A Duty to Report, a Chance to Protect

Suspicions of child abuse or neglect trigger a fundamental professional obligation

By Stuart Foxman

Certainty isn't always a luxury in the practice of medicine. So consider a few questions. If you're unsure of a case, yet have suspicions, how strong must they be to have them probed further? When would you consult other experts? Would you just assume it's nothing and let the matter go? What is your duty?

Here's one variable to weigh, which might help you answer. What if the suspected condition was so common that it affected perhaps one-third of children? Would that make you more likely or less likely to ensure the case received continued exploration?

In 2014, the *Canadian Medical Association Journal* reported that 32% of Canadians had experienced some type of child abuse. That includes physical abuse, sexual abuse or exposure to intimate partner violence. Abuse and other forms of neglect are an enormous health hazard for children – and also represent a duty to report for doctors when there are reasonable grounds to suspect it.

That duty means informing a

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Children's Aid Society (CAS) of any suspicions that a child is or may be in need of protection. Being aware of the duty to report, and how to act on it, is a critical obligation for doctors.

Referring to and relying on specialists for follow-up is second nature for doctors. In this case, the consultants happen to be CAS, says Dr. Michelle Shouldice, the former director of the SCAN (Suspected Child Abuse and Neglect) Program at SickKids and head of the Pediatric Medicine Division at SickKids. She said CAS can assess concerns of abuse and neglect in ways that physicians typically cannot – attending the home, for example.

Anyone can report that a child is in need of protection. However, Ontario's *Child and Family Services Act (CFSA)* recognizes that professionals working closely with children have a special awareness of the signs of child abuse and neglect, and a particular responsibility to make a report.

Under the *CFSA*, these individuals include health-care professionals; teachers and school principals; social workers and family counsellors; religious leaders; operators or employees of child care centres; youth and recreation workers, and child and youth service providers; peace officers; and coroners.

The duty to report was thrust into the spotlight after the tragic life and death of Jeffrey Baldwin of Toronto in 2002. The result of the Coroner's Inquest into Jeffrey's death was reported in 2014 and the series of recommendations that came out of the inquest continue to resonate to this day.

Jeffrey was born on January 20, 1997. He suffered years of mistreatment by his grandparents, who had involvement with the child protection system. On November 30, 2002, Jeffrey died at age 5 years and 10 months. He weighed 21 pounds, the same as when he was 2. Cause of death was pneumonia and septic shock due to chronic starvation. His grandparents were convicted of manslaughter.

The Coroner's Inquest jury made 103 recommendations, four of which focused on the duty to report as set out under the *CFSA*. Eight months after the jury reported, and 12 years after Jeffrey died, a life-size bronze statue of him was unveiled in Toronto's Greenwood Park. He is dressed up as Superman, the invincible hero who Jeffrey loved.

Living up to the duty

Recommendation #93 from the inquest called on the CPSO to ensure doctors have ongoing on-the-job training on the duty to report and recognize signs of child abuse and neglect. As a regulator, the CPSO doesn't do such training. But it does communicate expectations via policies, including one on **Mandatory and Permissive Reporting**.

First, it's vital to understand just who is a child in need of protection. See the sidebar, "When to Report", for the list of what constitutes possible abuse or neglect. The duty to report applies to any child who is, or appears to be, under 16. It also applies to children already under a child protection order who are 16 and 17.

The term "reasonable grounds" is important. Under the *CFSA*, you don't have to be certain a child is or may be in need of protection to make a report to a CAS. As the Ministry explains, "Reasonable grounds refer to the

Continued on pg. 13

What Would You Do?

How would you handle these three real-life case scenarios about child abuse?

CASE STUDY 1

Jordan, a 13-year-old male, is morbidly obese and has associated health issues, including Type 2 diabetes. Dr. X, Jordan's family physician, facilitates his enrollment in a weight management program to equip him with lifestyle tools. Jordan's attendance is inconsistent. The doctor's repeated attempts to discuss Jordan's health with his father are unproductive. Jordan's father is adamant that he won't support his son's participation in the weight management program. Dr. X and his team are concerned about Jordan's physical and mental health, as well as his social well-being.

Question: Should Dr. X make a report to CAS?

CASE STUDY 2

Bob, 52, discloses to his psychiatrist Dr. Y that he has sexual fantasies about young females. Bob also admits to a sexual relationship with a 14-year-old female two years prior. According to Bob, the child and her family have moved away. Bob says that although his sexual fantasies continue, he hasn't had sexual interactions with underage females since.

Question: Should Dr. Y report Bob's admission about the 14-year-old to CAS?

CASE STUDY 3

Avery, a 13-year-old-female, is brought to the Emergency Department in great emotional distress. Avery discloses to the emergency physician that she has been sexually abused by her mother's boyfriend. Avery also shares that she told her mother about the abuse, but her mother does not believe her. The emergency physician documents Avery's admission in her chart and pages the on-duty psychiatrist.

Question: Can the emergency physician rely on the psychiatrist to make a CAS report?

ANALYSIS

CASE STUDY 1:

Yes, Dr. X must promptly make a report to a CAS. Under the Child and Family Services Act (CFSA), a child in need of protection includes a child who has suffered, or is at risk of suffering abuse, neglect, or emotional harm. In this instance, Jordan has suffered or is at risk of that harm.

CASE STUDY 2:

*Yes, Dr. Y must promptly make a report to a CAS. Under the CFSA, physicians must promptly report any suspicions that a child is or may be in need of protection to a CAS. This includes cases where a child has suffered or is at risk of suffering sexual abuse. After receiving this report from Dr. Y, the CAS will investigate the information and may involve the police.**

CASE STUDY 3:

No, the emergency physician cannot rely on the psychiatrist to make a CAS report. The emergency physician must report directly to the CAS, even if the result is that two reports are made.

*Please Note: Physicians are not obligated to report suspicions of abuse to the police. However, if information provided by the physician to the CAS alleges that a criminal offence has been perpetrated against a child, the CAS will immediately inform the police, and work with the police according to established protocols for investigation.

When to Report?

What should prompt a doctor to report suspected child abuse or neglect to CAS? Under Section 72 (1) of the *Child and Family Services Act*, if you have reasonable grounds to suspect any of the following:

- **The child has suffered physical harm, or is at risk of that harm, from or caused by the person having charge of the child due to 1) failure to adequately care/provide for, supervise or protect the child; or 2) a pattern of neglect in caring/providing for, supervising or protecting the child.**
- **The child has been sexually molested or sexually exploited, or is at risk of that, by: 1) the person having charge of the child; or 2) by another person, where the person having charge of the child knows, or should know, of the possibility of sexual molestation/exploitation and fails to protect the child.**
- **The child requires medical treatment to cure, prevent or alleviate physical harm or suffering, and the child's parent (or the person having charge of the child) does not provide, refuses or is unavailable/unable to consent to, the treatment.**
- **The child has suffered emotional harm or is at risk of that harm – demonstrated by serious anxiety, depression, withdrawal, self-destructive or aggressive behaviour, or delayed development – and there are reasonable grounds to believe such results from the actions, failure to act or pattern of neglect by the child's parent or the person having charge of the child. This applies as well if the child's parent, or the person having charge of the child, doesn't provide, refuses or is unavailable/unable to consent to, services or treatment to remedy or alleviate the harm.**
- **The child suffers from a mental, emotional or developmental condition that, if not remedied, could seriously impair the child's development and the child's parent, or the person having charge, doesn't provide, refuses or is unavailable/unable to consent to, treatment to remedy or alleviate the condition.**
- **The child has been abandoned, the child's parent has died or is unavailable to exercise custodial rights over the child and hasn't made adequate provision for the child's care and custody or the child is in a residential placement, and the parent refuses or is unable/unwilling to resume the child's care and custody.**
- **The child is less than 12 and has killed or seriously injured someone, or caused serious damage to someone's property, and services or treatment are necessary to prevent a recurrence and the child's parent, or the person having charge, doesn't provide, refuses or is unavailable/unable to consent to, those services or treatment.**
- **The child is less than 12 and has on more than one occasion injured someone, or caused loss or damage to someone's property, with the encouragement of the person having charge or because of that person's failure/inability to supervise the child adequately.**

... Continued from pg. 10

information that an average person, using normal and honest judgment, would need in order to decide to report."

The rules also state that you can't rely on anyone else to report on your behalf. If you have suspicions, you have to report directly to CAS. (You can find information about any CAS at www.oacas.org.)

A professional must report that a child is or may be in need of protection even when the information is otherwise confidential or privileged. This duty overrides any other provincial statutes, and specifically overrides any provisions that would otherwise prohibit someone from making a disclosure.

Doctors who make reports are on solid legal grounds in another way. The *CFSA* provides that you're protected from liability (i.e., in a civil action resulting from a report) unless you acted maliciously or without having reasonable grounds for the suspicion.

The Ontario Medical Association has noted that the duty to report is among the most frequently asked practice management legal questions. In fact, anyone with a duty to report who fails to do so can face professional and statutory sanctions.

Overcoming reporting obstacles

If the duty is clear, it should be automatic in theory. Yet that doesn't always happen.

Dr. Shouldice notes a prominent U.S. study published in *Academic Pediatrics* in 2011. Researchers interviewed a sample of primary care health-care professionals about physical injury cases that they saw. The doctors were asked to rate, on a scale, the likelihood that the patient's injury was caused by abuse. Researchers then compared the doctors' ratings to the views of child abuse experts who reviewed the clinical vignettes.

For the most part, the doctors and child abuse experts agreed about the suspicion of abuse in the injury cases. However, the study found that the doctors did not report to child protective services in 21% of the injuries that the experts would have reported.

Several factors can influence whether doctors carry out the duty report. First, do they recognize the signs? Not always, says Dr. Shouldice. In the case of physical abuse, there are some signs which are very important, yet frequently overlooked by physicians, she said, such as bruising in infants before they are able to crawl and walk.

Yet suspicion in cases of physical injury may be stronger than in cases of possible sexual abuse. As Dr. Shouldice says, many physicians are not well trained when it comes to the assessment of concerns of sexual abuse, particularly in young children. Cases of possible neglect can be harder still for doctors to determine. "That's more of a grey area," she says, explaining that because neglect is often an ongoing failure to provide for a child's basic needs, the physician may not be sure when the concerns reach

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the level requiring a report to CAS versus giving the parents the benefit of the doubt or providing general supports.

Start then with a responsibility to learn about and understand the red flags. The physical signs, which are more obvious, include: bruises and fractures which are attributed to usual daily activity or unexplained, particularly in infants, and bruises in unusual areas (fleshy area of the facial cheeks, buttocks, abdomen).

Dr. Shouldice said the impact of abuse and neglect may include developmental, behavioural and mental health symptoms which may mimic conditions physicians commonly assess, including aggressive behaviour, anxiety, depression, impulsivity, and inattention.

"Physicians should consider inquiring about exposure to violence in the home, as they would about other psychosocial stressors, when assessing children presenting with behavioural or mental health symptoms. This requires speaking with the child separately from parents and using neutral, open-ended questions," she said.

When a doctor does have suspicions, it isn't his or her role to confirm them. Remember, this isn't about absolute certainty but about reasonable grounds.

Dr. Shouldice says if doctors do have genuine doubts about involving CAS, it may be useful to consult child maltreatment experts (you can find them in all the pediatric training centres), or to consult with CAS (i.e., discuss concerns in general, without providing identifying information).

"If you're consulting, it's generally because you're uncertain if you should be concerned," says Dr. Shouldice. "If you've already reached the threshold for reasonable grounds to be concerned, the report should go to CAS."

Yet other barriers can get in the way of reporting. Dr. Shouldice says there can be a tendency to believe a family when they explain away signs of possible abuse or neglect. She says the 2011 study in *Academic Pediatrics* found that the more familiar doctors were with families, the less likely they were to report.

Dr. William Watson, a family physician at St. Michael's Hospital in Toronto, says there's a reluctance to put families under a microscope, and perhaps a fear too that reporting can make the situation worse. He says doctors can also worry about what to say to families. Although that conversation can happen in a non-judgmental way: "Have you noticed anything different with your child?" or "I have a concern and would like to consult with someone else."

Child abuse and neglect is complex, but for doctors who have suspicions the answer is ultimately straightforward: let the experts figure it out. "If you can prevent a child from being abused," says Dr. Watson, "you may prevent a lifetime of problems for them."

Sources for Further Reading

- Mandatory and Permissive Reporting, CPSO policy, www.cpso.on.ca
- "Reporting Child Abuse and Neglect: It's Your Duty", Ministry of Children and Youth Services, www.children.gov.on.ca MD