Carolen Bailey papers

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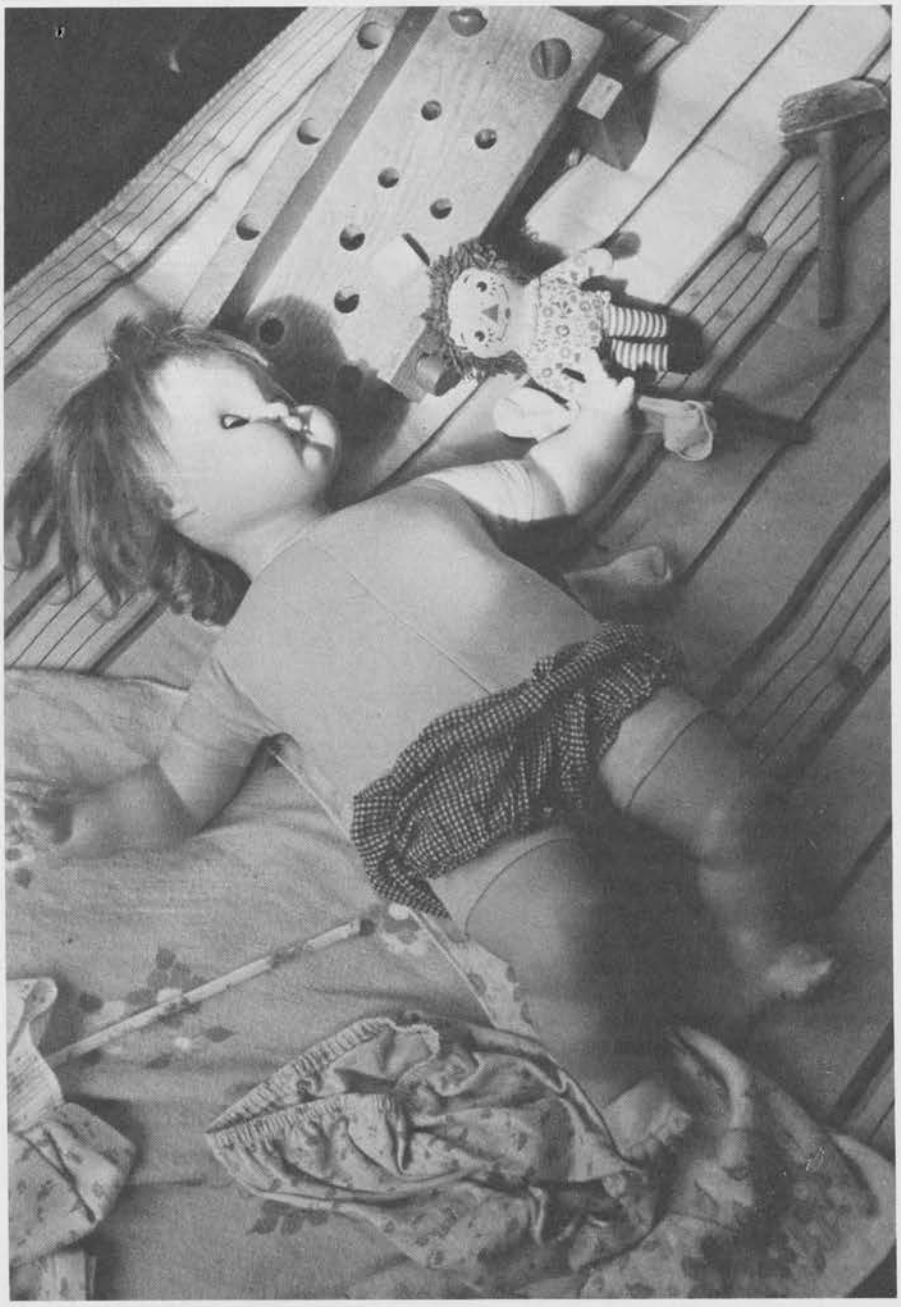
SEXUAL



Case No. 1: A Florida newspaper tersely reported to its readers early in 1975 that the city's youngest rape victim to date was only two months old at the time of the sexual assault. No other comment was offered.

Case No. 2: Two and one-half-year-old Jerry was admitted to the hospital because he cried when he passed urine and his mother noticed a discharge of pus from his penis. When his problem proved to be an acute gonorrhea infection, public health authorities investigated his home and found that Jerry's mother, father and an older sibling were all infected. His doctor was persuaded that a non-sexual mode of transmission had occurred because the family members were reported to share the same bed frequently. All of the family members were treated for infection simultaneously, Jerry's parents were counseled to avoid allowing their children to sleep in "contaminated sheets," and the case was closed.

An epilogue, however, was written several months later when an alert nursery school teacher noted that Judy, Jerry's 4-year-old sister, consistently refused to take her turn riding a rocking horse during playtime. When asked why, she replied "It hurts." A careful examination by the school's pediatrician that same day revealed the presence of sperm in Judy's vagina. An immediate joint police-Protective Services investigation of the family revealed that Jerry's and Judy's father had a long history of previous incidents of child-molesting although none had ever been proved. Their mother admitted she was aware that both children had been sexually assaulted by their father on numerous occasions.

Case No. 3: Stephanie, at age 17 months, was brought to a hospital emergency room by her mother who had noticed blood in the baby's diaper after she returned home from work. On examination, the child was found to have a small anal fissure that bled freely when touched. There was no previous history of abnormality or trauma and the mother was reassured that the fissure could be easily corrected surgically if it did not heal by itself. Several weeks later, Stephanie was found dead in her crib—a victim of asphyxiation. An autopsy revealed the presence of semen in her mouth and throat. When apprehended, the babysitter, a 19-year-old boy, freely admitted to sexual abuse of the child but protested "I didn't mean to kill her!"

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Coordinating bodies varied in composition, functions and administrative location. Most commonly, department heads and supervisors participated in coordinating efforts, which may indicate that the major function for the majority of coordinative mechanisms is interagency relations rather than actual case management. Emphasis upon the latter would require the participation of policemen, caseworkers, nurses and others directly engaged in the delivery of services. Teams and liaison groups usually met once a month, which also indicates agency coordination, not case management.

The lack of coordination is reflected in responses to a number of other questions. One question, for instance, sought to discover whether the ways other agencies handle cases of child abuse and neglect delay or cause problems to the respondent's own agency. The proportion of population represented by protective agencies encountering difficulties ranged from 29 percent for prosecuting attorneys offices to 57 percent for the schools.

Another question asked: "Considering the various facets of child abuse and neglect and the many agencies involved, what problems do you see in the way child abuse and neglect is handled in this area?" Here the most frequently mentioned problem was limitations in interagency cooperation.

Agencies' Performance

In many respects, the foregoing discussion indicates the levels of performance of programs addressed to the problems of abuse and neglect. The volume of cases identified and reported, the status of interagency coordination, the prevalence and nature of problems encountered by each of the agencies because of the ways other agencies handle abuse and neglect cases, and the nature of the criteria and structure for decision making all constitute important indicators of program performance. The survey also included other approaches to assessing performance that require more complex analysis than could be completed for the purposes of this initial report. However, responses to some direct questions are instructive.

We discovered, for example, that child protective agencies representing 50 percent of the population do not necessarily make home visits during the same day cases of child *abuse* are reported. The equivalent proportion for child *neglect* is 82 percent. On the other hand, police departments representing 96 percent of the population conduct a home visit during the same day for cases they consider to be emergencies, and 78 percent for other cases. When asked about the proportion of families that continue to abuse their children after protective services have become involved with them, respondents for agencies representing only one-third of the population answered "almost none" while respondents representing 14 percent of the population indicated a belief that one-half or more of the families continue abusing their children after protective services become involved.

Opinions were also sought concerning the effectiveness of programs. For example, respondents were asked to react to the statement, "Treatment for parents who mistreat their children is largely ineffectual." Agencies that agreed with this statement ranged from public health and protective services (representing 28 percent of the population) to the police and sheriff departments (representing 48 percent). When asked to evaluate the effectiveness of their own agencies, the police were most optimistic and public health departments most pessimistic. Similarly, the police were most generous in their assessment of the effectiveness of other agencies in the community, and the courts next. Public health departments continued to be the most pessimistic.

Many reasons for the lack of effectiveness were attributed in responses to questions seeking information about the availability of services and resources, priorities for program development should additional funds become available, and the nature of problems encountered by the respective agencies in handling the problem.

The proportion of the population ranged from 38 percent for schools to 85 percent for protective agencies that answered the following question affirmatively: "Are there any services that abused and neglected children or their families need that are unavailable or difficult to obtain?"

Counselling was the service most often mentioned as lacking by respondents from all agencies. The need for home support, placement facilities and financial support were also frequently indicated. Problems in interagency coordination and inadequacies in manpower and staff qualifications have already been pointed out as two major impediments to program effectiveness.

It is premature to attempt to draw conclusions during this initial stage of analysis of such an extensive and complex set of data. Rather, the objective was to present some of the important trends and to share some of the thoughts they provoked. The figures presented and the statements made are subject to further refinement and qualification as we proceed with future reports on this study. However, I hope that this report has provided some overview of programs on child abuse and neglect in this nation. ■

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[1] Sampling and data collection were carried out by the Survey Research Center of the University of Michigan's Institute for Social Research. The methodology for this sample is provided in Kish, L. and Hess, I., *The Survey Research Center's National Sampling of Dwellings,* Ann Arbor: Institute for Social Research, University of Michigan, 1969.

All percentage responses are carefully weighted to reflect the proportion of population they serve. Thus, the opinion of a judge or court worker in a metropolitan area is given more weight than that of a judge in a rural area who sees only a few cases per year.

[2] U.S. Bureau of the Census, "General Social and Economic Characteristics: U.S. Summary 1970," June 1972.

[3] Further analysis is needed before attempting to compare the figures obtained in this survey with earlier reports such as are found in Gill, D., *Violence Against Children,* The Commonwealth Fund, 1970 and Light, R., "Abused and Neglected Children in America: A Study of Alternative Policies," *Harvard Educational Review,* November 1973.

[4] See DeFrancis, V. and Lucht, C., *Child Abuse Legislation in the 1970's,* The American Humane Association, Denver, Colorado, 1974.

[5] Cohen, Stephen J., "A Study of Child Abuse Reporting Practices and Services in Four States," unpublished report submitted to OCD.

[6] See, for example, Nagi, S., "Gate-Keeping Decisions in Service Organizations When Validity Fails," *Human Organization,* Vol. 33, No. 1, Spring, 1974.

MOLESTATION OF CHILDREN

The Last Frontier in Child Abuse

by Suzanne M. Sgroi

Any member of the "helping professions" who is searching for an effective method to make himself unpopular with his peer group can probably achieve that goal by frequent involvement in cases such as those described above. The professional who becomes sufficiently concerned and knowledgeable about sexual abuse of children to be consistently alert to the possibility that sexual molestation *may* have occurred will often face a spectrum of reactions from his colleagues that range from incredulity to frank hostility. For although the pioneering efforts of many distinguished professionals and dedicated lay people over the past decade have made child abuse a national issue, the problem of sexual molestation of children remains a taboo topic in many areas.

This is not to argue that the problem of child abuse has been "solved" anywhere in the United States. It is, however, fair to assert that sexual abuse of children is the last remaining component of the maltreatment syndrome in children that has yet to be faced head-on. In medical parlance, child molestation is the least popular diagnosis. In the vernacular, it is not nearly so "in" a topic as child battering or neglect. Combatting these forms of maltreatment is publicly applauded and encouraged. But somehow, protecting children against sex crimes has received far less community sanction. It seems to be "too dirty," "too Freudian" or perhaps "too close to home." Thus one who becomes concerned with this particular aspect of child protection must be prepared to cope with a very high degree of resistance, innuendo and even harassment from some, as well as indifference from others. The pressure from one's peer group as well as the community to ignore, minimize or cover up the situation may be extreme.

Incidence of Molestation

No one knows the true incidence of child molestation in the United States today. Vincent DeFrancis, director of the Children's Division of the American Humane Association, conducted a comprehensive 3-year study of child molestation in New York City that was reported in 1969.[1] His estimate of approximately 3,000 cases each year in New York City alone is probably conservative. Considering the widespread reluctance to recognize and report this condition, it must be assumed that the reported incidents represent a small fraction of the cases.

Nevertheless, the reporting of suspected sexual abuse of children is encompassed in the child abuse reporting statutes of many states. Recent strengthening of these statutes and the establishment of child abuse hotlines has markedly increased the reporting of all forms of child maltreatment. In Connecticut, for example, passage of an expanded child abuse reporting law (P.A. 73-205, effective October 1, 1973), which involves a $500 fine for mandated reporters who fail to report suspected child abuse, resulted in 1,957 reported cases in fiscal year 1974—an increase of nearly 200 percent over the preceding fiscal year. A breakdown of the total by reporting source is shown in Table I below.

The opening of the Care-Line, a 24-hour statewide toll-free child abuse prevention and information line, probably had a significant impact since it facilitated the reporting process for many professionals and private citizens who called to express concern about children. The Connecticut Child Welfare Association (CCWA), a private statewide citizens' organization which operates the Care-Line, has also conducted a continuing education effort aimed at both the general public and the professional groups who have been required to report cases of suspected child abuse since 1971. Connecticut's Municipal Police Training Council has cooperated by incorporating lectures on child abuse detection and reporting

TABLE 1

Total Number of Children Reported As Suspected Abused in Connecticut*

	Physicians	Hospitals	Police	Schools	Social Workers	CCWA Care-Line	Others	Total
F.Y. 1973 number	37	205	107	122	65	**	133	669
percent	5.5%	30.6%	16%	18.2%	9.8%	**	19.9%	100%
F.Y. 1974 number	98	396	456	401	327	104	175	1957
percent	5%	20.3%	23.3%	20.5%	16.7%	5.3%	8.9%	100%

* *Connecticut State Welfare Department statistics.*

** *A statewide toll-free child abuse hotline has been operated by the Connecticut Child Welfare Association, a private citizen's organization, since October 1, 1973.*

into their mandatory training program for all newly-hired police officers in 166 of the state's 169 towns. These child abuse training sessions were initiated in 1972 as part of the CCWA Child Advocacy Project and have been conducted by Association staff at 6-week intervals ever since. In October 1973 the two groups jointly sponsored and taught three one-day seminars on child abuse which were attended by higher ranking police officers from all over the state. It is therefore not surprising that the percentage of reports of suspected child abuse by police officers increased markedly in F.Y. 1974, while reports by hospitals decreased proportionately and those by private physicians remained at the same low level—five percent.

It is noteworthy that during this same reporting period, the total number of reports of suspected sexual abuse of children in Connecticut increased, while the proportion of such reports to total child abuse reporting statistics declined slightly. Table 2, below, shows a breakdown of sexual abuse by type of report.

In fiscal years 1973 and 1974 in Connecticut, the relationship of the perpetrator to the child in all cases of suspected abuse was that of a parent or a parent-substitute in 80 percent of the cases. This complements DeFrancis' finding that parents were involved in the sexual molestation of children in 72 percent of the cases studied—either by perpetration of the offense (25 percent) or else by acts of omission or commission.[2] The most frequently named perpetrator in cases of sexual abuse is the father or a male relative or boyfriend—virtually always someone who has ready access to the child in his or her home. Ages of victims may range from early infancy (one to two months) all the way to 17 or 18 years.

Recognizing Sexual Abuse

Why is sexual molestation of children the last frontier in child abuse? And what are the major obstacles to identifying the sexually abused child?

In practical terms, the answers are lack of recognition of the phenomenon, failure to obtain adequate medical corroboration of the event, and reluctance to report. If one accepts the premise that it is impossible to protect the child victim of sexual molestation unless we know that he exists, these obstacles take on major importance. Each is rooted in ignorance and taboo and must be considered accordingly.

Recognition of sexual molestation in a child is entirely dependent on the individual's inherent willingness to entertain the possibility that the condition may exist. Unfortunately, willingness to consider the diagnosis of suspected child sexual molestation frequently seems to vary in inverse proportion to the individual's level of training. That is, the more advanced the training of some, the less willing they are to suspect molestation.

The lack of preparation and willingness of many physicians to assist patients with sexual problems in general has often been noted. When the patient is a child, these deficiencies are extremely serious.

If the victim of alleged sexual assault is a child, a complete physical examination with careful attention to any other signs of physical abuse or neglect must accompany the routinized perineal examination and laboratory tests. The examination is not complete unless the child is carefully scrutinized for evidence of oral and/or anal penetration as well as genital sexual contact. This includes inspection for trauma as well as laboratory tests for the presence of semen and venereal disease.

Unfortunately, all too few health professionals are trained to look for or to recognize the signs of rectal and urogenital gonorrhea infections in young children. This not only requires a high index of suspicion but again an inherent willingness to entertain the diagnosis of acquired venereal disease in a child. With the exception of congenital syphilis and gonococcal eye infection in newborns, the presence of a gonorrhea or syphilis infection in a child makes it imperative that sexual molestation be suspected unless or until it is ruled out by a careful joint medical and protective services investigation. The U.S. Public Health Service, which operates the National Communicable Disease Center in Atlanta, Georgia, has recently cautioned that "with gonococcal infection in children, the possibility of child abuse must be considered!" [3]

Medical Corroboration of Abuse

The next major obstacle to identifying and helping the child victim of sexual abuse is failure to obtain immediate medical corroboration of the assault. This occurs most frequently on the grounds that physical examination of the child will aggravate and intensify the psychological trauma that may already have been experienced. However, this attitude has little basis in fact and may be detrimental in the extreme to the future protection of the child. A gentle and thorough examination, as outlined above, conducted by a knowledgeable examiner, will be well tolerated by most children. The experience not only can be non-threatening but it may also be reassuring

TABLE 2

Reports of Suspected Sexual Abuse of Children in Connecticut *

	Incest & Rape	Sexual Molestation	Venereal Disease	Total Sexual Abuse	Total cases of Suspected Child Abuse	% Sexual Abuse
F.Y. 1973	19	57	**	76	669	11.4%
F.Y. 1974	47	108	17	172	1957	8.8%

* *Connecticut State Welfare Department statistics.*

** *Acquired venereal disease in children under age 13 years did not become reportable as suspected child abuse until fiscal year 1974 (October 1, 1973).*

Recognition of sexual molestation in a child is entirely dependent on the individual's inherent willingness to entertain the possibility that the condition may exist.

and welcomed by a child victim who is old enough to worry that he or she may have been harmed by the assault. For example, the examiner may find numerous opportunities to assure the child that all is well, that no harm has occurred or else that any injury incurred can be alleviated.

It is well to avoid repeated questioning of the child about circumstances relating to the incident of sexual abuse at any time. Such questioning is particularly to be avoided during the physical examination. Since repeated examinations may indeed be traumatic, the first should be comprehensive enough to preclude the necessity for further examinations if the child's condition does not require them.

Preventing a recurrence of sexual abuse should be a twin therapeutic goal along with preventing and alleviating any psychological damage incurred by the sexually molested child. Each of these goals should have equal priority. The therapist who counsels against a comprehensive and compassionate examination of the child in a case of suspected sexual assault (including, of course, a physical examination) effectively circumvents an adequate Protective Services investigation of the case. It is a known fact that judicial proceedings against child molesters virtually require that medical evidence of sexual assault be presented. Without such evidence, it is practically impossible to protect the child against repeated sexual assault by preventing or monitoring access of the child-molesting adult to the victim, especially in the intra-family situation.

The frequently recommended alternative of removing the child temporarily or permanently from the "at risk" situation by transferring custody from his or her parents to the state has the disadvantage of risking serious damage to the child by the act of premature separation from the "psychological parent." Thus the totality of risks must be carefully weighed in selecting what the authors of *Beyond the Best Interest of the Child* term "the least detrimental alternative." [4]

Regardless of the consequences, it would be unusual in any state for a child to be removed permanently from his parents to protect him from sexual abuse if corroborating medical evidence were not presented to verify that sexual molestation of that child had already occurred within the family. To put it another way, the future protection of a child victim of sexual assault is virtually impossible without a carefully recorded examination by a knowledgeable physician.

Reporting Sexual Abuse

Failure to report to the statutory authority is the last major obstacle to identifying the sexually abused child. Sexual abuse of a minor is a reportable condition in every state in the United States. Such a report is the triggering mechanism for a Protective Services investigation of the child and his family—thereby providing a conduit for professional help and community resources to strengthen and improve the home situation or, occasionally, to remove a child from an untenably dangerous environment. Nevertheless, sexual abuse of children is grossly underreported.

It is unconscionable that any member of the "helping professions" would violate the law as well as withhold potential help from the child victim by failure to report suspected sexual abuse. In most areas it is particularly inappropriate to withhold reports to the statutory authority on the grounds that more effective therapy for delicate internal family matters can be provided surreptitiously by a private agency or private practitioner. Since the success of the private agency's efforts to monitor the home situation for indications of recurrent abuse is directly dependent upon the family's voluntary compliance (which may cease at any time), such reasoning is fallacious. A far more appropriate course for the private help source who discovers the abuse is to report immediately and request to "service" the case in cooperation with the statutory authority. In most cases, cooperation with the frequently superior resources of the private source of help will be eagerly welcomed by the public agency. The result: a higher level of service available to the family as well as increased protection for the child.

For too long health professionals have skirted the issue of reporting suspected sexual molestation when an unmistakable diagnosis of acquired venereal disease has been made in a child. We have been content to do contact investigation within the family circle and to treat other family members—parents, aunts and uncles, older siblings, etc.—for venereal disease without asking why or how a 6-year-old boy acquired a gonorrheal urethritis or a 3-year-old girl contracted pelvic infection with gonococci. Because of reluctance to entertain the possibility of sexual molestation of a child by an adult, we have often postulated modes of transmission of venereal disease to children within the family circle that were long ago discarded in relation to adults, such as the possibility of transmission via clothing, towels and bedsheets. In view of what we know about the epidemiology of gonorrhea and syphilis in adults, it is absurd to cling to an erroneous double standard when we deal with acquired venereal disease in children. We must assume that these children have had some type of sexual contact, most probably with an adult, and investigate accordingly.

In the past, there has been some concern by public health authorities about violation of confidentiality by

(Continued on page 44)

PROJECT PROTECTION:

A School Program to Detect and Prevent Child Abuse and Neglect

by Diane D. Broadhurst

Montgomery County, Maryland, a suburban area bordering Washington, D.C., has one of the highest median income levels, and one of the largest school districts, in the United States. The median educational level for men residing in the county is 15 years and, for women, 12.8 years. The county has a high level of public education and well-developed health and social services. It also has abused and neglected children.

The brutal death in 1972 of a 9-year-old Montgomery County girl, and the indictments for murder of her father and stepmother, shocked residents and was the catalyst for an intensive effort to alert the public to the phenomenon of child abuse and neglect and to improve county policies and procedures for reporting and handling abuse and neglect cases.

Later that year a Task Force on Child Abuse—composed of members from county health, social services and law enforcement agencies, the school system and the public sector—was appointed by the County Executive and charged with developing specific programs and recommendations to improve services to abused and neglected children and their families. Under a comprehensive community plan developed by the Task Force, the position of child protection coordinator was established within the Office of Human Resources, health and social services staff were increased to extend coverage for receiving and investigating reports, and a multidisciplinary child protection team was formed to evaluate cases and develop service plans for them.

The Montgomery County Public Schools' Project PROTECTION, initiated in August 1974 with federal assistance, is an integral part of the county's efforts to combat child abuse and neglect. It is one of three projects funded by the U.S. Office of Education under Title III of the Elementary and Secondary Education Act to train teachers to recognize and properly refer children suspected of being abused or neglected.

Concern for the school-age child is long overdue. In testimony before the Senate Subcommittee on Children and Youth in 1973, David Gil stated that about half of the reported abuse incidents involved school-age children. In Montgomery County the median age of the abused child is nine—and about 75 percent of reported cases involve school-age children.[1]

Few school systems have recognized the challenge implicit in Dr. Gil's findings; fewer still have acted. The schools, however, are in a unique position to identify and to help abused and neglected children and their families. In school, a child's appearance and behavior are observed regularly by a number of people—among them the classroom teacher, school nurse, guidance counselor and principal. If these people are trained to recognize the characteristics of abuse and neglect and know how to report their suspicions to the proper authorities, they can make an important contribution to community efforts to combat child abuse and neglect.

Montgomery County's 135,000 school-age children attend 202 public and 60 nonpublic schools, where they are seen regularly by more than 7,000 teachers. A major objective of Project PROTECTION, as its name implies, is to afford maximum protection to these children by assuring that all school staff members are trained to recognize child abuse and neglect, are aware of their obligations to report it, and know the procedures for doing so. We are also working toward prevention of the phenomenon by developing curriculum units which will help teach future parents how to better understand and handle their own children.

Project PROTECTION involves three phases: policy revision, staff development and curriculum development. Under the first of these, the school district's Policy Statement on Child Abuse and Child Neglect, first adopted in 1973, was revised and adopted by the school board. The new statement requires that all school employees—including classroom teachers, principals, school health nurses and health aides, speech clinicians, guidance counselors, psychologists and social workers—refer to proper authorities all children whom they suspect may be abused or neglected. This provision conforms with 1974 amendments to the Maryland child abuse statute.

The policy statement defines an abused child as any child under age 18 who "a) has sustained physical injury as a result of cruel or inhumane treatment or as a result of malicious acts by his parent or any other person responsible for his care or supervision; b) has been sexually molested or exploited, whether or not he has sustained physical injury, by his parent or any other person responsible for his care or supervision." The statement points out that an employee does not necessarily have to observe any external physical signs of injury to the child to report. "It is sufficient merely to presume that abuse has occurred when a child complains of having been sexually molested or of pain, which he says has resulted from an inflicted injury. In such cases, the report should be made."

According to state guidelines, a neglected child may be malnourished, ill-clad and dirty; unattended; ill and lacking essential medical care; exploited and overworked; emotionally disturbed due to friction in the home; neglected emotionally by being denied "normal experiences that produce feelings of being loved"; and exposed to unwholesome and demoralizing circumstances.

The statement emphasizes that any doubt about reporting a suspected situation should be resolved in favor of the child.

One of the few such school policies in the nation, it also describes the procedures for reporting, explains that immunity from any civil or criminal liability is granted, and includes a sample of the county child abuse and neglect reporting form. Copies of the statement were sent to every school staff member and distributed widely in the community and to other school systems.

Developing a system-wide policy is an excellent first step for any school system to take to focus on child abuse and neglect. Such a policy should be designed for a system's particular needs and laws and then adopted by the school board. Once a school system has determined what it can and will do about child abuse and neglect, program design can follow naturally.

Staff Development

Staff development, the largest phase of the project, was conducted on three levels and across several disciplines. At the beginning of the current school year, a one-day conference was held to discuss the early identification of high-risk children and to explain the Maryland child abuse statute and county policies and procedures to all public school administrative and supervisory staff. About 500 people, including representatives from county health and social service agencies, nonpublic schools and neighboring school districts, attended.

Immediately following that conference, school pupil services staff—psychologists, social workers, pupil personnel workers and counselors—attended an intensive 2-day training workshop designed to prepare them to conduct staff development programs in individual schools.

Techniques for identifying abused and neglected children were described, the county supervisor of protective services explained what happens after a report is made and the county child abuse coordinator discussed the work of the county Child Protection Team. Other discussions focused on the psychodynamics of abusing and neglecting families, working with abused and neglected children and their families and sexual abuse of children.

Representatives from county departments, nonpublic schools and neighboring school districts also attended the workshop, and all 125 participants received a detailed information packet and a bibliography of the child abuse materials available in the school system's professional library.

In the third phase of staff development, members of pupil services staff conducted training programs during regularly scheduled faculty meetings in all public schools in the county. A model presentation was designed and adapted to fit the needs of the school served, for the purposes of helping staff members recognize child abuse and neglect; making them aware of their responsibility to report and the immunities provided; and informing them of the proper referral procedures.

Staff members described "indicators" which could alert teachers to the possibility of abuse or neglect of children in their classrooms. These include, for example:

- Unexplained injuries, or discrepancies between the explanation given and the degree of injury observed.
- Repeated or bizarre injuries, including cigarette burns and strap or rope marks.
- The odor of alcohol on a child.
- A child whose height or weight is three to four standard deviations be-

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low the norm for his age.

- A child who is afraid of his parents, or parents who show little or no concern about the child and his welfare.

Health and supporting services staff and executive committees of PTA and student government organizations were invited to attend. Project staff have also conducted information programs for high school and college classes and for PTAs and service groups.

Training programs have reached thousands of Montgomery County citizens—and the county has had a steady rise in the number of suspected cases reported.[3] More important, however, are the heightened awareness of child abuse and neglect problems in the schools and community and the steps being taken to help children and their families, as the following examples illustrate.

Alan Grey, a junior high special education student, was referred to Protective Service by his gym teacher who had noticed heavy bruising and cuts on the boy's back.

Alan readily admitted that his stepfather had beaten him with a belt buckle the night before, but added that he had deserved the beating. When questioned, Alan was extremely protective of his parents, saying that it was all right for them to beat him because he was "born bad." He expressed the fear that he would be placed in a foster home, something he had experienced several years before in another state.

Investigation revealed that Mr. Grey, a heavy drinker, had a history of violence. Mrs. Grey, an extremely passive woman, never interfered with her husband's disciplining of Alan. The family was known to social agencies wherever they had lived.

Because of its complexity, the case was referred to the County Child Protection Team. Although many of the agencies represented on the team already knew the Greys, none had been able to establish a successful relationship with them. The Greys were extremely resistant to help from anyone and had often expressed their distrust of professionals—with the single exception of Alan's special education teacher, whom the Greys seemed to like and respect.

Because Alan was already beset with emotional and behavioral problems and fearful of foster care, foster placement did not seem to be the answer. A better solution, the team felt, was to keep Alan at home and in his regular school where he already had a good relationship with his teacher. It was further made clear to the Greys that they had to see that Alan was properly cared for. They were encouraged to let Alan join some after-school activities.

Alan's teacher and his school were willing to work with the Greys. Frequent conferences were scheduled between the Greys and Alan's teacher, the school's social worker or psychologist. The school subsequently arranged for home visits by the social worker.

The situation is considered far from stable, and the case is carried as an active one by Protective Service. The Greys frequently talk of moving to another state; meanwhile, the school keeps a close eye on Alan, and the Child Protection Team receives routine reports on the Greys' progress.

In another case, Jimmy Brown was referred to Protective Service by his third grade teacher who noticed criss-cross black and blue marks on his face, apparently caused by a hard object of some kind.

Subsequently, investigations revealed Jimmy's bruises had been caused by his mother striking him with a heavy stick. Mrs. Brown explained that she always used a stick to discipline Jimmy, who was a "bad boy" and "needed it." Mrs. Brown said that she usually struck Jimmy on the back or buttocks, and that it was his own fault he had been struck on the face. She had told him to stand still, as she usually did, but this time he ducked, and the stick caught him across the face.

Both Mr. and Mrs. Brown were isolated people who expected too much of Jimmy. Neither would agree to any kind of family counseling or outside help; they said they preferred to solve their problems on their own, through meditation. Conversely, they were willing to learn more about alternative means of disciplining Jimmy, and it was possible to get them to join a parent education program at the local school.

A social worker continues to visit the Browns, and there is some hope that they will agree to family counseling after the parent education course concludes. There has been no further injury to Jimmy, but the situation continues to be monitored.

Of course, investigations may reveal that abuse did not in fact occur, as in the case of Ann Green. The investigation initiated by the report, however, has led to needed help for the Greens.

Seven-year-old Ann came to school one morning with a large, ugly bruise on her cheek, which she said had been caused by a blow from her father. Ann and her 9-year-old sister were new to their school. Thin, pale children, they were frequently absent and always shy and withdrawn. Although Ann was hazy about the injury and her story contained elements of fantasy, Ann's teacher still felt there was reason to file a report of suspected child abuse or neglect.

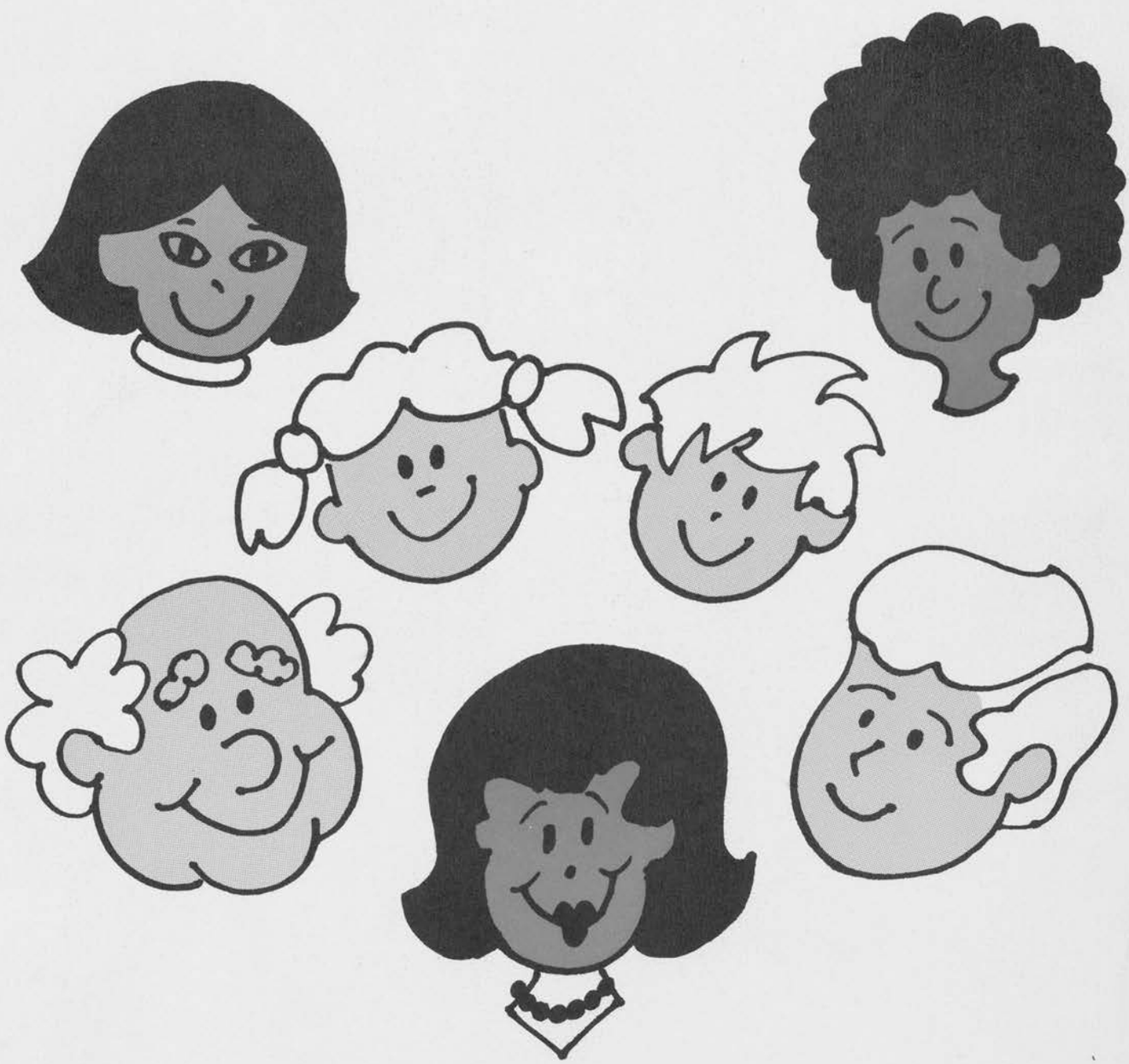
Investigators learned that the Green girls lived alone with their father in a rural home. Despondent over the accidental death of his wife the preceding year, Mr. Green, a college graduate, had left the profession for which he was trained and had moved to a new area to raise livestock. He worked long hours, and the girls were frequently left alone for extended periods of time. There were no near neighbors, no playmates and few visitors.

The investigation determined that Ann's injury had been the result of a fall, a fact corroborated by her sister. Mr. Green was cooperative with the social worker assigned to the case and clearly demonstrated his concern for the girls. He said he realized it was not good for them to be so isolated, but he could not seem to take an interest in anything. He had not known of Ann's injury. Both girls had been asleep when he returned the night before, and he had left the house that morning before either was awake.

Mr. Green readily agreed to work with the school to see that the girls attended more regularly, and he became involved in school activities. He also arranged after-school care for the girls.

Staff development activities also include cooperating with the school system's Department of Research to conduct a series of structured interviews

RED FLAG GREEN FLAG PEOPLE



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child ABUSE

child ABUSE

MANITOBA DEPARTMENT OF COMMUNITY SERVICES AND CORRECTIONS
CHILD AND FAMILY SERVICES

Revised Eighth Edition, April 1981
Manitoba

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What is child abuse?

Any injury **inflicted** on a child by an adult (usually parent), whether as the result of too harsh discipline or direct attack, should be regarded as child abuse. The injuries sustained by the child by these **non accidental** means, may vary in their severity and range from minor bruising, burns, welt marks to major fractures of the long bones and skull.

No inflicted injury however minor, should be disregarded; the parent or guardian is indicating by this act, his frustrations with the child and should be listened to and helped, even if the physical damage to the child appears to be slight.

The Child Welfare Act of Manitoba defines abuse as follows:

"1(a) "abuse" means acts of commission or omission on the part of the parent or the person in whose charge a child is which results in injury to the child but is not necessarily restricted to physical beating, physical assault, sexual abuse and failure to provide reasonable protection for the child from physical harm;"

What is a battered child?

The battered child is a child usually under the age of three years who on x-ray examination reveals the evidence of old repeated fractures to various parts of the head and body. Rarely has this child received medical attention for any of the former injuries and, therefore, the abuse is not detected until there have been repeated traumas.

The battered child should be regarded as being at the extreme end of the abuse continuum and the most vulnerable, due to the early age at which the injuries occur and the severity of the attack.

Who are child abusers?

Abusers may be male or female, and have no socio-economic characteristics which distinguish them from the rest of the population. They may be well educated or have limited educational capacity, they may belong to any ethnic, cultural or class grouping which exists in our society. This makes it difficult to

determine persons who abuse their children from those who don't. However, evidence of a particular type of malfunctioning in the child/parent relationship helps to identify the abusing parent. The majority of parents who abuse their children have unrealistic expectations of the child, they look to the child to satisfy the needs of the parent and when the child does not perform this function, they attack the child out of a sense of frustration. In most instances the parents are repeating their own childhood experiences when they were either abused themselves or constantly criticized for failing to live up to unrealistic expectations. (See further for additional description.)

Can the physical abuse be easily recognized?

Not as easy as it would seem. To the inexperienced the line separating "real abuse" from the "accidental" is a very thin one. The abusers usually have a plausible explanation for the injury to the child's body. Often parental abuse goes unrecognized even at the hospital setting when parental words are taken at face value due to the inherent repugnance of the idea that parents could be cruel to their own offspring . Frequently, the social factors play a decisive role in arousing suspicion and in contributing to a proper diagnosis.

Morris, Gould and Matthews have identified some of the typical reactions and attitudes of children and parents which are paraphrased under the headings of the next four questions:

What are some typical reactions and attitudes of protective parents to children's injuries?

- Parents are voluble and spontaneous in reporting details of a child's illness or injury.
- Show genuine concern about the degree of the damage.
- Show concern about the treatment.
- Show concern about the possibility of residual damage.

- Exhibit a sense of guilt. The younger the child, the more guilt the parents feel for not protecting him. Guilt and remorse are felt even when the parents have had no part in the child's injury.
- Ask many questions regarding the prognosis of the child's condition.
- Have difficulty in detaching themselves from the child on admission to the hospital.
- Visit their children in hospital frequently and stay long with them; always bring toys and gifts; want to be informed of the child's progress, discharge date, follow-up care.
- Identify with the child's feelings, both physical and emotional, when he is injured.
- Show warmth and relate positively to the child.

What are some typical reactions and attitudes of abusing parents ?

- Do not volunteer information about the child's illness or injury.
- Are evasive or contradict themselves regarding the circumstances under which the child's condition occurred.
- Show irritation at being asked about the development of the child's symptoms.
- Critical of the child and angry with him for being injured.
- Give no indication of feeling guilt or remorse regarding the child's condition.
- Show no concern about the injury, treatment or prognosis.
- Often disappear from the hospital during examination or shortly after the child is admitted.

- Maintain that the child had injured himself.
- Act as though the child's injuries are an assault on them.
- Show concern not about the child but about what will happen to themselves and others involved in the child's illness or injury.
- Tend not to visit the child in the hospital.
- Seldom touch the child or look at the child.
- Do not involve themselves in the child's care in the hospital.
- Do not inquire about the child's progress, discharge date or follow-up care.
- Respond to the child inappropriately, fail to show any warmth of feelings.
- Give no indication of having any perception of how a child could feel, physically or emotionally. Seem to be indifferent.
- Constantly criticize the child.
- Never mention any good quality in the child.
- Show no concept of the rights of others.
- Are preoccupied with themselves and the concrete things in life.
- Are often neglectful of their own physical health.
- Exhibit violent feelings and behaviour and in interviewing, reveal that this was a pattern in their original family.
- Reveal in the interviewing their concern about having been abandoned and punished by their own parents and are longing for a mother.
- Show overwhelming feelings that they and their children are worthless.

What are some typical forms of behaviour of well-nurtured children in a medical setting (doctor's office, hospital)?

- Cling to parents.
- Turn to parents for assurance.
- Turn to parents for comfort during and after examination and treatment.
- Constantly show by words and action that they want their parents and want to go home.
- Are reassured by their parents' visits.
- They find safety in their parents.

What are some typical forms of behaviour of abused children in a medical setting?

- Cry hopelessly under treatment and examination.
- Do not look to parents for assurance.
- Show no real expectation of being comforted.
- Are wary of physical contact initiated by parents or anyone else.
- Are apprehensive when other children cry and watch them with curiosity.
- Become apprehensive when adults approach some other crying child.
- Seem less afraid than other children when admitted to the wards and settle in quickly.
- Seem to seek safety in sizing up the situation rather than in their parents.

- Are constantly on the alert for danger.
- Are constantly asking in words and through their actions what will happen next.
- Are constantly in search for something: food, favours, things, services.
- Indicate having a feeling of being alone in a dangerous world with no real hope for safety (withdrawn).

How widespread and how serious is the problem?

No one knows for sure how widespread it is because the incidents of abuse usually occur in the privacy of a home without any witnesses and are committed on infants who can not talk or children who are too terrified to be able to talk. Cases of a serious nature are recorded and counted only when they come to the attention of doctors, hospitals, nurses, or social workers. It is estimated that there could be between thirty to fifty thousand of child abuse cases reported in the United States each year judging by reporting rates of the cities of Denver and New York. By the same token, Canada may have between 4,275 and 4,810 of such cases reported each year.

An offical of the Department of National Health and Welfare once estimated that approximately 2,000 children are killed or permanently harmed through abuse in Canada each year. It is said that the number of incidents is growing and with it the magnitude of the problem approaches significant proportions in terms of child mortality and permanent injury or brain damage inflicted on children.

Why treatment is preferred to intervention of criminal law?

- Treatment preserves and enhances the natural rearing milieu for the child.

- Treatment is the most constructive and humanitarian effort made equally on behalf of the innocent child as well as on behalf of the abuser caught in the web of tragic forces over which he or she may not have much control.
- In the sphere of irrational forces, the intervention of the criminal law process with its determination of guilt and subsequent imposition of punishment, no doubt, is of little value. Prosecution and jailing will not make better parents nor solve the basic problems which caused abuse. However, in hopeless cases, it becomes the last hope left and in cases resulting in the death of a child, the only possible intervention under the circumstances.

What prognosis of treatment?

The degree of success varies. Some cases lend themselves easily to guidance and counselling, and progress is quickly achieved. Others require long, protracted counselling combined with psychiatric therapy before any results could be evident. On the whole, it is reported that up to 75% of abusers can be treated successfully and children could be subsequently returned to them. Generally speaking, the success largely depends on the presence of many favourable factors such as these:

- Degree of emotional disturbance or psychological imbalance of abuser.
- His or her ability and willingness to engage in a counselling and/or therapy situation.
- Availability of psychiatric and social work services.
- Skill of professionals bringing help.
- Support of spouse or close relatives.
- Expectations as to the progress necessary in each individual case.

What is done about this problem in Manitoba?

In 1970, the reporting of child abuse incidents was made mandatory and at the same time the bona fide reporter was accorded legal protection from a civil court action.

In July 1971, the Registry for Physically Abused Children in Manitoba was established. Its purpose was to facilitate reporting and recording of child abuse and thus learn of the extent of the problem in our province as well as to protect victims of abuse through appropriate intervention.

Since 1974 the reporting of child abuse incidents has steadily increased from 82 in 1974 to 215 . . . for 1979 year [see Appendix "B"].

In August 1972, the Advisory Committee on Battered Children comprised of representatives from the medical, nursing, social work and teaching professions was established and an intensified assault on the child abuse problem began. The thrust went in two directions: remedial and preventative. The family-centered professional help was made available for those needing it everywhere in Manitoba through the Children's Aid Societies or Regional offices of the Department of Community Services and Corrections, and various measures were undertaken designed to interpret the problem and its consequences to the public at large.

The physical abuse of children has in recent years drawn attention from both federal and provincial governments across Canada. Although the welfare of children is a matter of Provincial jurisdiction, assault upon the person of a child is also a matter of federal jurisdiction under the Criminal Code.

Here in Manitoba, officials of the Department of the Attorney-General and the Department of Community Services & Corrections in consultation with various agencies and disciplines, have been working for several years to develop joint service guidelines to bring about closer cooperation amongst the agencies and disciplines involved in child abuse matters across the Province. The guidelines were put into effect in September 1976 [see Appendix "C"].

The guidelines mark a new approach in trust and mutual cooperation among disciplines. Mutual sharing of all information is provided for on a strictly confidential basis.

Recognizing the complexity of factors involved in all the child abuse incidents, the guidelines call for close consultation between social workers, doctors, law enforcement and prosecution lawyers before any criminal action can be commenced.

The general approach adopted in our guidelines is consistent with the policy of our two Departments, as well as with the recommendations made in 1976 to the House of Commons by the Standing Committee on Health, Welfare and Social Affairs after 18 months of study of the question of child abuse and neglect in Canada. This Committee endorsed the approach Manitoba has taken on the issue of the intervention of criminal law in child abuse incidents as summarized in this booklet under "Why treatment is preferred to intervention of criminal law?".

While similar programs have been developed in certain communities in Canada, e.g. Edmonton, we understand that this is the first province-wide program to come into effect and we are proud of our ability to have found a common path to serve our community better.

In December of 1978, the Advisory Committee on Battered Children was enlarged and subsequently renamed as a Provincial Advisory Committee on Child Abuse. The Committee now has 13 members who represent medical, nursing, social work professions, R.C.M.P., Winnipeg Police and the Department of the Attorney-General.

In 1979, The Child Welfare Act was revised. The amendments provided a legal definition of abuse and of the best interests of the child and, enlarged on the requirements for reporting abuse. It is the duty of everyone to report child abuse but it is a special duty of the professional person to report, who in the course of his professional or official duties learns of or has reason to suspect child abuse.

What are the mechanics of reporting and intervention?

- Anybody who has the knowledge of a child abuse incident should report it to the nearest office of the Children's Aid Society or the Regional or District office of the Department of Community Services & Corrections [see Appendix "A"] or to the local police department.
- When the information comes from a doctor, he is immediately consulted as to the action most appropriate under the circumstances to protect the child and then action is taken.
- When the information comes from persons other than medical doctors, its credibility is first checked out in strict confidence and then appropriate action is instituted.
- The Children's Aid Society or the Regional Office reports each incident of child abuse to the Registry for Physically Abused Children where the incident is recorded and checked for any recurrence.
- Depending on each individual case and using the guidelines' procedures, a combination of the following steps may be taken:

  (1) apprehend the child,

  (2) leave the child with parents under voluntarily agreed upon conditions,

  (3) apply to court for temporary or permanent guardianship of the child,

  (4) engage parents in treating their personal difficulties so as to improve the child rearing conditions in the family,

  (5) alert the Attorney-General's Department as to the criminal aspects of the case where warranted.

Where to report?

The offices of the Children's Aid Societies or the Regional and District offices of the Department of Health and Social Development are located in all the larger cities and towns of Manitoba. Contact the office nearest you [see Appendix "A"].

Children's Aid Societies, and Regional offices of the Man. Dept. of Community Services and Corrections

providing child protection services.

Children's Aid Societies:

C.A.S. of Winnipeg	4 - 114 Garry Street, Winnipeg	942-0511
Jewish Child and Family Service	304 - 956 Main Street, Winnipeg	589-6343
C.A.S. of Eastern Manitoba	123-B Marion Street Winnipeg	233-8931
C.A.S. of Central Manitoba	25 - 3rd Street S.E., Portage la Prairie	857-8751
C.A.S. of Western Manitoba	340 - 9th Street, Brandon	728-7000

Regional and District Offices:

Parklands Region	15 - 1st Avenue S.W., Dauphin	638-7024
District Office	201 - 4th Avenue S., Swan River	734-3436
Norman Region	Box 2550 Government Office Building, The Pas	623-6411
District Office	50 Church St. Flin Flon	687-3457
Thompson Region	871 Thompson Drive South Thompson	778-7371
District Office	Churchill Health Centre Churchill	675-8881
District Office	Box 99 L.G.D. Building, Gillam	652-2121
Eastman Region	Provincial Building 250 - 1st Street, Beausejour	268-1411
Interlake Region	202-446 Main St. Selkirk	482-4511

District Office	Thorwill Building, Ashern	768-2585
Winnipeg Child Welfare	1981 Portage Avenue, Winnipeg	885-4480

APPENDIX "B"

Cases reported from January 1 to December 31

REPORT ON PHYSICALLY ABUSED CHILDREN IN MANITOBA

Department of Community Services and Corrections Child and Family Services

Reports received: By Source, Age and Sex of Child, Description of Trauma and Alleged Abuser, Abuser's Sex and Age, Disposition of Children and Action Taken Against Abuser — 1975 to 1980.

SOURCE:	1975	1976	1977	1978	1979	1980
Children's Aid Societies	87	99	119	126	134	168
Central	3	4	9	16	24	22
Eastern	2	4	1	3	1	8
Western	12	14	14	10	13	23
Winnipeg	70	77	95	97	96	115
Regional Offices:	16	36	39	62	81	68
Winnipeg	—	2	1	5	15	6
Eastman	—	1	—	7	5	10
Interlake	11	6	6	9	17	10
Norman	4	3	6	10	6	4
Parklands	—	7	15	9	12	16
Thompson	1	17	11	22	26	22
TOTAL	103	135	158	188	215	236
AGE OF CHILD:						
Under 1 year	15	21	19	20	14	14
1 - 3 years	27	39	45	54	56	59
4 - 10 years	38	43	55	85	112	81
11 - 15 years	22	30	31	24	22	67
16 and over	1	2	8	5	11	15
TOTAL	103	135	158	188	215	236
SEX OF CHILD:						
Male	53	60	69	81	86	89
Female	50	75	89	107	129	147
TOTAL	103	135	158	188	215	236

TRAUMA:						
Death	2	2	6	—	—	1
Fractures	16	19	14	17	17	15
Burns	5	6	7	7	13	13
Bruises and welts	60	78	96	102	114	125
Rape	—	—	—	9	4	5
Sexual assault	6	15	26	26	38	51
Other	14	15	9	27	29	26
TOTAL	103	135	158	188	215	236
ALLEGED ABUSER: (cases)	1975	1976	1977	1978	1979	1980
Father	21	46	47	59	69	71
Mother	22	33	49	56	44	59
Both Parents	10	6	8	11	19	10
Common-law-spouse	16	17	20	19	21	18
Unknown	16	16	15	16	12	21
Other	18	17	19	27	50	57
TOTAL	103	135	158	188	215	236

ABUSERS: (1980)

Male 152

Female 78

Unknown 16

AGES OF ABUSERS: (1980)

14 to 20	17
21 to 30	87
31 to 50	95
51 to 81	17
unknown	30

In some instances there was more than one abuser per case.

DISPOSITION OF CHILDREN:						
1. Child left or returned home with or without agency supervision	51	57	69	82	107	98
2. Non-ward care	4	16	4	14	10	19
3. Temporary Guardianship	32	20	21	29	22	37
4. Permanent Guardianship	1	5	3	8	11	9
5. Deceased	2	2	6	—	—	1
6. Investigation only	12	30	39	28	55	58
7. Pending	1	5	16	27	10	14
TOTAL	103	135	158	188	215	236
ACTION(S) TAKEN AGAINST ALLEGED ABUSER:						
1. Home supervision	51	46	47	39	80	65
2. Child removed into non-ward care	4	16	3	12	10	19
3. Temporary loss of parental rights	29	20	21	19	22	37
4. Permanent loss of parental rights	1	5	3	7	11	9
5. Criminal Court proceedings	2	10	16	10	19	19
6. Investigation only	12	30	27	27	55	64
7. Pending (Family Court & Criminal Court)	4	8	16	32	10	14
8. Supportive or Therapeutic Services offered	—	—	25	42	21	19

Note:

1. In some cases an appropriate combination of two actions have been taken. (For example: Loss of parental rights and criminal action)
2. In 1980 — there were 10 double actions taken.

EXPLANATIONS:

- "Source" designates the child caring agency which reported the abuse incident as well as the area where the abuse occurred.
- "Other" under "Trauma" may mean

  cruel disciplining
  failure to thrive
  severe beating
  cut or torn lip
  lacerated cheek
  exposure to frost (frozen toes).
- "Other" under "Abuser" may mean

  babysitter
  putative father
  mother's boyfriend
  family's relative.
- "Non-ward care" means that parents or guardians agreed voluntarily to place the child in care of the Director of Child Welfare or a Children's Aid Society for a specified time.
- "Temporary Guardianship" means an order of the Family Court placing the child into care and custody of the Director or a Society for a specified limited time (temporary loss of parental rights).
- "Permanent Guardianship" means an order of the Family Court placing the child into care and custody of the Director or a Society for an unlimited period of time (permanent loss of parental rights).
- "Pending" means the case has not been concluded in the court of law as of December 31.
- "Investigation only" denotes instances where the child was left at home and no action was taken due to inconclusive evidence that abuse actually took place.

APPENDIX "C"

GUIDELINES IN CASES OF CHILD ABUSE

The problem of battered babies and abuse of children generally has very far-reaching and serious consequences for society as a whole. In order to prevent the spreading of this "disease", the cooperation of all child caring agencies, law enforcement agencies, medical personnel and other concerned persons is necessary. Therefore, the Honourable Minister of the Department of Health and Social Development and the Honourable Attorney-General, having given fullest consideration to all the aspects of child abuse in our Province and to existing law in that respect in Manitoba, have agreed to the following procedural guidelines in order to bring about the required cooperation of all agencies under their respective jurisdictions.

For the purposes of these guidelines, "child abuse" means the non-accidental use of physical force by a parent or a person in charge of a child which results in injury or death to a child.

GUIDELINES

1. Any case of suspected child abuse must be reported to the local regional office of the Department of Health and Social Development, the Children's Aid Society having jurisdiction in the area, or to the local police department.

2. Where the report is received by a child caring agency (regional office of the Department of Health and Social Development or the Children's Aid Society), the agency will immediately consult with the local police department. Similarly, where the report is received by the local police department, the police will immediately consult with the appropriate child caring agency. Investigation into a complaint of child abuse will be conducted by the child caring agency and/or the local police department in the spirit of mutual cooperation towards protecting the child and the best interests of the community. Following due consultation, the involvement of the local police department in the investigation of any case of suspected child abuse will vary from case to case depending upon the circumstances of the particular case.

3. In order to ensure that the best course of action is adopted in every case, there shall be a mutual sharing of confidential information respecting all facts uncovered in any investigation of child abuse between the child caring agency and the local police department.

4. Responsibility for the protection of the child shall be with the child caring agency and the agency will undertake appropriate action to protect any abused child as is provided by The Child Welfare Act and, will report each incident of alleged child abuse to the Registry for Physically Abused Children attached to the office of the Director of Child Welfare.

5. No criminal prosecution will be commenced without consultation among the local police department, the child caring agency and medical personnel, and only following approval by a Crown Attorney.

6. Should a Crown Attorney instruct a criminal charge more serious than assault causing bodily harm, e.g. murder, rape, manslaughter, wounding with intent, an Information will be laid in the appropriate Provincial Judges Court. Prosecution will follow the normal course.

7. Where the circumstances are such that the abusing parent might be subject to a charge of assault causing bodily harm or some less serious offence, there shall be consultation among the local police department, the child caring agency and medical personnel and the office of the Crown Attorney to determine whether criminal charges should be laid or whether the matter can be appropriately dealt with by counselling of the alleged offender. Any prosecution would be initiated in the Family Court.

8. Where an alleged child abuse is brought to the attention of the authorities on a second occasion, and there is a sound basis for laying a criminal charge, unless special mitigating circumstances are present, a charge will be laid.

In the Winnipeg area cooperation in child abuse cases between the child welfare authorities, the Children's Hospital and the law enforcement agencies has been established for some time. Social workers, doctors and representatives of police together review cases of child abuse and in joint consultation work out appropriate plans of action. It is the expressed hope of the two departments that this multidisciplinary team approach be expanded to the benefit of children in all parts of the province.

DATED at Winnipeg, in Manitoba, this 15th day of September, A.D. 1976.

Minister of Health and
Social Development.

Attorney-General

*Presently called The Department of Community Services & Corrections

MANITOBA

DEPARTMENT OF
COMMUNITY SERVICES & CORRECTIONS

MG-3338

child ABUSE

TEACHERS' PROTOCOL

child ABUSE

TEACHERS' PROTOCOL

prepared by:

The Manitoba Teachers' Society
in cooperation with:

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The Manitoba Association of School Superintendents
The Department of Education
The Department of Community Services and Corrections

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FOREWORD

In early 1979, because of increased societal and teacher concern over child abuse, The Manitoba Teachers' Society, through its Ideals and Practice Committee, began developing guidelines for teachers to follow in cases of suspected child abuse among school age children. The work of the Society in this area became even more timely and essential when revisions to The Child Welfare Act came into effect September 1, 1979. These provisions, particularly Sections 36(1) and 36(3), obligate any person or professional, which includes a teacher, to report forthwith any abuse or suspected abuse of a child.

The classroom teacher, who sees a child on a regular basis, is often in the best position in the school to identify abused children. This Protocol is intended for use by teachers to aid them in understanding child abuse, their professional and legal obligations to abused children, procedures which they should follow when they suspect child abuse, and the steps taken by other responsible agencies on being made aware of a problem. It should help teachers to better discharge their responsibilities and to receive assurance that the welfare of their students is being advanced by other professionals beyond the school system.

The Society is grateful for the support and assistance received from the Manitoba Department of Community Services and Corrections, the Manitoba Association of School Trustees and the Department of Education in developing and publishing this Protocol.

CHILDREN IN NEED OF PROTECTION

The words "child abuse" and "child neglect" are frequently used to signify a child who is in need of protection and consequently in need of community intervention on his behalf. The community has a legal, moral and ethical responsibility to assume an active role in response to child abuse and neglect. Most communities nowadays have the child abuse and neglect situations clearly defined and they have also a protective system in place. Manitoba's Child Welfare Act describes children in need of protection, provides for a comprehensive process of intervention and makes reporting of child abuse and neglect mandatory.

According to Section 16 of The Child Welfare Act a child in need of protection means

(a) a child who is an orphan or who has been abandoned or deserted by his parents and
  (i) who is not being properly cared for by anyone, or
  (ii) who with the consent of the person in whose charge he is, is brought before a judge to be dealt with under the Act;
(b) a child where the parent or person in whose charge he is cannot, by a reason of disease, infirmity, misfortune, incompetence, imprisonment, or any combination thereof, care properly for him;
(c) a child whose life, physical or mental health, or morals may be endangered by the conduct of the person in whose charge he is;
(d) a child who is beyond the control of his parents or person in whose charge he is;
(e) a child whose behaviour, condition, environment or association is injurious to himself or others;
(f) a child who refuses or is unable to provide properly and adequately for the health and welfare needs of herself or her child;
(g) a child born to parents not married to each other whose mother is unable or unwilling to care for him;
(h) a child where the parent or person in whose charge he is neglects or refuses to provide or obtain proper medical, surgical, or other remedial care or treatment necessary for health and well-being of the child, or refuses to permit such care or treatment to be supplied to the child when it is recommended by a duly qualified medical practitioner;
(i) a child whose emotional or mental development is endangered because of emotional rejection or deprivation of affection by the person in whose charge the child is;
(j) a child under the age of 12 years is left unattended for an unreasonable length of time without making reasonable provision for the supervision and safety of the child; or

(k) a child subjected to abuse.

The subsection 36(1) of the Act states that any person who has information respecting a child in need or apparent need for protection shall forthwith report the information to the Director of Child Welfare or to a child caring agency. The child caring agency in Manitoba means a Children's Aid Society or a regional office of the Department of Community Services and Corrections (see Appendix "A").

Child abuse and neglect is a complex problem which requires a community-wide approach and a network of services. This protocol is devoted to the abuse aspects of that problem. However, the guidelines contained here apply equally to the neglect situations and may be used interchangeably.

CHILD ABUSE — WHAT IS IT?

The Child Welfare Act defines child abuse in clause 1(a) as follows:

> "abuse" means acts of commission or omission on the part of the parent or the person in whose charge a child is which results in injury to the child but is not necessarily restricted to physical beating, physical assault, sexual abuse and failure to provide reasonable protection for the child from physical harm;.

There are a variety of manifestations and causes of child abuse. The generally accepted causes of abuse include severe emotional pressures or psychopathologies, a family heritage of violence and the environmental stresses and burdens. Usually child abuse occurs when there is an interplay of several negative forces affecting the family. These forces could be: 1) personal factors (health, intelligence, personality, previous life experience, etc.), 2) attitudes and values (variety of cultural forces), 3) specific life situations (marital discord, employment, housing condition, financial security, etc.), 4) general community welfare (influence on the family of community institutions such as police, schools, churches, radio and T.V., and availability of the service agencies).

Teachers have the same degree of protection and accountability as parents with regard to the use of physical punishment. If it is within reasonable limits under the circumstances, the teacher is within his(her) rights (although this may not be within some school division policies.) If the punishment exceeds reasonable limits under the circumstances, he or she is subject to the same action as parents would be, and the school administration would be required to report the incident to the child welfare authority.

INCIDENCE AND EFFECTS OF ABUSE

No one is absolutely sure how widespread child abuse is because it is probable that many incidents remain unreported. Reported incidents have increased, in Manitoba, from 81 in 1972 to 188 in 1978, and 215 in 1979. While this increase may be attributed partially to better records and increased awareness, child abuse remains a serious social problem.

The National Center on Child Abuse and Neglect estimates that in the U.S.A. approximately one million children are maltreated each year. Of these children, 100,000 to 200,000 are physically abused; 60,000 to 100,000 are sexually abused; and the remainder are neglected. Each year more than 2,000 children die in circumstances suggestive of abuse or neglect.

Child abuse can result in permanent and serious damage to the physical, emotional and mental development of the child. The physical effects may include damage to the brain, vital organs, eyes, ears, arms and legs, resulting in mental retardation, blindness, deafness, and in arrested overall development. The emotional damage may manifest itself in impairment of self-concept, ego competency, reality testing, defensive functioning and thought process. Often abused children have a higher level of aggression, anxiety, low impulse control, and tend to be self-destructive and anti-social. Their cognitive development may also be restricted. Their language, perceptual, and motor skills are often underdeveloped, creating barriers for such children's chances to succeed.

TYPICAL SIGNS OF CHILD ABUSE

Child abuse is not always easy to recognize. As a result, a teacher's judgment is called into play when he/she suspects abuse. The following are general but typical signs, and do not encompass every situation. Any one of these signs, a combination of these signs, or a pattern of these signs may or may not indicate child abuse:

- Suspicious welts, burns, scars, fractures, bruises, or other physical injuries.
- Frequent injuries and contusions with varying explanations from the child.
- Regressive behaviour, thumbsucking, loss of bladder control, temper tantrums over minor matters.
- Refusal to change into proper dress attire for Physical Education.
- Inadequate dress, dirty or torn clothing or unpleasant odor.
- Failure of a family to provide immunization or care for injuries.
- Failure of a family to provide glasses or dental work when finances appear adequate.

- Chronically tired and lethargic children.
- Inadequate nourishment and failure to thrive in comparison to peers.
- Children who are overly or consistently hyperactive, destructive, or aggressive; or, in contrast, passively or overly compliant.
- Children who express suicidal thoughts.
- Negative self-concepts, learning and communication problems.
- Late arrival at school or absences without valid excuses.
- Children who are reluctant to leave school but are not attached to relationships or activities.
- Inadequate interpersonal relationships with both peers and adults.
- Children who are fearful and cling to a teacher for emotional support.
- Excessive daydreaming, self-absorption, or inattentiveness.
- Children who display little emotion or pain.

In other words, any sign, which in the judgment of the teacher indicates that the child may be subjected to abuse should be given serious consideration.

TYPICAL REACTIONS OF ABUSING PARENT(S) OR GUARDIAN(S)

Parents and guardians may give the teacher cause to suspect child abuse. The following are some of the typical reactions and attitudes of parents or guardians who are child abusers. Again, the following are typical and general — any of these may or may not indicate child abuse but may confirm suspicions.

- Do not volunteer information about the child's illness or injury.
- Are evasive or contradict themselves regarding the circumstances under which the child's condition occurred.
- Show irritation at being asked about the development of the child's symptoms.
- Critical of the child and angry with him/her for being injured.
- Give no indication of feeling guilt or remorse regarding the child's condition.
- Maintain that the child had injured himself/herself.
- Show concern, not about the child, but about what will happen to themselves and others involved in the child's injury or illness.
- Seldom touch the child or look at the child.
- Give no indication of having any perception of how a child could feel, physically or emotionally. Seem to be indifferent.
- Constantly criticize the child.
- **Never mention any good quality in the child.**
- Show no concept of the rights of others.

- Are preoccupied with themselves and the concrete things in life.
- Are often neglectful of their own physical health.
- Exhibit violent feelings and behaviour, and in interviewing, reveal that this was a pattern in their original family.
- Reveal, in interviewing, their concern about having been abandoned and punished by their own parents.
- Show overwhelming feelings that they and their children are worthless.
- Feign cooperation which is not substantiated by an observed behavioural change.

ROLE OF THE SCHOOL SYSTEM

Though the primary responsibility for reporting child abuse rests with the teacher, the school system can, through its various constituents, provide much needed support to the teacher. A major effort must be made to raise the awareness and knowledge of teachers about the incidence and identification of child abuse, about their responsibility to report all suspected cases and about the community and provincial resources available to help children.

Schools can perform an important role in educating future parents about conditions leading to child abuse. The emphasis in family-life courses should be on parenting models, parent-child relationships, nutrition, child development, discipline, and emotional and psychological demands of parenthood. Our schools must ensure non-hostile, warm and caring environments for children who are abused in order that these children can come to expect logical, predictable consequences of their actions. School personnel must gain skills in responding to parents who abuse their children to ensure that as a result of their actions no further abuse is accorded to the child.

It is essential that school and school division administrators give support to teachers in carrying out their responsibilities — without their moral and technical support the teacher's job becomes more difficult. School Boards can provide resources for inservice programs and resource personnel to aid teachers in meeting their responsibilities; and can initiate discussions leading to supportive policy decisions. The Provincial organizations — The Manitoba Teachers' Society, the Manitoba Association of School Superintendents, the Manitoba Association of School Trustees, and the Department of Education are willing to make their resources available where necessary.

ROLE OF THE TEACHER

It is the role of the teacher to recognize the vulnerability of school-age children to abuse, to be alert to any physical signs of abuse and any signs of undue emotional or psychological neglect. It is the duty of the teacher according to Section 36(3) of The Child Welfare Act to report suspected abuse to the Director of Child Welfare or a child caring agency:

- "Notwithstanding the provisions of any other Act, every person who in the course of his professional or official duties, has reason to suspect that a child has suffered or is suffering from abuse that may have been caused or permitted by a person who has or had charge of the child, shall forthwith report the suspected abuse to the director or a child caring agency."

GUIDELINES FOR ACTION

1. Team Approach

When child abuse is suspected, the teacher should inform and involve, as soon as possible, the principal, the nurse and counsellor where they exist, of his/her suspicions. In the event of follow-up by the child caring agency one of these should become the school contact with the agency. However, the person who suspects child abuse is ultimately responsible to do the reporting. The report should be made to the child caring agency in your area — a list is provided in Appendix 'A'.

One member of the team may be designated as school contact to report, as an agent of the teacher whose suspicions were initially aroused, to the child caring agency on the teacher's behalf. However, the teacher remains responsible under the law for the action of his/her agent, and is primarily responsible if that agent does not report and the child suffers further injury as a result of failure to report. Thus the teacher should receive oral or written notification that the information has been reported; if not, and the teacher remains convinced of his/her suspicions, he/she must report directly to the child caring agency.

The Child Welfare Act provides legal protection to any person who reports in good faith the information about child abuse to a child caring agency. The Act states in subsection 36(4) as follows:

> "Subsections (1), (2) and (3) apply notwithstanding that the information is confidential or privileged; and no action lies against a person who reports information to the director or a child caring agency in accordance with this section unless the reporting of the information was done maliciously or without reasonable or probable cause."

2. Time is of the Essence

It is essential that the reporting to the child caring agency take place on the same day as the teacher suspects child abuse. If it is impossible to consult with others on the same day, the teacher should report his/her suspicions that day and discuss the matter with team members later.

3. Procedures Respecting Discovery of Abuse

Personal interviews or physical inspection should be conducted in a professional manner. Physical inspections need not go beyond ordinary observation of the child in the school or classroom setting. Teachers are not obliged to prove that abuse has taken place, but only to report observations to the child caring agency. Therefore, they need not conduct any investigation nor contact the parents to ascertain the cause of the child's condition.

4. Confidentiality/Anonymity

If using the team approach, strictest confidentiality should be maintained. Teachers and team members must be discrete in revealing suspicions to persons other than the child caring agency and other team members so as to protect not only themselves, but also the rights of the child and the suspected abuser. Strictest confidentiality should also be maintained so as to avoid prejudicing or jeopardizing the teacher-pupil-parent relationships.

The child caring agencies in Manitoba are obliged to investigate each and every report of the alleged child abuse even if it comes from a person who chooses to remain anonymous. Whereas private citizens may elect to identify themselves or remain anonymous when reporting child abuse, it is suggested by the Department of Community Services and Corrections that the teachers or any school official identify themselves and their school when doing the same. They believe it is imperative that public institutions such as schools give fullest support to the child caring agencies which are mandated by law to protect children.

5. School/School Board Policy

The teacher may, under school or school board policy, be required to report to the principal, counsellor, nurse, clinician and/or the superintendent. Written reporting procedures may be required, keeping the protection of confidentiality in mind, to provide accurate descriptions of the basis of suspicion for future reference.

6. Follow-up Procedures/Further School Responsibility

Follow-up procedures may be desirable, depending on the degree of involvement of school personnel in each particular situation, with the child caring agency. It is desirable that further contact with the child caring agency be done by a designated school contact (see No. 1). It should be noted, that once the reporting to the child caring agency has taken place, the case is out of the school's jurisdiction.

However, the school has, if the child remains in school, a special responsibility. Children known to be abused have special physical, social and emotional needs and should be given additional attention by teachers to reassure them that someone cares about them. The school team or teacher should, upon consultation with the child caring agency decide how the best environment can be achieved for the abused child and what actions would most benefit the child.

7. Dealing with Parent(s)/Guardian(s) After Reporting

If follow-up with the home results from a teacher's reporting to a child caring agency, teachers might anticipate parental/guardian suspicion of the school. Teachers are protected under subsection 4 earlier referred to and should not volunteer information, should not play the role of therapeutic agent for the home, and should refer the parent to the child caring agency if questioned.

WHAT HAPPENS AFTER A REPORT OF CHILD ABUSE

Although the case is outside the jurisdiction of the school, teachers may wish to know the steps taken by the child caring agency in proceeding with each case:

1. The child caring agency will check out the report in strict confidence and institute required action under The Child Welfare Act;
2. Depending on each case, the child caring agency may:
   a) apprehend the child;
   b) leave the child with parent(s)/guardian(s) under voluntarily-agreed-upon conditions;
   c) apply to the court for temporary or permanent guardianship of the child;
   d) engage parent(s)/guardian(s) in treating their personal difficulties so as to improve the child-rearing conditions of the family;
   e) alert law enforcement agencies as to the criminal aspects of the case where warranted (i.e. a clear case of child abuse).
3. The child caring agency should provide, through the school contact, follow-up to the school, which in turn, should keep the teachers involved informed.

APPENDICES

Included for teachers' information are two appendices:
APPENDIX "A" — Listing of Child Caring Agencies
APPENDIX "B" — Guidelines in Cases of Child Abuse, Manitoba 1976 (for information)

APPENDIX "A"

Children's Aid Societies, and Regional Offices of the Manitoba Department of Community Services and Corrections — providing child protection services

Children's Aid Societies

C.A.S. of Winnipeg	4 — 114 Garry Street, Winnipeg. R3C 1G3	942-0511
Jewish Child and Family Service	304 — 956 Main Street, Winnipeg. R2W 3P4	589-6343
C.A.S. of Eastern Manitoba	123-B Marion Street, Winnipeg. R2H 0T3	233-8931
C.A.S. of Central Manitoba	25 — 3rd Street S.E. Portage la Prairie. R1N 1N1	857-8751
C.A.S. of Western Manitoba	340 — 9th Street, Brandon. R7A 6C2	728-7000

Regional and District Offices

Parklands Region	15 — 1st Avenue S.W., Dauphin. R7N 1R9	638-7024
District Office	201 — 4th Avenue S., Swan River. R0L 1Z0	734-3436
Norman Region	Box 2550, Government Office Building, The Pas. R9A 1M4	623-6411
District Office	50 Church St. Flin Flon. R8A 1N4	687-3457
Thompson Region	871 Thompson Drive South, Thompson. R8N 0C8	778-7371
District Office	Churchill Health Centre, Churchill. R0B 0E0	675-8881
District Office	Box 99, L.G.D. Building, Gillam. R0B 0L0	652-2121
Eastman Region	Provincial Building, 20 — 1st Street, Beausejour. R0E 0C0	268-1411
Interlake Region	202-446 Main St. Selkirk R1A 1N7	482-4511
District Office	Thorwill Building, Ashern. R0C 0E9	768-2585
Winnipeg Region serving Charleswood and Assiniboia	1981 Portage Avenue, Winnipeg. R3J 0J8	885-4480

APPENDIX "B" (FOR INFORMATION ONLY)

GUIDELINES IN CASES OF CHILD ABUSE

The problem of battered babies and abuse of children generally has very far-reaching and serious consequences for society as a whole. In order to prevent the spreading of this "disease", the cooperation of all child caring agencies, law enforcement agencies, medical personnel and other concerned persons is necessary. Therefore, the Honourable Minister of the Department of Health and Social Development* and the Honourable Attorney-General, having given fullest consideration to all the aspects of child abuse in our Province and to existing law in that respect in Manitoba, have agreed to the following procedural guidelines in order to bring about the required cooperation of all agencies under their respective jurisdictions.

For the purposes of these guidelines, "child abuse" means the non-accidental use of physical force by a parent or a person in charge of a child which results in injury or death to a child.

GUIDELINES

1. Any case of suspected child abuse must be reported to the local regional office of the Department of Health and Social Development,* the Children's Aid Society having jurisdiction in the area, or to the local police department.
2. Where the report is received by a child caring agency (regional office of the Department of Health and Social Development* or the Children's Aid Society), the agency will immediately consult with the local police department. Similarly, where the report is received by the local police department, the police will immediately consult with the appropriate child caring agency. Investigation into a complaint of child abuse will be conducted by the child caring agency and/or the local police department in the spirit of mutual cooperation towards protecting the child and the best interests of the community. Following due consultation, the involvement of the local police department in the investigation of any case of suspected child abuse will vary from case to case depending upon the circumstances of the particular case.

3. In order to ensure that the best course of action is adopted in every case, there shall be a mutual sharing of confidential information respecting all facts uncovered in any investigation of child abuse between the child caring agency and the local police department.
4. Responsibility for the protection of the child shall be with the child caring agency and the agency will undertake appropriate action to protect any abused child as is provided by The Child Welfare Act, and will report each incident of alleged child abuse to the Registry for Physically Abused Children attached to the office of the Director of Child Welfare.
5. No criminal prosecution will be commenced without consultation among the local police department, the child caring agency and medical personnel, and only following approval by a Crown Attorney.
6. Should a Crown Attorney instruct a criminal charge more serious than assault causing bodily harm, e.g. murder, rape, manslaughter, wounding with intent, an Information will be laid in the appropriate Provincial Judges Court. Prosecution will follow the normal course.
7. Where the circumstances are such that the abusing parent might be subject to a charge of assault causing bodily harm or some less serious offence, there shall be consultation among the local police department, the child caring agency and medical personnel and the office of the Crown Attorney to determine whether criminal charges should be laid or whether the matter can be appropriately dealt with by counselling of the alleged offender. Any prosecution would be initiated in the Family Court.
8. Where an alleged abuse is brought to the attention of the authorities on a second occasion, and there is a sound basis for laying a criminal charge, unless special mitigating circumstances are present, a charge will be laid.

In the Winnipeg area cooperation in child abuse cases between the child welfare authorities, the Children's Hospital and the law enforcement agencies has been established for some time. Social workers, doctors and representatives of police together review cases of child abuse and in joint consultation work out appropriate plans of action. It is the expressed hope of the two departments that this multidisciplinary team approach be expanded to the benefit of children in all parts of the province.

DATED at Winnipeg, in Manitoba, this 15th day of September, A.D. 1976.

Minister of Health and Social Development

Attorney-General

**Presently called the Department of Community Services and Corrections.*

MANITOBA
DEPARTMENT OF HEALTH

MG-8041

child ABUSE

Physician's Protocol

child ABUSE

Physician's Protocol

prepared by

The College of Physicians and Surgeons of Manitoba

Produced by:
Department of Community Services and Corrections
Child and Family Services
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Manitoba

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FOREWORD

On September 15, 1976, the "Guidelines in Cases of Child Abuse" were jointly released by the Departments of Health and Community Services, presently called Department of Community Services and Corrections and the Attorney-General. Manitoba became the first province to formally adopt the multidisciplinary approach to child abuse.

Shortly after, through its Paediatric Death Review Committee, The College of Physicians and Surgeons of Manitoba began to review these guidelines in order to prepare a protocol which would assist physicians in assuming their role in the team. The College is particularly indebted to material received from The Professional Corporation of Physicians of Quebec which published a protocol for their physicians December 1976, and also from the Ontario Medical Association which published a special report on Child Abuse in January 1978.

When a draft protocol had been prepared, the Committee received assistance from several individual agencies. The Child and Family Service Directorate of the Department of Health and Community Services, was particularly helpful in this review process as was the Section of Paediatrics of the Manitoba Medical Association.

The College is grateful for the assistance received from the Manitoba Department of Health and Community Services presently called Department of Community Services and Corrections in arranging for the publication of this protocol.

The College of Physicians and Surgeons of Manitoba

ABOUT THE PROTOCOL

Any act of omission or commission by individuals, institutions or society and any conditions resulting from such acts or inactions which deprive children of equal rights and liberties and/or interfere with their optimal development, constitute, by definition, abusive or neglectful acts or conditions which may inhibit children's development.

In the child abuse and neglect situation, some six systems are involved in the identification, labelling and management. All involved must learn to interrelate positively, especially in prevention.

- The medical system (doctors, nurses, hospital administrators).
- The social service system (public and private agencies which provide amelioration services to families and individuals).
- The legal system (the police and courts).
- The school system (teachers and counsellors).
- The neighbourhood and friendship system.
- The family and kin system.

This protocol is directed primarily to the medical system but the other five components should be kept in mind and related to each part of the protocol.

PHYSICIANS AND LEGISLATION

The definition of CHILD ABUSE AND NEGLECT is not what the doctor thinks it should be, or what the social worker thinks it is, but is actually what the law says it is. The court is, of course, influenced by the public in its interpretation of the law and its definition will change from time to time and may differ in different localities based on the emotional climate of the area.

Introduction

The law in Manitoba relating to child neglect is contained in the Criminal Code of Canada and in The Child Welfare Act. It is very important to note the differences between the provisions of these two Acts. The relevant sections of the Criminal Code are penal in nature; they are intended to punish the parents for crimes committed towards the child; they are primarily concerned with punishing the wrongdoer as opposed to helping the victim;

they require proof beyond a reasonable doubt; they are very seldom invoked. On the other hand, The Child Welfare Act is not a punitive statute; the family court is concerned solely with determining what is **in the best interest of the child,** not with punishing blameworthy conduct; being a civil action, the degree of proof required is upon the balance of probability.

The "Child Welfare Act" enables the Manitoba physician to take an active role in the cooperative and consultative process designed to protect children and to prevent their becoming victims of neglect or abuse. Although the legislation pertains to all citizens, it is particularly applicable to the physician due to his role in the care and well-being of the family.

Reporting

Everyone is directed to report a suspected case of child abuse to the director of child welfare or to a child caring agency. It is considered the duty of a physician to report if he becomes aware of such a situation through his professional activities.

No action lies against the informant for reporting the information unless it is reported maliciously or without reasonable and probable cause.

Child in Need of Protection

The Child Welfare Act points out those situations where intervention is indicated. These include:

- a child who is an orphan or who has been abandoned or deserted by his parents and
  - (i) who is not being properly cared for by anyone, or
  - (ii) who with the consent of the person in whose charge he is, is brought before a judge to be dealt with under this Act;
- a child where the parent or person in whose charge he is cannot, by reason of disease, infirmity, misfortune, incompetence, imprisonment, or any combination thereof, care properly for him;
- a child whose life, physical or mental health, or morals may be endangered by the conduct of the person in whose charge he is;
- a child who is beyond the control of his parents or person in whose charge he is;

- a child whose behaviour, condition, environment or association is injurious to himself or others;
- a child born to parents not married to each other whose mother is unable or unwilling to care for him; or
- a child where the parent or person in whose charge he is neglects or refuses to provide or obtain proper medical, surgical, or other remedial care or treatment necessary for health and well-being of the child, or refuses to permit such care or treatment to be supplied to the child when it is recommended by a duly qualified medical practitioner;
- a child under the age of 12 years who is left unattended for an unreasonable length of time without making reasonable provision for the supervision and safety of the child;
- a child subjected to abuse.

Intervention

When a child "in need" has been identified, the Act further provides both for intervention and apprehension as well as enabling the following ultimate acts if preferred more positive approaches fail:

Entry Without Warrant in Certain Cases.

17(1) An officer of a child caring agency, or of a family court, or a peace officer, who on reasonable and probable grounds, believes that a child who is unable to look after and care for himself has been left without any person to care for him in any premises, may, without warrant, enter the premises for the purposes of investigating the matter and if in the opinion of the officer the child appears to be in need of protective guardianship, he may apprehend and take the child to a place of safety.

Apprehension of Child.

17(2) An officer of a child caring agency or of a family court or a peace officer who on reasonable and probable grounds believes that a child is in need of protective guardianship may apprehend the child without a warrant and take the child to a place of safety.

ETIOLOGY

Basically there are four components required for child abuse to occur.

1 — The Stimulus: That is some aspect of the child that evokes negative feeling in the parent.

This stems of course from the child, or more precisely, some feature of the child that evokes response in the parent. The feature need not be a real one, it is the perception held by the parent that is all important; this also explains why one child in a family may be singled out. For instance, a child may refuse more food simply because he has already eaten enough. The parental perception is rejection of their nurturing love and caring, and thus an angry, hurt response results.

2 — Parental Reaction: The angry destructive feelings experienced by the parent and directed at the child.

All parents need to experience a sense of satisfaction and worth from their children's behaviour and achievement, and when a child fails to live up to parental hopes, needs and expectations, a sense of disappointment may ensue. The expectation is often unrealistic and the reaction may accordingly appear inappropriate but nevertheless it is real.

3 — Parental Preparation: The life experience of the parents which has helped shape their own responses to the challenges of child-rearing.

They have often seen abuse and/or deprivation in their past themselves.

4 — The Precipitation Factor: Any life event which alters the equilibrium of the parent-child relationship. This ia a stress from any source.

CLINICAL FINDINGS

The physician must consider child abuse from the aspect of both the Overt Case and the High Risk Case.

Overt Case

The possibility of child abuse should be a diagnostic consideration when children are seen with any of the following clinical findings:

1 — Bruises: Active children often have small bruises on the shins or knees, and following a spontaneous fall, injury may occur

to the orbital ridge or forehead. Bruises in any other site, especially the trunk, buttocks and face, should be viewed with suspicion. Bruising and ecchymoses may be of unusual shapes or might even be recognizable as resulting from a blow with a stick, or a belt buckle.

Bite marks from human teeth are usually recognized.

Bruising, contusion, and wounds of the lips, gums, frenulum and buccal mucosa in infants occur from the foreceful use of the feeding bottle or spoon in an effort to make the child eat.

Retinal haemorrhage is often found in association with subdural haematomas in infants. They can also be caused by bobbing of the head during violent shaking or squeezing the chest of the child. Remember that "easy bruising" is always a suspect.

2 – Fractures: Spiral fractures of the limbs are uncommon in young children, the greenstick being the rule. A spiral fracture strongly suggests direct rotary twisting of the limb.

Ribs are a common site for fractures due to beatings.

Skull fractures can easily occur in infants if slapped on the face or head.

Fractures at more than one site are diagnostic of non-accidental injury, especially if found to be at different stages of healing.

Equally diagnostic is the radiological finding of healed fractures for which the parents never sought medical advice.

3 – Burns and Scalds: All cases of burn are suspect. Some occur as the result of direct action of the parent, but more commonly the circumstances leading to the burn reflect an inadequacy in parental protection and concern.

Cigarette burns are small, circular, and sometimes multiple. They are usually found on the exposed parts of the body such as the hands, face and legs.

4 – Accidents: As in the case of burns, an accident should always be regarded as preventable and therefore may imply some oversight or negligence on the part of the parent or guardian.

Many children in healthy family situations have at least one accidental fall. However, that should not lessen the need

to evaluate each and every case properly so as to quickly recognize those families where a real risk exists.

Whan a child is found to have had repeated accidents, there is a strong likelihood of family dysfunction or child neglect.

5 – Poisonings: All "accidental" ingestions of pills, solvents and other household materials should be viewed in the same context as physical accidents and for the same obvious reasons.

Repeated ingestion should prompt serious consideration of a disturbed family situation and a child at risk.

6 – Failure to Thrive: In the last decade it has become well established that psychosocial factors, excluding diet, have a profound effect on the physical growth of the child.

It is now postulated that at least 20 percent of all infants labelled as "failure to thrive" are suffering from deprivation of an environmental nature and should be included in the abuse spectrum. This means that any child who is not thriving should be evaluated from the psychosocial point of view as well as genetically and organically.

7 – Emotional Abuse: This is probably the commonest form of abuse that occurs and poses the greatest difficulty in recognition. The diagnostic difficulty arises largely from the fact that each of us may well accept a certain degree of verbal chastisement as an acceptable norm.

Verbal castigation can be considered abusive when (a) the negative feeling expressed towards the child is the major pervading emotion felt by the parent and is not an occasional intermittent event; (b) when the pervading atmosphere in which the child lives is one that denies his achievements and capabilities and constantly depreciates him as a person.

8 – Sexual Abuse: The degree to which sexual exploitation of children occurs is not yet fully known. There is reason to believe that it is not rare and constitutes yet another manifestation of child abuse to be recognized and dealt with. Not surprisingly in most instances it is covert and seldom seen as a presenting complaint. Usually it can only be exposed through skillful interview.

Contrary to the opinion in some paediatric textbooks, gonococcal infections in children should always be considered

to be the result of sexual molestation by an infected adult. The only exception is ophthalmia neonatorum.

9 – History: A suspicion of abuse should be aroused whenever a child with injury or burn presents with any of the following features:

(i) delay by the parents in seeking advice,
(ii) discrepancies or inconsistencies in the history,
(iii) a history which is not compatible with the injury,
(iv) vagueness about specific and important details,
(v) parents who do not wait around once the child has been admitted,
(vi) fail to visit or inquire about the child after admission.

The importance of the diagnostic interview cannot be overstressed in cases of possible child abuse. The interview is described in some detail on page 11 - 13.

High Risk Cases

It is most important to be able to recognize those situations where inadequacy in parenting is likely to occur. They can be detected prenatally, at birth (observation in the delivery room is now recognized as an optimal time for detection), and in the early postpartum period. High-risk situations should be considered:

1 – When the child is born unwanted or wanted for the wrong reasons (this is not synonymous with unplanned). Parents in such situations do not prepare for the baby's arrival, may not seek antenatal care and often will not choose a name for the baby.

2 – If maternal-child attachment is impaired. This risk is particularly heightened if the newborn baby is perceived to be abnormal by the parents.

3 – If there is separation of the mother from her newborn baby, as in the case of prematurity or by illness in the case of an infant whose neonatal course is complicated, particularly if the parents think the child's life is at risk.

4 – If the infant is difficult to handle because of problems with feeding, colic, vomiting, etc.

5 – If there are complaints of behaviourial difficulties such as hyperactivity, sleep-resistance, poor eating habits, failure to thrive.

6 – If the parents have a history of abuse, neglect or deprivation in their own childhood.

7 – If there are environmental problems such as poor housing, over-crowding, financial crisis, loss of work.

8 – In the presence of family breakdowns, separations, alcoholism and other forms of marital discord.

9 – Where there is acute or chronic ill health in a parent, be it physical or emotional.

10 – Whenever another child is born, thus leading to acute changes in family functioning. In all high risk situations, abuse may become a reality at any moment, therefore recognition and intervention in the situation is mandatory.

11 – When a teenage unmarried girl opts for keeping her baby.

HOW TO RESPOND AND WHAT TO DO

Overt Abuse

1 – Always admit the child, if an infant, thus providing an immediate place of safety. If the child is older, an alternate place of safety may be preferable. This will allow time:

(i) To conduct a thorough physical examination.
(ii) To x-ray the complete skeleton and obtain blood clotting studies.
(iii) To obtain details of previous hospital admissions or visits to casualty departments.
(iv) To check with community agencies for any past experience with the child and family.
(v) To obtain clinical photographs of any suspicious lesions.
(vi) To notify the local child caring agency. You are legally obliged to do so.
(vii) To make active use of the Child Abuse Registry (central and/or regional). This also allows speedy apprehension if there is a fear that the parent will flee with the child.

2 – Don't try to identify a culprit. Make the parents aware of the facts that you are required by law to report all suspect cases of abuse even though you do not necessarily feel the parents have done anything wrong. At the same time empathise with any feelings of frustration and anger expressed by them, whether at the child, the hospital or the legal system. Even

though outwardly angry with you they may well be relieved that someone has at last discovered their dreadful secret.

If you are honest, supportive, and non-judgmental they may learn to trust you and utilize your help in the future.

3 – Having called your local child caring agency, or Child Abuse Team if one exists in your area, work with them and be guided by their experience.

4 – The physician must not be confused by his feelings of "betrayal of the parents". He must keep his priorities straight and be the advocate of the child.

High Risk Cases

Once the potential of child abuse is recognized, it is essential to explore further. The session with the parents should be a dialogue, not an interrogation. It requires experience and empathy and aims at developing a picture of the parents as people. It must dwell on the circumstances of the child's conception, the parents feelings about the child from then until the present and should also elicit further relevant data on their present life situation culminating with the events leading to the current crisis.

Discussions should first focus on the mother's perception of the child and what it is like to live with him. What kind of feeling does he generate in the parents and are these feelings potentially harmful? Most parents experience angry, destructive emotions towards their children at times; this is quite normal. It is the background of the parents and their ability to handle, control and channel those feelings that makes the difference.

In a case where suspicions are aroused at an initial discussion, if possible it is best to invite the parents back at another time for a longer talk. If this is unlikely to occur, it is wise to take the discussion as far as possible when the subject first comes up and the parent feels like talking, rather than lose the opportunity.

When talking with one or both parents, the physician tries to learn more of the parents. What kind of a childhood did they have? How were they disciplined by their own parents? What other problems are they trying to cope with? How do they handle anger? If parents can acknowledge the destructive feelings they have towards the child and can control them by separating from the child at that point or by coming to each other's aid when either one is emotionally distressed, then there is less to fear.

Discussions of this kind should quickly expose any inadequacies

that the parents may feel in meeting their responsibilities and open the way to active help and intervention. This may be time-consuming and necessitate expertise in family work. It is often a good idea to have the interview handled by an experienced social worker, or another colleague with experience in such situations, and to sit in and listen as an advocate of the family until one has acquired the fundamentals of carrying out the interview oneself.

Finally, of course, once the parents feel they have a doctor who understands their situation and is willing to spend time with them they will feel less fearful about future problems and quite often their demands for services will diminish.

PREVENTION

It is important to recognize the degree to which healthy bonding between parents and their offspring strenghtens the positive aspects of the relationship and lessens the likelihood of negative parental feelings of a degree great enough to lead to abuse. Thus, everything that strengthens and supports the attachment process can be viewed as a preventive measure as far as child abuse is concerned.

The most fertile area for professional intervention of a prophylactic nature occurs in relation to conception, pregnancy, birth and the immediate neonatal period. That is why planned pregnancies are safer than unplanned and unwanted ones. The parental attitude towards the pregnancy indicates the degree to which the foetus is desired and cherished, or alternatively resented and feared. Mothers give many messages by words and behaviour. Doctors and nurses should listen and watch for such clues and respond to them promptly and appropriately.

At the time of the birth, it is preferable for the mother to be conscious to see her child's birth and to hold her baby as soon as possible. Many authorities feel that the interaction between parents and their newborn infant in the first half-hour of life may be a crucial event in establishing a positive relationship.

Finally, during the neonatal period, hospital procedures may tend to separate the mother from her child and family, and to impose all manner of routines which can provoke anxiety, such as the routine weighing of babies and measuring the amount of breast milk produced by the mother, routine blood tests on the infants, the use of lights to control jaundice, etc. Events which

are not conducive to healthy mother/child bonding bear careful re-evaluation in the light of all that we are beginning to understand about human parenting behaviour.

At any point along the life cycle from conception to neonate, there are opportunities for helpful professional intervention which can reduce future abuse and help foster more positive successful and enjoyable parenting.

During the first year, use should be made of the frequent visits for immunization demand and physical growth assessment. At these visits, the physician should watch for comments pertaining to parent-child handling, i.e., at four months "he doesn't like me" – inappropriate, - uses adult terms to describe the child's personality.

INCIDENCE

– The incidence of child abuse is approximately 500 new cases per million population per year (Colorado 1975). The inclusion of child neglect in mandatory reporting may double this figure.

– Types of child abuse are 85 percent physical abuse, 10 percent sexual abuse, and 5 percent failure to thrive secondary to nutritional deprivation. The incidence of nutritional deprivation in hospitalized cases is approximately 10 percent. Emotional abuse is not found in this analysis, because the types of cases that are severe enough to prove in court are almost always associated with physical abuse or serious neglect.

– There are approximately 2,000 deaths per year from physical abuse in the United States. This represents a major cause of death in children. The overall mortality rate is approximately 3 percent nationally. In areas where there is early detection and intervention, the death rate is less than one percent. In areas where the case finding is inadequate, the death rate may climb to ten percent.

– The ages of the victim vary according to the type of abuse and neglect. In physical abuse, approximately one-third of the cases occur under six months of age, one-third between six months and three years of age, and the remaining one-third over three years of age. In communities with a good finding system there is a larger incidence in school age children. Sexual abuse occurs almost totally in girls, and half the classes are in children under age 12. Failure to thrive occurs predominantly in the first 12 months of life.

– The risk of physical abuse occurring in siblings of an abused child is that in 20 percent of cases, there is concurrent abuse, and in 50 percent of cases, there is previous or future abuse.

– The abuser is a related caretaker in 90 percent of cases, a boyfriend in five percent of cases, an unrelated babysitter in four percent of cases, and a sibling in one percent of cases. Overall, adult females and males are equally involved. However, the most important factor is access, the mother being more commonly involved if she is totally responsible for child rearing, and the father being more commonly involved if he is out of work.

– Using the 500 per million population rate, Manitoba would be expected to have 500 cases per year reported. While such figures may reflect the actual incidence of child abuse in the province, the reported incidence for Manitoba is shown as follows:

Reported Child Abuse Cases in Manitoba

Year	Total Number of Reported Cases	Fatal Cases
1972	81	1
1973	70	0
1974	82	4
1975	103	2
1976	135	2
1977	158	6
1978	188	–
1979	215	–
1980	236	1

AGE	1972	1977	1980
Under 1 year	12	19	14
1 - 3 years	29	45	59
4 - 10 years	26	55	81
11 - 15 years	11	31	67
16 and over	3	8	15
	Totals 81	158	236

DIAGNOSIS

The diagnosis of abuse or neglect should be considered when some of the following are present:

When the Parent:

– Shows evidence of loss of control, or fear of losing control.

- Presents contradictory history.
- Projects cause of injury onto a sibling or third party.
- Has delayed unduly in bringing child in for care.
- Shows indifference towards the child.
- Reveals inappropriate awareness of seriousness of situation (either over-reaction or under-reaction).
- Continues to complain about irrelevant problems unrelated to the injury.
- Personally is misusing drugs or alcohol.
- Seems "suspicious" to the physician, for some unknown reason.
- Presents a history that cannot or does not explain the injury.
- Gives a flood of details the aim of which seems to be to confuse the explanation of the case or to hide the truth.
- Gives a history of repeated injury.
- Has no one to "bail" her(him) out when "up tight" with the child.
- Is reluctant to give information.
- Refuses consent for further diagnostic studies.
- Cannot be located.
- Hospital "shops" (goes from one hospital to another).
- Is psychotic or psychopathic.
- Has been reared in a "motherless" atmosphere.
- Has unrealistic expectations of the child.
- Wants the child discharged early.

When the Child:

- Has an unexplained injury.
- Shows evidence of dehydration and/or malnutrition without obvious cause.
- Has been given inappropriate food, drink and/or drugs.
- Seems to have been left alone.
- Is unusually fearful.
- Shows evidence of repeated injury.
- Takes the situation in hand and begins to be worried about the behaviour of his parents.
- Is seen as "different" or "bad" by the parents.
- Is indeed different in physical or emotional makeup.
- Is dressed inappropriately for degree or type of injury.
- Shows evidence of sexual abuse.
- Shows evidence of repeated skin injuries.
- Shows evidence of repeated fractures.

- Shows evidence of "characteristic" x-ray changes to long bones.
- Has injuries that are not mentioned in history.

TEAM APPROACH

In September 1976 the Minister of Health and Community Services and the Attorney-General jointly released the "Guidelines for Use in Cases of Child Abuse" (now appearing as Appendix C in the province's **Child Abuse** brochure) delineating the steps to be taken and the ways in which law enforcement and social services must work together to ensure the delivery of coordinated services to the abused child and his parents. The multidisciplinary approach pioneered in Winnipeg by child welfare, medicine and law enforcement is presented as a model for all of Manitoba.

The general approach adopted in the guidelines is consistent with the policy of the two Departments, as well as with the recommendations recently made to the House of Commons by the Standing Committee on Health, Welfare and Social Affairs after 18 months of study of the question of child abuse and neglect in Canada. This Committee endorsed the approach Manitoba has taken on the issue of the intervention of criminal law in child abuse incidents.

Reporting

Any case of suspected child abuse must be reported to the local regional office of the Department of Health and Community Services or the Children's Aid Society, the agency will immediately consult with the local police department. Similarly, where the report is received by the local police department, the police will immediately consult with the appropriate child caring agency. Investigation into a complaint of child abuse will be conducted in the spirit of mutual cooperation towards protecting the child and the best interests of the community. Following due consultation, the involvement of the local police department in the investigation of any case of suspected child abuse will vary from case to case depending upon the circumstances of the particular case.

Case Followup

In order to ensure that the best course of action is adopted in every case, there shall be a mutual sharing of confidential

information respecting all facts uncovered in any investigation of child abuse between the child caring agency and the local police department.

Intervention and Apprehension

Responsibility for the protection of the child shall be with the child caring agency and the agency will undertake appropriate action to protect any abused child as is provided by The Child Welfare Act and, will report each incident of alleged child abuse to the Registry for Physically Abused Children attached to the office of the Director of Child Welfare.

Prosecution

No criminal prosecution will be commenced without consultation among the local police department, the child caring agency and medical personnel, and only following approval by a Crown Attorney.

Should a Crown Attorney instruct a criminal charge more serious than assult causing bodily harm, e.g. murder, rape, manslaughter, wounding with intent, an Information will be laid in the appropriate Provincial Judges Court. Prosecution will follow the normal course.

Where the circumstances are such that the abusing parent might be subject to a charge of assault causing bodily harm or some less serious offence, there shall be consultation among the local police department, the child caring agency and medical personnel and the office of the Crown Attorney to determine whether criminal charges should be laid or whether the matter can be appropriately dealt with by counselling of the alleged offender. Any prosecution would be initiated in the Family Court.

Where an alleged child abuse is brought to the attention of the authorities on a second occasion, and there is a sound basis for laying a criminal charge, unless special mitigating circumstances are present, a charge will be laid.

CONFIDENTIALITY

The physician must be always aware of both the short and long term potential harm to a human being unable to defend himself and in need of an advocate.

A feeling of "Betrayal of the Parents" may be understandable

but failure to ensure that action is taken on behalf of the child is inexcusable. A person's action in such an advocacy role is protected by Section 36 of The Child Welfare Act which states that no action lies against the informant for reporting the information unless it is reported maliciously or without reasonable and probable cause.

Child Abuse - Physician's Protocol

Summary [1]

WHAT TO DO

1. Establish the diagnosis where possible.
2. Ensure that the child is "safe".
3. Do not evaluate your alternatives alone. Phone your local child caring agency and establish your desired role in the "Multidisciplinary Team".
   (a) Report your findings or suspicious to your local child caring agency. In those areas without 24 hour coverage. contact police for "the social worker on duty".
   (b) The social worker will establish a plan for long-term investigation and management. You must clarify your desired further involvement **at this time.**
   (c) Proceed on the basis of medical indications. Your subsequent involvement will depend on the plan agreed to with the social worker.

Note:

(1) If you are a "third party" then attempt to identify and contact the family doctor. If this is not possible, then report your concern to your local child caring agency directly.

(2) If you wish to remain **uninvolved** make this point clear to the social worker.

CHILDREN'S AID SOCIETIES, and REGIONAL OFFICES OF THE MANITOBA DEPARTMENT OF HEALTH AND COMMUNITY SERVICES
Providing Child Protection Services.

Central Region 857-8751
C.A.S., 25-3rd Street, S.E., Portage La Prairie

(1) Is available in a separate detached form.

Eastman Region Provincial Building, 20-1st Street, Beausejour	268-1411
Interlake Region 202-446 Main Street, Selkirk	482-4511
Norman Region Box 550, Government Office Building, The Pas	623-6411
District Office 50 Church St., Flin Flon	687-3457
Parklands Region 15-1st Avenue, S.W., Dauphin	638-7024
District Office 201-4th Avenue, S., Swan River	734-3436
Thompson Region 871 Thompson Drive S., Thompson	778-7371
District Office Churchill Health Centre, Churchill	675-8881
District Office Box 99 L.G.D. Building, Gillam	652-2121
Westman Region 340-9th Street, Brandon	728-7000
Winnipeg C.A.S. Of Winnipeg 4-114 Garry Street, Winnipeg	942-0511
Jewish Child and Family Service 304-956 Main Street, Winnipeg	589-6343
C.A.S. of Eastern Manitoba 123-B Marion Street, Winnipeg	233-8931
Winnipeg Region 1981 Portage Avenue, Winnipeg (serving Charleswood and Assiniboia)	885-4480

DIAGNOSIS

The diagnosis of abuse or neglect should be considered when some of the following are present:

When the Parent:

- Shows evidence of loss of control, or fear of losing control.

- Presents cotradictory history.
- Projects cause of injury onto a sibling or third party.
- Has delayed unduly in bringing child in for care.
- Shows indifference towards the child.
- Reveals inappropriate awareness of seriousness of situation (either over-reaction or under-reaction)
- Personally is misusing drugs or alcohol.
- Seems "suspicious" to the physician, for some unknown reason.
- Gives a flood of details the aim of which seems to be to confuse the explanation of the case or to hide the truth.
- Gives a history of repeated injury.
- Has no one to "bail" her(him) out when "up tight" with the child.
- Is reluctant to give information.
- Refuses consent for further diagnostic studies.
- Cannot be located.
- Hospital "shops" (goes from one hospital to another).
- Is psychotic or psychopathic.
- Has been reared in a "motherless" atmosphere.
- Has unrealistic expectations of the child.
- Wants the child discharged early.

When the Child:

- Has an unexplained injury.
- Shows evidence of dehydration and/or malnutrition without obvious cause.
- Has been given inappropriate food, drink and/or drugs.
- Seems to have been left alone.
- Is unusually fearful.
- Shows evidence of repeated injury.
- Takes the situation in hand and begins to be worried about the behaviour of his parents.
- Is indeed different in physical or emotional makeup.
- Is dressed inappropriately for degree or type of injury.
- Shows evidence of sexual abuse.
- Shows evidence of repeated skin injuries.
- Shows evidence of repeated fractures.
- Shows evidence of "characteristic" x-ray changes to long bones.
- Has injuries that are not mentioned in history.

SUSPECTED NON-ACCIDENTAL INJURY TO CHILDREN

M.H.S.C. NO: _____ RELIGION _____

Other Names: _____ Sex: F___ M ___

Previous Address: _____

ADMITTED			
Time	D	M	Y

ARRIVED BY:

Stretcher _____ Wheelchair _____

Carried _____ Walking _____

Date

Full Name

Address

Telephone No.

Date of Birth

Hospital No.

Physician

POLICE Notified: Yes _____ No _____

SOCIAL WORK Referral: Yes _____ No _____

HOSPITAL/CLINIC ORIGINATING

Name & Phone No. of Protection Agency

Other Agencies

ENTRANCE COMPLAINT

FAMILY DOCTOR

Relationship of suspected abuser to child

MARITAL STATUS OF PARENT/S

M___S___SEP___DIV___WID___C/L___

FATHER'S NAME _____ AGE _____

MOTHER'S NAME _____ AGE _____

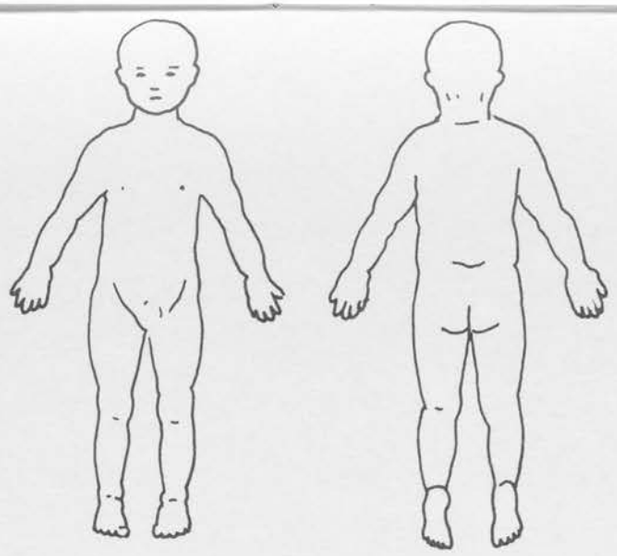
SIBLING: 1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

HISTORY & PHYSICAL EXAMINATION: ___ Height _____ cms. ___ Weight _____ kg. ___ Head Circumference _____ cms. ___

	Normal	Abnormal (please specify)
Head & Neck		
Throat & Ears		
Chest		
Heart		
Lungs		
B.P.		
Abdomen		
Liver & Spleen		
Genitalia		
Extremities		
Cranial Nerves		
Fundoscopic		
C.N.S.		
Skin		

PHOTOGRAPHS OBTAINED (B & W PRINTS)



Mark all evidence of trauma, cuts, burns, fractures, bruises, nail marks

INVESTIGATION:	Time Done	Result
Hemoglobin		
W.B.C.		
Platelets		
P.T.		
P.T.T.		
Bleeding Time		
Urinalysis		
V.D.R.L.		
X-ray (specify)		
X-ray, skeletal survey		

COMMENTS:

TREATMENT: Time: _____ SIGNATURE _____ M.D.

REFERRAL TO: Hospital _____ Physician _____ Other _____

MANITOBA

DEPARTMENT OF COMMUNITY
SERVICES AND CORRECTIONS

MG-8236

Protective Parenting

The Art of Teaching Children About Sexual Abuse

Prepared by

Minnesota Criminal Justice Program
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480 Cedar, St. Paul, MN 55101
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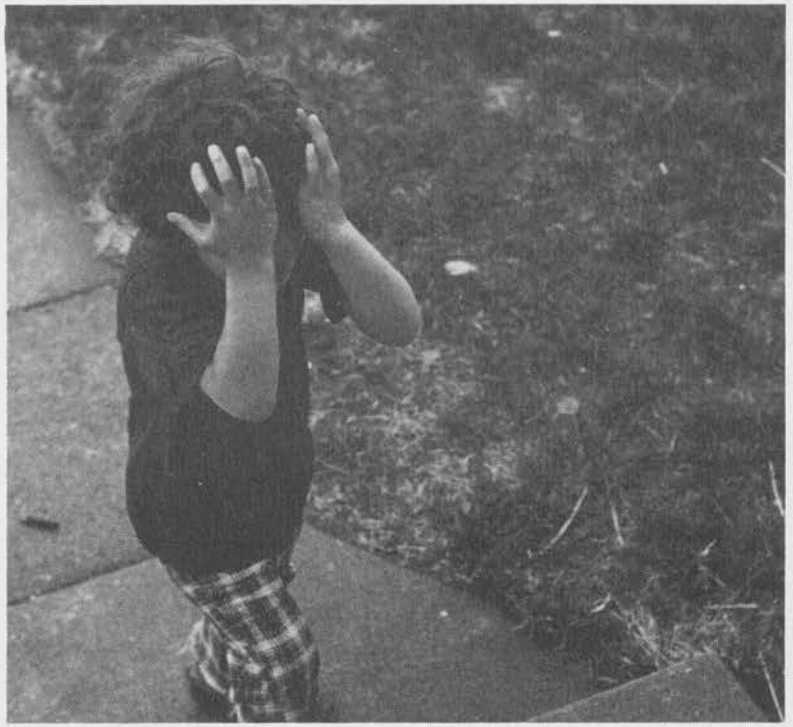
For further information, contact:

Minnesota Criminal Justice Program
or
Social Service Division
Department of Public Welfare
658 Cedar, St. Paul, MN 55155
(612) 296-8337

The Facts and the Fiction

Sexual abuse. It happens more often than you think. Approximately 2 out of 10 females and 1 out of 10 males are sexually assaulted in their lifetime. This is a learning pamphlet specifically prepared to help parents communicate with their children about sexual abuse—because it is a real threat.

Many of us know little about this form of assault because we were raised on the myths surrounding this "taboo." The chart on the next page straightens out the facts.



Myths	Facts
The assailant is a stranger.	Most often the victim knows his/her assailant—a relative, neighbor, family member, or friend.
The attack is the victim's fault.	Victims need support; they are not to blame.
Sex offenders are minorities from low income groups.	Sex crimes are committed by people of all races and incomes.
Sexual assault occurs at night.	It happens at any hour of the day or night.
Victims of sexual assault are young, attractive women.	Victims can be any age or sex; "looks" are unimportant.
Sexual abuse must not be discussed with children; it may frighten them.	Children should be informed for their own safety.
It is a rare occurrence.	Incidents occur frequently; 481 reports were made in Minnesota in 1978. Countless cases go unreported.
The assault is violent and brutal.	Sexual abuse can develop slowly over a period of time.

Preventive Measures

Forcing, manipulating, or tricking someone into sexual contact is sexual abuse. The assault may include touching the genitals, oral sex, requests for sexual favors, and attempts to penetrate the anus or vagina. Or it may involve no physical contact at all—obscene phone calls or suggestions that a child expose herself/himself.

Parents can have a certain amount of control over these situations. Children provided with accurate information at an early age learn to avoid or stop sexual advances. Conversely, an unprepared child may be too confused or ashamed to even confess that an assault has taken place.

Unfortunately, a child's first discussion regarding sexual abuse usually occurs *after* s/he has been assaulted. Don't wait. Information can be introduced as early as age two. Even very young children comprehend concepts related to abuse. Most know what it feels like to be held down and tickled. Sexual abuse is like that—a helplessness.

Relate to your children that their bodies are their own; they can decide who does or does not touch them. Sometimes children feel vulnerable because they have no control over who touches them. They learn to allow Uncle Joe and Aunt Marge to pat them on the bottom even if they don't approve. They are taught to submit politely instead of to recognize the uncomfortable or embarrassed feelings as possible warning signals. Rather than feeling helpless, a child should have the power to say, "Don't touch me like that." There is nothing wrong with saying "No."

Parents are full of warnings. "Don't play with matches." "Look both ways before you cross the street." "Stay out of the water." Safety rules start early; precautions regarding sexual abuse can and should be included in these general discussions. Without proper instruction, a child's understanding of sexual assault is limited to the stories learned from his/her friends. As a parent, you have an opportunity to dispell the myths. Children deserve and need accurate infor-

mation. Teach preventive measures against sexual assault.

Here's how.

First, *establish a common level of understanding between you and your child.* Teach your children a basic working vocabulary for all body parts. Now you can discuss sexual assault together in specific terms.

Then, *begin your discussion slowly.* Ask your children basic questions: Do you know what crime is? Have you heard of sexual abuse? What do the words victim and offender mean? From their answers, decide what clarifications need to be made before you continue. Answer questions fully. Emphasize that they can ask you about anything that confuses or upsets them, any time. You are always available to help and—most important—you will believe what they tell you. Your reassuring support may stop abuse, if it occurs, in its early stages before severe damage is done.

Other effective methods of communicating about sexual abuse can be introduced. Try them in addition to or instead of straight conversation.

Games

Make your talk a "game." Ask your children to solve various abuse-related problems. You can act as a guide here, steering them toward a "right" answer.

What should you do if you are followed by someone in a car?

What should you do if someone touches you in a way you don't like?

Story-Telling

Stories help children identify with situations. Make them up and discuss them. Encourage questions.

> Eight-year-old Linda was walking home from school one warm afternoon when Bob, a good friend of her family's, drove up. He pulled over and opened the car door, smiling. "Want a ride home?" Linda had known Bob since she was very little, so she climbed in. As they drove, he pointed to an envelope on the seat next to her. He asked if she'd like to see some pictures. She nodded, opening the envelope. The photos were of Bob, naked. Suddenly, he unzipped his trousers and exposed himself. Frightened, Linda asked to get out of the car. He let her go, warning her not to tell anyone. She ran straight home and poured out the whole story. Her mother hugged her. "You did the right thing," she told Linda, promising something would be done about the problem.

Role-Playing

In the same way as a story, drama involves children in a situation. The whole family can be a part of this. Act out incidents in which sexual assault could occur. Incorporate positive methods of dealing with the traumatic experiences. Reinforce the supportive parental role.

In Case of Assault . . .

Read the Signals

A child who is afraid, confused, or ashamed may not be able to express in words that s/he has been assaulted. Often, the signals are nonverbal behavior changes:

- unwillingness to be near a particular place or person
- nightmares
- sudden development of bedwetting
- loss of appetite
- unusual interest in the private body parts of other people
- sudden turning against one parent.

Although these are not *necessarily* signs that the child has been a victim of abuse, they may suggest a problem. Be aware of the warning signals. They can enable you to stop repeated or more severe assaults of your child.

Deal with the Trauma

Sexual abuse can be a shattering experience—for both you and your child. Parents may want to discuss their distress with someone trusted. If you feel this need, consult a family member, friend, or professional counselor. "Opening up" will relieve part of the pressure; you'll be better able to cope with the experience.

Once *you* have attempted to deal with the incident, help your child do the same. The truly crucial period for him or her comes *after* the assault. Your support is invaluable. Child abuse victims need to be assured that:

- you believe them
- you will protect them
- they were not to blame for the incident
- they were right in telling you.

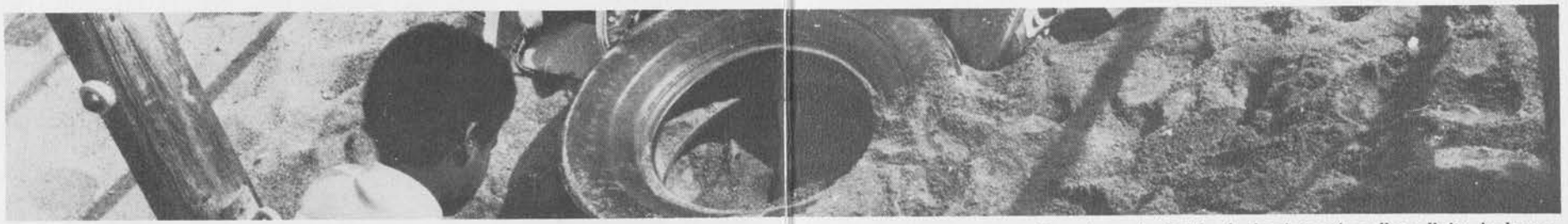
Your primary function here is to provide comfort and reassurance. Don't pressure her/him to discuss the assault. If the child seems reluctant, the best you can do is promise you'll be available to talk, any time.

Your child may need medical help. Consult your family doctor or visit a hospital emergency room. Even if no apparent physical harm was done, you may want an exam to be performed just to be sure. Make it clear to your child that the tests aren't being done because you don't trust her/him.

To Report Or . . .?

Report the assault? A difficult decision. The consequences, in either case, should be considered first. Sexual assault is against the law, and an offender will probably repeat his crimes until reported. As a parent, however, you may worry that your child could be further traumatized by testifying in court or that s/he won't be believed.

If you choose to report sexual abuse, do so directly to the police or county social services.



Minnesota Law

Minnesota is sensitive to the problem of sexual abuse of children, and gives it special attention. The legislature provides legal protection in five areas: 1) criminal sexual conduct, 2) incest, 3) prostitution, 4) promotion of minors to engage in obscene works, and 5) obligation to report sexual abuse.

Criminal Sexual Conduct

It is criminal to use force, threat of force, or fear of bodily harm to cause another person, including children, to participate in sexual acts.

Special considerations are taken into account when determining whether sexual abuse of a child has occurred. Aside from the use of force or fear, these include the age of the child, the age of the child as compared with the age of the accused, or the accused's authority over the child and the use of that authority. The child's consent or a mistake as to his/her age are not defenses in most cases.

Incest

Intercourse with any person of closer relation than first cousin is a criminal offense, whether half or whole blood relative.

Prostitution

Prostitution, specifically dealing with children, is divided into the following categories:

- Soliciation, Inducement, and Promotion. Heavy penalities are given to an individual who intentionally solicits, induces, or promotes (furnishing patrons, location, etc.) a child to engage in prostitution.
- Receiving Profit From Prostitution. Gaining profit from prostitution (or its promotion) of a child in the situation described above is subject to severe penalities.
- Other Prohibited Acts Involving Minors in Prostitution. Intentionally engaging in prostitution with a minor (under 18) or intentionally hiring or agreeing to hire a minor to engage in prostitution are criminal behaviors.

Promotion of Minors to Engage in Obscene Works

It is unlawful to promote, employ, use, or permit a minor to engage in or assist others in engaging in any sexual performance or in preparing an obscene work.

Obligation to Report

Minnesota law requires that professionals (or their delegates) engaged in healing arts, special services, hospital administration, psychiatric/psychological treatment, child care, education, or law enforcement who have reasonable cause to believe a child has been subjected to sexual abuse[1] must report that abuse. Any person not required to report sexual assault may voluntarily do so. Anyone reporting voluntarily or manditorily, in good faith and using due care, is immune from civil or criminal liability resulting from reporting.

[1] "Sexual abuse" includes subjection of the child by parents or guardians to criminal sexual conduct, prostitution, or the engaging in obscene works.

For Help. . .

The following agencies are specifically responsible for providing information and referral services to citizens in search of community services.

Statewide

Minnesota Program for Victims of Sexual Abuse

Purpose:	Statewide referral for victims of sexual abuse
Phone:	(612) 296-7084
Address:	430 Metro Square Building St. Paul, Minnesota 55101

Dakota County

Help line

Purpose:	Information and referral to assist citizens in search of community services
Phone:	(612) 894-2424
Address:	13760 Nicollet Avenue Burnsville, Minnesota 55337

Anoka County

Victim Witness Assistance

Purpose:	Twenty-four hour support and referral service for sexual assault victims.
Phone:	(612) 421-4760 427-1212 after 5 PM
Address:	Anoka County Courthouse 325 East Main Anoka, Minnesota 55303

Ramsey County

Know Phone

Purpose:	Information and referral to assist citizens in search of community services
Phone:	(612) 339-7033
Address:	608 20th Avenue, South Minneapolis, Minnesota 55454

Emergency Social Service

Purpose:	Information and referral
Phone:	(612) 291-6795
Address:	100 South Robert Street St. Paul, Minnesota 55107

Hennepin County

First Call For Help

Purpose:	General information and referral
Phone:	(612) 340-7431
Address:	4 South Eighth Street Minneapolis, Minnesota 55404

Hennepin County Child Protection Services

Purpose:	Child protection assistance—24-hour hotline
Phone:	(612) 348-3552 intake 24-hour hotline (612) 348-7510 information
Address:	A-1600 Government Center 300 South 6th Street Minneapolis, Minnesota 55487

Hennepin County Medical Center Emergency Department

Purpose:	Sexual assault evidence exams
Phone:	(612) 347-3131
Address:	Eighth Street and Park Avenue Minneapolis, Minnesota 55415

Washington County

Crisis Hotline

Purpose:	Information and referral
Phone:	(612) 777-1999
Address:	608 20th Avenue, South Minneapolis, Minnesota 55454

Outstate

Outstate residents should contact local police or county social services for assistance.

Are You an Innocent Victim of a Violent Crime

If so, you can obtain financial help . . .

PURPOSE OF THE MINNESOTA CRIME VICTIMS REPARATIONS LAW (Minn. Statutes 299B.01–299B.16)

To provide innocent victims of violent crime with compensation for loss of earnings or support and out-of-pocket loss for injuries sustained as a direct result of a crime committed against their person. Out-of-pocket loss means reasonable medical care or other services necessary as a result of injury. In the event of the death of the victim, reasonable medical care plus reasonable expenses of deceased for funeral, burial or cremation, plus loss of support to dependents of the deceased victim.

Who Is Eligible?

An innocent victim of a violent crime against his or her person.

A dependent or legal representative of an innocent victim who has met death as a result of a violent crime.

How Can I Recover Reparations?

By filing a Preliminary Claim Form with the Board. Forms can be obtained from your local law enforcement agency or by writing to the Crime Victims Reparations Board, 702 American Center Bldg., 160 East Kellogg Blvd., St. Paul, Minn. 55101, or calling (612) 296-7080.

For persons living outside of the 7-county Metro Area free calling zone, use the free state in-wats phone number, 1-800-652-9747.

How Much Can I Recover?

Up to a maximum of $25,000. There is a $100 deductible and further deductions for amounts received or to be received as a result of the injury:

(a) from or on behalf of the offender,

(b) under Hospitalization programs of any kind — Group Health, Workmen's Compensation, loss of wage insurance, etc. (except life insurance contracts),

(c) from public (city, county, state, or federal) funds.

What Must I Do To Be Eligible For Reparations?

1. *Must* report crime to law enforcement agency where crime was committed within five days of the event. If crime could not be reasonably reported within five days of its occurrence, then within five days of the time when a report could reasonably have been made.

2. *Must* be completely cooperative with the law enforcement agency.

3. *Must* be an *innocent* victim of crime.

4. *Must* file a Preliminary Claim Form with Crime Victims Reparations Board within *one year* of the happening of the event.

What Happens After I File?

Your claim is assigned to a member of the Board. It is then processed, investigated and evaluated. An award is then made or the claim is denied. It is possible for a claimant who urgently requires funds to request that an *emergency award* be made prior to final determination of whether an award is made or the claim denied.

An aggrieved claimant can appeal the decision of a Board member to the entire Board if he makes such an appeal in writing within 30 days after being notified of an award or denial of his claim.

Is There Any Expense To Me?

No.

Is The Loss of Personal Property Covered?

No.

This publication is designed to acquaint Minnesota citizens with the existence and scope of the law providing for innocent victims of violent crime against their persons to recover reparations.

— PLEASE NOTE —

CLAIMANT'S NAME WILL NOT BE USED IN PRESS RELEASES UNLESS PRIOR CONSENT IS GIVEN.

Copies of this pamphlet can be obtained by writing to:

Crime Victims Reparations Board
702 American Center Bldg.
160 East Kellogg Blvd.
St. Paul, Minnesota 55101
(612) 296-7080
1-800-652-9747

MINNESOTA DEPARTMENT OF
PUBLIC SAFETY
Highway Building, St. Paul, 55155

What Can You Do?

Your body belongs to you. If someone touches you and you don't like it, even if the person touching you is an adult, you can say, "Stop it. I don't want you to touch me like that." If you don't feel good about someone's touching you,

Say "No," Get Away and Tell Someone.

How Can You Help to Stop Sexual Assault?

1. Lock your doors and windows.
2. Don't let anyone in your house that you don't know.
3. Don't take rides from people you don't know or don't trust.
4. Don't go anywhere alone with a stranger or someone you don't trust.
5. Don't give people you don't know or don't trust your last name, address or phone number.
6. If anyone touches you in a way you don't like,

Say "No," Get Away And Tell Someone.

What If You Are Sexually Assaulted?

If someone touches you in a way you don't like, do not keep it a secret. Even if someone gives you a present or says not to tell, you must tell someone. It is not your fault that this happened to you. You are not a bad person. Sexual assault is a crime. The person who did this needs help.

Who Can You Tell?

You should tell someone you trust, like your mother or father, a teacher, person in charge, a grown-up friend or a police officer. If the person you tell doesn't believe your story, you must tell someone else. If you don't have anyone you can tell, here is a number you can call.

Sexual Assault Center

_____

Police Department

_____

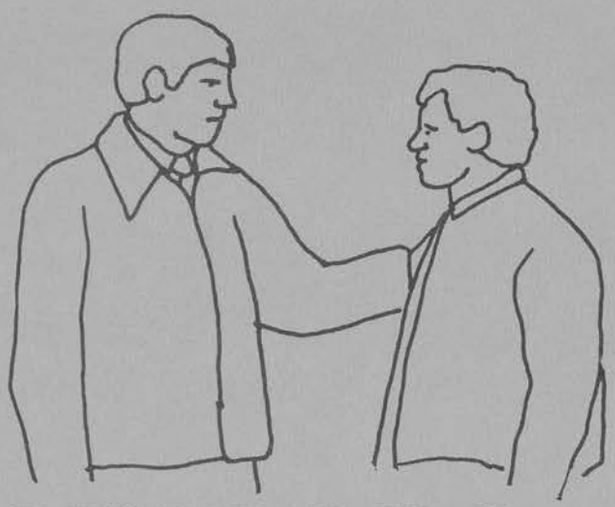
Other

_____

Portions of this brochure are adapted from *An Illusion Theater Guide for Teaching Mentally Retarded Persons about Sexual Abuse Prevention Education.*

Published by the Minnesota Program for Victims of Sexual Assault, Minnesota Department of Corrections, 430 Metro Square Building, St. Paul, Minnesota 55101, (612) 296-7084. Funded through a grant from the Northwest Area Foundation. January, 1983. Brochure designed by Cats' Pajamas.

Say "No," Get Away and Tell Someone



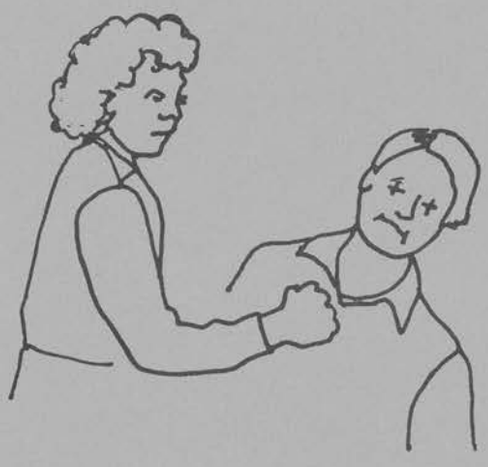
Let's Talk About Touch.

There are many different kinds of touch. Some touch feels good, like hugging, kissing or holding hands. You can do Good Touch with mom, dad, brothers, sisters, friends—many people. Some

touch, like wrestling or tickling can be fun, but when you don't want to wrestle any more, or when you get hurt, then it isn't fun. You want to stop.

Some touch always hurts, like hitting or pinching. When someone hits or pinches you,

Say "No,"
Get Away
and Tell Someone.



Let's Talk About Sexual Assault.

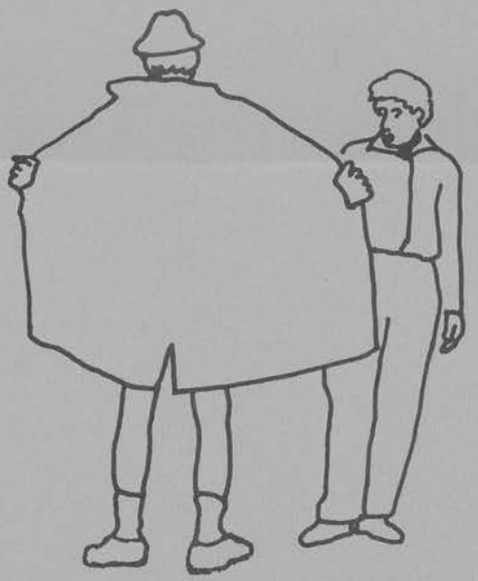
When someone touches different parts of your body, or has you touch different parts of their's when you don't want to, that may be one kind of *Sexual Assault.*

You may have your clothes on or off when this touch happens. Sexual assault can happen to boys or girls, or men and women. The person who touches you can be someone you know, like someone in charge, a friend or someone in your family. It could also be someone you don't know—a stranger. It could be a man or a woman. If you don't feel good about someone's touching you,

Say "No,"
Get Away
and Tell Someone.

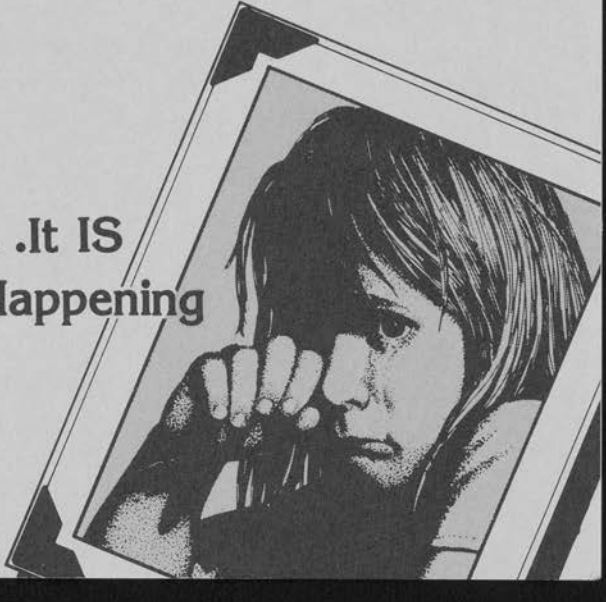
Sexual assault may also happen with no touch. It could be an obscene phone call, where someone calls you to frighten you

or an exposer, someone who shows you their private body parts to frighten you. If this happens,



Say "No,"
Get Away
and Tell Someone.

CHILD SEXUAL ABUSE



. . .It IS Happening

CHILD SEXUAL ABUSE . . .It IS Happening

Researchers report an astonishingly high incidence of child sexual abuse. From 10–20 percent of children have sexual contact with an adult – usually not a stranger – before they are 18. And most of them will *never* tell anyone . . .

Then How Can You Tell?

Older children may react in these ways:

- ☐ *Depression*
- ☐ *Withdrawal*
- ☐ *Poor self-image*
- ☐ *Chemical abuse*
- ☐ *Running away or aversion toward going home*
- ☐ *Recurrent physical complaints such as infections, cramping or abdominal pains, muscle aches, dizziness, gagging and severe headaches*
- ☐ *Self mutilations such as cutting, burning, tattooing*
- ☐ *Suicide attempts*
- ☐ *Truancy*
- ☐ *Change in school performance*
- ☐ *Overtly seductive behavior/promiscuity/prostitution*
- ☐ *Eating disorders such as anorexia, obesity, sudden weight gain and sudden weight loss*
- ☐ *Limited social life*
- ☐ *Attention-getting or delinquent behavior*

Young children may exhibit these signs:

- ☐ *Nightmares and other sleeping disturbances*
- ☐ *Bedwetting*
- ☐ *Fecal soiling*
- ☐ *Excessive masturbation*
- ☐ *Clinging/whining*
- ☐ *Regression to more infantile behavior*
- ☐ *Explicit sexual knowledge, behavior, or language unusual for their age*
- ☐ *Withdrawal*
- ☐ *Frequent genital infections*
- ☐ *Unexplained gagging*
- ☐ *Agitation/hyperactivity/irritability/aggressiveness*
- ☐ *Loss of appetite*

It has been said that recognizing child sexual abuse is dependent only upon our willingness to admit that it **may** exist. It's up to **you** . . .

It Can Leave Long-Lasting Scars:

Sexual abuse of children may result in:

- ☐ *Low self-esteem, stemming from hidden shame and guilt*
- ☐ *Abundant psychosomatic illnesses*
- ☐ *Chemical dependency*
- ☐ *Sexual problems such as aversion to sex or compulsive sex*
- ☐ *Marital/relationship problems*
- ☐ *Depression*
- ☐ *Suicidal tendencies*
- ☐ *Obsessive/compulsive disorders, like overeating or anorexia*
- ☐ *History of exploitive relationships*

What Is Sexual Abuse of Children?

It is the sexual exploitation of a child under 18 years of age who is not developmentally capable of understanding or resisting the contact or who may be psychologically, physically and socially dependent upon the offender. The sexual contact may range from body exposure to penetration.

Some Misconceptions:

Some of the misconceptions which prevent dealing effectively with the problem of sexual abuse of children include the following myths:

Myth: Children are most likely to be sexually abused by a stranger.

Fact: 75% to 95% of the offenders are known – and may be related – to the child.

Myth: Children often lie or fantasize about sexual activity with adults.

Fact: Children cannot make up sexual information unless they have been exposed to it. They speak from their own experience.

Myth: Non-violent sexual behavior between a child and an adult is not damaging to the child.

Fact: Nearly all victims will experience confusion, shame, guilt, anger and a poor self-image, though they may reveal no obvious outward signs.

Myth: A discussion of sexual abuse will just frighten or be damaging to children.

Fact: It is important for children to receive information about sexual assault for their own protection. Inaccurate or no information is more damaging to children.

Myth: Family sexual abuse is an isolated, one-time incident.

Fact: For most victims, the abuse continues for years. In most cases the offender will not stop until there is intervention.

Myth: Children provoke sexual abuse by their seductive behavior.

Fact: Seductive behavior is not the cause. Responsibility lies with the offender.

Myth: If the children did not want it, they could say, "stop."

Fact: Children generally do not question the behavior of adults. They are often coerced by bribes, threats and use of a position of authority.

Myth: All abuse victims are girls.

Fact: While the majority of reported victims are female, evidence shows increasing reports of male victims.

Myth: In family sexual abuse the "non-offending" parent always knows.

Fact: While some "non-offending" parents know and even collude with the offender, many because of their lack of awareness, may suspect something is wrong but are unclear as to what it is.

A Word For Parents:

Warning children about strangers – although wise – will not protect them from the friend or family member who uses bribery or threats.

Children need to be given information about sexuality, beginning at an early age. Without knowledge, they will not understand what is happening, and without words, they cannot tell you about it. They need to be aware of the dangers of abusive sexual behavior in the same way that they are aware of the danger of fire or of crossing a busy street.

Children should be aware that their bodies belong to them and that if they are uncomfortable about the way they are being touched, they have a right to say "no."

Create an atmosphere in which your child will feel comfortable discussing sexual matters.

What If It Happens To Your Child?

- ☐ *Try to remain calm, be aware of your own feelings of guilt, anger and hurt — the child may think you're angry or upset at her/him.*
- ☐ *If your child has told you, believe her/him.*
- ☐ *Tell your child that they did the right thing by telling you.*
- ☐ *Reassure your child that you will protect her/him.*
- ☐ *Report your suspicions to the police or child protection worker.*
- ☐ *Keep it as confidential as possible — respect your child's privacy.*
- ☐ *Try to follow regular routine around the home.*
- ☐ *Consult your physician regarding medical needs.*
- ☐ *Assure your child that she/he is not to blame.*
- ☐ *Use community resources to provide you, your child and other family members with support.*
- ☐ *Respond to questions or feelings your child expresses with a calm attitude, but do not pressure your child to talk about the abuse.*

A Word For People Who Work With Kids:

- ☐ *Be alert for signs of sexual abuse.*
- ☐ *Don't be afraid to ask the question.*
- ☐ *Believe the child.*
- ☐ *Know your school's or agency's reporting procedure.*
- ☐ *The responsibility to report lies with you.*

How To Talk With The Child About The Abuse:

- ☐ *Choose a private place.*
- ☐ *Do not suggest what happened.*
- ☐ *Use open-ended questions.*
- ☐ *Use words for body parts and sexual contact that the child can understand.*
- ☐ *Tell the child that it's o.k. to talk with you, even if she/he has been told by somebody else not to.*
- ☐ *Reassure the child that it was not her/his fault.*
- ☐ *Reassure the child that she/he is not "bad" because of what happened.*
- ☐ *Don't make it into an ordeal; a short period of talking about it is all most kids can handle.*
- ☐ *Ask the child what the experience was like for her/him; don't assume that it was traumatic.*
- ☐ *Tell the child she/he did the right thing by talking with you about it.*
- ☐ *Keep the child informed as to your progress in handling the information.*

What Is The Law?

Four laws apply directly to sexual abuse of children:

- ☐ **Reporting Of Maltreatment Of Minors**
  Anyone who works with children in a professional capacity must report whenever they have knowledge of or reasonable cause to believe a child is being neglected or physically or sexually abused.

- ☐ **Incest Law**
  Anyone having sexual intercourse with someone who is more closely related than first cousin is guilty of incest. The law stipulates no age limit.

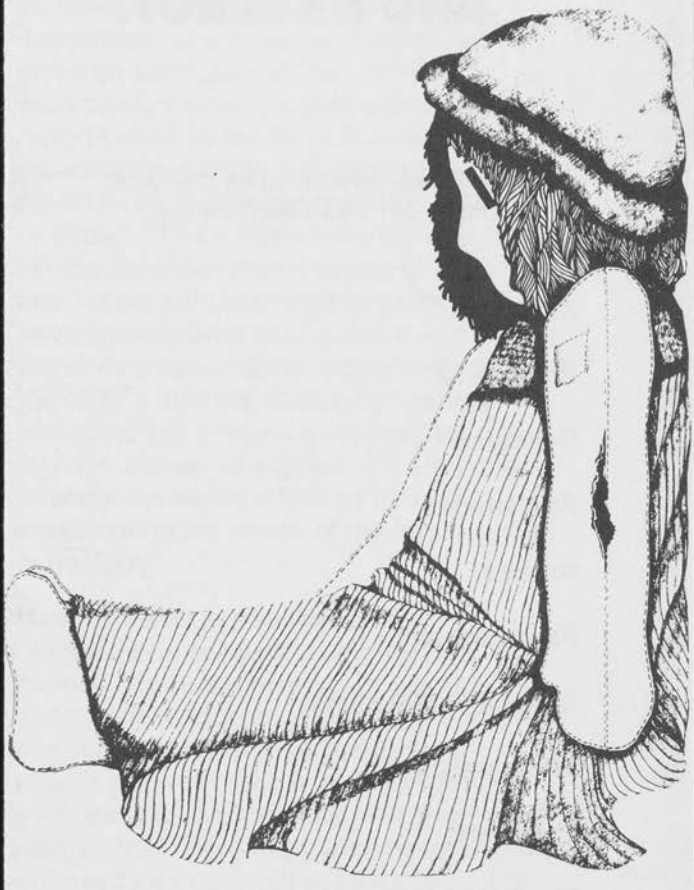
☐ **Intrafamilial Sexual Abuse Law**
Intrafamilial sexual abuse is sexual penetration or sexual contact with a child under the age of 18. The offender may be related to the victim by blood, marriage, adoption; may be a parent, guardian or someone responsible for the child's care; or may be any adult who resides in the same household as the victim either regularly or intermittently. The court has discretion to stay execution of the sentence if it is deemed in the best interest of the family, and may require the abusing party to participate in treatment or counseling. Consent is not an issue.

☐ **The Criminal Sexual Conduct Law**
The law is complex. However, any person who has had sexual intercourse with a child under the age of 16 and who is at least two years older than the child is guilty of criminal sexual conduct. Similarly, any person who has had intimate sexual contact with a child under the age of 16 and who is at least four years older than the child is guilty of criminal sexual conduct.

Published by
Minnesota Program For Victims of Sexual Assault, Minnesota Department of Corrections, 430 Metro Square Building, St. Paul, Minnesota 55101 (612) 296-7084
January, 1982

STATE OF OHIO

THE ABUSED AND NEGLECTED CHILD REPORTING LAW



OHIO DEPARTMENT OF PUBLIC WELFARE
30 EAST BROAD STREET
COLUMBUS, OHIO 43215

Section 2151.421, Revised Code

YOU HAVE A RESPONSIBILITY TO RECOGNIZE AND REPORT CHILD ABUSE AND NEGLECT.

This guide was prepared by the Ohio Department of Public Welfare for:

Attorneys

Physicians

Dentists

Podiatrists

Nurses

Psychologists

Speech Pathologists

Audiologists

Coroners

Day Care Personnel

School Teachers

School Authorities

Social Workers

Clergy

What would you do if you knew or suspected that:

- A father poured lighter fluid on his child's arm and lit it?
- A 3½-year-old child had been beaten and sexually abused by a babysitter?
- A man kicked a child in the face for making noise?
- A small child was left in a locked car on a 90-degree day?
- A parent failed to send a child to school regularly?
- A mother refused to seek necessary medical treatment for her children?

The above incidents were taken from actual reported cases of child abuse and neglect in Ohio. Child abuse and neglect involving beatings, bone fractures, burns, sexual abuse, malnutrition, lack of supervision, and abandonment continue to occur.

Most victims of abuse and neglect are infants who cannot talk or children who are too young to get help or don't know where to get help. You must be alert to protect them.

Highlights of Ohio Child Abuse and Neglect Laws:
Ohio Revised Code Section 2151.421

The amended law Section 2151.421, effective November 28, 1975, requires a county plan of cooperation, to be placed on file with the juvenile court and the Ohio Department of Public Welfare, outlining normal operating procedures to be employed by all concerned officials in the execution of their respective responsibilities. The amended law expanded the list of professionals required to report immediately suspected incidents of child abuse and neglect.

As established by previous legislation, citizens or professionals making a report or participating in a judicial proceeding resulting from a report are immune from civil and criminal liability. A state central registry is maintained and operated by the Ohio Department of Public Welfare, Division of Social Services.

What must you report?
Everyone should report suspicions of child abuse and neglect; however, the following professionals are required to report: "Any attorney, physician, including a hospital intern or resident, dentist, podiatrist, practitioner of a limited branch of medicine or surgery as defined in section 4731.15 of the Revised Code, registered or licensed practical nurse, visiting nurse, or other health care professional, licensed psychologist, speech pathologist or audiologist, coroner, administrator or employee of a child day-care center, or administrator or employee of a certified child care agency or other public or private children services agency, school teacher or school authority, social worker, or person rendering spiritual treatment through prayer in accordance with the tenets of a well recognized religion, acting in his official or professional capacity having reason to believe that a child less than eighteen years of age or any crippled or otherwise physically or mentally handicapped child under twenty-one years of age has suffered any wound, injury, disability, or condition of such a nature as to reasonably indicate abuse or neglect of the child shall immediately report or cause reports to be made of such information..." according to Ohio Revised Code, Section 2151.421.

Ohio law further states: "Any person who is required to report cases of child abuse or neglect may take or cause to be taken color photographs of areas of trauma visible on a child and, if medically indicated, cause to be performed radiological examinations of the child."

To whom should you report?
Immediately report your suspicions to the children services board or the county department of welfare exercising the children services function, or to a municipal or county peace officer. Such reports shall be made by telephone or in person and shall be followed by a written report if requested by the receiving agency or officer. "The written report shall contain: (A) the names and addresses of the child and his parents or person or persons having custody of such child, if known; (B) the child's age and the nature and extent of the child's injuries, abuse, or neglect, including any evidence of previous injuries, abuse, or neglect; (C) any other information which might be helpful in establishing the cause of the injury, abuse, or neglect."

How are you protected?
"Anyone or any hospital, institution, school, health department or agency participating in the making of the reports, or anyone participating in a judicial proceeding resulting from the reports, shall be immune from any civil or criminal liability that might otherwise be incurred or imposed as a result of such action. ...the physician-patient privilege shall not be a ground for excluding evidence regarding a child's injuries, abuse, or neglect..."

What happens to your report?
Whether receiving a report directly or through a peace officer, the county department of welfare or children services board shall investigate, within twenty-four hours, each report referred to it and determine the circumstances surrounding the injury or injuries, abuse, or neglect, the cause thereof, and the person or persons responsible. Such investigation shall be made in cooperation with the law enforcement agency. The county department of welfare or children services board shall report each case to a central registry which the state department of public welfare shall maintain in order to determine whether prior reports exist.

The department or board shall submit a report of its investigation in writing to the law enforcement agency.

What happens to the child and his family?
Reports shall result in protective services and emergency supportive services being made available by the county department of welfare or children services board on behalf of children about whom such reports are made, in an effort to prevent further neglect or abuse, to enhance their welfare, and, whenever possible, to preserve the family unit intact.

The following are possible courses of action:

- The child may remain in his home under the supervision of the county department of welfare or children services board, which will provide protective services to ensure the continued well being of the child and treat any social or environmental factors which may have precipitated the abuse or neglect of the child.
- The child may be removed from his home on an emergency basis if "in the judgment of the reporting physician and the officer, immediate removal is considered essential to protect the child from further abuse or neglect."
- Temporary or permanent removal of a child from his home may be deemed necessary and the county department of welfare or children services board shall make such recommendations to county prosecutor or city attorney. However, the final legal decision rests with the juvenile court and, according to Section 2151.281, "The court shall appoint a guardian ad litem to protect the interest of a child in any proceeding concerning an alleged abused or neglected child."

Child abuse and neglect must be recognized and reported. Children must be protected and the perpetrators of abuse and neglect helped. With the assistance of concerned citizens and alert professionals child abuse and neglect can be treated and future incidents prevented. Parents have the right to care for their children and children have the right to grow up to realize their potential. These rights must be protected.

Office of Public Information
Ohio Department of Public Welfare

ODPW 8004 (11/79)

CHILD ABUSE AND NEGLECT

THE HENNEPIN COUNTY GUIDE FOR PEOPLE WHO WORK WITH CHILDREN

TO REPORT SUSPECTED CHILD ABUSE OR NEGLECT, CALL:

348-3552

24-HOUR
HENNEPIN COUNTY CHILD PROTECTION LINE

IF THE CHILD IS IN IMMEDIATE DANGER,
CALL YOUR LOCAL POLICE DEPARTMENT
OR THE COUNTY SHERIFF.

If you work with children in Minnesota, the law requires that you report suspected physical abuse, sexual abuse or neglect of children to authorities.

Getting help for children who are experiencing abuse or neglect involves the efforts of many people in the community. A community in which children can be safe and grow with the care of adult people does not just happen. It takes vigilance, a willingness to change whatever hurts children and a commitment by many to be involved on behalf of children.

As a person who works with children and families, you are in a key position to be aware of child abuse and neglect and to report whatever comes to your attention.

This guide is designed to help you make a decision about when a child needs special protection and what to do about it.

Most important, we want to emphasize the importance of calling Child Protection or your local police when you have reason to believe a child is neglected or abused. The law requires you to report *suspected* child maltreatment. The law assigns the responsibility for determining the existence of maltreatment to the county's child protection program. However, we must first hear from you. Call us to discuss the situation so we can determine with you if intervention is necessary and if other resources might be helpful to the family.

We welcome suggestions so that services can be improved to children and their families.

WHO MUST REPORT

Anyone may report abuse or neglect. Under our state law, however, people who are required to report include: "A professional or his delegate who is engaged in the practice of the healing arts, social services, hospital administration, psychological or psychiatric treatment, child care, education, or law enforcement..."

Doctors, dentists, educators, day care and group home staff, foster parents, pharmacists, nurses — they are among the people who must step in to help children.

WHAT YOU MUST REPORT

Although the law has gone through several changes in recent years, the central point is the requirement to report neglect, physical abuse and sexual abuse which has affected children or currently is endangering them.

In this booklet, you will find some guidance in three sections:

1. Information about Child Protection and conditions for identifying neglect and abuse which Child Protection has drawn directly from the law and our own experience. These represent situations which ought to be referred;
2. Some observable characteristics of children and families who may need help;
3. Some major laws which you should know about. You may want your legal counsel to be familiar with these.

Most important, however, remember that Child Protection would prefer that you call and talk over what has come to your attention. We will help you sort things out. A good rule of thumb is, "when in doubt, call 348-3552."

WHEN TO CALL

You may call Child Protection at 348-3552 about any case of neglect or abuse. When a child is abandoned or subject to a real or imminent threat, call your local police department immediately. Officers can remove a minor from a threatening environment in order to protect the child. They can cooperate with other government agencies through investigation and gathering evidence in critical cases.

In most cases, one call will get things moving. For future reference, you may want to write in the number of your local police department here: _____.

The Hennepin County Sheriff's number is **348-3771.**

WHAT CHILD PROTECTION NEEDS TO KNOW

When you call, we will need information that will allow us to identify the family, evaluate the problem and respond quickly and appropriately.

We need to know what happened to the child and when. How do you view this situation, and what firsthand knowledge do you have? Where is the child now, and is the child in danger? We always need the names and addresses of the parents or caretakers, and your name and phone. Let us know if you have been involved with the family, or if you have made attempts to work with them on the problem. It is helpful if you can tell us how the parents responded to any attempts to help.

WHY REPORT TO CHILD PROTECTION

By legal mandate and Hennepin County policy, Child Protection has a specialized role in working with children and their families. Briefly, Child Protection's responsibilities are to:

- Respond promptly to reports of alleged neglect, abuse or exploitation of children to determine the validity of the report;
- Assess the damage to children resulting from neglect or abuse;
- Evaluate the risk of further injury to the child while in the home and whether the child should remain in the home while rehabilitative services are provided;
- Determine and identify the family problem or problems which contributed to or resulted in neglect or abuse;
- Evaluate the potential for treatment to correct conditions and rehabilitate the family;
- Plan a course of treatment calculated to stabilize and rehabilitate the family through services of the protective agency and the use of other appropriate community resources to meet special needs of the child and parents;
- Initiate the treatment plan and stimulate involvement of services from community resources to meet identified special needs;
- Invoke the authority of the Juvenile or Family Court in situations where treatment potential is minimal or where there is risk if the child remains at home.

WHAT HAPPENS AFTER YOU CALL IN YOUR REPORT

If you are one of those people required to report, you must follow up as soon as possible with a written report. (Other people, such as neighbors and friends who report, aren't required to put anything in writing.)

If the child is in immediate danger, we will call the police. (In this kind of situation, it would be best if you would call the police first, then call us.) The police will investigate to see whether a crime has been committed or whether the children need to be removed for their safety. In some cases, the parent or other adults involved may be subject to prosecution.

It is Child Protection's policy to attempt immediate contact with the family. Minnesota Department of Public Welfare policy is that Child Protection must respond to abuse reports within 24 hours. Families reported to be neglectful must be contacted with 72 hours.

If the family must be separated for the child's protection, it is our aim to reunite the family members under better circumstances. When it's possible, we have the children stay with relatives. This helps them maintain their family identity, and makes the eventual transition back to their own homes easier.

Fortunately, once help is offered, most families cooperate in a treatment plan. They receive help with marital distress, parenting problems, health and financial problems and other stressful situations.

WHAT WE CAN TELL YOU ABOUT THE CASE

Because of confidentiality and privacy laws, we are sometimes limited in what we can discuss with you, even when you are working with the family in counseling. We will keep you informed to the extent that we can, and also will let every mandated reporter of abuse know whether we've accepted his or her particular case.

WHAT IS NEGLECT?

Neglect of children is defined in two places in state law. The mandated conditions for reporting are found in MS 626.556. Other conditions of neglect and dependency are in MS 260.015. Relevant parts of the statutes are reprinted at the back of this guide.

The following are conditions under which the law requires a report to Child Protection or a law enforcement agency:

- Inadequate food.
- Inadequate clothing.
- Inadequate shelter.
- Inadequate medical care.
- Failure to protect a child from conditions or actions which imminently and seriously endanger the child's physical or mental health when reasonably able to do so.

In addition, Minnesota statutes state other factors which constitute neglect in MS 260.015. While not required by law, you are encouraged to report these forms of neglect as well. The following list, which is not exclusive, is drawn from the law and departmental

experience to guide your thinking about referrals:

- Failure to thrive due to parental neglect.
- Child is abandoned, left alone, or "placed in a manner detrimental to his/her welfare or in violation of law."
- Parent, guardian or other person responsible refuses to plan for child.
- Child is in placement or multiple placements without plan or court involvement.
- Child is in imminent danger due to parent's condition including state of immaturity. This could include a referral prior to the child's birth.
- Child is suffering emotional damage and parent or guardian is unwilling/unable to provide or permit necessary treatment for the child.
- Neglect due to mental illness, mental retardation or chemical dependency of parent or guardian.
- Child is without proper care because of faults or habits of parent or guardian.
- Lack of parental supervision resulting in neglect to child.
- Truancy (through grade six) due to parental neglect.
- Delinquent child (through grade six) due to parental neglect.
- Parent, guardian or custodian desires to be relieved of child's care and custody for good cause.

As you see, neglect and dependency are extremely difficult elements of behavior to judge. But it is crucial that people who work with children consider the array of factors which deny children the feeling of being loved or deny children basic physical necessities. We encourage you to think about the many forms of neglect and call us to discuss the appropriateness of referrals when you have doubts.

WHAT IS PHYSICAL ABUSE?

Under Minnesota statute, physical abuse means: "Any physical injury inflicted by a parent, guardian, or other person responsible for the child's care on a child other than by accidental means; or...Any physical injury that cannot reasonably be explained by the history of injuries provided by a parent, guardian or other person responsible for the child's care."

Children who are physically abused sometimes bear signs of injury such as bruises, welts, burns, fractures, swellings, or lost teeth. The list of possibilities is long and unpleasant. While internal injuries are seldom detectable without a hospital exam, anyone in close contact with children should be alert to multiple injuries, a history of repeated injury, new injuries added to old, and untreated injuries.

The older child may attribute the injury to an improbable cause, lying for fear of parental retaliation. The younger child, on the other hand, may be unaware that severe beating is unacceptable and may admit to having been abused.

The following are conditions of physical abuse that should be referred:

- Child has suffered an injury which appears to be nonaccidental in nature.
- Child has suffered a physical injury as a result of hazardous conditions uncorrected by parent or guardian.
- Child suffers physical injury due to inadequate supervision by parent or guardian.
- There is substantial likelihood that the child will imminently suffer a physical injury.

WHAT IS SEXUAL ABUSE?

Approximately 75 percent of the sexual abusers are known to the child or the child's family. Since the sexually abused child lacks the symptoms of battering, sexual abuse is difficult to identify. Short of the child telling someone, the best indicators may be a sudden change in behavior and signs of emotional disturbance. The child, for example, may unexplainably begin to cry easily and seem excessively nervous.

Sexual abuse is defined in several Minnesota Statutes cited at the end of this booklet.

The following are conditions of sexual abuse which should

be referred:

- A child is the victim of criminal sexual conduct by a parent, guardian, caregiver or sibling.
- A child is engaged in prostitution.
- A juvenile is the perpetrator of sexual abuse.
- Child is the subject of pornographic materials.
- Although some situations occurring outside the family such as rape are not mandatory for reporting, we urge referral of these matters to us so we can help with appropriate legal action, medical services and counseling.

CHILDREN WHO MAY NEED HELP

The following points, which may be helpful in identifying children and parents in need of protection, are based on materials developed by school personnel. While no one thing can let you know for sure that a child is being neglected or abused, there are some things you can be alert to. Abused or neglected children are likely to have at least several of the following characteristics:

- They may seem unduly afraid of their parents.
- They may often bear welts, bruises, untreated sores or other injuries.
- Their injuries seem to be inadequately treated.
- They may show evidence of poor overall care.
- They may be given inappropriate food, drink or medication.
- They may exhibit behavioral extremes. For example: crying often or crying very little and showing no real expectation of being comforted; being excessively fearful, or seeming fearless of adult authority; being unusually aggressive and destructive, or extremely passive and withdrawn.
- Some are wary of physical contact, especially when it is initiated by an adult; they become apprehensive when an adult approaches another child, particularly one who is crying. Others are inappropriately hungry for affection, yet may have difficulty relating to children and adults. Based on their past experiences, these children cannot risk getting too close to others.
- They may exhibit a sudden change in behavior. For example: displaying regressive behavior — pants wetting, thumb sucking, frequent whining, becoming disruptive or becoming uncommonly shy and passive.
- They may take over the role of the parent, being protective or otherwise attempting to take care of the parent's needs.
- They may have learning problems that cannot be diagnosed. If a child's IQ and medical tests indicate no abnormalities, but the child still cannot meet normal expectations, the answer may well be problems in the home — one of which might be abuse or neglect. Particular attention should be given to the child whose attention wanders and who easily becomes self-absorbed.
- They may be habitually truant or late to school. Frequent or prolonged absences sometimes result when a parent keeps an injured child at home until the evidence of abuse disappears. In other cases, truancy indicates lack of parental concern or ability to regulate the child's schedule.
- In some cases, they arrive at school too early and remain after classes rather than going home.
- They may be always tired and often sleep in class.
- They may be inappropriately dressed for the weather. Children who never have coats or shoes in cold weather are receiving subminimal care. On the other hand, those who regularly wear long sleeves or high necklines on hot days may be dressed to hide bruises, burns or other marks of abuse.

FAMILIES WHO MAY NEED HELP

The parents of an abused or neglected child *may* exhibit any of the following traits:

- They often are isolated from family supports such as friends, relatives, neighbors and community groups. They consistently fail to keep appointments, discourage social contacts and never participate in school activities or events.
- They seem to trust no one.
- They might have been abused or neglected when they were children.
- They often are reluctant to give information about the child's injuries or condition. When questioned, they are unable to explain or they offer farfetched or contradictory explanations.
- They frequently respond inappropriately to the seriousness of

the child's condition. They either overreact, seeming hostile or antagonistic when questioned even casually, or underreact, showing little concern or awareness and seeming more preoccupied with their own problems than those of the child.

- They may refuse to consent to diagnostic studies.
- They may fail or delay to take the child for medical care — for routine checkups, for optometry or dental care, or for treatment of an injury or illness. In taking an injured child for medical care, they may choose a different hospital or doctor each time.
- They might be too critical of the child and seldom, if ever, discuss the child in positive terms.
- Some parents have unrealistic expectations of the child, expecting or demanding behavior that is beyond the child's years or ability.
- They may believe in the necessity of harsh punishment for children.
- They seldom touch or look at the child; they ignore the child's crying or react with impatience.
- They sometimes keep the child confined — perhaps in a crib or playpen — for long periods of time.
- They seem to lack understanding of the child's physical, emotional and psychological needs.
- They may be misusing alcohol or drugs.
- They appear to lack control or fear losing control.

MAJOR LAWS ON CHILD ABUSE AND NEGLECT WHICH YOU MAY FIND USEFUL

I. REPORTING OF THE MALTREATMENT OF MINORS

Minnesota Statutes Section 626.556

Purpose of the law

SUBDIVISION 1. PUBLIC POLICY. The Legislature hereby declares that the public policy of this state is to protect children whose health or welfare may be jeopardized through physical abuse, neglect or sexual abuse; to strengthen the family and make the home safe for children through improvement of parental and guardian capacity for responsible child care; and to provide a safe temporary or permanent home environment for physically or sexually abused children.

In addition, it is the policy of this state to require the reporting of suspected neglect, physical or sexual abuse of children; to provide for the voluntary reporting of abuse or neglect of children; to require the investigation of such reports; and to provide protective and counseling services in appropriate cases.

Definitions of neglect and abuse

SUBDIVISION 2. DEFINITIONS. As used in this section, the following terms have the meanings given them unless the specific content indicates otherwise:

(a) "Sexual abuse" means the subjection by the child's parents, guardian or person responsible for the child's care, to any act which constitutes a violation of sections 609.342, 609.343, 609.344 or 609.345. Sexual abuse also includes any act which involves a minor which constitutes a violation of section 609.32 or 617.246.

(b) "Neglect" means failure by a parent, guardian or other person responsible for a child's care to supply a child with necessary food, clothing, shelter or medical care when reasonably able to do so or failure to protect a child from conditions or actions which imminently and seriously endanger the child's physical and mental health when reasonably able to do so. Nothing in this section shall be construed to mean that a child is neglected solely because the child's parent, guardian or other person responsible for his care in good faith selects and depends upon spiritual means or prayer for treatment or care of

disease or remedial care of the child.

(c) "Physical abuse" means:

(i) Any physical injury inflicted by a parent, guardian or other person responsible for the child's care on a child other than by accidental means; or

(ii) Any physical injury that cannot reasonably be explained by the history of injuries provided by a parent, guardian or other person responsible for the child's care.

(d) "Report" means any report received by the local welfare agency, police department or county sheriff pursuant to this section.

Who must report

SUBDIVISION 3. PERSONS MANDATED TO REPORT. A professional or his delegate who is engaged in the practice of the healing arts, social services, hospital administration, psychological or psychiatric treatment, child care, education or law enforcement who has knowledge of or reasonable cause to believe a child is being neglected or physically or sexually abused shall immediately report the information to the local welfare agency, police department or the county sheriff. The police department or the county sheriff, upon receiving a report, shall immediately notify the local welfare agency. The local welfare agency, upon receiving a report, shall immediately notify the local police department or the county sheriff. Nothing in this Subdivision shall be construed to require more than one report from any institution, facility, school or agency.

Who may report

Where to report

Any person not required to report under the provisions of this Subdivision may voluntarily report to the local welfare agency, police department or the county sheriff if he has knowledge of or reasonable cause to believe a child is being neglected or subjected to physical or sexual abuse. The police department or the county sheriff, upon receiving a report, shall immediately notify the local welfare agency.

Legal protection

SUBDIVISION 4. IMMUNITY FROM LIABILITY. Any person, including those voluntarily making reports and those required to make reports under Subdivision 3, participating in good faith and exercising due care in the making of a report pursuant to this Section shall have immunity from any liability, civil or criminal, that otherwise might result by reason of his action.

SUBDIVISION 5. FALSIFIED REPORTS. Any person who willfully or recklessly makes a false report under the provisions of this Act shall be liable in a civil suit for any actual damages suffered by the person or persons so reported and for any punitive damages set by the court or jury.

Penalties for NOT reporting

SUBDIVISION 6. FAILURE TO REPORT. Any person required by this Section to report suspected physical or sexual child abuse or neglect who willfully fails to do so shall be guilty of a misdemeanor.

What is done with the report

SUBDIVISION 7. REPORT. An oral report shall be made immediately by telephone or otherwise. An oral report made by a person required under Subdivision 3 to report shall be followed as soon as possible by a report in writing to the appropriate police department, the county sheriff or local welfare agency. Any report shall be of sufficient content to identify the child, the parent, guardian or other person responsible for his care, the nature and extent of the child's injuries and the name and address of the reporter. Written reports received by a police department or the county sheriff shall be forwarded immediately to the local welfare agency. The police department or the county sheriff may keep copies of reports received by them. Copies of written reports received by a local welfare department shall be forwarded immediately to the local police department or the county sheriff.

Evidence is not privileged

SUBDIVISION 8. EVIDENCE NOT PRIVILEGED. No evidence regarding the child's injuries shall be excluded in any proceeding arising out of the alleged neglect or physical or sexual abuse on the grounds of either a physician-patient or husband-wife privilege.

Reporting to medical examiner in the event of death

SUBDIVISION 9. MANDATORY REPORTING TO A MEDICAL EXAMINER OR CORONER. When a person required to report under the provisions of Subdivision 3 has reasonable cause to believe a child has died as a result of neglect or physical or sexual abuse, he shall report that information to the appropriate medical examiner or coroner instead of the local welfare agency, police department or county sheriff. Medical examiners or coroners shall notify the local welfare agency or police department or county sheriff in instances in which they believe that the child has died as a result of neglect or physical or sexual abuse. The medical examiner or coroner shall complete an investigation as soon as feasible and report the findings to the police department or county sheriff and the local welfare agency.

SUBDIVISION 10. DUTIES OF LOCAL WELFARE AGENCY UPON RECEIPT OF A REPORT. The local welfare agency shall immediately investigate and offer protective social services for purposes of preventing further abuses, safeguarding and enhancing the welfare of the abused or neglected minor and preserving family life whenever possible. When necessary the local welfare agency shall seek authority to remove the child from the custody of his parent, guardian or adult with whom he is living. In performing any of these duties, the local welfare agency shall maintain appropriate records.

SUBDIVISION 11. RECORDS. All records maintained by a local welfare agency under this Section, including any written reports filed under Subdivision 7, shall be private data on individuals, except insofar as copies of reports are required by Subdivision 7 to be sent to the local police department or the county sheriff. Report records maintained by any police department or the county sheriff shall be private data on individuals except such reports shall be made available to the prosecuting authority. The welfare board shall make available to the prosecuting authority only those records which contain information relating to a specific incident of neglect or abuse which is under litigation. The records shall be collected and maintained in accordance with the provisions of Sections 15.162 to 15.168, and an individual subject of a record shall have access to the record in accordance with those Sections, except that the name of the reporter shall be disclosed only (a) by the local welfare agency if the report is found to be unsubstantiated or (b) by the local welfare agency upon court order if the report is found to be substantiated.

Records maintained by local welfare agencies, the police department or county sheriff under this Section must be destroyed as follows:

(a) All records relating to reports which, upon investigation, are found to be false shall be destroyed immediately;

(b) All records relating to reports which, upon investigation, are found to be substantiated shall be destroyed seven years after the date of the final entry in the case record; and

(c) All records of reports which, upon initial investigation, cannot be substantiated or disproved to the satisfaction of the local welfare agency, local police department or county sheriff may be kept for a period of one year. If the local welfare agency, local police department or county sheriff is unable to substantiate the report within that period, each agency unable to substantiate the report shall destroy its records relating to the report.

II.

NEGLECT AND DEPENDENCY STATUTES

Minnesota Statutes Section 260.015, Subdivision 10

"NEGLECTED CHILD" MEANS A CHILD:

(a) Who is abandoned by his parent, guardian or other custodian; or

(b) Who is without proper parental care because of the faults or habits of his parent; guardian or other custodian; or

(c) Who is without necessary subsistence, education or other care necessary for his physical or mental health or morals because his parent , guardian or other custodian neglects or refuses to provide it; or

(d) Who is without the special care made necessary by his physical or mental condition because his parent, guardian or other custodian neglects or refuses to provide it; or

(e) Whose occupation, behavior, condition, environment or associations are such as to be injurious or dangerous to himself or others; or

(f) Who is living in a facility for foster care which is not licensed as required by law, unless the child is living in the facility under court order; or

(g) Whose parent, guardian or custodian has made arrangements for his placement in a manner detrimental to the welfare of the child or in violation of law; or

(h) Who comes within the provisions of Subdivision 5, but whose conduct results in whole or in part from parental neglect.

Minnesota Statutes Section 260.015, Subdivision 6

"DEPENDENT CHILD" MEANS A CHILD:

(a) Who is without a parent, guardian or other custodian; or

(b) Who is in need of special care and treatment required by his physical or mental condition and whose parent, guardian or other custodian is unable to provide it; or

(c) Whose parent, guardian or other custodian for good cause desires to be relieved of his care and custody; or

(d) Who is without proper parental care because of the emotional, mental, or physical disability or state of immaturity of his parent, guardian or other custodian.

STATUTORY REFERENCE ON SEXUAL ABUSE

III.

Minnesota Statutes Sections 609.342, 609.343, 609.344 and 609.345 deal with Criminal Sexual Conduct in the first, second, third and fourth degrees. You may want to review these laws with your legal counsel.

A few relevant excerpts from the Definitions Section of the Criminal Sexual Conduct Law, Minnesota Statutes Section 609.341 may be useful in giving some description of prohibited behavior.

Minnesota Statutes Section 609.341, Definitions

SUBDIVISION II. "Sexual contact" includes any of the following acts committed without the complainant's consent, if the acts can reasonably be construed as being for the purpose of satisfying the actor's sexual or aggressive impulses, except in those cases where consent is not a defense: (i) The intentional touching by the actor of the complainant's intimate parts, or (ii) The coerced touching by the complainant of the actor's, the complainant's or another's intimate parts, or (iii) The coerced touching by another of the complainant's intimate parts, or (iv) In any of the cases above, of the clothing covering the immediate area of the intimate parts.

SUBDIVISION 12. "Sexual penetration" means sexual intercourse, cunnilingus, fellatio, anal intercourse or any intrusion however slight into the genital or anal openings of the complainant's body of any part of the actor's body or any object used by the actor for this purpose, where the act is committed without the complainant's consent, except in those cases where consent is not a defense. Emission of semen is not necessary.

SUBDIVISION 5. "Intimate parts" includes the primary genital area, groin, inner thigh, buttocks or breast of a human being.

In addition to the above there is statutory prohibition of child abuse related to Prostitution in Minnesota Statutes Section 609.32, Incest in Minnesota Statutes Section 609.365 and Promotion of Minors to Engage in Obscene Works in Minnesota Statutes Section 617.246.

Prepared by Hennepin County Child Protection and Public Affairs

First Printing, March 1980.

HENNEPIN

Hennepin County Child Protection Program
A-15 Government Center
300 South Sixth Street
Minneapolis, MN 55487

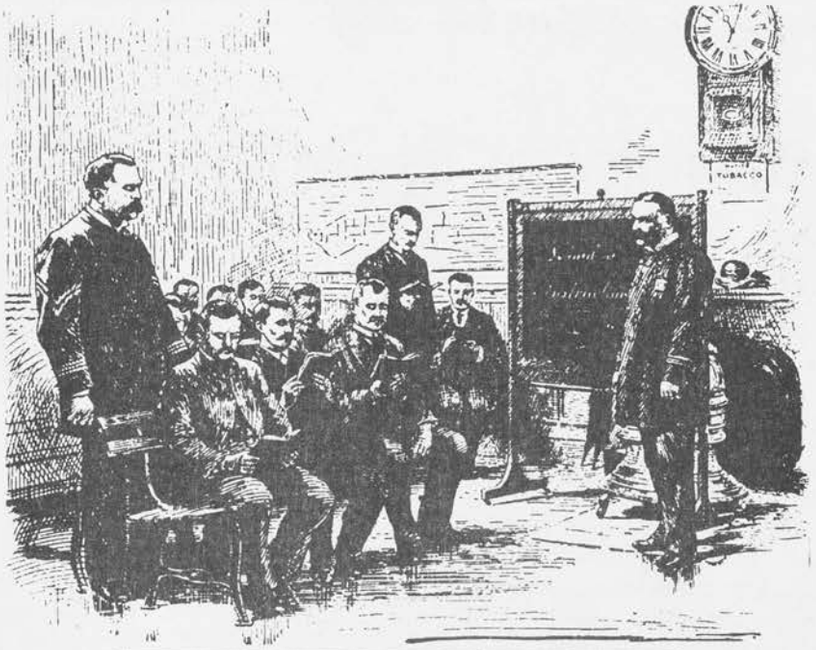
Govt. Org.
U.S. POSTAGE
PAID
Mpls., MN
Permit
No. 1264

TO:

348-3552

24-Hour Hennepin County Child Protection Line

Once I Was A Little Bit Frightened



was described by August Vollmer as "informal and demoralizing" training. Becoming acquainted with his duties by a one or two week tour with an older officer, he was told "to hear all, see all, say nothing, do as little as possible, and never forget that there is more law at the end of the police club than in all the law books of the nation."

Apprenticeship and experience were obviously the means by which people had learned for centuries. But radical changes in 20th Century society would see the creation of entire systems of education, and so much special knowledge to be learned from industrial, scientific, and even managerial revolutions, that formal training became a necessity. In the first two decades of the century, police departments — growing as cities grew — tried to attract better personnel, adopted new technologies, and developed special units. Systematic instruction was essential for the new technical knowledge of, for example, the automobile and scientific methods for criminal investigation developing from the newly established science of criminalistics. In this environment, some police leaders understood that, for their officers, experience was "a most expensive and inefficient teacher."

The first steps were taken by 1910 to develop training manuals, courses of study, and training programs. In 1908, Chief Vollmer of Berkeley, California, a leader in police training and education, began one of the first in-service programs for experienced officers. The offerings included: elementary law, criminal law, sanitation law, police methods, first aid, photography, and lectures on fingerprinting and the Bertillon method of identification. These last two scientific methods were just being introduced in police departments around the country. In 1909, New York City established an academy which had evolved over ten years from the School of Pistol Practice. This academy training was for recruits as well as experienced officers.

Even as the first efforts for formal training were being made, a new element was added to police work. Women were appointed to departments after 1910 as policewomen. Their role was largely defined as one of prevention and protection. When they entered police work, pioneer policewomen, like Alice Stebbins Wells of the LAPD and Minnie Fay Hessian of the St. Paul PD, were already trained in what was called "philanthropy" — social work, corrections, child and women's welfare work.

Although there were policewomen in 25 cities in 20 states by 1916, no definite qualifications existed for their appointment and duties. Often as women were appointed, the rules were made. Some had uniforms, some did not. Some had a height requirement, others none. Some were called Auxiliary Police, and others policewomen. Despite these early uncertainties, the New York State Assembly in 1914 had already set future standards for qualifications and, in effect, training needs in a bill requiring New York City to hire policewomen. The women had to be citizens, at least five feet eight inches in height, and between 30 and 45 years of age. They would receive the same salary as policemen. They could be ordered on duty at public parks, dance halls, places of amusement, or on patrol duty on the streets.

For all police personnel — recruits, experienced officers, the new "class" of policewomen — access to formal training in the first 50 years of the 20th Century was difficult or non-existent, particularly in the smaller cities and towns of rural America. For many chiefs and officers alike, experience was the best teacher. They would agree with Chief Braddock's statement way back in 1904, that while the officer "does not necessarily need to be an educated man, on the other hand, he must have a fair share of that uncommon article, "common sense." Nevertheless, by the 1920's policing was becoming ever more complex and experience alone would not suffice to learn "the job."

In just two decades, all kinds of systematic instruction were developed, laying the groundwork for modern formal police training. New manuals were published and courses created from 1910 to the 1920's everywhere in the United States. They were devoted to the "art", or the "science", or the "profession" of policing. Manuals developed from *Police Duty: Course of Study For Policemen Everywhere* (1912), to *The Policeman's and Detectives Guide To Professional Knowledge* (1923) and *The Policeman's Art As Taught In the New York School for Police* (1923).

Articles appeared in nationally circulated magazines on legal training for police, training for the "Policewoman's Job," the traffic officer and his training, and such specific topics as instruction in public speaking and training police "to hear and see straight." General and special schools were established by state governments and local police departments. The University of California, Berkeley, began to offer a 3-year training course in 1916. Northwestern University had a course for police in 1917, and Boston University, a School for Police by 1924. And in the 1920's, Chicago established its Police Automobile School where officers assigned to the new patrol cars (2-man) were trained "in the care and driving of a Ford." If this growing profusion of training materials and programs was never enough to meet the need, it indicated just how extraordinary the requirements had become for modern policing. On the future of all this, more next time.

LATENT FACTS

by

Lieutenant John McCabe

One of the perks I have as the Crime Lab Commander is receiving a publication from the Royal Canadian Mounted Police appropriately titled, *Royal Canadian Mounted Police Gazette*. It is an excellent publication and because the R.C.M.P. is a national force, the publication ranks on a par with the *F.B.I. Law Enforcement Bulletin*.

Like the *Bulletin*, the *Gazette* receives articles from RCMP officers, officers from other agencies and articles from academicians and experts from various fields.

The following article by Prov. Constable Frank Daulby originally appeared in the March 1988 issue of the *O.P.P. Review* and was reprinted with their permission in the Vol. 50, No. 12, 1988 *Gazette*. With further permission, I am bringing it to the readers' attention because I found the test to be interesting. I took it and so did the Crime Laboratory secretary, and because I embarrass easily, I do not believe the results will be made public, especially because of the Data Privacy Act.

I hope you enjoy the test.

TEST YOUR MEMORY OF EYEWITNESS RECALL

Despite what most people think, a police artist is not a person who likes to draw. If that were true, every part-time painter could call himself a police artist. A police artist is someone who constantly studies the human face. He draws faces almost daily to hone his drawing skills and enjoys interviewing people. He must be a student of anthropology and should practice his craft both on and off duty doing portraits, caricatures and life studies. He must search for unusual faces and study them by drawing the individual features. Most importantly, he must understand why people remember and how they recall memory. Mount Forest's Prov. Const. Frank Daulby, identification officer and Force artist, has compiled the following true and false questions which may provide a better understanding of memory and eyewitness recall.

1. Police officers have better memory for faces than the average witness.

2. A witness who says she saw the suspect's face but can't describe it should still be interviewed by a police artist.

3. A good way to remember a face is to ask yourself if you would buy a used car from the person.

5. An eyewitness should be advised to record any memories subsequent to the initial statement.

6. A witness' memory of a sequence of events occurring in various rooms of a house will be more accurate if the witness walks those rooms while giving a statement.

7. A witness who describes a suspect as looking like a friend or relative will probably produce a good drawing of the suspect.

8. A police artist will want to read your incident report before interviewing the witness.

9. You should obtain a general description of the suspect's face before starting your investigation or calling a police artist.

10. Witnesses remember the details of a violent crime i.e. assault better than a non-violent crime i.e. bank robbery.

11. The more confident a witness seems to be, the more accurate the witness will be.

12. Witnesses are as likely to under estimate the duration of a crime as to over estimate it.

13. A witness is more apt to remember a pleasant face than an ugly one.

14. An investigator can wait up to 24 hours before calling a police artist.

15. A photo-line-up should be used before a police artist drawing is produced.

16. When conducting a photo or physical line-up, the witness should view all the line-up at one time.

17. A police artist's drawing is meant to be a likeness not a sameness of a suspect.

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Answers to the questions appear on inside back cover.

Answers to witness recall

1. False — Police officers generally give better testimony in court but have no better recall for faces than the average witness.

2. True — You may not be able to describe your mother's face, but you would recognize her individual features if you were shown photographs.

3. True — This question forces you to study a face. It evokes an emotional response such as trust or concern.

4. False — The brain is better compared to a reporter's notebook with only highlights recorded.

5. True — Memory recall occurs as seemingly unconnected events trigger old memories.

6. True — Memory encoded in an area is best remembered in that same area.

7. False — This witness has transferred the memory of her friend to the suspect and this close association may block accurate recall of the suspect.

8. False — A police artist should not be given any written or verbal report of the incident nor shown any photos prior to a composite.

9. False — Verbal descriptions may distort the witness' memory of the face and very few arrests result from these descriptions. Restrict your questions to height, weight, age, clothing worn, hair color and length and facial hair.

10. False — The violent crimes cause a memory-blocking stress in many witnesses.

11. False — Subjective confidence is not an indicator of accurate memory.

12. False — Witnesses almost always overestimate the length of time a crime took. The more violent the crime, the greater the overestimation.

13. True — A pleasant face stimulates memory. An ugly face repels the eye. Most witnesses describe their suspects as being better looking than they really are.

14. False — The eyewitness and the police artist should be working together as soon as possible after the occurrence. Let the artist decide if the witness is calm enough for an interview.

15. False — The drawing should always precede a photo-lineup — to avoid memory contamination.

16. False — The photos or participants should be shown to the witness one at a time. This allows the witness to concentrate on an individual face and compare that image to the memory of the suspect. Group viewing can actually confuse the witness and cause memory blocking.

17. True — The resulting police artist's drawing is a drawing of the witness' memory of the suspect, not a portrait. It is meant to suggest not to arrest.

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NEW EAP LIBRARY

A fine special collection of books, pamphlets, and tapes is available at the Employee Assistance Program headquarters. Subjects range from chemical dependency, therapies, and family relationships to people skills, personal psychology, and more. Some of the books are in tape form for those of you who choose to listen. Also a good selection of relaxation tapes. This library will be of value to you personally and in your work.

Target Range News

Sgt. Don Bulver

Since Dec. 88 the range staff has been involved in our annual inspection and recertification of all department weapons.

The department shotguns had some parts problems but overall rust, dirt and corrosion were the biggest problem by far. All personnel are requested, if they note the shotgun assigned to their unit is in need of cleaning, to contact the range staff for repairs or maintenance and not wait for the firearm to fail at our annual inspection.

The Glock service pistols have fared very well in their first 18 months of service. We have found practically no problems during our inspection. However, one problem that should be addressed is the overloading of the magazines. It has been noted that occasionally when an officer attempts to put too many rounds in a magazine (18 or 16) the feed lips will become spread. This usually shows up as the gun slide locks open with one round remaining in the magazine. The problem can be corrected by the department armours. Any officer having his/her slide lock back with a round still in the magazine should note which magazine it is and at the [illegible]

parts of the backstop. These repairs have now been completed and we will open in April for the monthly qualifications.

The range staff and administration have been working on long range plans to make the outdoor range safer and to assure the future of our use of the facility. Two major changes will occur in this area. First, a piece of property was purchased by the department as a buffer zone on the east side of the range insuring that no one could build up close to our present boundaries. The second phase now in the planning stage is an overhead baffling system to cover the center PPC Range. This will reduce the chances of an errant round getting out of the area of the range.

Rumors have been circulating that St. Paul had a Glock pistol blow up. This rumor is false. The weapon in question was one owned by Ramsey County. I have inspected the gun and have photos of the damage. The problem was caused by an overloaded or weak piece of brass. The back portion of the cartridge case was blown out. This carried a small piece of the frame with it on the right side of the gun above the shooter's hand. No injury was sustained by the shooter. The grip area of the frame had two cracks in it, but held together. Talking to the Ramsey Co. officers, they are very satisfied with the Glock's performance under the circumstances. No one is sure what would have happened if the gun would have had an alloy frame and had been built to U.S. specifications rather than the higher NATO specifications the Glock is built to.

BOMB SQUAD

Sgt. Gary McAlpine

In May of this year, there will be a simulated hazardous material exercise in the area of 280 and Kasota.

In view of some of the recent incidents involving hazardous materials, officers should again be cognizant of the dangers they could encounter. An inappropriate response to a hazardous material incident endangers both emergency personnel and the public alike.

The threat of fire, explosion or toxic vapors is always present at a hazardous material incident. As first responders to an incident, emergency personnel are expected to have the knowledge, composure, and information to act in an efficient, professional, and *safe* manner.

The number of incidents involving hazardous materials is steadily increasing. With over 2 billion tons of hazardous materials being transported annually, we can only anticipate this alarming trend will continue. Officers should also be aware that gasoline related incidents account for over fifty percent of all hazardous material fatalities.

All officers should familiarize themselves with the information presented in the *Emergency Guidebook for Hazardous Materials.* The book provides an excellent, quick reference to some of the numerous chemicals and the potential hazard they represent.

Remember, an improper or negligent action by officers at a hazardous material incident could cause instant death to themselves and possibly others.

Some hazardous material definitions which officers should be aware of include the following:

Hazardous Materials

A substance or material in a quantity or form that may pose an unreasonable risk to health, safety, and/or property when stored or transported.

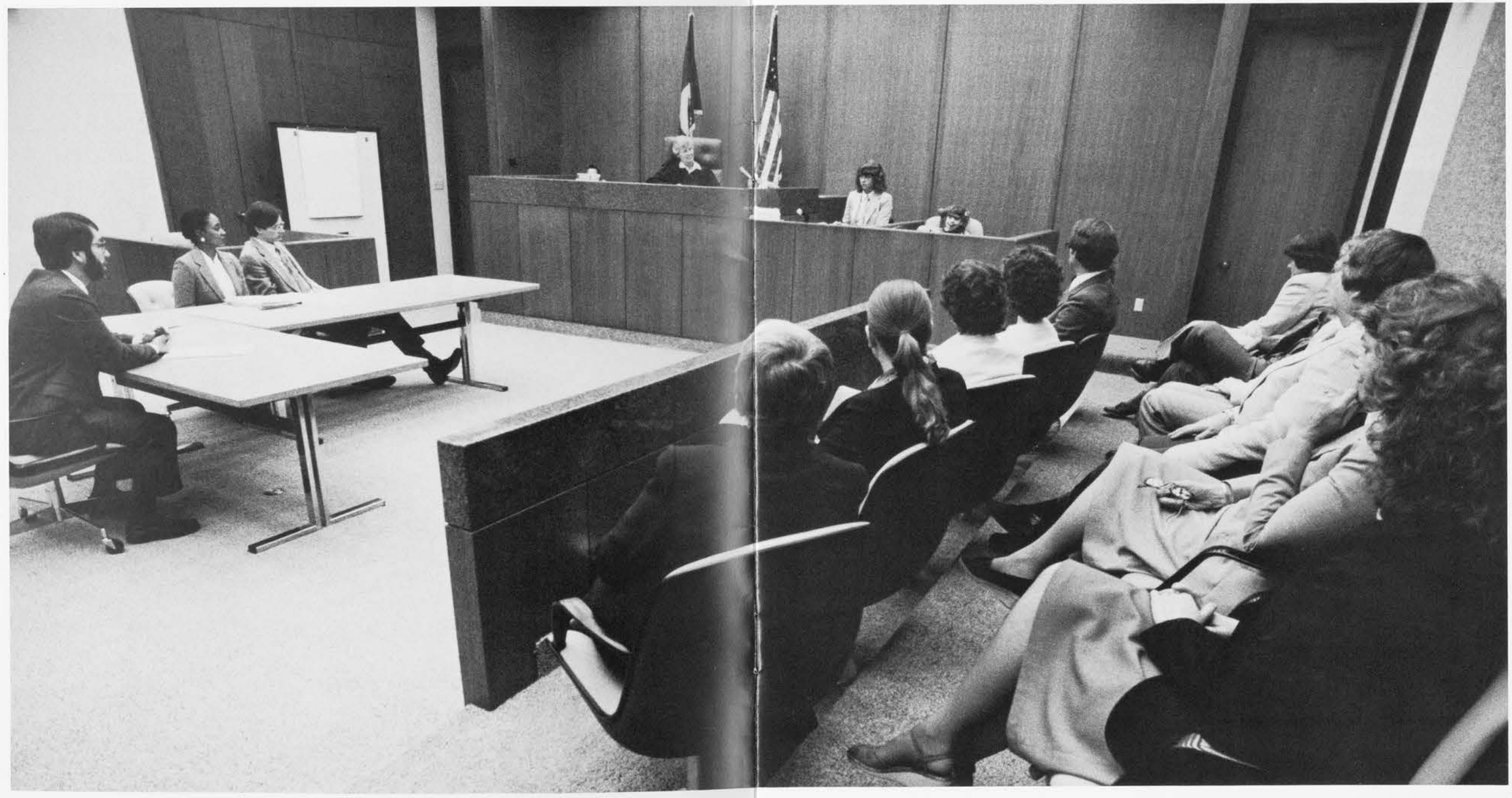
Toxic

Materials that can be poisonous if inhaled, swallowed or absorbed into the body.

[illegible]

KIDS GO TO COURT, TOO.

WHAT YOU WILL SEE AND DO.



COURTROOM

Your school has rules so that work gets done and no one gets hurt. What are some of the rules at your school?

There are rules for grownups, too. These rules are called laws, and they are made by the State of Minnesota for everyone who lives here.

Our laws help make things work better so people don't get hurt.

One of the most important laws says that grownups should never sexually assault girls or boys. Sexual assault is when a grownup wants you to take off your clothes, or touches your private parts or makes you touch their private parts. Maybe this has happened to you. If it did, the grownup broke a very important law.

The grownup who did this is called the offender. The offender usually knows the child. But sometimes the offender is a stranger. Grownups who sexually assault kids need to get help to stop. A kid doesn't make the offender sexually assault him or her.

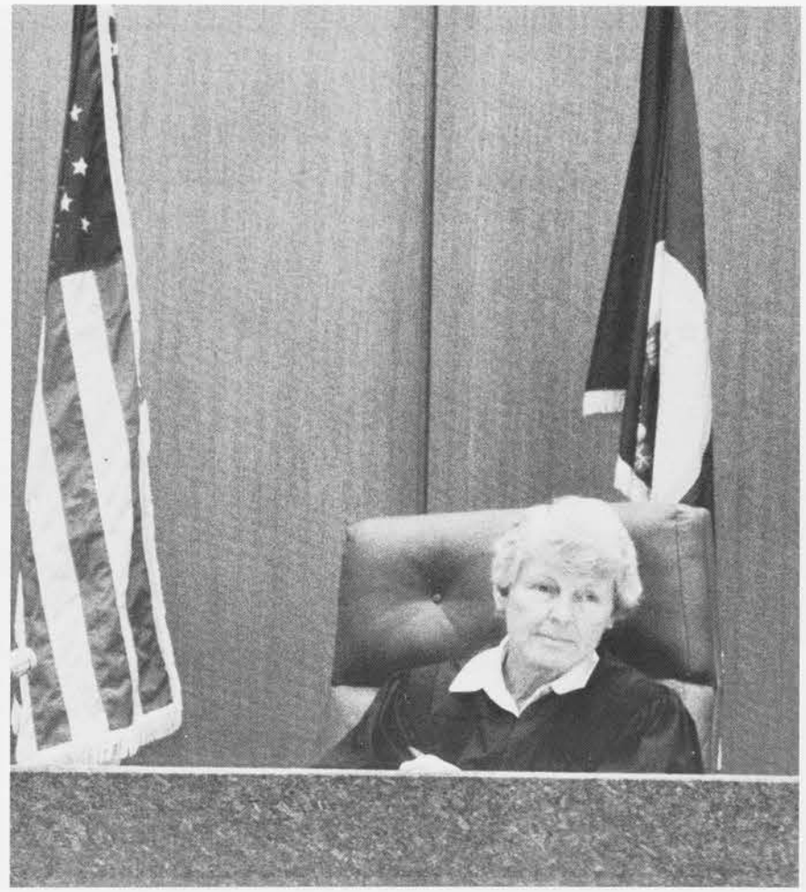
IT IS NEVER THE KID'S FAULT

When a grownup sexually assaults a kid he has broken the law. The State of Minnesota may have a trial to show that the law was broken. The trial happens in a courtroom.

In this booklet there are pictures of a courtroom and of the people who have jobs there for the trial.

THIS BOOKLET IS FOR YOU.

This is a JUDGE. She is the boss of the courtroom. Her job is to make sure that everyone follows the court's rules.



This is the PROSECUTING ATTORNEY. His job is to show that the offender broke the law and to show that the offender sexually assaulted a girl or boy.

This is the OFFENDER and his attorney. The offender is called the defendant at the trial. His attorney's job is to make sure that the defendant is treated fairly.

This is the LEGAL SERVICES ADVISOR. Her job is to help the girl or boy who was sexually assaulted. She talks to him or her about how they feel and tells them what will happen at the trial. She answers all of their questions.

This is the child who was sexually assaulted. At the trial she is a WITNESS. Her/his job is to tell the truth about what happened. It is scary for the child to see the defendant, but he cannot talk to the witness or touch the witness. It is a very brave thing to be a witness.

This is the JURY. The jury has a very hard job. They must decide if the State of Minnesota has shown that the offender has sexually assaulted the child.

WHAT HAPPENS TO THE OFFENDER?

When the offender is found "guilty," it is up to the judge to decide the best way to help him and to protect the victim.

Usually that means the offender must go to counseling to learn how to change his behavior. He might have to live in a half-way house, and sometimes he has to go to jail.

WHAT HAPPENS TO THE VICTIM?

Victims sometimes feel confused, alone, and different from other kids.

It is important to get help with those feelings. One way to do that is with counseling. In counseling, victims talk with adults who help them with their confusing feelings.

IT IS NEVER THE VICTIM'S FAULT.

You may be a witness at a trial. The Legal Services Advisor who will help you is

_____

Her phone number is

_____

REMEMBER, SEXUAL ASSAULT

IS NOT YOUR FAULT!

The child pictured in this booklet is a model, not a real witness. The courtroom scenes are in a real Hennepin County courtroom with real attorneys, bailiff and judge. The jury members are models, and the offender is an actor provided by the ILLUSION THEATER.

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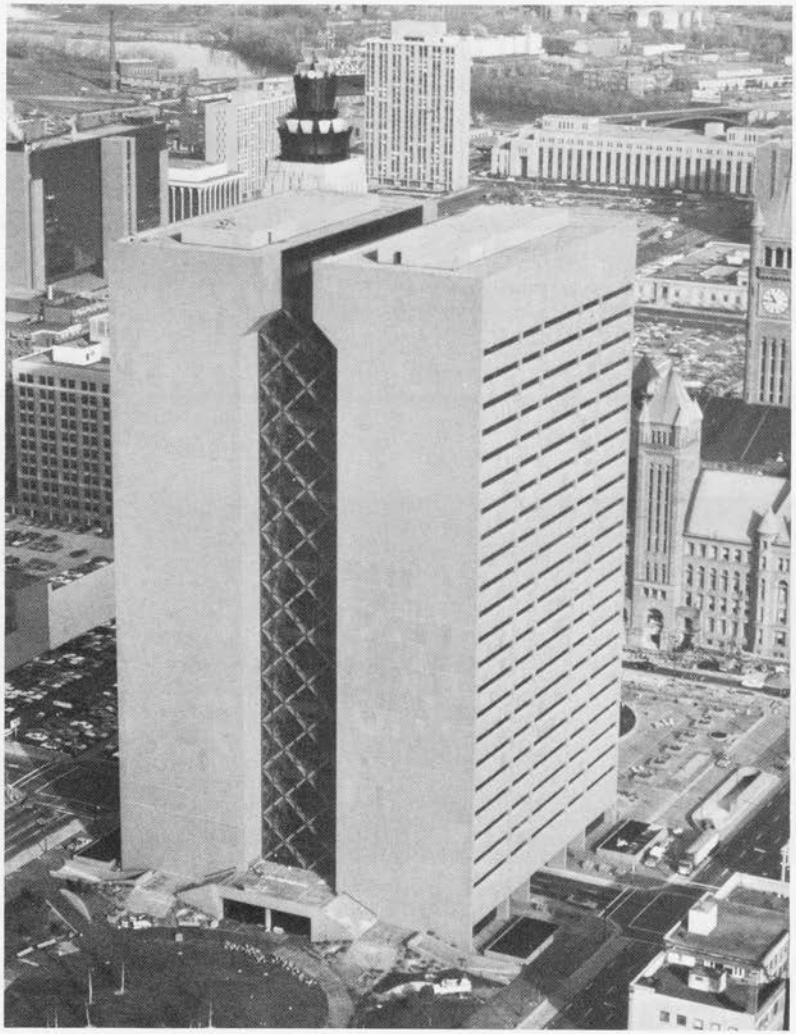
HENNEPIN COUNTY GOVERNMENT CENTER



HENNEPIN

Hennepin County provides equal access to employment, programs and services without regard to race, color, creed, religion, age, sex, handicap, marital status, affectional preference, public assistance, criminal record, or national origin. As required by Section 504 of the Rehabilitation Act of 1973, Hennepin County provides a procedure to resolve complaints of discrimination on the basis of handicap. If you believe you have been discriminated against, contact the Affirmative Action Programs Department, A-303 Government Center, Minneapolis, MN 55487. 348-4096.

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