Chapter 18

Mandatory Reporting of Child Maltreatment

Felicity Goodyear-Smith

18.1 History of Child Protection and Mandatory Reporting

Recognition that children may be mistreated or neglected is not a new phenomenon, although there was little reference to this in the medical literature, apart from the occasional case story, until the late nineteenth century [1]. Throughout most of human history, children were considered small adults with no special rights. They were owned by their parents or guardians, who could exert absolute control. Initial consideration of children's rights centred around public concern about the plight of young children employed in inhumane conditions in mines and factories during the Industrial Revolution in the late eighteenth to the early nineteenth century, with calls to abolish exploitative child labour.

In 1860, French forensic pathologist Tardieu published 32 cases of physical abuse and neglect of children, generally severely badly beaten, sometimes fatally, by either or both parents [2]. However, his work failed to receive much attention. Gradually there was increasing social recognition of potential mistreatment of children within families. In 1874, the New York Society for the Prevention of Cruelty to Children was founded, followed by the Society for the Prevention of Cruelty to Children in Britain in 1883. The latter saw parents convicted for a number of crimes against their children, including physical assault and 'dangerous neglect'.

The first half of the twentieth century saw a growing literature regarding infantile subdural haematoma (SDH). In 1936, Ingalls recorded a strong association of SDH in infants with malnourishment and scurvy [3]. Ingraham and Matson reported 98 cases of SDH in 1944 which they postulated were always due to trauma [4]. In only about half the cases was there history of either birth or postnatal trauma including falls. Retinal haemorrhages (RH) were found in 21 and skull fractures in 11 of these children, and many also had systemic disease (infection, vitamin C or vitamin K deficiency, and other effects of malnutrition), which the authors considered as likely exacerbating factors increasing the risk of bleeding. In 1946, Caffey described six infants with SDH who also had fresh and healed fractures in long bones with no acknowledged history of trauma from caregivers [5].

During the 1940s and 1950s, there was debate as to whether skeletal lesions with the appearance of fractures (with or without the presence of SDH) where parents gave no history of trauma were due to abuse ('undesirable vectors of force') [6], or to natural phenomena ('underlying structural abnormality of the growing skeleton') [7]. In 1962, Kempe et al. published their seminal paper in which they coined the term 'battered-child syndrome' [8]. They argued that this should always 'be considered in any child exhibiting evidence of fracture of any bone, subdural hematoma, failure to thrive, soft tissue swellings

https://doi.org/10.1017/9781009177894.019 Published online by Cambridge University Press

or skin bruising, in any child who dies suddenly, or where the degree and type of injury is at variance with the history given regarding the occurrence of the trauma'. Kempe et al. declared that physicians must overcome their reluctance and believe that 'parents were guilty of abuse'.

Guthkelch described cases of SDH in 1971 where there were no external signs of injury, and hypothesised that this may be due to the infant having been shaken [9]. This was followed up in 1972 by Caffey, who described how the 'whiplash' shaking of babies can cause 'grave permanent damage to infantile brains and eyes' as well as 'skeletal lesions' and was a common cause of death [10]. He extended this discussion in 1974 where he identified the presence of SDH and RH, with or without lesions to the long bones, usually where there is 'no history of trauma of any kind', as 'whiplash shaken infant syndrome' [11]. The term 'shaken baby syndrome' (SBS) subsequently came into common usage, diagnosed by the presence of SDH, RH, and cerebral oedema/encephalopathy. By the turn of the century, the term SBS was being replaced by non-accidental head injury (NAHI) [12] or abusive head trauma (AHT), which might include trauma caused by direct impact to the head. The Committee on Child Abuse and Neglect described SBS as 'a subset of AHT' [13].

Where the 'triad' of SDH, RH and encephalopathy was present, there was a general assumption that an infant must have been violently shaken, often resulting in children removed from their homes and parents prosecuted. However, as this book attests, the 'triad' has been described as occurring from both trauma and natural causes: 'after delivery and in association with such conditions as various convulsive states, certain haemorrhagic diseases, infectious diseases, metabolic disorders, immunological diseases, skeletal diseases and vascular malformations' [14] (see Chapters 3–9). The biomechanics of shaking actually causing such findings is also in question [15] (see Chapter 14).

Kempe's diagnosis of battered child syndrome and the spotlight on child abuse led to major developments to address maltreated children in the United States, Britain, and other nations, particularly in the developed world. Child protection agencies were set up in many countries, with laws, policies, regulations, and services developed to prevent and address the abuse, neglect, and exploitation of children. In 1974, the Child Abuse Prevention and Treatment Act was passed in the United States to fund Child Protective Services and hotlines to protect children from maltreatment [16]. Britain passed the Children Act 1989 and a large number of other countries soon followed suit [17].

There was a rapid proliferation of research into child maltreatment. Kempe was the founding editor of the peer-reviewed journal *Child Abuse and Neglect*, dedicated to the topic of child protection. The sub-specialty of child abuse paediatrics was established for the evaluation of children who may be victims of abuse or neglect. The definition of child abuse expanded to include sexual and psychological maltreatment and exposure to family violence. In 2006, the World Health Organization defined child abuse and neglect as 'All forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power' [18]. In many countries, professionals working in health, educational, or social settings are now mandated to report to authorities whenever they encounter a child whom they suspect might be abused or neglected.

There is a potential cognitive bias when doctors are specialised as child abuse paediatricians, invoking the law of the hammer ('if all you have is a hammer, everything looks like a nail'). In the desire to keep children safe, there may be a reluctance to accept possible non-abuse causes

https://doi.org/10.1017/9781009177894.019 Published online by Cambridge University Press

for medical findings. When SDH and RH are defined as signs of head injury, the assumption is that some trauma must have occurred. However, when erring on the side of safety and mandating reports of suspicions, the potential harmful effects of such actions are rarely considered (see also Chapter 19). Parents facing such accusations may be bewildered, frightened, or angry, and the investigative process may be stressful to the family even when no abuse has occurred. The massive increase in reporting, particularly as the definition of abuse progressively broadened, has overloaded the child protection services, which may be unable to adequately respond and investigate all these cases [19]. Huge numbers of cases are unsubstantiated, but often the media equate the number of referrals as actual child maltreatment cases, making the problem seem much larger than it is. Families may be stigmatised. 'Once an agency . . . labels a parent as abusive, other agencies tend to accept this label and treat the family accordingly' [20]. They may be subjected to statutory child protection assessments before they can receive any support services, which may reduce their willingness to access these. Children may be removed from their families and placed in care, sometimes permanently, because authorities fear that abuse might have occurred despite absence of proof. Children raised in foster homes have significantly worse physical and mental health than those not placed in care, and such action should not be taken lightly [21].

There are examples where overzealous paediatricians have wrongly equated physical findings as evidence of child abuse with devastating consequences. In 1983, US paediatrician Hendrika Cantwell published a paper claiming that a hymenal opening in pre-pubertal girls greater than 4 mm was an indicator of sexual molestation [22]. For a number of years, sexual abuse was diagnosed on the basis of this sign, with children removed from families and fathers facing criminal charges. This sign was subsequently discredited and paediatricians stopped measuring the diameter of the vaginal opening.

In 1986, paediatricians Marietta Hobbs and Geoffrey Wyatt described the sign of reflex anal dilatation as an indicator that a child had been victim of buggery [23]. More than 120 children were removed from their parents in the English county of Cleveland alone on the basis of this diagnostic test. Following public outcry, the Butler-Sloss inquiry concluded that most of the diagnoses were incorrect and this test is also now discredited. Further, there is overwhelming evidence that, as well as sexual transmission, vulvovaginal gonorrhoea in pre-pubertal girls may be acquired non-sexually via contaminated fingers, bathing in contaminated water, or via fomites such as washcloths and towels [24]. Despite this, international guidelines assert that gonorrhoea in children is definitive, or nearly always definitive, evidence of sexual abuse, leading to children placed in care and alleged perpetrators prosecuted.

18.2 Case History from New Zealand

I present a case history on the diagnosis of SBS/AHT and the operation of child protection services in my own country, New Zealand (NZ). Child abuse is defined in the NZ Children, Young Persons and their Families Act 1989, now the Children, Young Persons, and Their Families (Oranga Tamariki) Legislation Act 2017, as 'the harming (whether physically, emotionally, or sexually), ill-treatment, abuse, neglect or deprivation of any child or young person'. Reporting of child abuse is not mandated in NZ.

Because of the broad range of types and severity of activities that might be included in this definition (e.g., from smacking a child to inflicting fatal trauma), it is difficult to give

https://doi.org/10.1017/9781009177894.019 Published online by Cambridge University Press

figures for the prevalence of non-fatal abuse. New Zealand was reported as having an average 1.2 deaths from maltreatment of children under 15 years per 100,000 children over a 5-year period in the 1990s (fifth highest in the Organisation for Economic Co-operation and Development (OECD)) [25]. In the 5-year period from 2015 to 2019, 11 children aged under 1 year, 19 aged 1–4 years, < 6 aged 5–14 years, and 45 aged 15–24 years were reported to have died from assault, an overall rate of 1.01/100,000 population. The majority were young people, not pre-school children. This figure is therefore less than that reported from the 1990s [26].

In many countries, there are a few key professionals who drive the call to identify and address cases of child abuse. In NZ, the leading advocate is paediatrician Dr Patrick Kelly, clinical director of the Starship Child Protection Team based in a multi-agency child advocacy centre. The Starship is the paediatric hospital in Auckland and the site of the country's only paediatric intensive care unit. Kelly has been a key member of the Paediatric Society of New Zealand and was its chair from 2000 to 2012. He frequently appears as an expert witness in child abuse and homicide court cases. He received a NZ Order of Merit in 2016 and was cited as NZ's 'foremost expert witness on child protection' and the driving force behind establishing NZ's first multi-agency child protection service [27].

Since the 1990s, Kelly has repeatedly called for mandatory reporting of suspected child abuse by general practitioners and other health professionals. Despite this, reporting is not mandated, although people are encouraged to report any suspicions of abuse to a statutory agency, the police, or the Ministry for Children (Oranga Tamariki) [28]. However, effectively there is mandatory reporting from hospitals. In 2011, the Clinical Network for Child Protection, a group under the Paediatric Society of New Zealand led by Kelly and contracted by the Ministry of Health, arranged for all of the country's District Health Boards (DHBs) to sign a memorandum of understanding (MoU) with Oranga Tamariki and the police [29]. The DHBs run all of NZ's public hospitals. The MoU includes a guideline for the management of children and young people admitted to hospital with actual or suspected child abuse and/or neglect. The DHBs must report their concerns to Oranga Tamariki, who in general also notify the police. The Child Protection Protocol between the police and Oranga Tamariki 'creates a process whereby when either party is advised of serious child abuse, they will immediately consult with each other, agree [on] an investigation plan, implement the plan, and advise each other of the outcomes'.

When abuse is suspected, there will be a meeting of the clinical team, Oranga Tamariki social workers, and the police within 24 hours of a receipt of concern to develop a Multi-agency Management Plan to address safety issues for the child, as well as for siblings and other children living in the home [29]. This may lead to a Place of Safety Warrant, or a declaration that children, and sometimes their siblings, are in need of care and protection and hence removed from their families and placed into care under the Children, Young Persons, and Their Families (Oranga Tamariki) Legislation Act 2017.

Kelly started diagnosing SBS in the 1990s. In 2004, he published a NZ case review of children aged under 2 years with SDH and RH between 1988 and 1998 [30], and, in 2008, a NZ case report of SBS, to which he also referred as NAHI, between 2000 and 2002 [12]. Kelly et al. conducted a 20-year (1991 to 2020) review of 345 children referred to the Child Protection Team for suspected accidental head injury (AHI). They found that the numbers had escalated from 88 in the first decade to 257 in the second [31]. Children under the age of 2 years were likely to be diagnosed as AHI where there was SDH and hypoxic-ischaemic

https://doi.org/10.1017/9781009177894.019 Published online by Cambridge University Press

injury with no history of trauma. The actual incidence of AHI was expected to be much higher because 'children who may be shaken in a manner that does not lead to symptoms may never be counted' [32].

In their public educational material, Kelly et al. still refer to SBS rather than AHT or NAHI. The Paediatric Society of New Zealand and the Starship Foundation, supported and funded by the Ministry of Health, run KidsHealth, a public-facing website. This aims to provide 'parents and whānau [family] with accurate and reliable information about the health and wellbeing of tamariki [children] and rangatahi [young people] in Aotearoa [New Zealand]' [33]. Shaken baby syndrome is said to be 'the single most preventable cause of serious head injury in babies under one year of age in New Zealand. It is a combination of serious injuries that can occur when someone violently shakes an infant or young toddler'. The public are told:

> [I]t may only take one or two hard shakes to seriously injure a small child. This is because babies and toddlers have relatively big, heavy heads and weak neck muscles. When they are shaken, the brain slams back and forth inside the skull, resulting in bleeding around the brain and damage to the brain itself. Some babies may even stop breathing, which can cause further brain damage. The shaking can also cause bleeding into the back of the eyes. Many babies who are shaken also have broken ribs because they are held forcibly around the chest and squeezed when they are shaken. They may also suffer other broken bones during the shaking.

The site states that, '[O]verall, in babies diagnosed with shaken baby syndrome, approximately 20% will die and 30–60% will suffer moderate to severe injuries.'

Kelly et al. emphasise that there should be a high suspicion of NAHI where SDH is detected but parents deny any history of trauma. In a 10-year review of 519 children aged under 3 years with 'structural head injury', they found that many aged under 6 months had SDH with no history of trauma and no natural conditions that might cause SDH, and hence 'it must be seriously considered that the history is false' [34]. In an opinion piece on the diagnosis of AHT in the United States and other selected countries/regions 'where child abuse physicians are actively involved in the evaluation of AHT', they claim that the legal system does not serve children well, with defence lawyers contesting that SBS or AHT may not have occurred. They complain that 'highly paid defence experts, mostly from the US and the UK, travel internationally to refute and challenge a diagnosis that has a strong history and evolution of research to support its basis' [32]. In an article giving advice to ophthalmologists giving evidence to the court, they claim that RH 'are exceedingly rare in accidental head trauma' but commonly occur in SBS 'from a direct mechanical effect at the vitreoretinal interface with resulting traction from (possibly repeated) acceleration–deceleration' [35]. They caution that using the term 'consistent with' NAHI is problematic and, where there is no other evidence, ophthalmology expert witnesses should 'explain why, in your view, alternative diagnoses are not consistent with the findings you observed'. In other words, the experts should be unequivocal that RH indicates NAHI.

A further study by Kelly et al. looked at fatal head injuries in children under 15 years seen by the Auckland coroner's office from 1991 to 2020 [36]. They found 12 children aged under 2 years with SDH and RH who were diagnosed with AHT. In their retrospective case review of the outcome of referrals to statutory authorities from 1988 to 1998 [37], 39 infants out of 64 cases of infantile SDH were deemed to have an NAHI, with the rest assigned as accidental

https://doi.org/10.1017/9781009177894.019 Published online by Cambridge University Press

injury. Of these 39 children, 6 had died, 15 were placed with other family members, 9 were placed permanently away from home, and charges were laid in 18 cases, resulting in 15 cases going to trial and 14 convictions (11 fathers, 3 mothers, 1 stepfather).

18.3 Child Protection and Mandated Reporting in a Selection of Other Countries

Abuse reporting laws were enacted in every US state by 1967 [38]. Initially, mandatory reporting applied only to physicians reporting serious non-accidental physical injuries [20]. Amendments to the federal Child Abuse Prevention and Treatment Act subsequently included nurses, teachers, social workers, mental health workers, and other professionals as mandated reporters, with criminal penalties for those who failed to report. Rather than investigate themselves or wait for proof, professionals are mandated to report any suspicions of abuse to Child Protective Services, who then conduct the investigations. Rapid action is advocated to prevent the suspected victim undergoing further harm. In 20 states, everyone, even strangers, is legally required to report their suspicions using the hotlines and they have immunity from civil and criminal liability for their 'good faith' reporting [38]. The laws now cover all forms of suspected child maltreatment (physical, emotional, and sexual).

Mandatory reporting has been introduced in many other countries (see also Chapters 21–26). Israel followed the US lead and introduced a law to mandate reporting of child abuse in 1980 [39]. Doctors, teachers, social workers, psychologists, and other professionals are obligated by law to report any suspicion of child abuse, with failure to report being a criminal offence. Israeli common law has recognised SBS/AHT since the early 2000s. Medical protocols in hospitals specify that signs of the 'triad' are grounds for suspecting abuse and sufficient for a medical diagnosis of SBS/AHT. Doctors are ordered to report to the police or social services about cases with observed 'triad' signs for which there are no other explanations, such as traffic accidents. However, SBS may be diagnosed solely on the basis of RH and cerebral oedema in the absence of SDH [40].

Anglo-American countries generally follow a similar model to the United States. England has had a strong child protection focus although no mandatory reporting. While only social workers and police are obliged to report child abuse suspicions, health professionals and teachers have often been expected to do so. Central government lays out detailed guidance for both professionals and citizens to refer to local-authority statutory child-welfare agencies when they have any concerns that a child might be at risk of harm [41]. Volunteer counsellors at the National Society for the Prevention of Cruelty to Children receive thousands of calls daily from both children and adults on their free phone lines. Local authorities also have their own detailed procedures for child protection work, with severe consequences for professionals and organisations where the guidance has not been followed, if things go wrong. Penalties may include job dismissal, removal from a professional register, or being pilloried in the press.

The 1970s through the 1990s saw growing public concern about the failures of UK health and welfare professionals to protect certain children from death or serious injury in high-profile cases. On the other hand, the forensic approach to child protection gave rise to concerns about over-intervention, with children inappropriately removed from their parents [41]. In the mid-2000s, child welfare departments were established, and the Every Child Matters: Change for Children programme was launched, aiming for a 'shift to prevention

https://doi.org/10.1017/9781009177894.019 Published online by Cambridge University Press

whilst strengthening protection'. All children, at some point in their lives, might be vulnerable to some form of risk, and the idea was to identify problems and provide early help.

In 2007, the death of a baby reignited public criticism of the failure of the system to protect children, and, since 2009, the UK government has reverted to framing policy in terms of child protection rather than safeguarding and promoting the welfare of the child. The system is not coping with demand. More than one in five children born in 2009 and 2010 were referred to children's services before the age of five [42]. A quarter of these were formally investigated and a high proportion were not offered support. Suspicion of child abuse is concentrated on families living in poorer communities [43], which can create a climate of fear and distrust [44].

In Canada, provincial and territorial laws mandate the reporting of suspicions of child abuse or neglect [45]. There is a long list of professional groups considered mandated reporters, including medical, mental health, and educational personnel and anyone else working with children or youth. In 1998, 45% of 135,573 reported cases were said to be substantiated, which included physical, emotional, and sexual maltreatment and neglect [46]. Shaken baby syndrome was substantiated in 200 cases. The use of standardised risk assessment is said to have led to social workers giving high-risk scores for fear of making a mistake, with increasing numbers of children placed in care [47].

All Australian states and territories have legislation requiring doctors and other professionals to report suspicion of child abuse to statutory child protection services, although in Western Australia this is only for child sexual abuse [48] (see Chapter 25). During 2019 to 2020, investigations of reported abuse/neglect were conducted for 117,900 children, with 48,900 cases (42%) substantiated [49]. One in 23 (14,300) of these were Aboriginal and Torres Strait Islander children, almost seven times the rate of non-Indigenous children. Approximately 46,000 children were in out-of-home care, 30,600 for 2 years or more, with 42% long-term placements for Indigenous children. Physical abuse accounted for 14% of cases said to be substantiated, but specific diagnoses were not reported. In 2012, the rate of AHT requiring hospital admission in Queensland was an estimated 29.6 per 100,000 children under the age of 2 years [50].

Other countries with mandated reporting include Brazil, where child maltreatment was added to the compulsory notification of diseases ordinance [51]. Notification should be enforced by the health and educational systems, although significant underreporting appears likely [52]. In South Korea, mandatory reporting obligations are imposed on medical personnel, teachers, facility workers of specialised child protection institutions, and public officials under the Child Welfare Act [53]. In Taiwan, a series of legislative acts since 1993 stipulates that doctors, nurses, social workers, clinical psychology workers, educational and day-care personnel, police, and other providers of children and youth welfare services must report all suspected cases of child abuse to the authorities [54]. In the best interests of the children, the authorities may place children and youth in foster families or turn them over to relatives, third parties, or children and youth welfare or other placement institutions.

Although there is no special law against child abuse in China, people have been subject to criminal punishment under the Law of the People's Republic of China on the Protection of Minors. Mandatory reporting is just being introduced in China, with the Supreme People's Procuratorate in conjunction with a number of government agencies issuing an 'Opinion on establishing a system for compulsory reporting of cases against minors' for trial implementation [55]. Under this Opinion, organisations in close contact with minors are

https://doi.org/10.1017/9781009177894.019 Published online by Cambridge University Press

obliged to immediately report suspected child abuse, sexual assault, injury, abandonment, and abduction (see Chapter 26).

18.4 Family-Support Focus

Some countries have a family-support rather than a child protection focus [19]. This could be considered to be in line with the Convention on the Rights of the Child, ratified by the General Assembly of the United Nations in 1989. The Convention states that every child has basic rights, including the right to be raised by their parents within a family or cultural grouping and to have a relationship with both parents, even if they are separated. While the child-protection-focused system focuses on managing risk of abuse and neglect, the priority of the family-support model is to respond to family needs and address child abuse prevention, protection, and support in a holistic manner [19]. Such a system looks to work with family dysfunction before problems escalate [56]. It provides supportive or therapeutic responses to help resolve issues facing children and families, rather than legalistic and investigative processes formulating child-safety plans. These flexible services are often embedded within and normalised by broad child welfare and public health services, in comparison to the adversarial, standardised 'standalone' child protection orientation. Removal of children from their families is a last resort and mainly voluntary [19].

Nordic countries, with their social democratic welfare state regimes, have family support-oriented child welfare systems, with or without a mandatory reporting component. When a referral is made in Sweden by a mandated reporter, the object of the investigation is not to determine whether an allegation is correct (see Chapter 23). Rather, family functioning is examined, including parent–child interactions, and support is offered to address issues rather than impose intrusive state interventions [56]. Family centres are universally provided resources focused on parents and children, with integration of antenatal and child healthcare, pre-school education, and social welfare activities. A range of different professional groups work together with families including midwives, paediatric nurses, paediatricians, pre-school teachers, social workers, and psychologists, providing health and social services, ongoing education, and support on good parenting practices [57]. In Finland, there is a similar orientation, with a strength-based approach assessing notified cases as to what service might be provided, rather than focusing on problems or risks [58]. Social workers assess in relation to what might be expected to be a 'good enough' childhood or family life, rather than against a gold standard of parenting. Open-care measures are prioritised, with provision of a wide range of psychosocial, financial, and practical supportive services. Placing a child into care is a last resort.

Continental European countries generally also orientate towards a family support approach, with different policies on mandatory reporting. In the Netherlands, the Department for Youth and Family generally focuses more broadly on reducing poverty and promoting safety and health, rather than specifically on child abuse. Reporting child maltreatment is not mandatory although it is being increasingly encouraged [59]. Families are seen to malfunction frequently and introduction of the Electronic Child Dossier provides monitoring of every family in the country, facilitating intervention when young people at risk are identified. Mostly these interventions seek to support the family's autonomy instead of undermining it. Belgium also does not have mandatory reporting, although it is considered the moral responsibility of all to provide or facilitate help if confronted with

https://doi.org/10.1017/9781009177894.019 Published online by Cambridge University Press

a situation of suspected child abuse and neglect [60].[1] The Belgian system operates on the continuum between caring for children and their families and criminalising parents deemed abusive [60]. The majority of services are aimed at preventing abuse and contributing to the welfare of children, with a small group of cases dealt with by services tasked to improve the safety and well-being of abused and neglected children. The focus is on easily accessible help and care, not forensic evaluation, aiming to restore safe relationships between children and parents and safe parenting.

18.5 Conclusion

The way child abuse is framed may influence what happens to children and their families to a greater extent than whether there is mandatory reporting. Child protection-oriented services are adversarial, demanding that children are protected from harm that might be inflicted by parents and other relatives. Removal of children from their homes is seen to be warranted, as it is better to be safe than sorry. In contrast, the family-support-orientated approach views abuse as a problem of family conflict or dysfunction arising from social and psychological difficulties, which will respond to support and assistance. The system operates in partnership with parents. The state's focus on safeguarding children is with policies that emphasise participation, prevention, and family support rather than a forensic approach.

The implications of this are of particular concern where authorities believe that the presence of SDH, RH, and/or the 'triad' is diagnostic of SBS/AHT. The fact that the parents deny the occurrence of any traumatic event is interpreted as giving a false history and confirms that they cannot be trusted with the care of their children. Their denial means that they present an ongoing risk. Removal of children from their care is justified to keep them safe from dangerous parents. Where the children have died, those deemed responsible are to be held criminally liable [34].

However, SBS is not a medical diagnosis; it is the diagnosis of a crime, a statement that an illegal act has taken place. In countries where there is a child protection orientation, a diagnosis of SBS is likely to lead to loss of child custody and parental incarceration. Likewise the term 'abusive head trauma' presupposes an action with malicious intent. This emotive label should have no place in a medical diagnosis.

References

1. Lynch MA. Child abuse before Kempe: An historical literature review. *Child Abuse and Neglect*. 1985;9(1):7–15.
2. Roche AJ, Fortin G, Labbé J, Brown J, Chadwick D. The work of Ambroise Tardieu: The first definitive description of child abuse. *Child Abuse and Neglect*. 2005;29(4):325–34.
3. Ingalls TH. The role of scurvy in the etiology of chronic subdural hematoma. *New England Journal of Medicine*. 1936;215(27):1279–81.
4. Ingraham FD, Matson DD. Subdural hematoma in infancy. *Journal of Pediatrics*. 1944;24(1):1–37.
5. Caffey J. Multiple fractures in the long bones of infants suffering from chronic subdural hematoma. *American Journal of Roentgenology Radium Therapy and Nuclear Medicine*. 1946;56(2):163–73.
6. Woolley PV, Evans WA. Significance of skeletal lesions in infants resembling those of traumatic origin. *JAMA*. 1955;158 (7):539–43.

[1] See Chapter 22 for an overview of the situation in France.

https://doi.org/10.1017/9781009177894.019 Published online by Cambridge University Press

7. Astley R. Multiple metaphyseal fractures in small children (metaphyseal fragility of bone). *British Journal of Radiology*. 1953;26 (311):577–83.
8. Kempe CH, Silverman FN, Steele BF, Droegemueller W, Silver HK. The battered child syndrome. *JAMA*. 1962;181(1):17–24.
9. Guthkelch AN. Infantile subdural haematoma and its relationship to whiplash injuries. *British Medical Journal*. 1971;2(5759):430–1.
10. Caffey J. On the theory and practice of shaking infants: Its potential residual effects of permanent brain damage and mental retardation. *American Journal of Diseases of Children*. 1972;124(2):161–9.
11. Caffey J. The whiplash shaken infant syndrome: Manual shaking by the extremities with whiplash-induced intracranial and intraocular bleedings, linked with residual permanent brain damage and mental retardation. *Pediatrics*. 1974;54(4):396–403.
12. Kelly P, Farrant B. Shaken baby syndrome in New Zealand, 2000–2002. *Journal of Paediatrics and Child Health*. 2008;44 (3):99–107.
13. Christian CW, Block R. Abusive head trauma in infants and children. *Pediatrics*. 2009;123(5):1409–11.
14. Elinder G, Eriksson A, Hallberg B et al. Traumatic shaking: The role of the triad in medical investigations of suspected traumatic shaking. *Acta Paediatrica*. 2018;107:3–23.
15. Squier W. The triad of retinal haemorrhage, subdural haemorrhage and encephalopathy in an infant unassociated with evidence of physical injury is not the result of shaking, but is most likely to have been caused by a natural disease: Yes. *Journal of Primary Health Care*. 2011;3 (2):159–61.
16. US Congress. Child Abuse Prevention and Treatment Act (CAPTA). PL 93-247, 1974.
17. UK Government. The Children Act 1989. House of Commons Vol. C41. London, 1989.
18. World Health Organization. *Preventing child maltreatment: A guide to taking action and generating evidence*. World Health Organization, 2006.
19. Price-Robertson R, Bromfield L, Lamont A. International approaches to child protection: What can Australia learn? CFCA paper. *Australian Institute of Family Studies*. 2014;23:1–11.
20. Besharov DJ. Responding to child sexual abuse: The need for a balanced approach. *Future Child*. 1994;4(2):135–55.
21. Turney K, Wildeman C. Mental and physical health of children in foster care. *Pediatrics*. 2016;138(5):1–11.
22. Cantwell HB. Vaginal inspection as it relates to child sexual abuse in girls under thirteen. *Child Abuse and Neglect*. 1983;7 (2):171–6.
23. Hobbs C, Wynne J. Buggery in childhood: A common syndrome of child abuse. *Lancet*. 1986;2:792–6.
24. Goodyear-Smith F. What is the evidence for non-sexual transmission of gonorrhoea in children after the neonatal period? A systematic review. *Journal of Forensic and Legal Medicine*. 2007;14 (8):489–502.
25. United Nations International Children's Emergency Fund (UNICEF). *A league table of child maltreatment deaths in rich countries*. Innocenti Research Centre, 2003.
26. Child and Youth Mortality Review Committee. *15th data report Te pūrongo raraunga 15 2015–19*. Wellington Health Quality & Safety Commission, 2021.
27. SM. Influential Auckland pediatrician recognised with ONZM. *Stuff*. 2016, 5 June.
28. Ministry of Health. Family violence questions and answers: Is it mandatory to report abuse? www.health.govt.nz/our-work/preventative-health-wellness/family-violence/family-violence-questions-and-answers.
29. Clinical Network for Child Protection. *Schedule 1: Children admitted to hospital with suspected or confirmed abuse or neglect*. Clinical Network for Child Protection, 2011.
30. Kelly P, Hayes I. Infantile subdural haematoma in Auckland, New

https://doi.org/10.1017/9781009177894.019 Published online by Cambridge University Press

Zealand: 1988–1998. *New Zealand Medical Journal*. 2004;117(1201):U1047.

31. Kelly P, John S, Vincent AL, Reed P. Abusive head trauma and accidental head injury: A 20-year comparative study of referrals to a hospital child protection team. *Archives of Disease in Childhood*. 2015;100(12):1123–30.
32. Frasier LD, Kelly P, al-Eissa M, Otterman GJ. International issues in abusive head trauma. *Pediatric Radiology*. 2014;44(Suppl 4):S647–53.
33. KidsHealth. What is shaken baby syndrome? www.kidshealth.org.nz/never-ever-shake-baby.
34. John SM, Kelly P, Vincent A. Patterns of structural head injury in children younger than 3 years: A ten-year review of 519 patients. *Journal of Trauma and Acute Care Surgery*. 2013;74(1):276–81.
35. Vincent AL, Kelly P. Retinal haemorrhages in inflicted traumatic brain injury: The ophthalmologist in court. *Clinical and Experimental Ophthalmology*. 2010;38 (5):521–32.
36. John SM, Jones P, Kelly P, Vincent A. Fatal pediatric head injuries: A 20-year review of cases through the Auckland coroner's office. *American Journal of Forensic Medicine and Pathology*. 2013;34 (3):277–82.
37. Kelly P, MacCormick J, Strange R. Non-accidental head injury in New Zealand: The outcome of referral to statutory authorities. *Child Abuse and Neglect*. 2009;33 (6):393–401.
38. Pence DM, Wilson CA. Reporting and investigating child sexual abuse. *Future Child*. 1994;4(2):70–83.
39. Oz S, Balshan D. Mandatory reporting of childhood sexual abuse in Israel: What happens after the report? International research. *Journal of Child Sex Abuse*. 2007;16(4):1–22.
40. Morad Y, Avni I, Capra L et al. Shaken baby syndrome without intracranial hemorrhage on initial computed tomography. *Journal of Pediatric Ophthalmology and Strabismus*. 2004;8 (6):521–7.
41. Parton N, Berridge D. Child protection in England. In *Child protection systems: International trends and orientations*. N Gilbert, N Parton, M Skivenes, eds. Oxford University Press, 2011, pp. 60–85.
42. Bilson A, Martin KEC. Referrals and child protection in England: One in five children referred to children's services and one in nineteen investigated before the age of five. *British Journal of Social Work*. 2016;47 (3):793–811.
43. Bywaters P, Brady G, Sparks T, Bos E. Inequalities in child welfare intervention rates: The intersection of deprivation and identity. *Child and Family Social Work*. 2016;21(4):452–63.
44. Hooper C, Gorin S, Cabral C, Dyson C. *Living with hardship 24/7: The diverse experiences of families in poverty in England*. Frank Buttle Trust, 2007.
45. Tufford L. *Child abuse and neglect in Canada: A guide for mandatory reporters*. Oxford University Press, 2019.
46. Trocmé NM, Tourigny M, MacLaurin B, Fallon B. Major findings from the Canadian incidence study of reported child abuse and neglect. *Child Abuse and Neglect*. 2003;27(12):1427–39.
47. Swift K. Canadian child welfare. In *Child protection systems: International trends and orientations*. N Gilbert, N Parton, M Skivenes, eds. Oxford University Press, 2011, pp. 36–59.
48. Bird S. Child abuse: Mandatory reporting requirements. *Australian Family Physician*. 2011;40(11):921–6.
49. Australian Institute of Health and Welfare. *Child protection Australia 2019–20*. Australian Institute of Health and Welfare, 2021.
50. Liley W, Stephens A, Kaltner M et al. Infant abusive head trauma incidence, outcomes and awareness. *Australian Family Physician*. 2012;41 (10):823–6.

51. Ministry of Health Brazil. *Annex 1 Ordinance No 104 Federative Republic of Brazil*. Brasilia, 2011.

52. Cardia N, Lagatta P, Affonso C. *Assessment of child maltreatment prevention readiness: Country report*. University of São Paulo, 2012.

53. Republic of Korea. Child Welfare Act. In Welfare PS. 12361. Seoul 2014.

54. Ministry of Health and Welfare. *The protection of children and youths welfare and rights act*. Republic of China, 2003.

55. Supreme People's Procuratorate, National Supervision Commission, Ministry of Education et al. *Opinions on establishing a mandatory reporting system for cases of violations against juveniles (provisional) in procuratorate SPs*. Supreme People's Procuratorate, 2020.

56. Wiklund S. Signs of child maltreatment. The extent and nature of referrals to Swedish child welfare agencies Barnavårdsanmälningar i Sverige: omfattning, källor och problembilder. *European Journal of Social Work*. 2006;9 (1):39–58.

57. Ångman I, Gustafsson M. *Combating child abuse and neglect in Sweden*. 2011.

58. Pösö T. Combatting child abuse in Finland. In *Child protection systems: International trends and orientations*. N Gilbert, N Parton, M Skivenes, eds. Oxford University Press, 2011, pp. 112–30.

59. Knijn T, Van Nijnatten C. Child welfare in the Netherlands. In *Child protection systems: International trends and orientations*. N Gilbert, N Parton, M Skivenes, eds. Oxford University Press, 2011, pp. 223–40.

60. Desair K, Adriaenssens P. Policy toward child abuse and neglect in Belgium. In *Child protection systems: International trends and orientations*. N Gilbert, N Parton, M Skivenes, eds. Oxford University Press, 2011, pp. 204–22.