



Representing the Victim in a Failure to Diagnose Child Abuse Case

by Thomas L. Gowen

At the age of four weeks the infant son of a Young Air Force couple was brought to the Family Practice Clinic of a major Air Force teaching hospital in California. The child had been vomiting blood while in the care of his father. The physicians at the Medical Center noticed lesions in the soft palate and in the posterior pharynx. After several consultations over the next couple of days and x-rays which were read as normal, the diagnosis of a rare congenital defect known as Split Notochord Syndrome was made. The anxious mother was told that she had nothing to worry about; that the baby had a mild case of Split Notochord Syndrome and that no surgery would be necessary. At the baby's three month check-up, at the same facility, it was noticed that the congenital defect apparently had disappeared.

Several months later the family was at home, in the Philadelphia area when

the baby, again in the care of the father was reported by the father to have swallowed a home made toy which was about the size of a cigarette pack. The mother and grandmother rushed to the child's aid but could not extricate the toy which was fully below the uvula. The toy was not removed until seven or eight minutes later when the medics arrived and removed it with hemostats. He was taken to the major children's hospital in Philadelphia, where the father's story of the baby swallowing this toy was immediately suspected. A child abuse skeletal survey was ordered and seven fractured ribs and a fractured clavicle in remote stages of healing were noted. The father was arrested and charged with various criminal offenses including aggravated assault and attempted murder. The previously normal baby survived as a catastrophically brain damaged quadriplegic.

As tragic as this incident was, perhaps the most tragic aspect of it was that it could have been prevented had child abuse been suspected when the baby was brought to the Air Force hospital at four weeks of age and the process of family intervention begun on the baby's behalf.

Since 1962, when C. Henry Kempe

M.D. published his seminal article, *The Battered Child Syndrome*,¹ the understanding of the medical profession of child abuse has grown significantly. Central to this understanding is the concept that a child presenting at a medical facility with an intentionally inflicted injury even of a relatively minor nature is a member of a high risk group for future abuse which all too often is of a seriously injurious or life threatening nature. As the office of the California Attorney General stated in the introduction to its manual on child abuse:

A parent or caretaker may begin by inflicting minor injuries and go on to cause more serious harm over a period of time. Therefore, detecting initially inflicted small injuries and intervening with preventative action may save a child from future permanent injury or death.²

In recognition of the understanding of the repetitive and often escalatory nature of child abuse, all 50 states have adopted laws requiring the reporting of suspected child abuse and neglect. Most statutes impose criminal penalties on professionals for failure to report suspected child abuse and eight states

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have civil penalties within their statutes.³ The statutes require the reporting of child abuse by professionals dealing with potentially abused children including doctors, nurses, social workers, teachers, and others.

Since it is recognized that the diagnosis of abuse is frequently not made to an absolute certainty, the statutes have required reporting when abuse is suspected. Upon reporting, further investigation of the family situation by the social welfare agency empowered to deal with possible child abuse in the jurisdiction is required. Prior to or simultaneously with reporting, doctors are empowered to admit children to the hospital in order to evaluate their condition and provide short term protection. Generally this admission may be ordered without parental consent. In the military, Child Advocacy Committees have been established to receive reports of abuse and to provide experienced intervention on behalf of the child. The work of the Child Advocacy Committee takes place in conjunction with that of the civilian authorities.

While it is often argued that the military and civilian agencies described

above are frequently overworked and understaffed, the authorities in the field generally agree that the passage of the Child Abuse Reporting Laws has dramatically improved the system for dealing with the problem of abuse and consequently improved the outcome for untold numbers of children. New York State reported a decline in child abuse fatalities of 50 percent within five years of the passage of its child abuse reporting statute and in Denver, Colorado the number of children who died from inflicted injuries declined from 20 a year to less than one per year. At the same time, according to the National Council on Child Abuse and Family Violence, documented reports of child abuse have risen from a level of approximately 150,000 in 1963 to 1,712,641 in 1984. Between 1976 and 1982 reports of abuse and neglect increased by 123 percent.⁴

Although the statistics show progress, it is also recognized that many of the most devastating presentations of child abuse were preceded by visits to doctors, medical centers or social agencies for less serious sequelae of abuse and the relatively minor trauma was not recognized as abuse. In other cases there may have been recognition or suspicion but no reporting. Consequently many children are returned to

their abusing parents without so much as counseling. Far too many subsequently become victims of more serious abuse than that with which they initially presented. According to a study conducted for the federal government in 1979, professionals failed to report as many as half of the maltreated children with whom they came in contact and as many as 50,000 children with observable injuries severe enough to require hospitalization were not reported.⁵

Proof of Civil Liability For Subsequently Sustained Abuse

Civil liability for failure to diagnose and report child abuse may be established under traditional principles of medical negligence as well as pursuant to statute in eight states. The criminal penalties provided under the statute for failure to report as well as the statutory civil penalties require willful failure to report and have been rather infrequently enforced given the magnitude of nonreporting that is believed to occur in the United States.

The traditional negligence approach to establishing liability for failure to diagnose child abuse has numerous advantages over the criminal enforcement penalties. First a negligence action can be brought on behalf of an abused child for failure to diagnose child abuse and if successful, result in a judgment that may be of critical importance to the future welfare of the abused child. Second, the action may be predicated upon a failure by the medical professionals to be cognizant of the diagnostic tools and criterion established within the medical profession for recognizing child abuse. Action may also be based upon the failure of the doctor or nurse to apply the established child abuse protocols of his/her institution to analyze a case of possible abuse. Proof is not dependent upon a knowing failure to report which will often be very difficult to prove.

Legally the case of failure to diagnose child abuse is founded in the *Restatement (Second) of Torts* 449:

If the likelihood that a third per-

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son may act in a particular manner is the hazard or one of the hazards which makes the actor negligent, such an act whether innocent, negligent, intentionally tortious, or criminal does not prevent the actor from being liable for harm caused thereby.

The failure to suspect child abuse and to begin the process of interven-

community. Virtually all of the literature on the subject and most competent experts agree that the standard of care at this time requires the physician to recognize trauma, to investigate the possibility of intentional trauma as well as other possible causes of the presenting condition, and to report suspected abuse to the constituted authorities. The failure to recognize and/or report a

relatively minor nature and which gives the alert medical practitioners the opportunity to interrupt the cycle of abuse.

The leading medical literature on abuse indicates that in physical abuse several categories of presentation are considered diagnostic or at least highly suggestive of intentional trauma. These include: 1) Eyewitness history; 2) Unexplained injury—particularly in an infant or very young child. Where an injury has genuinely been caused by accident the parents will usually be able to explain how it occurred; 3) Implausible history—where parents tell a story that is unlikely or which does not make sense; such as multiple bruises on various parts of the body resulting from a fall off a chair onto a thick carpet; 4) Alleged self-inflicted injuries such as the child scalded his/her back with hot water, or rolled over in his/her crib and broke his/her arm. A very young child is usually developmentally incapable of causing injuries to himself/herself which an abusing parent attributes to him/her. Many doctors consider this to be a particularly dangerous category for further abuse; 5) Alleged sibling inflicted injury; and 6) Delay in seeking medical care for a traumatic injury

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tion by which the child can be protected from future harm is a legal cause of harm to the child who is injured after being returned to abusing parents without any diagnosis or reporting of a presentation of abuse because the risk of future, more serious abuse is foreseeable. The Supreme Court of California in 1976, delivered the landmark opinion in this field of law applying § 449 to the diagnosis of battered child syndrome in *Landeros v. Flood*.⁶ The *Landeros* case which went through the California courts in the early years of heightened awareness of child abuse within the medical profession, held that the medical literature on diagnosis and treatment of child abuse was probative on the standard of care and that the degree to which the standard espoused in the literature had been adopted by the medical community in 1971, would be strictly a matter for expert testimony before the jury.⁷

Proof of liability for injuries inflicted subsequent to an initial presentation where the diagnosis is missed requires a two-pronged presentation of evidence. First it is necessary to show that in the late 1980s knowledge of child abuse and the importance of intervention on behalf of the child is widely known and accepted in the medical

finding that reasonably could be considered to be intentionally inflicted is the first element in establishing negligence in this type of case. The second phase of proof requires the plaintiff's attorney to prove that it is now well recognized that child abuse is a repetitive phenomenon that frequently escalates and too often results in severe injury or death to children for whom therapeutic or custodial intervention is not obtained. Hence subsequent abuse is and should be foreseeable to the competent medical professional handling the presentation of abuse. Injury from subsequent abuse is therefore actionable when the physician has negligently or knowingly failed to begin the process of intervention on behalf of the abused child.

Critical to the first phase of proof is the showing by expert testimony that the medical understanding of child abuse and the tools for early recognition have expanded greatly since the time of *Landeros*. The literature recognizes three major categories of abuse: physical, sexual, and neglect. All of these forms of abuse can result in grievous harm to the children. Physical abuse and neglect cases share the characteristic of commonly having precursor presentations when the abuse is of

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which may occur because the parent does not want to take the chance of being discovered at the medical facility.⁸

Within these categories are numerous medical findings which may be considered highly suggestive of child abuse. These include multiple bruises, particularly in soft or fleshy parts of the body, bizarre marks such as may be caused by cigarette burns, lacerations

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with forks or the bottom of a shoe, or human hand marks or strap marks that suggest either beating or attempted strangulation. According to a recent statement by the Committee on Early Childhood, Adoption and Dependent Care published in *Pediatrics*:

craniofacial injuries occur in half of child abuse cases. . . Some authorities believe the oral cavity may be a central focus for physi-

Action may be based upon failure of the doctor or nurse to apply established child abuse protocols

cal abuse because of its significance in communication and nutrition." Injuries to the face and oral cavity may include bruises, lacerations, traumatized or avulsed teeth, fractures, burns, and other injuries.⁹

As such dentists also play a key role in the system of recognizing abuse before it becomes catastrophic as the injury may be primarily dental in nature yet require the same inquiry as to its etiology as injuries presenting at a medical facility.

Because a great many bruises and cuts occur in the normal course of childhood activities and are not intentionally inflicted by caretakers it is very important that medical diagnosticians be familiar with the types of injuries that are suggestive of abuse. Merely disregarding lacerations, bruises, burn marks, or fractures as childhood injuries without critical questioning and evaluation of their type and location may cause the physician to miss the only opportunity that that child will have to receive help before he/she is

catastrophically injured or killed.

Differential Diagnosis

Given the more advanced state of medical knowledge in the latter half of the 1980s, the standard of care requires the use of the process of differential diagnosis in the evaluation of a child presenting with a condition which may have resulted from intentional trauma. Many diagnoses are missed because a doctor seizes upon a single erroneous diagnosis and does not subject his conclusions to the process of differential diagnosis in which all of the reasonable etiologies are listed and progressively eliminated. The question must be, "could the presenting condition be the result of a disease process, trauma, congenital anomaly, or other cause?" The follow-up question should be, "if a disease process or congenital anomaly is considered a possible cause; which disease or defect most resembles the finding?" If trauma is a possibility the question of accidental versus inflicted trauma must be raised. In a neglect case the issue of parental negligence should be considered. If several possible explanations for the presenting condition exist the physician should go through the process of eliminating conditions and ranking those that cannot be eliminated. If intentional trauma remains on the list after this process then child abuse follow-up should be instituted. This would include social work evaluation, body scan x-rays in young children, further evaluation of the primary injury, and complete documentation of the injury. This process recognizes that one or more of the alternative diagnoses may remain on the differential at this point. Differential diagnosis helps prevent rejection of what might be the most reasonable explanation for the presenting condition. Where intentional trauma remains on the differential, further evaluation for abuse is required. This is critical because a doctor not evaluating for abuse may miss pathognomonic signs such as posterior rib fractures, which would make the diagnosis certain.

Duty to Report Suspicion of Abuse

A critical issue in a case may become whether the duty to report exists when intentional trauma remains on the differential diagnosis along with one or more other possibilities after completion of the medical and social work examinations. The law in all states requires reporting at the level of suspicion. When abuse remains on the differential diagnosis at any reasonable level of suspicion it should be reported so that the process of intervention can be initiated. Certainly if the diagnosis of intentional trauma is a 20 or 30 percent possibility in the eyes of the examining physician a report should be made. Failure to report at this level may well be considered negligence in a lawsuit arising from subsequent injuries to this child.

For example in the case of the child described at the beginning of this article, upon presentation at the medical facility with bleeding from the mouth and lesions observed in the soft palate and posterior pharynx, the differential diagnosis should have included accidental trauma, intentional trauma, infection, or congenital defect. Accidental trauma could have been eliminated because the parents denied knowledge of any accident and because an infant of four weeks of age would be developmentally incapable of causing this type of injury to himself/herself. If an accident has occurred the parents will usually be able to explain the event in a manner that is consistent with the presenting injury.

Infection could have been eliminated by the appearance of the wound and by culture. Congenital defect would have to be considered in terms of whether there is a known defect that presents in a manner consistent with these lesions. If so, questions should have been raised as to the general incidence or rarity of such a defect, as to an explanation for bleeding in a congenital defect and as to whether the defect had been noted at birth or at any other examinations. Since the answers to these questions in this case should have made a congenital defect seem

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somewhat unlikely, then the remaining possibility of intentional trauma should have appeared to be stronger.

Medical Management of Suspected Abuse

Further follow-up within the medical facility should include social work evaluation of the family. Dr. Kempe recognized in 1972, that many cases of child abuse appear at the emergency ward where they are handled by inexperienced residents. At that time he stated that the initial handling of these emotionally charged situations should be kept simple and straightforward. He recommended that abuse be considered in all cases of traumatic injury in small children, that all preschool children and most older children be admitted to the hospital, and that a pediatrician or an experienced social worker should be consulted by the emergency room doctor.¹⁰

A strong argument can be made that when child abuse remains on the differential diagnosis that further evaluation of the family by a trained social worker is critical to the care and final diagnosis of the child. In many instances, abuse is confirmed or at least the level of suspicion is increased by the involvement of a skilled social work professional. Failure by a medical center to do social work follow-up on a possible case of child abuse may be negligence, particularly if evidence can be developed that the social work evaluation would have produced confirmatory evidence.

Medical follow-up in most child abuse protocols where physical abuse is suspected in young children requires a skeletal survey in which the child's entire skeleton is x-rayed and the radiologist pays particular attention to those bones which are typically fractured in the process of shaking or battering young children. These include the ribs, particularly the posterior ribs in the area of the costo-vertebral junc-

tion and the long bones of the arms and legs. Possible skull fractures are also evaluated in this process. Fractures of the posterior ribs and certain fractures of the long bones are pathognomonic of child abuse. If they are observed on the x-ray, the diagnosis rises to a level of virtual certainty. But if abuse is not suspected by the screening physician, the body scan x-ray will probably not be ordered. If any x-rays are done they may not be read with the purpose of evaluating child abuse and many subtle fractures may be missed. For an excellent reference on this topic see *The Diagnostic Imaging of Child Abuse* by Paul Kleinman, M.D. published in 1987.¹¹

Most medical school curriculums now include child abuse. Pediatric, family practice, emergency, and radiology rotations usually include exposure of the physician to the handling of child abuse and the literature in the field. Therefore, the attorney representing the misdiagnosed child can rely on much of the authoritative literature such as the Kempe and Helfer texts referenced above to help establish the standard of care. Additionally, many hospitals have specific protocols for the handling of possible abuse cases which can also be used to establish the standard of care.

Despite the widespread inclusion of child abuse education in the medical curriculum and the substantial amount of authoritative medical literature on the subject, many doctors remain unaware of the diagnostic signs of abuse and/or are reluctant to suspect and report abuse. Consequently many children who could have been spared severe injury or death at the hands of their caretakers are returned to the homes in which they suffered minor injuries only to be returned dead or seriously injured at a later date.

Because the criminal penalties for nonreporting are relatively rarely enforced, civil liability may be the most important available societal tool to encourage those physicians who are reluctant to report or who remain oblivious to the problem of child abuse and its diagnostic criteria. As a result of a

successful lawsuit, children such as the one described at the onset may be able to afford the kind of medical care and therapy that they need as a result of their injuries which in most cases would be beyond the means of their families to provide. While the cases do involve a mixture of medical diagnosis, sociology, psychology, and social policy there are sufficient standards within the medical profession to enable the lawyer to recognize and prove that his/her client could have been spared the foreseeable additional abuse inflicted by his/her parents had the early treating physicians been sensitive to the issue of child abuse. Hopefully with liability as a spur, physicians, social workers, hospitals and welfare agencies will become more aggressive in their handling of possible cases of child abuse and prevent the type of catastrophic harm that has occurred to many children throughout the country as a result of abuse.

Footnotes

- ¹ Kempe, Silverman, Steele, Droegemueller and Silver, *The Battered Child Syndrome*, Journal of the American Medical Association (JAMA) pg. 105 (1962).
- ² *The Problem of the Abused and Neglected Child*, Office of the California Attorney General, California Department of Justice Information Pamphlet Number 8.
- ³ See Besharov, Douglas, *The Vulnerable Social Worker*, National Association of Social Workers, page 26 (1985). States with civil penalties provided in the statutes are Arizona, Colorado, Iowa, Maine, Michigan, Montana, New York and Rhode Island.
- ⁴ Besharov, Douglas, *Child Abuse*, Harvard Journal of Law and Public Policy.
- ⁵ *U.S. National Center on Child Abuse and Neglect National Study of the Incidence and Severity of Child Abuse and Neglect II* (DSHS 1981) also Besharov, note 4 at page 551.
- ⁶ *Landeros v. Flood* 17 Cal. 3d. 399, 131 Cal. Rptr. 69, 551 P2d. 389 (1976).
- ⁷ *Landeros*, supra at 410.
- ⁸ Barton Schmidt, *The Child With Non Accidental Trauma* in Kempe and Helfer, *The Battered Child* 3d, University of Chicago Press page 128 (1980).
- ⁹ The Committee on Early Childhood, Adoption and Dependent Care, *Oral and Dental Aspects of Child Abuse and Neglect Pediatrics* Vol. 78 No. 3, page 537 (Sept. 1986).
- ¹⁰ Kempe and Helfer, *Helping the Battered Child and the Family*, J.B. Lippincott Company, Philadelphia (1972).
- ¹¹ Kleinman, Paul, M.D. *The Diagnostic Imaging of Child Abuse*, Williams and Wilkins (1987).