reports in addition to making a child abuse report to DHS:

- **Internal report** – Persons who must make a child abuse report in their capacity as member of the staff of a medical or other public or private institution, school, facility, or agency, also must notify the head of the institution, school, facility, or agency or other designated agent, such as their supervisor, immediately after making their mandated oral or electronic report to DHS. Once notified, the head or other designated agent is responsible for facilitating the cooperation of the institution, school, facility, or agency with the investigation of the report.¹⁷
- **Coroner report** – A mandated reporter who has reasonable cause to suspect that a child died as a result of child abuse must report that suspicion to the county coroner or medical examiner.¹⁸
- **Law enforcement** – The Crimes Code requires physicians to immediately report to law enforcement when a patient dies or sustains serious bodily injury when a patient has been injured by a deadly weapon or a criminal act.¹⁹ This would include criminal assaults that result in death or serious bodily injury.²⁰ Serious bodily injury means an injury that creates a substantial risk of death or causes serious permanent disfigurement or protracted loss or impairment of function of any bodily member or organ.²¹ Reports to law enforcement also should be made in the case of sexual abuse crimes, including statutory rape.

Photographs and tests

If physicians suspect child abuse, they may take or order photographs of the child and clinically indicated radiological examinations and other medical tests for the child. Medical summaries or reports of the photographs, X-rays, and medical tests must be sent to the county agency at the time the written report is

sent or, if the written report is made electronically, within 48 hours or as soon thereafter as possible. The county CYA may review and obtain upon request the originals or duplicates of the photographs and X-rays. In addition, law enforcement now has access to medical summaries or reports of photographs, X-rays, and medical tests when they are investigating suspected child abuse.²² PAMED's *Quick Consult on Signs and Symptoms of Child Abuse* includes AAP recommendations on the Initial Evaluation of Suspected Physical Abuse. It and other resources can be found at www.pamedsoc.org/childabuselaws.

Investigation of reports

Upon receipt of a child abuse report, DHS must immediately forward the report to the appropriate county CYA.²³ If the person suspected of committing the abuse is a defined perpetrator, the CYA must investigate the report and take appropriate and timely action to ensure the child's safety and well-being.²⁴ If the report does not involve a defined perpetrator but warrants investigation because it involves criminal conduct, the CYA must refer the matter to law enforcement.²⁵ In addition, DHS must refer reports involving both a defined perpetrator and criminal conduct to law enforcement for a joint investigation.²⁶ When a CYA finds substantial evidence of child abuse, the report is classified as "indicated." A report alternatively will be classified as "founded" in certain circumstances, such as when a court rules there was child abuse. A report that is neither indicated nor founded is classified as "unfounded."²⁷

Obligation to cooperate

Physicians and other certified health professionals, regardless of whether they made a child abuse report, are required to share information about a child, whose medical health is negatively affected, with a county CYA that is conducting a child abuse investigation, is assessing the child for general protective services, or has accepted the child's family for services, including:²⁸

- Relevant medical information regarding the child's prior and current health
- Information from a subsequent examination
- Information regarding treatment of the child
- Relevant medical information about another child in the household that may contribute to the assessment, investigation, or provision of services to the child or other children in the household

The law further provides that parental consent is not required for the physician to provide this information.²⁹

Right-to-know

The changes to the CPSL added new rights-to-know for mandated reporters and medical practitioners:

Mandated reporter – A mandated reporter who makes a report of suspected child abuse now has the right to receive information about the final status of the report – that is whether the report is indicated, founded, or unfounded – and about services that the county CYA provides or arranges to protect the child. Upon request, DHS must provide this information to the mandated reporter within three business days of the department's receipt of the results of the investigation.³⁰

Certified medical practitioners – A child's primary care physician, as well as other certified medical practitioners who are providing medical care to the child, also now have the right to receive information to ensure the proper medical care of the child, regardless of whether they made a report of suspected child abuse. Upon request, the county CYA must provide.³¹

- The final status of any assessment of general protective services or investigation of child abuse, if the report of child abuse is indicated or founded
- Information on an unfounded report of child abuse if the certified medical practitioner made the report as a mandated reporter
- If accepted for services, any service provided, arranged for or to be provided by the county CYA
- The identity of other certified medical practitioners providing medical care to the child to allow for sharing of medical records and coordination of care between medical practitioners

In circumstances where the medical health of a child is negatively affected, the county CYA now must affirmatively communicate, regardless of a request, the first three categories of information to the certified medical practitioner who is the child's primary care provider, if known.³²

Patient confidentiality

Physicians and other mandated reporters cannot justify failing to make a mandated child abuse report based upon patient confidentiality requirements. The CPSL provides that the child abuse reporting obligation overrides state privileges that protect the confidentiality of privileged communications, with limited exceptions not applicable to physicians and other health care professionals (confidential communications to the clergy and attorneys).³³ The HIPAA privacy rule also provides an exception to the patient authorization requirement for mandated child abuse reports.³⁴ The confidentiality requirements in the physician licensing regulations likewise permit compliance with mandatory reporting requirements.³⁵ For more information on the HIPAA rules, go to www.pamedsoc.org/HIPAA.

In addition, several laws and regulations governing confidentiality of super-protected information permit compliance with child abuse reporting requirements, as follows:

- **Mental health** – The regulations implementing the Mental Health Procedures Act (MHPA) confidentiality requirement provide that the CPSL reporting requirements prevail whenever there is a conflict between the two laws.³⁶
- **Drug and alcohol treatment** – The regulations governing the confidentiality requirement applicable to federally-assisted drug and alcohol treatment programs allow disclosure to make mandated child abuse and neglect reports.³⁷ However, patient authorization or a court order still is required to provide access to the original alcohol- or drug-abuse patient records maintained by the program, including their disclosure and use for civil or criminal proceedings that may arise out of the report of suspected child abuse and neglect.

Protections for reporting

Physicians and others who make a child abuse report – including voluntary reporters – are accorded several protections under the law:

- **Protection of identity** – DHS and the county are prohibited from identifying a person who made a child abuse report or who cooperated in a subsequent investigation, except to law enforcement and the district attorney's office. Law enforcement officials are required to treat all reporting sources as confidential informants. The requirement to protect the identity of a person who reports or cooperates also applies to an institution, school, facility or agency when their staff notify them of a report or cooperate with the investigation.³⁸

- Liability protection** – The CPSL provides that any person who, in good faith, makes a child abuse report, cooperates with a child abuse investigation, testifies in a proceeding arising out alleged child abuse, or takes other actions authorized under the law, such as photographs, X-rays, and medical tests to document suspected child abuse, is immune from criminal and civil liability under state law. It further provides that mandated reporters are presumed to be acting in good faith.³⁹ The physician licensing regulations extend this immunity to disciplinary action.⁴⁰
- Protection from retaliation** – Physicians and other mandated reporters are protected from retaliatory employment actions.⁴¹ They may obtain damages and other appropriate relief in a lawsuit if they are fired or are discriminated against with respect to compensation, hire, tenure, terms, conditions, or privileges of employment as a result of making a mandated child abuse report, as long as the report was made in good faith. This protection also now extends to voluntary reporters. In light of the protection against retaliatory employment action, physician practices should be careful not to discriminate against office staff who make a child abuse report.

Penalties for failing to report

Physicians and other mandated reporters who willfully fail to make a required report of suspected child abuse face severe criminal penalties, including fines and incarceration:⁴²

Violation	Potential penalty ⁴³
Initial offense No aggravating factors Failure continues while knowing or having reasonable cause to believe child is actively being subjected to child abuse, but abuse does not rise to first-degree felony or higher Have direct knowledge of the suspected child abuse and abuse constitutes a first-degree felony or higher	Up to \$5,000 fine and two years imprisonment Up to \$10,000 fine and five years imprisonment Up to \$15,000 fine and seven years imprisonment
Second and subsequent offenses	Up to \$15,000 fine and seven years imprisonment

Training requirements

Physicians have new child abuse training requirements.⁴⁴ Effective Jan. 1, 2015, professional licensing boards must require child abuse recognition and reporting training as a condition of licensure for mandated reporters. Physicians applying for a new license are required to complete three hours of training through a state-approved course. Physicians applying for a renewal license are required to complete two hours of training through a state-approved course, per licensure cycle. The two hours of required training is counted toward the 100 hours of the total continuing education required for biennial license renewal. PAMED offers state-approved training for Pennsylvania physicians at www.pamedsoc.org/cme.

Additional resources

Department of Human Services, [Keep Kids Safe PA website](#)
 American Academy of Pediatrics, [Evaluation of Suspected Child Physical Abuse](#), Pediatrics, June 2007
 U.S. Health and Human Services, [National Center on Substance Abuse and Child Welfare](#)

Pennsylvania Academy of Pediatrics, [Suspected Child Abuse and Neglect \(SCAN\) Training](#)

¹ 23 Pa.C.S. § 6301 *et seq.*

² 55 Pa. Code §§ 3490.1 *et seq.*; See also Testimony of Beverly Mackereth, Acting Secretary of Department of Public Welfare, *Overview of Pennsylvania's Child Welfare System*, Joint Hearing of the Senate Aging and Youth and the Senate Public Health and Welfare Committees (April 9, 2013). Retrieved Dec, 16, 2014 from www.dpw.state.pa.us/cs/groups/webcontent/documents/presentation/p_033429.pdf.

³ 23 Pa.C.S. § 6303(b.1); See also related definitions at § 6303(a).

⁴ *Id.* at 6311(a).

⁵ *Id.* at 6311(b)(1).

⁶ *Id.* at 6311(b)(3).

⁷ *Id.* at 6312.

⁸ Pennsylvania Child Resource Center, *Recognizing and Reporting Child Abuse, Mandated and Permissive Reporting in Pennsylvania*. Retrieved Dec. 16, 2104 from www.reportabusepa.pitt.edu.

⁹ American Academy of Pediatrics, [Just a Cheat Sheet for the Initial Evaluation of Suspected Child Physical Abuse](#). (Bright yellow laminated copies of this cheat sheet are available at no cost through the SCAN program, www.pascan.org.)

¹⁰ 23 Pa.C.S. § 6313(a)(1).

¹¹ *Id.* at 6305.

¹² *Id.* at 6313(a)(2).

¹³ *Id.* at 6311(b).

¹⁴ *Id.* at 6311(c).

¹⁵ *Id.*

¹⁶ *Id.* at 6313(b).

¹⁷ *Id.* at 6311(c).

¹⁸ *Id.* at 6317.

¹⁹ 18 Pa.C.S. § 5106.

²⁰ *Id.* at 2702.

²¹ *Id.* at 2301.

²² 23 Pa.C.S. § 6314.

²³ *Id.* at 6334(b).

²⁴ *Id.* at 6368

²⁵ *Id.* at 6368(j).

²⁶ *Id.* §§ 6334(c); 6365(c).

²⁷ *Id.* at 6303.

²⁸ *Id.* at 6340.1(a).

²⁹ *Id.* at 6340.1(b).

³⁰ *Id.* at 6368(h).

³⁰ *Id.* at 6340.1(c).

³² *Id.* at 6340.1(d).

³³ *Id.* at 6311.1.

³⁴ 45 C.F.R. § 164.512(b)(1)(ii).

³⁵ 49 Pa. Code §§ 16.61(a)(1), 16.106 (medical doctors), 25.213(c)(4), 25.415 (osteopathic physicians).

³⁶ 55 Pa. Code § 5100.38.

³⁷ 42 C.F.R. § 2.12(c)(6).

³⁸ 23 Pa.C.S. § 6340(c).

³⁹ *Id.* at 6318.

⁴⁰ 49 Pa. Code §§ 16.105 (medical doctors), 25.414 (osteopathic physicians).

⁴¹ 23 Pa.C.S. § 6320.

⁴² 23 Pa.C.S. § 6319.

⁴³ 18 Pa.C.S. §§ 1101 (fines), 1103 (imprisonment for felonies), 1104 (imprisonment for misdemeanors).

⁴⁴ *Id.* at 6383.



Definition of Child Abuse

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The below chart outlines the types of conduct that the Child Protective Services Law (CPSL) defines as child abuse, when done intentionally, knowingly, or recklessly to a child. The specific conduct and the related definitions listed in the chart are taken verbatim from the law, but reorganized into categories to aid understanding. The changes in the law refer to amendments, effective Dec. 31, 2014.

Causing or creating reasonable likelihood of bodily injury or death	
<p>Specific conduct in category</p> <p>Causing bodily injury to a child through any recent act or failure to act.</p> <p>Creating a reasonable likelihood of bodily injury to a child through any recent act or failure to act.</p> <p>Causing the death of the child through any act or failure to act.</p> <p>Related definitions</p> <p>“Bodily injury.” Impairment of physical condition or substantial pain.</p>	<p>Key issues and changes</p> <p>The new law lowers the threshold for physical injuries that trigger the causal conduct to be considered child abuse – replacing “serious physical injury” with “bodily injury.”</p> <ul style="list-style-type: none"> • The law defines “serious physical injury” as severe pain or significant impairment of physical functioning. • The new law’s definition of “bodily injury” substitutes <i>substantial</i> pain for <i>severe</i> pain • “Bodily injury” as defined by the new law also includes <i>any</i> impairment of physical condition regardless of the significance.

Causing or substantially contributing to serious mental injury	
<p>Specific conduct in category</p> <p>Causing or substantially contributing to serious mental injury to a child through any act or failure to act or a series of such acts or failures to act.</p> <p>Related definitions</p> <p>“Serious mental injury.” A psychological condition, as diagnosed by a physician or licensed psychologist, including the refusal of appropriate</p>	<p>Key issues and changes</p> <p>The prior law limits this category to <i>direct causes</i> of serious mental injury. The new law expands this category to include an act or a series of acts over a course of time that <i>substantially contribute</i> to – though do not necessarily directly cause – a child to be fearful, agitated, depressed, anxious, etc.</p>

treatment, that:

- (1) renders a child chronically and severely anxious, agitated, depressed, socially withdrawn, psychotic or in reasonable fear that the child's life or safety is threatened; or
- (2) seriously interferes with a child's ability to accomplish age-appropriate developmental and social tasks.

Causing or creating likelihood of sexual abuse or exploitation

Specific conduct in category

Causing sexual abuse or exploitation of a child through any act or failure to act.

Creating a likelihood of sexual abuse or exploitation of a child through any recent act or failure to act.

Related definitions

“**Sexual abuse or exploitation.**” Any of the following:

- (1) The employment, use, persuasion, inducement, enticement or coercion of a child to engage in or assist another individual to engage in sexually explicit conduct, which includes, but is not limited to, the following:
 - (i) Looking at the sexual or other intimate parts of a child or another individual for the purpose of arousing or gratifying sexual desire in any individual.
 - (ii) Participating in sexually explicit conversation either in person, by telephone, by computer or by a computer-aided device for the purpose of sexual stimulation or gratification of any individual.
 - (iii) Actual or simulated sexual activity or nudity for the purpose of sexual stimulation or gratification of any individual.
 - (iv) Actual or simulated sexual activity for the purpose of producing visual depiction, including photographing, videotaping, computer depicting or filming.

This paragraph does not include consensual activities between a child who is 14 years of age or older and another person who is 14 years of age or older and whose age is within four years of the

Key issues and changes

The sexual abuse or exploitation definition is largely unchanged. It includes coaxing or forcing a child to engage in, or assist someone else to engage in, sexually explicit conduct, such as looking at intimate parts, sexually explicit conversation, and actual or simulated sexual activity. It also includes a list of crimes that are deemed *per se* child abuse when committed against a child, such as rape.

One change involves the *per se* child abuse criminal offences. Statutory sexual assault is added. Sexual intercourse with a child under 13 was included previously as this constitutes rape. The law negates any consent by a child under 13 regardless of the offender's age. Statutory sexual assault addresses sexual intercourse with a child under 16. This is “statutory rape” when the offender is more than four years older than the child and is not married to the child.

The changes in the law also clarified that sexual abuse or exploitation does not encompass consensual activities between a child who is 14 or older and another individual whose age is 14 or older and within 4 years of the child's age.

<p>child's age.</p> <p>(2) Any of the following offenses committed against a child:</p> <p>(i) Rape as defined in 18 Pa.C.S. § 3121 (relating to rape).</p> <p>(ii) Statutory sexual assault as defined in 18 Pa.C.S. § 3122.1 (relating to statutory sexual assault).</p> <p>(iii) Involuntary deviate sexual intercourse as defined in 18 Pa.C.S. § 3123 (relating to involuntary deviate sexual intercourse).</p> <p>(iv) Sexual assault as defined in 18 Pa.C.S. § 3124.1 (relating to sexual assault).</p> <p>(v) Institutional sexual assault as defined in 18 Pa.C.S. § 3124.2 (relating to institutional sexual assault).</p> <p>(vi) Aggravated indecent assault as defined in 18 Pa.C.S. § 3125 (relating to aggravated indecent assault).</p> <p>(vii) Indecent assault as defined in 18 Pa.C.S. § 3126 (relating to indecent assault).</p> <p>(viii) Indecent exposure as defined in 18 Pa.C.S. § 3127 (relating to indecent exposure).</p> <p>(ix) Incest as defined in 18 Pa.C.S. § 4302 (relating to incest).</p> <p>(x) Prostitution as defined in 18 Pa.C.S. § 5902 (relating to prostitution and related offenses).</p> <p>(xi) Sexual abuse as defined in 18 Pa.C.S. § 6312 (relating to sexual abuse of children).</p> <p>(xii) Unlawful contact with a minor as defined in 18 Pa.C.S. § 6318 (relating to unlawful contact with minor).</p> <p>(xiii) Sexual exploitation as defined in 18 Pa.C.S. § 6320 (relating to sexual exploitation of children).</p>	
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Putting a child at imminent risk via specified acts	
<p>Specific conduct in category</p> <p>Engaging in any of the following recent acts:</p> <p>(i) Kicking, biting, throwing, burning, stabbing or cutting a child in a manner that endangers the child.</p> <p>(ii) Unreasonably restraining or confining a child, based on consideration of the method, location or the duration of the restraint or confinement.</p> <p>(iii) Forcefully shaking a child under one year of</p>	<p>Key issues and changes</p> <p>This new category essentially replaces more general language in the current law that covers conduct that puts the child at “imminent risk” of bodily injury or sexual abuse or exploitation. It identifies culpable conduct that is <i>per se</i> child abuse; that is, intentionally, knowingly, or recklessly engaging in the listed conduct – in and</p>

<p>age.</p> <p>(iv) Forcefully slapping or otherwise striking a child under one year of age.</p> <p>(v) Interfering with the breathing of a child.</p> <p>(vi) Causing a child to be present at a location while a violation of 18 Pa.C.S. § 7508.2 (relating to operation of methamphetamine laboratory) is occurring, provided that the violation is being investigated by law enforcement.</p> <p>(vii) Leaving a child unsupervised with an individual, other than the child's parent, who the actor knows or reasonably should have known:</p> <p>(A) Is required to register as a Tier II or Tier III sexual offender under 42 Pa.C.S. Ch. 97 Subch. H (relating to registration of sexual offenders), where the victim of the sexual offense was under 18 years of age when the crime was committed.</p> <p>(B) Has been determined to be a sexually violent predator under 42 Pa.C.S. § 9799.24 (relating to assessments) or any of its predecessors.</p> <p>(C) Has been determined to be a sexually violent delinquent child as defined in 42 Pa.C.S. § 9799.12 (relating to definitions).</p>	<p>of itself – constitutes child abuse regardless of whether an injury results.</p> <p>The <i>per se</i> conduct is not limited to specified acts of physical force, such as kicking, biting, and forcefully shaking an infant. Keeping a child at an illegal methamphetamine lab can be <i>per se</i> child abuse. It also can include leaving a child with a non-parent who is required to register under Meghan's Law or who has been determined under the law to be a sexually violent predator or delinquent child.</p>
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Causing serious physical neglect	
<p>Specific conduct in category</p> <p>Causing serious physical neglect of a child.</p> <p>Related definitions</p> <p>“Serious physical neglect.” Any of the following when committed by a perpetrator that endangers a child's life or health, threatens a child's well-being, causes bodily injury or impairs a child's health, development or functioning:</p> <p>(1) A repeated, prolonged or unconscionable egregious failure to supervise a child in a manner that is appropriate considering the child's developmental age and abilities.</p> <p>(2) The failure to provide a child with adequate essentials of life, including food, shelter or medical care.</p> <p>“Perpetrator.” A person who has committed child abuse as defined in this section. The following shall apply:</p>	<p>Key issues and changes</p> <p>The new law expands the definition of serious physical neglect to include egregious behavior that – although occurring only one time – is so blatant that the child's health or development has been impacted. This contrasts with prior law under which the neglect has to be prolonged or repeated behavior.</p> <p>Also of note, <i>for this category only</i>, the conduct must be committed by a “perpetrator,” a defined term limited to persons with a specified family or other relationship with the child.</p> <p>Children aged 14-18 can be held accountable for committing acts of child abuse. However, there are limited circumstances under which they are held accountable for omissions of neglect. For example, a 15 year old parent of the child could be found to have committed serious physical neglect, but a</p>

- (1) The term includes only the following:
- (i) A parent of the child.
 - (ii) A spouse or former spouse of the child's parent.
 - (iii) A paramour or former paramour of the child's parent.
 - (iv) A person 14 years of age or older and responsible for the child's welfare or having direct contact with children as an employee of child-care services, a school, or through a program, activity or service.
 - (v) An individual 14 years of age or older who resides in the same home as the child.
 - (vi) An individual 18 years of age or older who does not reside in the same home as the child but is related within the third degree of consanguinity or affinity by birth or adoption to the child.
- (2) Only the following may be considered a perpetrator for failing to act, as provided in this section:
- (i) A parent of the child.
 - (ii) A spouse or former spouse of the child's parent.
 - (iii) A paramour or former paramour of the child's parent.
 - (iv) A person 18 years of age or older and responsible for the child's welfare.
 - (v) A person 18 years of age or older who resides in the same home as the child.

"Parent." A biological parent, adoptive parent or legal guardian.

"Person responsible for the child's welfare." A person who provides permanent or temporary care, supervision, mental health diagnosis or treatment, training or control of a child in lieu of parental care, supervision and control. The term includes any such person who has direct or regular contact with a child through any program, activity or service sponsored by a school, for-profit organization or religious or other not-for-profit organization.

sibling under age 18 who is living in the same household will not be held accountable for failing to prevent neglect.

The definition of person responsible for the welfare of a child has been expanded to include certain persons who were previously excluded, including school employees.

Engaging in Munchausen by proxy behavior

Specific conduct in category

Fabricating, feigning or intentionally exaggerating or inducing a medical symptom or disease which results in a potentially harmful medical evaluation or treatment to the child through any recent act.

Key issues and changes

This category is new. It makes explicit that Munchausen by proxy behavior is child abuse.



Signs and Symptoms of Child Abuse

Dec. 31, 2014

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Introduction and Background

Child abuse is a sensitive subject that frustrates physicians because they often don't know how to assess abuse in their patients and provide appropriate intervention. Physicians in a variety of settings see problems resulting from child abuse and will benefit from being more knowledgeable about how to identify and assist these patients. According to the American Academy of Pediatrics, each year approximately three million cases of child abuse or neglect involving over five million children are reported in the United States.¹

In 2013, approximately 27,000 reports of child abuse or neglect were registered through Pennsylvania's child abuse hotline, ChildLine. This figure represents almost 300 additional reports over the 2012 reporting period. It also reflects the largest number of registered reports ever on record in Pennsylvania. The percentage of substantiated cases was about 13%, a figure which has remained fairly constant over the last few years.² Pennsylvania Department of Public Welfare's 2013 Annual Child Abuse Report includes detailed statistics on reports involving child abuse and neglect in Pennsylvania. Access the full report at www.dhs.state.pa.us/cs/groups/webcontent/documents/report/c_086251.pdf

Child abuse and neglect occur in all demographic groups. Children age 5 and older are abused more often than younger children. However, when younger children and babies are abused, they are more likely to suffer serious injuries or even die from their injuries. Younger children are at higher risk of being neglected than older children. Most child abuse is perpetrated by someone the child knows rather than by a stranger.

Risk Factors

Child abuse is not rare and it does not discriminate. It occurs in any number of social and economic situations. There is no "typical" child abuser so physicians must be willing to consider the likelihood of child abuse in situations where a history, physical examination, and/or the results of any laboratory and imaging tests warrant a reasonable cause to suspect it.

According to the website MayoClinic.org³, several factors may trigger abusive behavior including:

- Being mistreated as a child or the victim of domestic violence

- Depression or anxiety
- Marital conflict or financial stress
- Alcohol or drug addiction
- Social isolation
- Limited parental education or experience

Additional information on risk factors contributing to abusive behavior is available at <http://www.mayoclinic.org/diseases-conditions/child-abuse/basics/risk-factors/con-20033789>

Signs and Symptoms of Major Types of Child Abuse and Neglect

According to the factsheet entitled “What is Child Abuse and Neglect? Recognizing the Signs and Symptoms” produced by Child Welfare Information Gateway, U.S. Department of Health and Human Services, Children’s Bureau, the four most recognized types of maltreatment of children include physical abuse, neglect, sexual abuse, and emotional abuse. Substance abuse and abandonment are also sometimes classified as child abuse and neglect. ⁴Access the factsheet at <https://www.childwelfare.gov/pubPDFs/whatiscan.pdf>

In this next section, we’ll focus on the signs and symptoms of the most common issues – physical abuse, neglect, sexual abuse, and emotional abuse.

As a physician, there are often “red flags” displayed by either the child or a parent/caregiver, that could give you pause for further consideration. Some observations you may wish to note include:

- Has the child had recent changes in behavior or school performance?
- Has the child had a sudden withdrawal from friends or usual activities?
- Has the child had frequent absences from school?
- Does the child appear guilty or ashamed to talk about something?
- Has the child attempted to run away from home?
- Does the child avoid making eye contact or physical contact with the parent/caregiver?
- Does the parent/caregiver show little concern for or offer little comfort to the child?
- Does the parent/caregiver describe the child with negative terms or belittle and berate the child?
- Does the parent/caregiver deny that any problems exist at home or school, or blames the child for the problems?

The existence of these red flags or other similar behaviors does not, of course, automatically indicate that a child is being abused or that a parent/caregiver is abusive. If these warning signs align with other physical indications for abuse, however, it is imperative to consider all options and not ignore the possibility of child abuse.

When identifying potential signs or symptoms associated with **physical abuse**, resources commonly list the following^{4,5}:

- Unexplained injuries, such as bruises, fractures, burns, or a black eye/battered face
- Untreated medical or dental problems
- An apparent fear of parents or adult caregivers or avoidance of contact with adults
- A discrepancy between the extent of the injuries and the explanation given for the injuries
- Abuse of animals or pets

Common signs or symptoms of **neglect** may include^{4,5}:

- Poor growth
- Unusually thin cheeks or extremities
- Indifference
- Poor hygiene
- Frequent absences from school
- Begs or steals food or money
- Inappropriate clothing for seasonal weather

Some signs and symptoms such as depression or sleep problems are associated with both **sexual abuse** and **emotional abuse**. Changes in behavior – from one extreme to another – are often also noted for both maltreatments. Other common signs or symptoms of **sexual abuse** may include^{4,5}:

- Sexual behavior or knowledge that is inappropriate for the child's age
- Blood in the child's underwear
- Trouble walking or sitting
- A sudden change in appetite
- Pregnancy or venereal disease
- Refusal to dress in front of others
- Running away from home/school

In addition to the signs or symptoms listed above, victims of emotional abuse may also demonstrate signs or symptoms including^{4,5}:

- Delayed or inappropriate emotional development
- Loss of self-confidence or self-esteem
- Headaches
- Stomachaches
- Avoidance of certain situations, such as refusing to go to school
- Seeks affection from other adults
- Attempted suicide

Effective Physician-Patient Communications Could Make a Difference

Since many cases of child abuse center on the needs and problems of the parents, the American Academy of Family Physicians (AAFP) recommends that in order to prevent abuse, physicians must first help the parents to nurture and protect their children. Parents with multiple medical, financial, emotional, and other needs find it difficult to meet the needs of their children. While physicians may find this is difficult to do, it is important to remember that providing needed support to the parents may ultimately help the children.

When attempting to assess the risk of child abuse, physicians should ask parents the following types of questions:

- “How are things between you and your partner?”
- “What is it like for you taking care of this baby?”
- “Who helps you with the children?”
- “What do you do when your child's behavior drives you crazy?”
- “Do you have time for yourself?”

By responding to the answers to these questions in a non-judgmental manner, physicians may find that the parent is willing to discuss the problems they are experiencing in a more open manner. Because children frequently do not complain about being abused, physicians must always be alert to the possibility that abuse may be occurring, even when the child says nothing or says they have not been hurt. When dealing with a child whom the physician suspects may be a victim of abuse, it is important to obtain a detailed medical history from the child (if possible) and from the child's caretakers. The physician must be sensitive to the child's fears when discussing the home situation and tailor the interview to the child's developmental level.

The physician should sit near the child at eye level and should attempt to establish an empathic, trusting relationship. Questions beginning with "How come" are more productive than questions beginning with "Why". If the child's responses to the physician's questions are unclear, the child should be asked to explain words or terms that are unclear. The physician should not press the child for answers he or she is not willing to give, suggest answers to the child, or criticize the choice of language used by the child to describe what has occurred. It is important to realize that the child's safety is the physician's primary concern. All findings should be documented in the medical record, which may provide critical evidence in court proceedings.

Important Considerations When Abuse Is Suspected

David Turkewitz, MD, FAAP, chairman of pediatrics and section director of pediatric emergency medicine at York Hospital, serves as the Medical Director for the regional Children's Advocacy Centers in York and Adams counties. He lectures frequently on child abuse including presentations of the Educating Physicians in Communities, Suspected Child Abuse and Neglect program (EPIC SCAN). This program, developed by the Pennsylvania Chapter of the American Academy of Pediatrics in 1998, meets the learning needs of community based physicians, hospital staff, school nurses, and EMS personnel.

Dr. Turkewitz notes the challenges that physicians have when it comes to recognizing, managing, and reporting child abuse. The physician must be willing to consider abuse in the differential diagnosis, even in the absence of risk factors. If abuse is missed, many of these children will suffer from further abuse that may be fatal. Physicians may be unfamiliar with the reasonable suspicion threshold for reporting. If the physician has a reasonable suspicion of child abuse, then the physician must report. Dr. Turkewitz notes that what is a reasonable threshold for one physician may not be for another as differences of opinion can occur based on training and clinical experience. In the past, physicians have been reluctant to report because they may not have seen themselves as experts. Moving forward, however, physicians are considered mandated reporters and must register a report if there is a reasonable suspicion of child abuse.

Dr. Turkewitz often hears that physicians are uncomfortable when informing parents that there is a possibility of abuse. Physicians need to be truthful as parents can usually recognize when physicians are being evasive. However, physicians should not notify parents of a report of suspected abuse if they (physicians) feel doing so might place a child at increased risk. Also, the physician must suppress any tendency to be angry or upset as this can only hinder effective communication with the family. Dr. Turkewitz suggests the following dialogue for breaking the news:

"I can see how much you care about your child. Because you care so much, you would not want me to miss anything. I am not saying that abuse occurred, but child abuse can possibly cause injuries like your child has, so we must investigate for that possibility. Of course, it may turn out the injuries were not from abuse, but we still need to look, as a missed diagnosis of abuse often leads to re-injury and sometimes death. Also, I have no choice as Pennsylvania law requires that I report."

By using the “common concern for the child” approach, parents are not given a way to rationally disagree with what the physician must do. Dr. Turkewitz recommends that physicians inform the family what will happen once a report has been made, ie that they will be contacted by Children and Youth services.

Parents should be told that Children and Youth will always be involved and law enforcement may be involved. Parents should be counseled to be honest and not argumentative when working with Children and Youth and the police. Advance preparation helps once a decision is made to report. The office should know how to access the PA child abuse reporting form, the ChildLine phone number, and how to contact the local Children and Youth Services.

Dr. Turkewitz recommends that physicians incorporate child abuse prevention as part of well child anticipatory guidance. Parents should be advised that corporal punishment as a form of discipline can cross over into physical abuse and that alternative discipline techniques are more conducive to healthy relationships between parents and children and better life-long outcomes.

Conclusion

Physicians are in a unique position to detect the injuries and behavioral problems resulting from child abuse and neglect. As such, they can be powerful advocates for the most vulnerable members of our society.

Additional Resources

Pennsylvania physicians have access to CME on child abuse recognition and reporting that meets the state’s licensure requirements. Access this and other resources from PAMED at www.pamedsoc.org/childabuselaws.

- ¹ <http://www.healthychildren.org/English/safety-prevention/at-home/Pages/What-to-Know-about-Child-Abuse.aspx> accessed December 2014
- ² Pennsylvania Department of Public Welfare. (2014) *Annual Child Abuse Report, 2013*. Harrisburg, PA: Commonwealth of Pennsylvania. www.dhs.state.pa.us/cs/groups/webcontent/documents/report/c_086251.pdf
- ³ <http://www.mayoclinic.org/diseases-conditions/child-abuse/basics/risk-factors/con-20033789> accessed December 2014
- ⁴ Child Welfare Information Gateway. (2013). *What is child abuse and neglect? Recognizing the signs and symptoms*. Washington, DC: U.S. Department of Health and Human Services, Children’s Bureau. <https://www.childwelfare.gov/pubPDFs/whatiscan.pdf>
- ⁵ <http://www.mayoclinic.org/diseases-conditions/child-abuse/basics/symptoms/con-20033789> accessed December 2014