Prevention of Shaken Baby Syndrome and Abusive Head Trauma

PAGE 1–ABUSIVE HEAD TRAUMA
Welcome to the prevention of shaken baby syndrome and abusive head trauma section of the museum.

By the end of your visit here you will be able to:

- define the term Abusive Head Trauma;
- recognize signs and symptoms of possible Abusive Head Trauma; and
- explain your role as a mandated reporter.

Abusive Head Trauma, or AHT was formerly called Shaken Baby Syndrome, or SBS. Abusive Head Trauma is an injury to the skull or intracranial contents of an infant or young child (younger than 5 years of age) due to inflicted blunt impact and/or violent shaking.

It occurs because a young child’s head is large and heavy and the neck is relatively weak, so the shaking causes the brain to rattle around inside the skull causing hemorrhaging or bleeding in the brain.

The American Academy of Pediatrics estimates that about 30 children younger than one year of age per 100,000 are injured from Abusive Head Trauma, resulting in at least 1,200 seriously injured infants and at least 80 deaths per year in the United States.

PAGE 2–ABUSIVE HEAD TRAUMA INFORMATION
Let’s go to this video where Margo Singer, the Program Coordinator at the Brain Injury Association of New York, shares more information about Abusive Head Trauma, a condition that is 100% preventable.

[VIDEO]

Moderator: So, how does damage occur when a child is shaken?

Margo Singer: Sure. Well, that forceful whip-like motion of the shaking back and forth will cause the brain to be injured. Um, as I described earlier with traumatic brain injury, ah, the motion will cause the blood vessels to rupture. Um, and also blood cells to swell up and to be damaged. So it’s basically the blood that pools up that puts pressure on the brain and destroys parts of the brain cells and the brain.
**Moderator:** What are the potential signs that a child may have been shaken?

**Margo Singer:** OK. Well, initially there might actually not be any visible signs to the head per se, it may be more bruising on the child’s, ah, arms or um, you know, as I said, shoulders or there may be some other broken bones, but it might not be visible. In fact, we often call, ah, brain injury an invisible epidemic because you don’t necessarily see it. Ah, but what you’ll notice in a child is ah, irritability, ah, changes perhaps in their eating patterns, um, they’ll be tired, they might be almost like lifeless like a doll. Um, they might have trouble breathing. There might even be some vomiting, um, pupils might be dilated so there might be some things with the eyes that you might be able to detect.

**Moderator:** I’m thinking that it’s those changes, you know, you’re seeing something that’s not typical.

**Becky Wood Hulbert:** A child...right. A child that is not acting like themselves may have reoccurring issues like that.

**Margo Singer:** Right.

**Moderator:** So if we suspect a child has been shaken, what do we need to do?

**Margo Singer:** Well, the first thing is to get, uh, immediate medical treatment. Um, and obviously, the earlier the better. And then we would want to call the Central Registry, uh, staff to, you know, inform them. But medical treatment is, you know, 9-1-1 immediately. That could be the difference between life and death.

**Moderator:** How is Shaken Baby Syndrome diagnosed?

**Margo Singer:** Well, it is difficult to diagnose. First of all, the parents might, ah, be bringing the child in. They might not be aware of the situation, the circumstances. Perhaps the child was hurt in a day care setting or perhaps the parents themselves might be involved and they don’t want to disclose. So it may be difficult for the medical personnel because they might not be getting the full story of the circumstances. Ah, and because brain injury is more of a functional injury than a structural injury it might not show up normally on a CT scan or MRI. But a CT scan or MRI would be helpful in looking for
that blood pooling, the subdural hematoma and there’s also eye tests that can be done to take a look and see if there is any retinal hemorrhaging taking place.

**Moderator:** Is there any treatment for SBS?

**Margo Singer:** Well, usually what we’re talking about at the instance is emergency treatment. I mean, that child might even need, ah, extreme, you know, respiratory, ah, care, you know, life sustaining measures to support. In fact, I think children under age 1, they’re most likely to need assistance in the ER to be treated for this. Ah, there might be some medications to reduce the swelling, um, there might be some surgery as I said to relieve that blood pooling, the pressure on the brain. Um, so again with an MRI or a CT test, you know, that they would need that to make a more definitive diagnosis.

**Moderator:** In comparison with accidental traumatic brain injury in infants, Shaken Baby injuries have a much worse prognosis. Tell us about this.

**Margo Singer:** Right. Because first of all the baby’s brain is still developing, um, so some of those cognitive, emotional problems that we talked about, um, you know, they’re going to be much more serious. Um, and then when you’re talking about things, for instance, damage to the eyes, to the retina, you might see some blindness. Um, I would say the majority, uh, maybe 80% of those children who survive Shaken Baby Syndrome are going to have lifelong um, medical or neurological impairments. Um, you know, as we said, the most severe, worst outcome is death. But we also see paralysis, and we also see children in a coma or might need lifelong medical care.

**Moderator:** So what is being done to prevent, or help prevent Shaken Baby Syndrome?

**Margo Singer:** Sure. Well, here in NYS we have regulations that talk about providing new mothers with information before they leave the hospital. Ah, we know that caregivers in New York State are required to take training in Shaken Baby Syndrome. We have a lot of good prevention materials. The state health department now has three excellent, ah, they’re like little documentaries, so they do talk with real families about Shaken Baby Syndrome and they’re about 7 minutes so that’s a good prevention message. These are available on you tube. Ah, one is for parents, one is for day care providers, and one is for fathers. So there’s a lot of good prevention information out there.

**Moderator:** Can you help us with some tips for preventing Shaken Baby?
Margo Singer: Sure. Sure. Well, sometimes it’s just important for the parents to know that sometimes a baby needs to cry. It’s not necessarily a bad thing. And the parent of course needs to check to make sure that the baby’s not hungry, that the baby, you know, doesn’t need a bottle or doesn’t need their diaper changed, that the baby’s comfortable. But sometimes you might just need to let the baby cry out. Maybe massage the baby’s back or try to make them feel comfortable. But if that doesn’t change the situation, then it might be incumbent on the caregiver or the parent to perhaps put the baby in the crib or playpen safely and then leave the room and be in charge of their own emotions because as you said at the beginning that it may be their stress or frustration, maybe something else is going on in their life and the baby’s crying is just kind of elevating, you know, some tension and frustration there.

Moderator: And for our childcare providers they always have to make sure that they’re supervising appropriately and, you know, they’re providing that competent supervision at all times.

Margo Singer: Yes. Very important.

Moderator: And you now, I think too, as a child care provider we should encourage, you know, to call the family and say we’re having a rough time you now, is there something that you know, you can help, you can, you know, you can get some more information about maybe why the baby’s crying. (Right) Reach out to the family.

Links to the New York State Department of Health videos Margo Singer referred to are listed in the resource section of this training.

Additional information about Abusive Head Trauma including Downloadable radio PSAs for parents and caregivers can also be found on the “Preventing Abusive Head Trauma in Children” page of the Centers for Disease Control and Prevention, or CDC, Website. The link to this specific information can be found in the resource section of this training.

PAGE 3—SKIPPER’S STORY
Now that you know more information about Abusive Head Trauma, let’s go to this video where we hear from Peggy Whalen and George Lithco, who lost their son, Skipper, to Abusive Head Trauma.

[VIDEO]
Narrator: Taking care of children can be the most satisfying and stimulating job imaginable but it is at times frustrating and exhausting as well.

George: I mean people don’t leave children with care providers that look like their gonna shake the baby or that their gonna hit the baby or their going to commit some form of physical abuse but what they don’t realize is that by leaving your child with someone who doesn’t realize the danger, you’re, you’re essentially not taking a step that’s really important to protecting the baby and that is the simplest thing, shaking’s dangerous, if you have a problem give me a call.

Peggy: I think that we need to change the attitude that having to call the parents is a bad sign that I think the parents need to change the attitude on that too but that the daycare provider should definitely feel that if things aren’t going right, if their getting edgy they should be able to call either the parent or one of the emergency numbers listed and along with that the parents have to realize that it doesn’t mean the daycare providers incompetent, that it’s probably the best sign if that person is honest enough to call you and say you need to come and take your child right now, this is you know, they need to be home.

Narrator: The death of a child is an overwhelming loss for any family.

Peggy: There is no such thing really as closure.

GRAPHIC:
THE INFORMAL DAY CARE PROVIDER PLED GUILTY TO SECOND-DEGREE MANSLAUGHTER AND IS CURRENTLY SERVING A THREE TO TEN YEAR SENTENCE IN A MAXIMUM-SECURITY WOMEN’S PRISON.

SPECIAL THANKS TO PEGGY WHALEN AND GEORGE LITHCO FOR SHARING THEIR STORY WITH US.

Narrator: Skipper’s story is heartbreaking. But there are steps you can take in your program to prevent or minimize children’s distress, and lessen the amount of crying before it starts. The best way to minimize or prevent children’s stress is to anticipate their needs. Know their schedules and keep them predictable. Be alert to early signs of hunger, sleepiness or irritability. Provide an environment that’s stimulating, but not too stimulating. And safe—but not restrictive. In every child’s day there will be times to cry. When it happens, try to comfort them immediately. Research shows that babies who are comforted quickly tend to cry less. And babies like to be up on your shoulder, close to your body where
it’s warm and can hear your breathing and your heart. All children are different and some can be soothed more quickly than others. Always remember—Abusive Head Trauma is 100 percent preventable. Take the time to develop your plan and communicate with families.

PAGE 4–PREVENTING STRESS
The leading cause of Abusive Head Trauma is that a baby won’t stop crying and the adult gets stressed out and is unable to calm the child.

Be sure to have a plan in place for times like these. Remember to:

- stop and take a breath;
- relax;
- seek assistance if you need it; and
- try again.

PAGE 5–CALMING STRATEGIES
Some calming strategies you can use to help a crying baby include:

- Go for a walk in a carrier or stroller
- Try giving the child a pacifier or teether to chew on
- Engage in mirror play
- Blow bubbles for the child
- Be silly
- Dance with the baby or sing to music
- Create white noise such as running the vacuum or dishwasher
- Undress the baby and blow on his or her skin (not the eyes)

And remember to communicate with the families to see what strategies work with the baby at home.

PAGE 6–ABUSIVE HEAD TRAUMA AND OLDER CHILDREN
If you care for school-age children, you might think that Abusive Head Trauma would never apply to the children in your care. Keep in mind that Abusive Head Trauma can occur in children as old as five (kindergarten age). A child who has survived Abusive Head Trauma may experience aftereffects of various levels of intensity well into the school-age years and beyond, even well into adulthood.
If you care for school-age children in a Day Care Center, for example, having this knowledge is helpful if you ever end up caring for younger children, either on a short-term/temporary/floater or long-term basis.

If you work with school-age children in a Day Care Center or School Age Child Care program, the families you serve may also have children of various ages enrolled in child care—so being educated yourself in Abusive Head Trauma can help you inform parents about it and in turn protect their younger children.

PAGE 7–REPORTING CHILD ABUSE
If you notice signs of Abusive Head Trauma or other forms of child abuse or maltreatment, you should call the Statewide Central Register to make a report. In fact, all child care providers have a responsibility to report child abuse and maltreatment, so if you ever find yourself questioning a child’s safety you should make the call.

Let’s watch this video for more information.

[VIDEO]

**Narrator:** Child care programs are often the only places where young children are seen on a daily basis for an extended period of time. Children who are being abused or maltreated may not be able to develop to their maximum potential. They may carry emotional scars the rest of their lives and depending on the type and severity of abuse or maltreatment, there can be long-term physical effects as well.

There are certain people, called 'mandated reporters' who are required by law to report suspected child abuse. Mandated reporters include child care providers and other people who come into contact with children on a regular basis. As a mandated reporter, you may be the first person to suspect and report child abuse or maltreatment. It’s essential that you become knowledgeable about these issues, and take action to interrupt the 'cycle of abuse' even though you may have mixed feelings about doing so.

You also have an important role in educating parents about child abuse and maltreatment and helping them find the resources they need during difficult times.
Let's find out more about what it means to be a mandated reporter....

**Colleen:** So Brian, what are the responsibilities of a mandated reporter?

**Brian:** Well, mandated reporters, they’re individuals who have been specifically named in family or social services law that have contact with children. They’re specific responsibilities are if they have reason to believe that a child has been maltreated or abused to contact the state central register.

**Colleen:** Who are these individuals that are named mandated reporters?

**Brian:** Well, they’re law officers, hospital personnel, social service workers, day care providers, just to name a few.

**Colleen:** Now, there’s specific language that is used, um, to describe child abuse and maltreatment. Can you share that with us?

**Brian:** Well, the definition of maltreatment and abuse actually are when you have a child that’s at risk of, or is in imminent risk of permanent or protracted injury. Sex abuse. Physical maltreatment, if you will, would qualify any child when that abuse or maltreatment has been perpetrated or allowed to be perpetrated by a person legally responsible. They should then contact the state central register.

**Colleen:** And when you say person legally responsible, what does that mean?

**Brian:** Well, the state says that any person that has regular, consistent contact with the child can be considered a person legally responsible. But we’re talking about people who act in a parental role, babysitters, day care providers, a neighbor who regularly watches a child. So technically, any person who has regular, frequent contact with a child can be considered a person legally responsible.

**Colleen:** Let’s get on to the definition of maltreatment. How do you describe it?

**Brian:** Well, basically, maltreatment is when the emotional, physical, or mental capacity of a child is at risk of being diminished or for lack of a better way of putting it, the minimum degree of care that New York State says a child must be given. If that level isn’t reached, that child would be considered maltreated.
Colleen: Brian, what does minimum degree of care mean?

Brian: Minimum degree of care is just that, the minimum standard. What you and I might consider the minimum degree is what New York State says. Any child, regardless of their race, color, or creed, they’re entitled to proper medical, education, clothing, shelter, food, basic nutrition. Those are items that every child is entitled to. And then when minimum degree isn’t reached, at that point a call can be made to the register.

Colleen: OK. But let’s say that a family doesn’t have the resources to provide for their child?

Brian: Which unfortunately we may still register a report. At no time would we look at a person’s economic status to determine whether or not a report would be registered. Um, our job is to get the child, or provide help for the family. If a person isn’t able to afford proper medical or whatever the treatment may be it’s our job to let them know what’s out there for them—the services that are available. After we’ve, I guess, let the parents or the persons legally responsible, make them aware of what those services are at that point a follow-up isn’t, you know, if that hasn’t taken place at that time we would register a report.

Colleen: OK. So we provide the information. We tell them where they can go, what’s available.

Brian: Yes.

Colleen: And then if they don’t follow through?

Brian: Yes. That’s not in every instance. There are some instances where even though we might know that a person cannot afford whatever those services are we would still register the report. Social services law says that a family may be unable or unwilling. So in either scenario we would probably still register the report.

Colleen: OK. And get the family help.

Brian: The help that they require. Correct.
Colleen: How do we know, as a mandated reporter, when to make the report?

Brian: Well, there are certain signs that everyone should be aware of. There are marks and bruises. Typically, if a child tells you how they sustained the injury and you’re alerted or the mandated reporter is made aware that the person legally responsible caused it or allowed it to happen. History in a household is, is very important. The types of bruises. There are types of burns where you can tell if a child was immersed or whether or not it was a spill. Um, so there are, ah, quite a few red flags that mandated reporters can be, that, you know, they should look out for.

Colleen: And make a report.

Brian: Absolutely.

For more detailed training on being a mandated reporter, take the New York State Office of Children and Family Services’ e-Learning titled “Mandated Reporter Online Training”.

https://www.ecetp.pdp.albany.edu/elearn_catalog.shtm

PAGE 8–PHYSICAL INDICATORS
There are specific physical and behavioral indicators you should be looking for and documenting if you suspect child abuse or maltreatment.

Let’s watch this video for more information.

[VIDEO]

Narrator: When it comes to child abuse or maltreatment, there are some specific things to look for called ‘indicators’.

Indicators are physical and behavioral signs exhibited by children and parents that may indicate that abuse or maltreatment is taking place.

Let's hear more....

Colleen: So Brian can you give us a few examples of physical indicators of child abuse?
Brian: Well, bruising obviously is a big one. I mean, normally children who are toddlers who fall, they’ll fall on elbows, you know, bony protrusions—that’s normal. Um, handprints, belt marks, generally when children are hit with an object it will leave the imprint of the object with which they were hit. Switches, um, again, cuts, marks, bruises, but primarily what does, if the child is able to communicate, what did the child say?

Colleen: Right. They tell you something.

Brian: They will tell you exactly.

Colleen: And you see a mark.

Brian: Absolutely.

Colleen: Making that connection. So, Brian, how can a provider tell the difference between a typical childhood injury and a suspicious one?

Brian: Well, again, it can be difficult, but when children fall typically they’re going to fall on those bony portions, um, knees. And again, we’ll ask the child exactly what happened but when an injury is of the abdomen, the back, those, typically those areas that are covered, that should raise a red flag. And again, we look at everything—the relationship they have with the parents. What are the persons legally responsible saying? What’s the child saying? Is there a history of this type of behavior with this particular child? And a lot of instances children just fall down a lot. They get bruised. That happens. But in other instances those bruises are caused or at least allowed to be caused by the person legally responsible. So primarily they have to look at bony areas and then those areas that are covered. Day care personnel would be better apt to do that. They know their children. They’re with them every day. They have the ability to inspect those areas that are normally covered. They then might become suspicious based on the history they have with the family, based on what the child said, and based on the area, the shape, the size, um, of the bruise. At that point they would be mandated to call us and at least discuss it with us.

Colleen: And that’s why for child care providers their documentation is just critical. If you’re seeing something, document it so that…
Brian: Absolutely.

Colleen: ...if you identify a pattern you have that information...

Brian: Absolutely.

Colleen: ...and if you have reasonable cause to suspect and you contact the state central register.

Brian: Absolutely. They must document.

Colleen: Well, and then behavior also plays an enormous role in the observation and identification of abuse and maltreatment. What should we be looking for in children?

Brian: Well, behavior changes, drastic changes primarily. A child who’s normally not reticent, they’re very talkative, they’re involved with their classmates and that child all of the sudden is quiet. They’ve, they’re’ ostracized, um, for whatever reason, um, that is to me would be a red flag. Doesn’t mean that we would necessarily register a report, but I think that mandated reporter, the person that’s in charge of that child should inquire to find out what the problem is.

Colleen: Right. And that is talking to the family. Find out what’s going on and then documenting their observations...

Brian: Absolutely.

Colleen: ...at the child care providers.

Brian: Absolutely. In some instances that behavior might continue that could be detrimental to themselves or other children in the classroom.

Colleen: What are some behavioral indicators then that a parent or guardian might exhibit? So, beyond the child.

Brian: Ideally, well, I won’t say ideally, typically, we will have a caller that will describe the parent’s demeanor when an issue is being described to the parent. Generally this might be school officials or
someone that has a day to day contact with the child and the parent. We will have inconsistent explanations as to how a child was injured. The child will indicate that they fell down and the parent might give us a totally different explanation. Again, it’s a red flag. We won’t register in every instance but in most we will always err on the side of the child and register the report.

**Colleen:** Ok. I’m just thinking if with experience a mandated reporter, a child care provider’s experience if they see an injury that just doesn’t make sense and the parent’s telling you one thing and you’ve got other indicators going on...

**Brian:** Absolutely.

**Colleen:** ...maybe not just this isolated incident...

**Brian:** Absolutely. Those are things that we question for. Um, whether or not the teacher or the person that’s called us have they spoken to the child’s friends? Do they have any information that would indicate that maybe it wasn’t exactly as it was explained by the parent? You don’t have to have firsthand knowledge. You don’t have to have witnessed it. It doesn’t have to be fact. All it has to be is based on your suspicion, and of course your suspicion has to be reasonable, and we’ll register the report just based on that information.

**Colleen:** So then this suspicion, it’s more than gut feeling?

**Brian:** It is much more than a gut feeling. Unfortunately people have been intuitive and they will know somethings going on, unfortunately we need to know why other than your gut. It has to be something we can see, taste or smell so to speak. Divine intervention or your guessing unfortunately isn’t enough for us to register a report.

**Colleen:** But that’s why there’s the guideline of the indicators...

**Brian:** Absolutely.

**Colleen:** ...that can help support...

**Brian:** Absolutely.
Colleen: ...your observations.

Brian: It would be definitely to the advantage of any new mandated reporter, even someone that’s been doing it for a while to review those indicators. You know about bruises and burns. You know, we all know that children fall down. We’ve all done it ourselves. We know what those bruises and marks look like. If it doesn’t fit that pattern, and even if you have questions or you’re not sure, call us. We’ll walk you through it. We’ll make the determination if it’s something that should be reported.

Colleen: That’s great. That’s really great.

Narrator: It’s important for you to be familiar with these indicators for two reasons: first you need to know what to watch for, and second you need to know what language to use as you document your observations.

PAGE 9–REASONABLE CAUSE TO SUSPECT
But how do you know when it’s the right time to make the call?

Let’s watch this video that explains reasonable cause to suspect and what to expect if you should have to make a call to the Statewide Central Register.

[VIDEO]
Narrator: The decision to call the Statewide Central Register to report suspected child abuse or maltreatment is an individual professional responsibility, based on your own reasonable cause to suspect.

It’s a decision you make based on your general knowledge of what is reasonable in terms of injuries and explanations and your specific understanding of each child in your care.

Let’s hear more:

Colleen: Brian, what’s the meaning of reasonable cause to suspect?
Brian: Reasonable cause to suspect can be a little bit ambiguous, but what reasonable cause to suspect is should, you come across a situation, you were to explain that situation to a reasonable person that you would come to the same conclusion. It’s not fact. It’s not necessarily truth for that matter but it’s based on what you see and you’re able to substantiate what you see and we think of it as being reasonable.

Colleen: So it’s more than a gut feeling?

Brian: It’s a lot more than a gut feeling. Um, you have some information that backs up your reasonable cause to suspect. For instance, you have a child with a handprint on their arm. It’s reasonable to suspect that someone hit that child. What we have to then determine is who hit that child or who allowed that child to be placed in that situation? That’s where the confusion may come. It’s not, um, unreasonable to call us, um, and explain to us why you feel the way you do. Gut feelings, unfortunately, legally, are, that’s not reasonable for us to move on a gut feeling.

Colleen: Now if you see something, um, that doesn’t give you reasonable cause to suspect, but it’s a change. It’s a change in, um, the parent’s behavior, the child’s behavior…just a change, what do you do?

Brian: Depends on the change. Um, some changes children go through. Everyone goes through changes. There are a lot of reasons for those changes. Families split for whatever reason. Parents divorce. Death in the family. Ah, a sibling gets hurt or injured. Um, those changes, it’s reasonable for a child to maybe their behavior change a little bit. Where we would then want to be involved is if that change would be what we consider over the top and its long lasting. It’s not something that you can say is attributed, as a mandated reporter say that it’s attributed to the death of a parent or, um, a loved one. You don’t really have a reason that you can think of for that child, for their behavior to change as drastically as it has. Those are the things that we would be interested in and those are the items um that we would ask you to question the child about.

Colleen: And so you could call the Statewide…

Brian: Absolutely.

Colleen: ...Central Register and talk about these changes that you’ve been documenting?
Brian: Absolutely. And again, particularly with behavioral issues, the persons, the parents, or the persons legally responsible have to be aware of them, or they should be aware of them. And younger children, it’s, it’s a given, a parent should be aware of what their child is going through. When you get into those middle ages, as early as 10 in some cases, children do things that parents aren’t all aware of and they may not be aware of what their child is doing so again, we have to know that the person legally responsible is aware of the behavior and for whatever reason they’ve not taken the steps to correct it.

Colleen: So, let’s say I have reasonable cause to suspect and I’m ready to call the Statewide Central Register, what do I need to do?

Brian: Well, the first thing that you need to do is fill out the DSS-2221A form. If that form is filled out that’s pretty much ¾ of the way. When you call us we’re going to ask you things like demographics and the names and addresses. It mirrors the same form that we fill out. So primarily fill out that form. You have reasonable cause to suspect. Call us and then we’ll discuss it.

Colleen: So that really helps the mandated reporter prepare for that call? Kind of getting everything together...

Brian: Absolutely.

Colleen: ...seeing if there’s any holes or anything and then you call the 800 number.

Brian: Absolutely. That form is, as I mentioned before, mirrors everything that we do. It has the name, it has the address, it has the ethnicity, ages, everything that we would possibly ask you concerning that family’s demographics is on that form.

Colleen: What would you say to a mandated reporter if they’re kind of struggling with this concept about making a report? You know, it’s hard. You have a relationship with the child and the family.

Brian: It is. It is difficult but the primary, your primary focus for all mandated reporters is the child. You have to put your personal feelings aside. It, we know it’s a very tough thing to do to make a report on a family, particularly one that you’re familiar with, but again, the primary person that we’re here to
protect is that child and the family. So it’s imperative that they call. And again, put your personal feelings aside. Right now we’re here to help the child. Make the call.

**Colleen:** And it’s their legal responsibility.

**Brian:** Yes it is. You are mandated to make the call. If you should not, or decide not to and it’s found that that child was in fact injured it could come back on that mandated reporter who did not make that call.

**Colleen:** Brian, thank you, and to the staff at the Statewide Central Register for all the work that you do for the children and families of New York State. Thank you very much.

**Brian:** Thank you for having us. Thank you.

**Narrator:** Determining reasonable cause to suspect is not always an easy task. Use fair, accurate, careful and timely observations. Look for a combination or pattern of indicators or a change in behavior. Anyone can and should report suspected child abuse or maltreatment. As long as the report is based on good faith, the reporter will be immune from liability.

Remember, reporting suspected child abuse or maltreatment is not only your legal responsibility; it’s the right thing to do.

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**PAGE 10—REVIEW WHAT YOU’VE LEARNED**

Before we move on, let’s review some of the terms we’ve heard about Abusive Head Trauma and Child Abuse and Maltreatment Read each description and choices and determine which one is correct.

1. Any person who has regular, frequent contact with a child can be considered this.
   - Person Legally Responsible
   - Person Validly Responsible
   - Person Legally Accountable

Answer: Person Legally Responsible
2. When the emotional, physical, or mental capacity of a child is at risk of being diminished.
   Mistreatment
   Maltreatment
   Exploitation

   Answer: Maltreatment

3. The leading cause of Abusive Head Trauma.
   Falls
   Biting
   Crying

   Answer: Crying

4. An injury to the skull or intracranial contents of an infant or young child (younger than 5 years of age) due to inflicted blunt impact and/or violent shaking. It was formerly referred to as Shaken Baby Syndrome or SBS
   Abusive Head Trauma
   Abusive Mind Trauma
   Abusive Head Injury

   Answer: Abusive Head Trauma

5. Abusive Head Trauma is 100% this.
   Inescapable
   Preventable
   Unavoidable

   Answer: Preventable

6. Certain people who are required by law to report suspected child abuse that include licensed or registered child care providers and other people who come into contact with children on a regular basis.

   Required Reporter
Mandated Reporter
Assigned Reporter

Answer: Mandated Reporter

7. Physical and behavioral sign exhibited by children and parents that may signal that abuse or maltreatment is taking place.

- Indicator
- Criterion
- Benchmark

Answer: Indicator

8. When a child is at risk of, or is in imminent risk of permanent or protracted injury that has been perpetrated or allowed to be perpetrated by a person legally responsible.

- Minor Abuse
- Youth Abuse
- Child Abuse

Answer: Child Abuse

9. Items such as proper medical care, education, clothing, shelter, food and basic nutrition that every child is entitled to.

- Maximum Degree of Care
- Minimum Degree of Care
- Supreme Degree of Care

Answer: Minimum Degree of Care

PAGE 10–PUNCH YOUR TICKET
You have successfully completed touring the prevention of shaken baby syndrome and abusive head trauma section of the museum. Let’s punch your ticket.

Close this window to continue the course.