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DEFINITIONS OF ABUSE AND NEGLECT

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DEFINITIONS OF ABUSE AND NEGLECT

2.1 Introduction

The statutory and regulatory authority establishing the foundation for the categories of abuse and neglect are found in Chapter 15 of the Code of Virginia and [22 VAC 40-705-30](#) of the Virginia Administrative Code. This section also contains footnotes of relevant court decisions impacting the definition of abuse and neglect for the CPS program.

The Virginia Administrative Code defines abuser or neglector as:

[\(22 VAC 40-705-10\)](#). "Abuser or Neglector" means any person who is found to have committed the abuse and/or neglect of a child pursuant to Chapter 15 (§ [63.2-1500](#) et seq.) of Title 63.2 of the Code of Virginia.

The Virginia Administrative Code establishes five (5) categories of abuse or neglect, including:

- Physical abuse.
- Physical neglect.
- Medical neglect.
- Mental abuse or neglect.
- Sexual abuse.

2.2 Injury and threat of injury or harm to a child

Inherent within each category of abuse or neglect is an actual injury or the existence of a threat of an injury or harm to the child. Although there are five categories of abuse or neglect, there are only two kinds of injuries possible; an injury may be a physical injury or a mental injury. Also, an injury may be an actual injury or a threatened injury. The threat of injury has been upheld by the courts.¹

The CPS worker must consider the circumstances surrounding the alleged act or omission by the caretaker influencing whether the child sustained an injury or whether there was a threat of an injury or of harm to the child. The evidence may establish circumstances that may create a threat of harm.

2.3 Physical abuse

2.3.1 Statutory and regulatory definition

The Code of Virginia [§ 63.2 -100](#) provides the statutory definition of physical abuse. The Virginia Administrative Code provides the same definition of physical abuse:

[\(22 VAC 40-705-30 A\)](#). Physical abuse occurs when a caretaker creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon a child a physical injury by other than accidental means or creates a substantial risk of death, disfigurement, or impairment of bodily functions, including, but not limited to, a child who is with his parent or other person responsible for his care either (i) during the manufacture or attempted manufacture of a Schedule I or II controlled substance or (ii) during the unlawful sale of such substance by that child's parents or other person responsible for his care, where such manufacture, or attempted manufacture or unlawful sale would constitute a felony violation of [§ 18.2-248](#) of the Code of Virginia.

2.3.2 Types of physical abuse

The types of physical abuse include but are not limited to:

2.3.2.1 Asphyxiation

Asphyxiation means being rendered unconscious as a result of oxygen deprivation.

¹ "[T]he statutory definitions of an abused or neglected child do not require proof of actual harm or impairment having been experienced by the child. The term 'substantial risk' speaks in futuro." *Jenkins v. Winchester Dep't of Soc. Servs.*, 12 Va. App. 1178, 1183, 409 S.E.2d 16, 19 (1991). "The Commonwealth's policy is to protect abused children and to prevent further abuse of those children. This policy would be meaningless if the child must suffer an actual injury from the behavior of his or her parent . . . [T]he statute [does not] impose such trauma upon a child." *Jackson v. W.*, 14 Va. App. 391, 402, 419 S.E.2d 385, 391 (1992).

2.3.2.2 Bone fracture

- Chip fracture. A small piece of bone is flaked from the major part of the bone.
- Simple fracture. The bone is broken, but there is no external wound.
- Compound fracture. The bone is broken, and there is an external wound leading down to the site of fracture or fragments of bone protrude through the skin.
- Comminuted fracture. The bone is broken or splintered into pieces.
- Spiral fracture. Twisting causes the line of the fracture to encircle the bone in the form of a spiral.

2.3.2.3 Head injuries

- Brain damage. Injury to the large, soft mass of nerve tissue contained within the cranium or skull.
- Skull fracture. A broken bone in the skull.
- Subdural hematoma. A swelling or mass of blood (usually clotted) caused by a break in a blood vessel located beneath the outer membrane covering the spinal cord and brain.

2.3.2.4 Burns/scalding

- Burn. Tissue injury resulting from excessive exposure to thermal, chemical, electrical or radioactive agents.
- Scald. A burn to the skin or flesh caused by moist heat from vapors or steam.

The degree of a burn must be classified by a physician and is usually classified as:

- First degree. Superficial burns, damage being limited to the outer layer of skin, scorching or painful redness of the skin.
- Second degree. The damage extends through the outer layer of the skin into the inner layers. Blistering will be present within 24 hours.
- Third degree. The skin is destroyed with damage extending into underlying tissues, which may be charred or coagulated.

2.3.2.5 Cuts, bruises, welts, abrasions

- Cut. An opening, incision, or break in the skin.
- Bruise. An injury that results in bleeding within the skin, where the skin is discolored but not broken.
- Welt. An elevation on the skin produced by a lash or blow. The skin is not broken.
- Abrasions. Areas of the skin where patches of the surface have been scraped off.

2.3.2.6 Internal injuries

An injury that is not visible from the outside, such as an injury to the organs occupying the thoracic or abdominal cavities.

2.3.2.7 Poisoning

Ingestion, inhalation, injection, or absorption of any substance given to a child that interferes with normal physiological functions. The term poison implies an excessive amount as well as a specific group of substances. Virtually any substance can be poisonous if consumed in sufficient quantity.

2.3.2.8 Sprains/dislocation

- Sprain. Trauma to a joint which causes pain and disability depending upon the degree of injury to ligaments. In a severe sprain, ligaments may be completely torn.
- Dislocation. The displacement of a bone from its normal position in a joint.

2.3.2.9 Gunshot wounds

Wounds resulting from a gunshot.

2.3.2.10 Stabbing wounds

Wounds resulting from a stabbing.

2.3.2.11 Munchausen syndrome by proxy

A condition characterized by habitual presentation for hospital treatment of an apparent acute illness, the patient giving a plausible and dramatic history, all of which is false.² Munchausen syndrome by proxy occurs when a parent or guardian falsifies a child's medical history or alters a child's laboratory test or actually causes an illness or injury in a child in order to gain medical attention for the child, which may result in innumerable harmful hospital procedures.³ This classification must be supported by medical evidence.

2.3.2.12 Bizarre discipline

Bizarre discipline means any actions in which the caretaker uses eccentric, irrational, or grossly inappropriate procedures or devices to modify the child's behavior. The caretaker's actions must result in physical harm to the child or create the threat of physical harm to the child.

Bizarre discipline is also a type of mental abuse or neglect.

2.3.2.13 Abusive Head Trauma, traumatic inflicted brain injury, or shaken baby syndrome; battered child syndrome

Abusive Head Trauma, also known as traumatic inflicted brain injury or shaken baby syndrome, and battered child syndrome are caused by non-accidental trauma.

- Abusive Head Trauma, also known as traumatic inflicted brain injury or shaken baby syndrome, is a medical diagnosis that must be made by a physician. This type of injury occurs during violent shaking of an infant or young child causing the child's head to whip back and forth. The shaking causes the child's brain to move about, causing blood vessels in the skull to stretch and tear. The child may suffer one or several of the following injuries: retinal hemorrhages; subdural or subarachnoid hemorrhages; cerebral contusions; skull fracture; rib fractures; fractures in the long bones and limbs; metaphyseal fractures; axonal shearing (tearing of the brain tissue); and cerebral edema (swelling of the brain). The absence of external injury does not rule out a diagnosis of shaken baby syndrome.

² Dorland's Illustrated Medical Dictionary 1295 (26th ed. 1981).

³ Zumwalt & Hirsch, Pathology of Fatal Child Abuse and Neglect, in Child Abuse and Neglect 276 (R. Helfer & R. Kempe eds., 4th ed. 1987).

- Battered child syndrome refers to a “constellation of medical and psychological conditions of a child who has suffered continuing injuries that could not be accidental and are therefore presumed to have been inflicted by someone close to the child, usually a caregiver. Diagnosis typically results from a radiological finding of distinct bone trauma and persistent tissue damage caused by intentional injury, such as twisting or hitting with violence.”⁴ The battered child syndrome “exists when a child has sustained repeated and/or serious injuries by non-accidental means.”⁵ Battered child syndrome must be diagnosed by a physician.

Presenting signs and symptoms of this type of injury include: irritability, convulsions, seizures, lethargy or altered level of consciousness, coma, respiratory problems, vomiting, and death.⁶

2.3.2.14 Exposure to sale or manufacture of certain controlled substances

The sale of drugs by a caretaker in the presence of a child can pose a threat to the child’s safety. Manufacturing drugs, especially in methamphetamine laboratories, can expose children to serious toxins. There is more information about specific toxins in Appendix C in Section 4, *Family Assessment and Investigation*, as well as information about [Schedule 1 and Schedule 2 drugs](#) on the Department of Justice website.

CPS reports alleging this type of physical abuse shall be reported to the Commonwealth Attorney and to local law enforcement. The CPS worker should not be the first responder to a setting where the manufacture of drugs is suspected.

There is a sample protocol for a joint response to these reports with local law enforcement and emergency personnel in Appendix C in Section 4, *Family Assessment and Investigation*.

2.3.2.15 Other physical abuse

Most types of physical abuse of a child can be defined in one of the above types. However, if the child has suffered a type of physical abuse that is not one of the above specified types, the CPS worker may document the type as Other Abuse and specifically describe the type of physical abuse.

⁴ Black’s Law Dictionary, 172 (9th ed. 2009).

⁵ *Estelle v. McGuire*, 502 U.S. 62 (1991).

⁶ Monteleone, Dr. James A., and Dr. Armand E. Brodeur, *Child Maltreatment: A Clinical Guide and Reference*, 14-16 (G.W. Medical Publishing 1994).

2.3.3 Substantial risk of death, disfigurement, or impairment of bodily functions

The CPS worker may determine that a physical abuse definition has been met when the information collected during the family assessment or investigation establishes that the caretaker created a substantial risk of death, disfigurement, or impairment of bodily functions.

2.4 Physical neglect

2.4.1 Statutory and regulatory definition

The Code of Virginia [§ 63.2-100](#) provides the statutory foundation for the definition of physical neglect. The Virginia Administrative Code provides the regulatory definition for physical neglect:

([22 VAC 40-705-30 B](#)). Physical neglect occurs when there is the failure to provide food, clothing, shelter, or supervision for a child to the extent that the child's health or safety is endangered. This also includes abandonment and situations where the parent or caretaker's own incapacitating behavior or absence prevents or severely limits the performing of child caring tasks pursuant to [§ 63.2 –100](#) of the Code of Virginia. This also includes a child under the age of 18 whose parent or other person responsible for his care knowingly leaves the child alone in the same dwelling as a person, not related by blood or marriage, who has been convicted of an offense against a minor for which registration is required as a violent sexual offender pursuant to [§ 9.1-902](#).

([22 VAC 40-705-30 B1](#)). Physical neglect may include multiple occurrences or a one-time critical or severe event that results in a threat to health or safety.

2.4.2 Types of physical neglect

The types of physical neglect include but are not limited to:

2.4.2.1 Abandonment

Abandonment means conduct or actions by the caretaker implying a disregard of caretaking responsibilities. Such caretaker actions or conduct includes extreme lack of interest or commitment to the child, or leaving the child without a caretaker and without making proper arrangements for the care of the child and with no plan for the child's care, or demonstrating no interest or intent of returning to take custody of the child.

The Code of Virginia §§ [18.2-371](#), [40.1-103](#), [8.01-226.5:2](#), and [63.2-910.1](#) provide immunity from liability to hospital and rescue squad staff who receive an abandoned infant and provide an affirmative defense in the criminal and civil statutes to any parent who is prosecuted as a result of leaving an infant with these personnel. Hospital and rescue squad staffs are still expected to report these instances of child abandonment and the LDSS is required to respond to these reports of child abandonment. Even though these statutes allow an affirmative defense for a parent abandoning her infant under certain conditions, this action still meets the definition of abandonment for a CPS response.

2.4.2.2 Inadequate supervision

The child has been left in the care of an inadequate caretaker or in a situation requiring judgment or actions greater than the child's level of maturity, physical condition, and/or mental abilities would reasonably dictate. Inadequate supervision includes minimal care or supervision by the caretaker resulting in placing the child in jeopardy of sexual or other exploitation, physical injury, or results in status offenses, criminal acts by the child, or alcohol or drug abuse.

2.4.2.3 Inadequate clothing

Failure to provide appropriate and sufficient clothing for environmental conditions or failure to provide articles of proper fit that do not restrict physical growth and normal activity.

2.4.2.4 Inadequate shelter

Failure to provide protection from the weather and observable environmental hazards, which have the potential for injury or illness, in and around the home.

2.4.2.5 Inadequate personal hygiene

Failure to provide the appropriate facilities for personal cleanliness to the extent that illness, disease or social ostracism has occurred or may occur. In the case of a young child, the caretaker must not only provide such facilities but also make use of them for the child.

2.4.2.6 Inadequate food

Failure to provide and ensure an acceptable quality and quantity of diet to the extent that illness, disease, developmental delay, or impairment has occurred or may result.

2.4.2.7 Malnutrition

Chronic lack of necessary or proper nutrition in the body caused by inadequate food, lack of food, or insufficient amounts of vitamins or minerals. This condition requires a medical diagnosis.

2.4.2.8 Knowingly leaving a child with a person required to register as violent sex offender

The following three elements are required for this type of physical neglect:

- The parent has knowingly left the child alone with a person not related by blood or marriage.
- That person has been convicted of an offense against a minor.
- That person is required to register as a violent sexual offender pursuant to the Code of Virginia [§ 9.1-902](#).

Some of the offenses for which registration as a violent sexual offender include:

- Abduction with intent to defile.
- Rape.
- Forcible sodomy.
- Object sexual penetration.
- Aggravated sexual battery.
- Sexual battery where the perpetrator is 18 years of age or older and the victim is under the age of six.
- Taking indecent liberties with children.
- Taking indecent liberties with child by person in custodial or supervisory relationship.

In addition, the Code of Virginia requires registration as a violent sexual offender of persons who have committed certain offenses multiple times.

To determine if the report should be validated for this type of physical neglect, the CPS worker must determine if the person is required to register as a violent sexual offender on the [Virginia State Police Sex Offender and Crimes Against Minors Registry](#). This registry provides a complete list of offenses and the specific section of the Code of Virginia for which registration as a Sex Offender

is required. Each registered offender's web profile will identify the person as either a Violent Sexual Offender or Sexual Offender. In this definition, the alleged abuser is the child's parent or other caretaker who has left the child with a person, not related by blood or marriage, required to register as a violent sex offender.

If the allegations do not meet this specific definition of physical neglect/leaving child with a known sex offender, the LDSS should evaluate the information to determine if the report should be validated as physical neglect/inadequate supervision by the child's parent or guardian. A child may still be at risk of abuse or neglect by a person who is required to register on the Sex Offender and Crimes Against Minors Registry, but who is not identified as a violent sex offender or who is related to the child by blood or marriage.

If in the course of responding to the physical neglect report, there is reason to suspect the child has been sexually abused, the local worker must enter a separate CPS referral into the automated data system for the sex abuse allegation, the alleged abuser and victim. Refer to Section 3, Complaints and Reports, for new allegations in an existing referral. Sexual abuse complaints shall be placed in the Investigation Track.

2.4.2.9 Failure to thrive

([22 VAC 40-705-30 B 2 a](#)). Failure to thrive occurs as a syndrome of infancy and early childhood which is characterized by growth failure, signs of severe malnutrition, and variable degrees of developmental retardation.

([22 VAC 40-705-30 B 2 b](#)). Failure to thrive can only be diagnosed by a physician and is caused by nonorganic factors.

Failure to thrive describes several conditions in infants and children. Failure to thrive can be caused by a number of medical problems. In some children, failure to thrive can be caused by extreme neglect. Failure to thrive describes the malnourished and depressed condition of infants, implying not only growth deficits, but also disorders of behavior and development. Failure to thrive is classified as organic failure to thrive or nonorganic failure to thrive. Only nonorganic failure to thrive is considered to be a type of physical neglect or mental neglect. For a further discussion about failure to thrive, see [Appendix B: Failure to Thrive Syndrome](#).

2.4.2.10 Other physical neglect

Most types of physical neglect a child has suffered can be defined in one of the above types. However, if the child has suffered a type of physical neglect that is not one of the above specified types, the CPS worker may document the type as Other Physical neglect and specifically describe the type of physical neglect.

2.4.3 Family poverty and lack of resources

([22 VAC 40-705-30 B](#)). In situations where the neglect is the result of family poverty and there are no outside resources available to the family, the parent or caretaker shall not be determined to have neglected the child; however, the local department may provide appropriate services to the family.

The LDSS should not render a founded disposition of physical neglect when the neglect resulted from poverty and a lack of available resources. If the neglect resulted from poverty, then the LDSS may provide services in lieu of making a founded disposition. However, in situations where resources are available, a founded disposition may be warranted if, after appropriate services are offered, the caretakers still refuse to accept.

2.4.3.1 Multiple occurrences or one-time incident

([22 VAC 40-705-30 B1](#)). Physical neglect may include multiple occurrences or a one-time critical or severe event that results in a threat to health or safety.

2.5 Medical neglect

2.5.1 Statutory and regulatory definition

The statutory foundation for the definition of medical neglect can be found in the Code of Virginia [§ 63.2-100](#). The regulatory definition of medical neglect follows:

([22 VAC 40-705-30 C](#)). Medical neglect occurs when there is the failure by the caretaker to obtain and or follow through with a complete regimen of medical, mental or dental care for a condition which if untreated could result in illness or developmental delays pursuant to [§ 63.2-100](#) of the Code of Virginia. However a decision by parents or other persons legally responsible for the child to refuse a particular medical treatment for a child with life-threatening condition shall not be deemed a refusal to provide necessary care if (i) such decision is made jointly by the parents or other person legally responsible for the child and the child; (ii) the child has reached 14 years of age and is sufficiently mature to have an informed opinion on the subject of his medical treatment; (iii) the parents or other person legally responsible for the child and the child have considered alternative treatment options; and (iv) the parents or other person legally responsible for the child and the child believe in good faith that such decision is in the child's best interest. Medical neglect also includes withholding of medically indicated treatment.

Parents and caretakers have a legal duty to support and maintain their children, including the provision of necessary medical care. Preventive health care, such as obtaining immunizations and well-baby check-ups, is a matter of parental choice.

Failure to obtain preventive health care for children does not constitute medical neglect.

2.5.2 Types of medical neglect

Medical neglect includes the caretaker failing to obtain immediate necessary medical, mental or dental treatment or care for a child. Medical neglect also includes when the caretaker fails to provide or allow necessary emergency care in accordance with recommendations of a competent health care professional.

2.5.2.1 Emergency medical care or treatment

Medical neglect includes a caretaker failing to obtain necessary emergency care or treatment. Cases of acute illness are usually considered emergencies. The clearest examples involve life-saving medical care or treatment for a child.

Other examples include parents refusing to allow a blood transfusion to save a child in shock, or parents refusing to admit a severely dehydrated child to the hospital. Medical neglect includes any life-threatening internal injuries and the parents or caretakers do not seek or provide medical treatment or care. Additional examples include, but are not limited to, situations where the child sustains a fracture, a severe burn, laceration, mutilation, maiming, or the ingestion of a dangerous substance and the caretaker fails or refuses to obtain care or treatment.

2.5.2.2 Necessary medical care or treatment

Medical neglect includes a caretaker failing to provide or allow necessary treatment or care for a child medically at risk with a diagnosed disabling or chronic condition, or disease. Such cases may involve children who will develop permanent disfigurement or disability if they do not receive treatment. Examples include children with congenital glaucoma or cataracts, which will eventually develop into blindness if surgery is not performed; a child born with a congenital anomaly of a major organ system.

Another example: Caretaker fails to provide or allow necessary treatment or care for a child medically diagnosed with a disease or condition. Diseases or conditions include, but are not limited to, those requiring continual monitoring, medication or therapy, and are left untreated by the parents or caretakers. Children at greatest medical risk are those under the care of a sub-specialist.

For example, a child has a serious seizure disorder and parents refuse to provide medication; parents' refusal places child in imminent danger. Another example: When a child with a treatable serious chronic disease or condition has frequent hospitalizations or significant deterioration because the parents ignore medical recommendations.

2.5.2.3 Necessary dental care or treatment

Medical neglect includes a caretaker's failure to provide or allow necessary dental treatment or care for a child. Necessary dental care does not include preventive dental care.

2.5.2.4 Necessary mental care or treatment

Medical neglect includes a caretaker failure to provide or allow necessary mental treatment or care for a child who may be depressed or at risk for suicide.

2.5.2.5 Other medical neglect

Most types of medical neglect a child may suffer can be defined in one of the above types. However, if the child has suffered a type of medical neglect that is not one of the above specified types, the CPS worker may document the type as Other Medical Neglect and specifically describe the type of medical neglect.

2.5.3 Factors to consider when determining if medical neglect definition has been met

It is the parent's responsibility to determine and obtain appropriate medical, mental and dental care for a child. What constitutes adequate medical treatment for a child must be decided on its own particular facts. The focus of the CPS response is whether the caretaker failed to provide medical treatment and whether the child was harmed or placed at risk of harm as a result of the failure. Cultural and religious child-rearing practices and beliefs that differ from general community standards should not be considered a basis for medical neglect, unless the practices present a specific danger to the physical or emotional safety of the child.

2.5.3.1 Treatment or care must be necessary

The statutory definition of medical neglect requires that the caretaker neglects or refuses to provide necessary care for the child's health. Therefore, the LDSS must establish that the caretaker's failure to follow through with a complete regimen of medical, mental, or dental care for a child was necessary for the child's health. The result of the caretaker's failure to provide necessary care could be illness or developmental delays.

The challenging issue is determining when medical care is necessary for the child's health. Obviously, life-saving medical treatment is necessary and falls within the definition. However, when parents or caretakers refuse medical care that is important to their child's well being but is not essential to life, the issue becomes more complicated in determining whether the medical care is necessary.

2.5.3.2 Parent refuses treatment for life-threatening condition

Pursuant to the Code of Virginia § [63.2-100](#), a parent's decision to refuse a particular medical treatment for a child with a life-threatening condition shall not be deemed a refusal to provide necessary care when all the following conditions are met:

- The decision is made jointly by the parents or other person legally responsible for the child and the child.
- The child has reached 14 years of age and sufficiently mature to have an informed opinion on the subject of his medical treatment.
- The parents or other person legally responsible for the child and the child have considered alternative treatment options.
- The parents or other person legally responsible for the child and the child believe in good faith that such decision is in the child's best interest.

([22 VAC 40-705-10](#)). "Particular medical treatment" means a process or procedure that is recommended by conventional medical providers and accepted by the conventional medical community.

"Sufficiently mature" is determined on a case-by-case basis and means that a child has no impairment of his cognitive ability and is of a maturity level capable of having intelligent views on the subject of his health condition and medical care.

"Informed opinion" means that the child has been informed and understands the benefits and risks, to the extent known, of the treatment recommended by conventional medical providers for his condition and the alternative treatment being considered as well as the basis of efficacy for each, or lack thereof.

"Alternative treatment options" means treatments used to prevent or treat illnesses or promote health and well-being outside the realm of modern conventional medicine.

"Life-threatening condition" means a condition that if left untreated more likely than not will result in death and for which the recommended medical treatments carry a probable chance of impairing the health of the individual or a risk of terminating the life of the individual.

2.5.4 Child under alternative treatment

([22 VAC 40-705-30 C1](#)). A child who, in good faith, is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination pursuant to [§ 63.2-100](#) of the Code of Virginia, shall not for that reason alone be considered a neglected child.

The Code of Virginia provides that no child shall be considered an abused or neglected child only for the reason that the child is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination. The religious exemption to a founded disposition of child abuse or neglect mirrors the statute providing a religious defense to criminal child abuse and neglect.⁷ This exemption means that a founded disposition cannot be based only upon the religious practices of the parents or caretakers. A founded disposition can be rendered for other reasons. For example, if the parent caused the injury in the first place, the religious exemption would not apply. The religious exemption to a founded disposition of abuse or neglect is designed to protect a family's right to freedom of religion. The religious exemption statute is not to provide a shield for a person to abuse or neglect a child.⁸

Should there be a question concerning whether a child is under the treatment in accordance with a tenet or practice of a recognized church or religious denomination, the LDSS should seek the court's assistance. The court should decide whether the parent or caretaker is adhering to religious beliefs as the basis for refusal of medical or dental treatment.

2.5.5 Medical neglect of infants with life-threatening conditions

The Virginia Administrative Code [22 VAC 40-705-30 C](#) states that medical neglect includes withholding of medically indicated treatment. The definition section of [22 VAC 40-705-10](#) et seq. defines withholding of medically indicated treatment as specific to infants. When conducting an investigation involving an infant deprived of necessary medical treatment or care, the LDSS must be aware of the ancillary definitions and guidance requirements.

([22 VAC 40-705-10](#)). "Withholding of medically indicated treatment" means the failure to respond to the infant's life-threatening condition by providing treatment (including appropriate nutrition, hydration, and medication) which in the treating physician's or

7 See Code of Virginia [§ 18.2-371.1 C](#). Any parent, guardian or other person having care, custody, or control of a minor child who in good faith is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination shall not, for that reason alone, be considered in violation of this section.

8 The United States Supreme Court held in 1944 that "parents may be free to become martyrs themselves. But it does not follow that they are free, in identical circumstances, to make martyrs of their children before they can reach the age of full and legal discretion when they can make that choice for themselves." *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944).

physicians' reasonable medical judgment will be most likely to be effective in ameliorating or correcting all such conditions.

This definition applies to situations where parents do not attempt to get a diagnosis even when the child's symptoms are severe and observable.

2.5.5.1 Withholding of medically indicated treatment when treatment is futile

([22 VAC 40-705-30 C2](#)). For the purposes of this regulation, "withholding of medically indicated treatment" does not include the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to an infant when in the treating physician's or physicians' reasonable medical judgment:

- a. The infant is chronically and irreversibly comatose;
- b. The infant has a terminal condition and the provision of such treatment would:
 - (1) Merely prolong dying;
 - (2) Not be effective in ameliorating or correcting all of the infant's life-threatening conditions; or
 - (3) Otherwise be futile in terms of the survival of the infant; or
 - (4) The infant has a terminal condition and the provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.

2.5.5.2 Definitions of chronically and irreversibly comatose and terminal condition

([22 VAC 40-705-10](#)). "Chronically and irreversibly comatose" means a condition caused by injury, disease or illness in which a patient has suffered a loss of consciousness with no behavioral evidence of self-awareness or awareness of surroundings in a learned manner other than reflexive activity of muscles and nerves for low-level conditioned response and from which to a reasonable degree of medical probability there can be no recovery.

([22 VAC 40-705-10](#)). "Terminal condition" means a condition caused by injury, disease or illness from which to a reasonable degree of medical probability a patient cannot recover and (i) the patient's death is imminent or (ii) the patient is chronically and irreversibly comatose.

2.6 Mental abuse or mental neglect

2.6.1 Statutory and regulatory authority

The Code of Virginia § [63.2-100](#) defines abused or neglected child. The Virginia Administrative Code defines mental abuse or neglect.

([22 VAC 40-705-30 D](#)). Mental abuse or neglect occurs when a caretaker creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon such child a mental injury by other than accidental means or creates a substantial risk of impairment of mental functions.

2.6.2 Caretaker's actions or omissions

Mental abuse or mental neglect includes acts or omissions by the caretaker resulting in harm to a child's psychological or emotional health or development. As a result of the caretaker's action or inaction, the child demonstrates or may demonstrate psychological or emotional dysfunction.

Mental abuse or mental neglect may result from caretaker actions or inactions such as: overprotection, ignoring, indifference, rigidity, apathy, chaotic lifestyle, or other behaviors related to the caretaker's own mental problems.

Mental abuse or mental neglect may result from caretaker behavior, which is rejecting, chaotic, bizarre, violent, or hostile. Such behavior may include bizarre discipline. Bizarre discipline means any actions in which the caretaker uses eccentric, irrational or grossly inappropriate procedures or devices to modify the child's behavior. The consequence for the child may be mental injury or the denial of basic physical necessities or the threat of mental injury or denial of basic physical necessities.

Mental abuse or mental neglect includes the caretaker verbally abusing the child resulting in mental dysfunction. The caretaker creates a climate of fear, bullies and frightens the child. The caretaker's actions include patterns of criticizing, intimidating, humiliating, ridiculing, shouting or excessively guilt producing. Such behavior by the caretaker may result in demonstrated dysfunction by the child or the threat of harm to the child's mental functioning.

Mental abuse or mental neglect may also include incidents of domestic violence when the domestic violence may result in demonstrated dysfunction by the child or the threat of dysfunction in the child's mental functioning.

2.6.3 Professional documentation required for mental abuse or mental neglect

When making a founded disposition of mental abuse or mental neglect, the CPS worker must obtain professional documentation supporting a nexus between the actions or inactions of the caretaker and the mental dysfunction demonstrated by the child or the threat of mental dysfunction in the child. Professional documentation may include psychiatric evaluations or examinations, psychological evaluations or examinations, written summaries and letters. Professional documentation may be authored by psychiatrists, psychologists, Licensed Professional Counselors (L.P.C.) and Licensed Clinical Social Workers (L.C.S.W.), or any person acting in a professional capacity and providing therapy or services to a child or family in relationship to the alleged mental abuse. An employee of the LDSS may not serve as both the CPS investigator and the professional who documents mental abuse or mental neglect.

Failure to thrive describes several conditions in infants and children. Failure to thrive can be caused by a number of medical problems. In some children, failure to thrive can be caused by extreme neglect. Failure to thrive describes the malnourished and depressed condition of infants, implying not only growth deficits, but also disorders of behavior and development. Failure to thrive is classified as organic failure to thrive or nonorganic failure to thrive. Only nonorganic failure to thrive is considered to be a type of physical neglect or mental neglect. For a further discussion about failure to thrive, see [Appendix B: Failure to thrive syndrome](#).

2.6.4 Organic failure to thrive

([22 VAC 40-705-30 D1](#)). Failure to thrive occurs as a syndrome of infancy and early childhood which is characterized by growth failure, signs of severe malnutrition, and variable degrees of developmental retardation.

([22 VAC 40-705-30 D2](#)). Failure to thrive can only be diagnosed by a physician and is caused by nonorganic factors.

Failure to thrive is used to designate growth failure both as a symptom and as a syndrome.⁹ As a symptom, it occurs in early childhood with a variety of acute or chronic illnesses that are known to interfere with normal nutrient intake, absorption, metabolism, or excretion, or to result in greater-than-normal energy requirements to sustain or promote growth. In these instances, it is referred to as organic failure to thrive and is not considered to be a child abuse or neglect.

⁹ Berkow, M.D., Robert, Andrew J. Fletcher, M.B., Mark H. Beers, M.D., and Anil R. Londhe, Ph.D., Internet Edition-The Merck Manual, *Section 15, Pediatrics and Genetics*, 191. *Developmental Problems*, (17th ed. 1992).

2.6.5 Nonorganic failure to thrive

Nonorganic failure to thrive is considered to be physical neglect or mental abuse or neglect. Nonorganic failure to thrive most commonly refers to growth failure in the infant or child who suffers from environmental neglect or stimulus deprivation.¹⁰ Nonorganic failure to thrive generally indicates the absence of a physiologic disorder sufficient to account for the observed growth deficiency.

Most children with nonorganic failure to thrive will manifest growth failure before one year of age, and in many children growth failure will become evident by 6 months of age. Nonorganic failure to thrive may be due to impoverishment, poor understanding of feeding techniques, improperly prepared formula, or inadequate supply of breast milk. Nonorganic failure to thrive is an interactional disorder in which parental expectations, parental skills and the home environment are intertwined with the child's development.¹¹ If left untreated, failure to thrive can lead to restricted growth and mental development. In extreme cases, it can be fatal.

2.6.5.1 Establish nexus with caretaker's action or inaction and the nonorganic failure to thrive

When making a disposition, the CPS worker must establish a link between the caretaker's actions or inactions and the fact that the child suffers from nonorganic failure to thrive.

When responding to an allegation of failure to thrive, the LDSS should consider whether the caretaker sought accredited medical assistance and was aware of the seriousness of the child's affliction. The LDSS should consider whether the parents or caretakers provided an acceptable course of medical treatment for their child in light of all the surrounding circumstances.

2.7 Sexual abuse

2.7.1 Statutory and regulatory definition

The Code of Virginia [§ 63.2-100](#) defines abuse and neglect.

([22 VAC 40-705-30 E](#)). Sexual abuse occurs when there is any act of sexual exploitation or any sexual act upon a child in violation of the law which is committed or allowed to be committed by the child's parents or other persons responsible for the care of the child pursuant to [§ 63.2-100](#) of the Code of Virginia.

¹⁰ Id.

¹¹ Monteleone, Dr. James A., and Dr. Armand E. Brodeur, *Child Maltreatment: A Clinical Guide and Reference*, 14-16 (G.W. Medical Publishing 1994).

The above regulatory definition includes any sexual act upon a child that violates the Code of Virginia. Although there is a definition of criminal sexual abuse in [§ 18.2-67.10 6](#), the CPS worker should consult with the local Commonwealth's Attorney or law enforcement. For a discussion about physical evidence and child sexual abuse, please see [Appendix D: Sexual abuse](#).

2.7.2 Types of sexual abuse

All CPS sexual abuse reports shall be investigated. The types of sexual abuse include but are not limited to:

2.7.2.1 Sexual exploitation

Sexual exploitation includes but is not limited to:

- The caretaker of the child allowing, permitting or encouraging a child to engage in prostitution as defined by the Code of Virginia.
- The caretaker of the child allowing, permitting, encouraging, or engaging in the obscene or pornographic photographing, filming, or depicting of a child engaging in any sexual act as defined by the Code of Virginia.

2.7.2.2 Other sexual abuse

Most types of sexual abuse a child may suffer can be defined in one of the specified types. However, if the child has suffered a type of sexual abuse that is not one of the specified types, the CPS worker may document the type as Other Sexual Abuse and specifically describe the type of sexual abuse. Other sexual abuse may include, but is not limited to:

- Indecent solicitation of a child or explicit verbal or written enticement for the purpose of sexual arousal, sexual stimulation or gratification.
- Exposing the male or female genitals, pubic area or buttocks, the female breast below the top of the nipple, or the depiction of covered or uncovered male genitals in a discernibly turgid state to a child for the purpose of sexual arousal or gratification.
- Forcing a child to watch sexual conduct.

"Sexual conduct" includes actual or explicitly simulated acts of masturbation, sodomy, sexual intercourse, bestiality, or physical contact in an act of apparent sexual stimulation or gratification with a person's clothed or unclothed genitals, pubic area, buttocks, or breast.

- Pursuant to § [18.2-370.6](#) of the Code of Virginia, French kissing a child younger than 13 years of age by an adult caretaker.

2.7.2.3 Sexual molestation

Sexual molestation means an act committed with the intent to sexually molest, arouse, or gratify any person, including, but not limited to:

- The caretaker intentionally touches the child's intimate parts or clothing directly covering such intimate parts.
- The caretaker forces the child to touch the caretaker's, *the child's* or another person's intimate parts or clothing directly covering such intimate parts.
- The caretaker forces another person to touch the child's intimate parts or clothing directly covering such intimate parts. "Intimate parts" means the genitalia, anus, groin, breast, or buttocks of any person.
- The caretaker causes or assists a child under the age of 13 to touch the caretaker's, the child's own, or another person's intimate parts or material directly covering such intimate parts.

2.7.2.4 Intercourse and sodomy

Intercourse or sodomy includes acts commonly known as oral sex (cunnilingus, anilingus, and fellatio), anal penetration, vaginal intercourse, and inanimate object penetration.

2.7.3 Establishing sexual gratification or arousal

To make a founded disposition of sexual abuse in some cases, the LDSS may be required to establish sexual gratification or arousal. It may not be necessary to prove actual sexual gratification, including but not limited to that one of the parties achieved sexual gratification. However, it may be necessary to establish that the act committed was for the purpose of sexual gratification. The Virginia Administrative Code does not specify which party (the perpetrator or the alleged victim child) needs to be the party intended to be sexually gratified.

In some cases there will be physical evidence of sexual gratification, including but not limited to the presence of semen. Sexual gratification or arousal may be inferred by the totality of the circumstances surrounding the alleged act.¹² Sexual gratification

¹² For example, in *McKeon V. Commonwealth*, 211 Va. 24, 175 S.E.2d 282 (1970), the Virginia Supreme Court held that a man who exposed his genitals to a child 35 feet away did not violate Va. Code '18.1-214 (1950). The defendant claimed that he had a robe on, and that, although there was a breeze, he did not believe his private parts became exposed. The child alleged that the man was standing on his porch smiling with his hands on his hips and

may be established by considering the act committed and the alleged abuser's explanation or rationale for the act.¹³ The act itself may be probative of the caretaker's intent to arouse or sexually gratify.¹⁴ It may be helpful to consider the definition of lascivious intent or intent to defile, since establishing lascivious intent or intent to defile is necessary in many child sexual abuse criminal offenses.¹⁵ When attempting to show that an act committed was for the purpose of sexual gratification, the LDSS must consider the evidence in its totality.

his genitals exposed. The Court said that, even accepting the child's testimony as true, the Commonwealth failed to prove lascivious intent:

[T]here is no evidence that the defendant was sexually aroused; that he made any gestures toward himself or to her, that he made any improper remarks to her; or that he asked her to do anything wrong. The fact that defendant told [the victim] to turn around and that he was smiling at the time, when she was 35 feet away from him, is not proof beyond a reasonable doubt that he knowingly and intentionally exposed himself with lascivious intent.

In McKeon V. Commonwealth, the Court looked for another evidence indicating that the alleged perpetrator intentionally exposed himself to the child and found none. If the alleged perpetrator had made any comments or actions to the child suggesting that the child look at his exposed genitals, then the court may have held differently. If the alleged perpetrator had been sexually aroused and exposed himself directly to the child, the court may have sustained the conviction. However, in Campbell v. Commonwealth 227 Va. 196, 313 S.E.2d 402 (1984), the court found the evidence that the perpetrator gestured to an eight-year-old girl 87 feet away from him, pulled his pants down to his knees, then gestured again was sufficient to establish lascivious intent.

¹³ For example, in Walker v. Commonwealth 12 Va. App. 438, 404 S.E.2d 394 (1991), the court found the evidence sufficient to establish criminal intent in defendant's touching the vagina of a seven-year-old daughter of his girlfriend even though he claimed to be touching her to determine if she and some boys in the neighborhood had been touching each other. The court found the alleged perpetrator's explanation for touching the child's vaginal area to be woefully unsatisfactory.

¹⁴ In some investigations, evidence establishing the act will be sufficient, in and of itself, to establish sexual gratification or arousal. For example, in Moore v. Commonwealth, 222 Va. 72, 77, 278 S.E.2d 822, 825 (1981), the court found the evidence establishing that the perpetrator touched his penis to the child's buttocks was sufficient to show defendant's lascivious intent.

¹⁵ Lascivious is defined as "tending to excite; lust; lewd; indecent; obscene." Black's Law Dictionary 897, (8th ed. 2004). Defile is defined as "4. To morally corrupt (someone). 5. *Archaic*. To debauch (a person); to deprive (a person) of chastity." Black's Law Dictionary 455 (8th ed. 2004)

2.8 Appendix A: Battered child syndrome

Battered Child Syndrome refers to “a constellation of medical and psychological conditions of a child who has suffered continuing injuries that could not be accidental and are therefore presumed to have been inflicted by someone close to the child, usually a caregiver. Diagnosis typically results from a radiological finding of distinct bone trauma and persistent tissue damage caused by intentional injury, such as twisting or hitting with violence.”¹⁶ The battered child syndrome “exists when a child has sustained repeated and/or serious injuries by non-accidental means.”¹⁷

Obvious physical signs are cuts, bruises, broken bones, or burns. Although all of these injuries can easily be caused by accidents, examinations of battered children usually find that the injuries are not compatible with the account of the accident. The exam may reveal evidence of past injuries as well. Often, the perpetrator is careful to avoid areas of the child’s body that are open to view, such as the head and arms. Subsequently, teachers, friends, and others who come into contact with the child may never suspect there is a problem unless they are aware of specific behaviors commonly exhibited by battered children. Watch for surreptitious or manipulative behavior, limited impulse control, angry outbursts, and poor judgment as to what is safe or unsafe. The child may become withdrawn, use drugs or alcohol, do poorly in school, and seem to have no focus or purpose.¹⁸

¹⁶ Black’s Law Dictionary, 172 (9th ed. 2009).

¹⁷ *Estelle v. McGuire*, 502 U.S. 62 (1991).

¹⁸ UCSO Healthcare, *Health Guide* “Battered Child Syndrome.”

2.9 Appendix B: Failure to thrive syndrome

2.9.1 Organic and nonorganic failure to thrive

Failure to thrive syndrome describes the malnourished and depressed condition of infants, implying not only growth deficits, but also disorders of behavior and development.

2.9.1.1 Organic failure to thrive

Failure to thrive is used to designate growth failure both as a symptom and as a syndrome. As a symptom, it occurs in patients with a variety of acute or chronic illnesses that are known to interfere with normal nutrient intake, absorption, metabolism, or excretion, or to result in greater-than-normal energy requirements to sustain or promote growth. In these instances, it is referred to as organic FTT.

2.9.1.2 Nonorganic failure to thrive

Nonorganic failure to thrive is an interactional disorder in which parental expectations, parental skills, and the resulting home environment are intertwined with the child's developmental capabilities. Since the mother is the primary caretaker in most families, this syndrome has been associated with maternal deprivation (see physical neglect-failure to thrive definition) and/or emotional abuse. Failure to thrive syndrome has been referred to as psychosocial dwarfism disorder. It is characterized by physical and developmental retardation associated with a dysfunctional mother – infant relationship. Nonorganic failure to thrive involves the parents' failure to provide nurturance and attachment to the child.

When the term is used to designate a syndrome, it most commonly refers to growth failure in the infant or child who suffers from environmental neglect or stimulus deprivation. It is then designated nonorganic failure to thrive, indicating the absence of a physiologic disorder sufficient to account for the observed growth deficiency.

2.9.1.3 Mixed etiology

Using the most restrictive definition, only those children who were full-term and normally grown at birth and who, by careful investigation, have no congenital or acquired illness are included in the group designated Nonorganic failure to thrive. Organic failure to thrive and nonorganic failure to thrive are not mutually exclusive. There can be children who have growth failure of mixed etiology. This mixed etiology group includes children who were born prematurely but have evidence of disproportionate growth failure in later infancy; children who have or have had some defect that cannot sufficiently explain the current

growth failure (e.g., successful cleft palate repair in the past); and children who are frustrating (e.g., because of a neurologically impaired suck) or extremely aversive (e.g., because of a deformity) to the care giver.

2.9.1.4 Inadequate causes

In failure to thrive of any etiology, the physiologic basis for impaired growth is inadequate nutrition to support weight gain. In nonorganic failure to thrive, lack of food may be due to impoverishment, poor understanding of feeding techniques, improperly prepared formula, or inadequate supply of breast milk.

The psychological basis for nonorganic failure to thrive appears to be similar to that seen in hospitals, a syndrome observed in infants kept in sterile environments who suffer from depression secondary to stimulus deprivation. The non-stimulated child becomes depressed, apathetic, and ultimately anorexic. The unavailability of the stimulating person (usually, the mother) may be secondary to that person's own depression, poor parenting skills, anxiety in or lack of fulfillment from the caretaking role, sense of hostility toward the child, or response to real or perceived external stresses (demands of other children, marital dysfunction, a significant loss, or financial difficulties).

Nonorganic failure to thrive may be considered the result of a disordered interaction between mother and child in which the child's temperament, capacities, and responses help shape maternal nurturance patterns. Failure to thrive is not necessarily the effect of poor care giving by an inadequate or troubled mother. Nonorganic failure to thrive can be the result of a variety of interactional disorders ranging from the severely disturbed or ill child, whose care poses a major challenge to even the most competent parent, to the potentially most undemanding and compliant child being cared for by a mentally ill parent without adequate social, emotional, financial, cognitive, or physical resources. Within these extremes are maternal-child "misfits" in which the demands of the child, although not pathologic, cannot be adequately met by the mother, who might, however, do well with a child of different needs or even with the same child but under different life circumstances.

2.9.2 Characteristics of failure to thrive

2.9.2.1 Appearance

- Short stature (height and weight consistently fall below the third percentile on the Standard Growth Chart).
- Unusually thin.
- Infantile proportions.

- Potbelly (with episodes of diarrhea).
- Skin dull, pale, and cold.
- Limbs pink or purple, cold and mottled.
- Edema of the feet, legs, hands, and forearms.
- Poor skin care, excoriations, abrasions, and ulcers.
- Sparse, dry hair with patches of alopecia (hair loss).
- Dejection (avoid personal contact) and apathy (avoid eye contact).
- May have bruises, small cuts, burns, or scars (appear to be insensitive to pain and have self inflicted injuries).

2.9.2.2 Behavior

- Passive with or without catatonia.
- Rocking or head banging.
- Retarded speech and language.
- Delayed development.
- Solitary and unable to play.
- Insomnia and disrupted sleep.
- Easily bullied.
- Gorging food and scavenging from garbage cans, wastebaskets, toilet bowl, or dog/cat dish.

Note: During their convalescent stay in a hospital, they have marked growth spurts that relapse as soon as they return to their home environment.

2.9.2.3 Progress in the hospital

- Rapid recover of growth and liveliness.
- Slower progress with speech and language.
- Affection seeking, but may be casual or indiscriminate.

- Attention seeking.
- Severe tantrums at the slightest frustration.
- Rocking and head banging when upset.
- Continues to want to eat and drink more than can reasonably consume and may scavenge food.

2.9.2.4 Long-term behaviors

- Speech and language immaturity.
- Gorging of food that may last six months or more.
- Restlessness with short attention span.
- Rocking and head banging if stressed.
- Difficulties with peer group and learning in school.
- Soiling and wetting (encopretic and enuresis).
- Stealing and lying.
- Tantrums and aggression.

2.9.2.5 Investigating allegation involving suspected failure to thrive syndrome

Nonorganic failure to thrive requires a medical diagnosis. Organic failure to thrive has to be ruled out. During the investigation, the worker should gather as much information as possible about the child and pass it on to the examining physician.

2.9.2.5.1 Basis of medical diagnosis

Engaging the parents in the search for the basis of the problem and its treatment is essential and helps to foster their self-esteem. This avoids blaming those who may already feel frustrated or guilty because of an inability to perform the most basic of parental roles—adequate nurturance of their child. The family should be encouraged to visit as often and as long as possible. They should be made to feel welcome and the staff should support their attempts to feed the child, provide toys as well as ideas that promote parent-child play and other interactions, and avoid any comments that state

or imply parental inadequacy, irresponsibility, or other fault as the cause of the failure to thrive.

2.9.2.5.2 Child's growth history

The growth chart, including measurements obtained at birth if possible, should be examined to determine the child's trend in growth rate. Except in severe cases where malnutrition is obvious, the diagnosis of FTT should not be based on a single measurement, because of the wide variations existing in the normal population.

2.9.2.5.3 The child's dietary history

A detailed dietary history is essential, including techniques for preparation and feeding of formula or adequacy of breast milk supply, and feeding schedule. Observation of the primary care givers feeding the infant to evaluate their technique as well as the child's vigor of sucking should be undertaken as soon as possible. Easy fatigability may indicate underlying exercise intolerance; enthusiastic burping or rapid rocking during feeding may result in excessive spitting up or even vomiting; disinterest on the part of the care giver may be a sign of depression or apathy, indicating a psychosocial environment for the infant that is devoid of stimulation and interaction.

An assessment of the child's elimination pattern to determine abnormal losses through urine, stool, or emesis should be undertaken to investigate underlying renal disease, a malabsorption syndrome, pyloric stenosis, or gastro esophageal reflux.

2.9.2.5.4 Past medical history

Past medical history inquiries should be directed toward evidence of intrauterine growth retardation or prematurity with uncompensated growth delay; of unusual, prolonged, or chronic infection; of neurologic, cardiac, pulmonary, or renal disease; or of possible food intolerance.

2.9.2.5.5 Family history

The family history should include information about familial growth patterns, especially in parents and siblings; the occurrence of diseases known to affect growth (e.g., cystic fibrosis); or recent physical or psychiatric illness that has resulted in the infant's primary care giver being unavailable or unable to provide consistent stimulation and nurturance.

2.9.2.5.6 Social history

The social history should include attention to family composition; socioeconomic status; desire for this pregnancy and acceptance of the child; parental depression; and any stresses such as job changes, family moves, separation, divorce, deaths, or other losses. Infants in large or chaotic families or infants who are unwanted may be relatively neglected because of the demands of other children, life events, or parental apathy; financial difficulties may result in over dilution of formula to “stretch” the meager supply; breast-feeding mothers who are under stress or are poorly nourished themselves may have decreased milk production.

2.9.2.5.7 Physical examination

Physical examination should include careful observation of the child’s interaction with individuals in the environment and evidence of self-stimulatory behaviors (rocking, head banging). Children with Nonorganic FTT have been described as hyper vigilant and wary of close contact with people, preferring interactions with inanimate objects if they are interactive at all. Although Nonorganic FTT is more consistent with neglectful than abusive parenting, the child should be examined carefully for any evidence of abuse. A screening test of developmental level should be performed and followed up with a more sophisticated development assessment if indicated.

2.9.3 Bibliography

The Merck Manual. Pediatrics and Genetics, Section 15. (16th ed. 1992). The Seventeenth Edition of the Merck Manual will be available in early 1998).

Bennett, S. Failure to Thrive, *Pediatric Child Health* 1(3):206-210, 1996.

Monteleone, J., & Brodeur, A. *Child Maltreatment: A Clinical Guide and Reference*, 159 (G.W. Medical Publishing 1994).

2.10 Appendix C: Munchausen syndrome by proxy

Munchausen syndrome by proxy in adults is “a condition characterized by habitual presentation for hospital treatment of an apparent acute illness, the patient giving a plausible and dramatic history, all of which is false.”¹⁹ “Munchausen syndrome by proxy occurs when a parent or guardian falsifies a child’s medical history or alters a child’s laboratory test or actually causes an illness or injury in a child in order to gain medical attention for the child which may result in innumerable harmful hospital procedures.”²⁰ Munchausen syndrome by proxy involves an apparent deeply caring caretaker who repeatedly fabricates symptoms or provokes actual illnesses in her helpless infant or child.

Maybe the most important aspect of this syndrome is the immense ability of the caretaker to fool doctors and the susceptibility of physicians to that person’s manipulations. The hospital, which is the most common setting for Munchausen syndrome by proxy cases, is where as much as 75% of the Munchausen syndrome by proxy related morbidity occurs as a consequence of attempts by physicians to diagnose and treat the affected child or infant. More than 98% of Munchausen syndrome by proxy cases involve female perpetrators.

2.10.1 Commonly fabricated illnesses and symptoms

The most common fabrications or modes of symptom inducement in Munchausen syndrome by proxy involve seizures, failure to thrive, vomiting and diarrhea, asthma, and allergies and infections.

2.10.2 Indicators for suspecting and identifying Munchausen syndrome by proxy

- A child who has one or more medical problems that do not respond to treatment or that follow an unusual course that is persistent, puzzling, and unexplained.
- Physical or laboratory findings that are highly unusual, discrepant with history, or physically or clinically impossible.
- A parent, usually the mother, who appears to be medically knowledgeable and/or fascinated with medical details and hospital gossip, appears to enjoy the hospital environment, and expresses interest in the details of other patients’ problems.

¹⁹ Dorland’s Illustrated Medical Dictionary 1295 (26th ed. 1981).

²⁰ Zumwalt & Hirsh, *Pathology of Fatal Child Abuse and Neglect*, Child Abuse and Neglect 276 (R. Helfer & Kempe eds., 4th ed. 1987).

- A highly attentive parent who is reluctant to leave her child's side and who herself seems to require constant attention.
- A parent who appears to be unusually calm in the face of serious difficulties in her child's medical course while being highly supportive and encouraging of the physician, or one who is angry, devalues staff, and demands further intervention, more procedures, second opinions, and transfers to other more sophisticated facilities.
- The suspected parent may work in the health care field herself or profess interest in a health-related job.
- The signs and symptoms of a child's illness do not occur in the parent's absence (hospitalization and careful monitoring may be necessary to establish this casual relationship).
- A family history of similar sibling illness or unexplained sibling illness or death.
- A parent with symptoms similar to her child's own medical problems or an illness history that itself is puzzling and unusual.
- A suspected parent with an emotionally distant relationship with her spouse; the spouse often fails to visit the patient and has little contact with physicians even when the child is hospitalized with serious illness.
- A parent who reports dramatic, negative events, such as house fires, burglaries, car accidents, that affect her and her family while her child is undergoing treatment.
- A parent who seems to have an insatiable need for adulation or who makes self-serving efforts at public acknowledgment of her abilities.

2.10.3 Bibliography

Monteleone, J., & Brodeur, A. Child Maltreatment: A Clinical Guide and Reference, 159 (G.W. Medical Publishing 1994).

Zumwalt & Hirsh, Pathology of Fatal Child Abuse and Neglect, Child Abuse and Neglect 276 (R. Helfer & R. Kempe eds., 4th ed. 1987).

The Merck Manual. Pediatrics and Genetics, Section 15. (16th ed. 1992).

2.11 Appendix D: Sexual abuse

The information below is compiled from articles and medical journals listed in the bibliography. The information is not intended to be comprehensive. If further information or clarification is needed consult a physician or the sources listed in the bibliography.

2.11.1 Physical examinations for possible sexual abuse

A normal physical examination is common in child sexual abuse. An absence of physical findings in sexually abused children can be explained in a number of ways. Many types of sexual molestation do not involve penetration and will not leave physical findings. Evidence of ejaculate may not be present if the child has washed, urinated, or defecated and if more than 72 hours has elapsed since the assault. The hymen is elastic and penetration by a finger or penis, especially in an older child, may cause no injury or may only enlarge the hymenal opening. Moreover, injuries can heal rapidly. Hymenal healing occurs in 6 to 30 days and can be complete. Partial hymenal tears can heal as soon as 9 days after injury, while extensive tears may take up to 24 days to heal.

2.11.1.1 Medical categorization of the physical examination for sexual abuse

Medical professionals commonly will classify the findings of the physical examination into one of four categories:

- Category I: Normal Appearing Genitalia. The majority (60% or more) of abused children fall into this category.
- Category II: Nonspecific Findings. Abnormalities of the genitalia that could have been caused by sexual abuse but are also seen in girls who are not victims of sexual abuse. Included in this category are redness or inflammation of the external genitalia, increased vascular pattern of the vestibular and labia mucosa, presence of purulent discharge from the vagina, small skin fissures or lacerations in the area of the posterior fourchette, and agglutination of the labia minora. Nonspecific Findings are often seen in children who have not been sexually abused.
- Category III: Specific Findings. The presence of one or more abnormalities strongly suggesting sexual abuse. Such findings include recent or healed lacerations of the hymen and vaginal mucosa, hymenal opening of one or more centimeters, proctoepisiotomy (a laceration of the vaginal mucosa extending to involve the rectal mucosa) and indentations on the vulvar skin indicating teeth marks (bite marks). This category also includes patients with laboratory confirmation of a venereal disease (e.g., gonorrhea). Category III is suspicious or highly suspicious for sexual abuse.

- Category IV: Definitive Findings. Any presence of sperm or sexually transmitted disease. Category IV is conclusive of sexual abuse, especially with children under 12 years of age. Older children may be sexually active.

2.11.1.2 Classification of physical findings in sexual abuse examinations

Specific physical findings are strongly indicative of sexual abuse beyond reasonable doubt as follows:

- Clear-cut tears, fresh or old scars; significant distortion of the normal shape of the hymen and/or hymenal bruising.
- Lacerations, scars, bruises, and healing abraded areas, often accompanied by neovasularization, of the posterior fourchette.
- Anal dilation greater than 15 mm transverse diameter with gentle buttock traction with the child in knee-chest position. Large anal scars in the absence of a history that could explain the scars.

2.11.1.3 Possible physical indicators in sexually abused girls

Certain types and locations of hymenal injuries are often seen after sexual abuse. The hymenal membrane at its midline (6 o'clock position) attachment along the posterior rim of the introitus, during actual or attempted penetration, is the portion of the hymen most likely to be damaged. A narrowed (attenuated) hymen at this position is usually indicative of an injury. Mounds, projections, or notches on the edge of the hymen and the exposure of intravaginal ridges increase the possibility of abuse. Generally, attempted forced vaginal penetration results in hymenal tears and fissures between the 3 and 9 o'clock positions and may extend across the vestibule and fourchette. Other physical signs indicating abuse include:

2.11.1.4 Erythema, inflammation, and increased vascularity

In sexual abuse cases, redness of the skin or mucous membranes due to congestion of the capillaries. Normal vaginal mucosa has a pale pink coloration.

2.11.1.5 Increased friability

A small dehiscence (or breakdown) of the tissues of the posterior fourchette may be precipitated by the examination, with occasional oozing of blood. This is usually associated with labial adhesions. When the adherent area is large, greater than 2 mm, the suspicion of abuse should be greater.

2.11.1.6 Angulation of the hymenal edge

There may be V-shaped or angular configuration of the edge of the hymen. The hymenal edge should be smooth and round. Angulation often marks a healed old injury.

2.11.1.7 Labial adhesions

Although labial adhesions are a nonspecific finding often seen in girls with no history of sexual abuse, they may also be a manifestation of chronic irritation and can be seen in children who have been abused.

2.11.1.8 Urethral dilation

Urethral dilation may be an abnormal physical finding in sexually abused girls. Mild to moderate urethral dilation is probably normal, although higher grades may be considered a manifestation of sexual abuse, probably the result of digital manipulation of the urethral orifice.

2.11.1.9 Hymenal or vaginal tear

Deep breaks in the mucosa of the vagina and hymen are referred to as tears. These injuries can be seen with accidental injuries as well as with abuse. Often they occur when a history of impaling is given.

Genital injuries should be considered abuse until proven otherwise. The bony pelvis and labia usually protects the hymen from accidental injury. Straddle injuries from falls onto a pointed object, the object rarely penetrates through the hymenal orifice into the vagina. A violent stretching injury, as seen when a child does a sudden, forceful split on a slippery surface, can cause midline lacerations. These injuries can also be caused during sexual abuse by forceful, sudden abduction of the legs.

2.11.1.10 Discharge

Vaginal secretions are of various consistencies, colors and odors. The usual cause of vaginal discharge in a nonspecific vaginitis. Nonspecific vaginitis is seen most often in children between two and seven years of age. Some genital discharges are not caused by infection or inflammation. The signs of nonspecific vaginitis are vaginal inflammation and discharge. The child may or may not have symptoms. The only complaint may be a yellowish stain on the child's underpants noticed by the mother. The character of the discharge, the appearance of the vaginal mucosa, and the child's symptoms do not help to identify the etiologic agent or the type of bacterial causing the infection.

2.11.1.11 Fissures

Superficial breaks in the skin or mucous membranes fissures may ooze blood and be painful. They heal completely and leave no sequelae unless they become infected in which case they may result in a small scar or an anal tag.

2.11.1.12 New or healed lacerations

Lacerations are deep breaks in the skin or mucous membranes of the vagina or anus. They often leave scar formation after healing.

2.11.1.13 Enlarged hymenal introital opening

One criterion often used to make a diagnosis of sexual abuse is an enlargement of hymenal introital opening. A vaginal introital diameter of greater than four (4) mm is highly associated with sexual contact in children less than 13 years of age. The size of the hymenal opening can vary with increasing age and pubertal development of the child. Other factors such as the position of the child during the measurement, the degree of traction placed on the external genitalia, and the degree of relaxation of the child can influence the measurements. The nature of the abuse and the time elapsed since the abuse can also change genital findings.

2.11.1.14 Sexually transmitted diseases

Transmission of sexually transmitted diseases outside the perinatal period by nonsexual means is rare. Gonorrhea or syphilis infections are diagnostic of sexual abuse after perinatal transmission has been ruled out. Herpes type 2, Chlamydia, Trichomoniasis, and condyloma infections are extremely unlikely to be due to anything but abuse, particularly in children beyond infancy.

2.11.1.15 Sperm

If the abuse occurred within 72 hours, the physical examination may reveal the presence of sperm. The survival time of sperm is shortened in prepubertal girls because they lack cervical mucus; if there is a delay before an examination, the likelihood of finding sperm is diminished.

2.11.1.16 Physical findings associated with anal sexual abuse

Anal assaults comprise a significant proportion of child sexual abuse attacks. Genital injuries or abnormalities are more often recognized as possible signs of abuse, while anal and perianal injuries may be dismissed as being associated with common bowel disorders such as constipation or diarrhea. The anal sphincter is pliant and, with care and lubrication, can easily allow passage of a penis or an object of comparable diameter without injury. The anal sphincter and anal canal are elastic and allow for dilation. Digital penetration usually does

not leave a tear of the anal mucosa or sphincter. Penetration by a larger object may result in injury varying from a little swelling of the anal verge to gross tearing of the sphincter. If lubrication is used and the sphincter is relaxed, it is possible that no physical evidence will be found. Even penetration by an adult penis can occur without significant injury. After penetration, sphincter laxity, swelling, and small mucosal tears of the anal verge may be observed as well as sphincter spasm. Within a few days the swelling subsides and the mucosal tears heal. Skin tags can form as a result of the tears. Repeated anal penetration over a long period may cause a loose anal sphincter and an enlarged opening. Physical indicators of anal sexual abuse include, but are not limited to:

2.11.1.17 Perineal erythema

Reddening of the skin overlying the perineum as well as the inner aspects of the thighs and labia generally indicates that there has been intra crural intercourse (penis between legs and laid along the perineum). Erythema in this area, however, also results from diaper rash, poor hygiene, or after scratching and irritation from pinworms.

2.11.1.18 Swelling of the perianal tissues

Circumferential perianal swelling appears as a thickened ring around the anus and has been called the tire sign. It is an acute sign and can reflect traumatic edema.

2.11.1.19 Fissures

Breaks in the skin/mucosal covering of the rectum, anus, anal skin occur as a result of overstretching and frictional force exerted on the tissues. This can occur following passage of a hard stool or abusive traumatic penetration of the anus. Tiny superficial cracks in the verge or perianal skin often result from scratching with pinworms or with excoriation from acute diarrhea or diaper rash.

2.11.1.20 Large tears

Large breaks in the skin extending into the anal canal or across the perineum are usually painful and can cause anal spasm. Tears often heal with scarring and leave a skin tag at the site of the trauma.

2.11.1.21 Skin changes

Repeated acts of penetration will lead to changes in the anal verge skin. Repeated friction and stretching of the fibers of the corrugated cutis and muscle results in thickening and smoothing away of the anal skin folds. The skin appears smooth, pink, and shiny, with a loss of normal fold pattern. The

presence of these skin changes suggests chronicity of abuse. Scars are evidence of earlier trauma.

2.11.1.22 Funneling

Funneling is a traditional sign of chronic anal sexual abuse but its presence in children has been questioned. The appearance of funneling or a hollowing-out of the perianal area is caused by loss of fat tissue or fat atrophy of the subcutaneous area. Although this is often associated with chronic anal sex, it has also been described to occur in non-abused children.

2.11.1.23 Hematoma and/or bruising

Subcutaneous accumulations of old and new blood and bruising are strong indicators of trauma. It would be very unlikely for these to occur without a history to explain them. These injuries are not likely to be accidental.

2.11.1.24 Anal warts

Anal warts can occur as an isolated physical finding or in conjunction with other signs consistent with abuse, either anal or genital. Anal warts in children under age two years whose mother has a history of genital warts are most likely not the result of abuse. If no history of genital warts is elicited, the family should be evaluated for their presence. In children over four years of age with new genital warts, abuse should be considered and the child carefully interviewed by an experienced evaluator. Evaluation of genital warts is difficult in the nonverbal child.

2.11.1.25 Physical findings and abnormalities mistaken for anal sexual abuse

Perianal abnormalities are often seen in children with Crohn disease or Hirschsprung disease. The anal canal gapes in children with significant constipation. The distended rectum, with a normal anorectal reflex, initiates the gaping. Stool is often seen in the anal canal. Small fissures can also be seen. These children may have trouble with fecal soiling, which causes reddening of the perianal area. Unfortunately, children who were anally abused often suffer from functional constipation, which results in a damaged anal sphincter and fecal soiling. The pain and injury that follow the anal assault may cause spasm of the sphincter and result in functional constipation.

2.11.1.26 Conditions that can be mistaken for sexual abuse

- Lichen sclerosus et atrophicus
- Accidental straddle injuries

- Accidental impaling injuries
- Nonspecific vulvovaginitis and proctitis
- Group A streptococcal vaginitis and proctitis
- Diaper dermatitis
- Foreign bodies
- Lower extremity girdle paralysis as in myelomeningocele
- Defects which cause chronic constipation, Hirschprung disease, anteriorly displaced anus
- Chronic gastrointestinal disease, Crohn disease
- Labial adhesions
- Anal fissures

Some dermatologic, congenital, traumatic, and infectious physical findings can be mistaken for sexual abuse. The most common dermatologic condition confused with trauma from sexual assault is lichen sclerosis. It can present in a variety of ways from mild irritation of the labia and vaginal mucosa to dramatic findings such as subepidermal hemorrhages of the genital or anal area involving the labia and vaginal mucosa and/or the anus. Monteleone, J., & Brodeur, A. Child Maltreatment: A Clinical Guide and Reference, 159 (G.W. Medical Publishing 1994).

2.11.2 Common questions and issues

These questions and answers are taken from Monteleone, J., & Brodeur, A. Child Maltreatment: A Clinical Guide and Reference, 159 (G.W. Medical Publishing 1994).

Can a child be born without a hymen to explain physical findings described?

There is no documented case of an infant girl born without a hymen.

Can excessive masturbation or the use of tampons explain abnormal vaginal findings?

Masturbation and tampons do not cause injury to the hymen or internal genital structures. There is no evidence that use of tampons causes trauma to the hymen. Masturbation in girls usually involves clitoral or labial stimulation and does not cause hymenal injury. Children who masturbate excessively or insert foreign objects into body orifices usually show no genital or anal injuries.

Can a child contract a sexually transmitted disease by merely sharing the same bed, toilet seat or towel with an infected individual?

In general, as the title implies, sexually transmitted diseases are sexually transmitted.

Can horseback riding, gymnastics or dancing cause permanent genital changes?

Injuries can occur with physical activities. When such injuries involve the genitalia, the event is very dramatic and will be reported immediately. If a physician finds hymenal changes after a child has disclosed sexual abuse or during a routine examination, injury from one of these activities is not being investigated because it would not be a reasonable explanation for the changes.

2.11.3 Bibliography

Bays, J., and Jenny, C., Genital Conditions Confused with Child Sexual Abuse, *Child Abuse & Neglect*, v. 17, 91-110, (1990).

Bays, J. and Chadwick, D. Medical Diagnosis of the Sexually Abused Child, *Child Abuse & Neglect*, 17:91-110, 1993.

Camps, F.E., (E.D.). *Gradwohl's Legal Medicine*. Baltimore, MD: Williams & Wilkins Company (1968).

DeJong, A., and Finkel, M., Sexual Abuse of Children, *Current Problems in Pediatrics*, v. XX, 490-567, 1990.

Heger, A., & Emans, D., American Academy of Pediatrics: Introital Diameter as the Criterion for Sexual Abuse, *Pediatrics* 85:222-223, 1990.

Herman-Giddens, M. & Frothingham, T., Prepubertal Female Genitalia: Examination for Evidence of Sexual Abuse, *Pediatrics*, 80:203-206, 1987.

Hobbs, C.J., & Wynne, J.M., Sexual Abuse of English Boys and Girls: The Importance of Anal Examination, *Child Abuse & Neglect*, 13:195-210, (1989).

McCann, J., Voris, J., Simon, M., & Wells, R., Perianal Findings in Prepubertal Children Selected for Nonabuse: A Descriptive Study, *Child Abuse & Neglect* 13:179-193, 1989.

McCann, J., Voris, J., Simon, M., & Wells, R., Comparison of Genital Examination Techniques in Prepubertal Girls, *Pediatrics* 85:182-187, 1990.

McCann, J., Voris, J., Simon, M., & Wells, R., Perianal Findings in Prepubertal Children Selected for Nonabuse: A Descriptive Study, *Pediatrics* 86:428-439, 1990.

McCann, John, M.d., Robert Wells, M.D., Simon, M.D., and Joan Voris, M.D., Genital Findings in Prepubertal Girls Selected for Nonabuse: A Descriptive Study, Pediatrics Vol. 86 No. 3 September 1990.

McCann, J., Voris, J., & Simon, M., Genital Injuries Resulting from Sexual Abuse: A Longitudinal Study, Pediatrics 89:307-317, 1992.

Monteleone, J., & Brodeur, A. Child Maltreatment: A Clinical Guide and Reference, 159 (G.W. Medical Publishing 1994).

Monteleone, J., Brewer, J., Scalzo, A., Doerhoff, F., Munkel, W., Heaney, S., Bowen, K., Scherzinger, P., & LaRock, T., Urethral Dilation as a Physical Finding in Sexual Abuse, VII International Congress on Child Abuse and Neglect Book of Abstracts (1988).

Paradise, J., Predictive Accuracy and the Diagnosis of Sexual Abuse, Pediatric Clinic North America, v. 37, 839-862, 1989.

Paul, D.M., The Medical Examination in Sexual Offenses Against Children, Medical Science Law, 17:251-258, 1977.

Pokorny, S.F., & Kozinetz, C.A. Configuration and Other Anatomic Details of the Prepubertal Hymen, Adolescent and Pediatric Gynecology, 1, 97-103 (1988).

Teixeira, W., Hymenal Colposcopic Examination in Sexual Offenses, American Journal of Forensic Medicine Pathol v. 3, 209-214, 1981.

White, S, Ingram, D. and Lyna, P., Vaginal Introital Diameter in the Evaluation of Sexual Abuse, Child Abuse & Neglect 10:111-114, 1986. Also, Heger, A. & Emans, S.J., American Academy of Pediatrics: Introital Diameter as the Criterion for Sexual Abuse, Pediatrics 85:222-223, 1990.

Woodling, B., and Heger, A., The Use of the Colposcope in the Diagnosis of Sexual Abuse in the Pediatric Age Group, Child Abuse & Neglect, 10:111-114 (1986).