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Congress Should Think Twice Before Supposing that S.B. 1009 will Stop Infant Abuse or Prevent Fatalities

S.B. 1009 is a well-intentioned but misguided approach to protecting vulnerable children—one that rests on some mistaken assumptions and lacks objectivity and neutrality. Not only does this bill fall short on its promise to stop infant abuse and prevent fatalities, it holds the real potential to *harm* children. A growing number of child and family advocacy groups oppose S.B. 1009 because of its potential to increase the number of wrongful abuse conclusions while overlooking underlying medical conditions or accidental injuries.

WHAT S.B. 1009 DOES

This bill creates a new fund of $10 million—in addition the funding already contained in the authorization of the Child Abuse Prevention and Treatment Act— to create protocols for the identification and assessment of unexplained faint marks, sometimes called "sentinel injuries", in infants under the age of 7 months. While abused children are known to have unexplained marks at significantly higher rates than non-abused children, prosecutors and child protection investigators operate on the false assumption that child abuse pediatricians have a "crystal ball" that enables them to tell whether or not a faint mark was caused by abuse.

The bill increases the funding available for the investigation of so-called "sentinel injuries" without providing funding for objective scientific (and peer reviewed) research that would help medical providers, prosecutors, or child protection investigators to be able to distinguish between marks caused by abuse, accidental injury, and undiagnosed medical conditions. By excluding neutral doctors and family advocates from the development of policies, the bill opens the door to increasing prosecutions of innocent parents, especially minority parents and the parents of disabled children and those with rare disorders.

CHILD ABUSE SHOULD NOT BE A DEFAULT DIAGNOSIS

- **The use of the term "injury" presupposes abusive causation.** Neutral medical terms for the types of medical findings discussed in this bill are "cutaneous and oral lesions", terms that simply refer to changes in the skin and mouth. Medical doctors can diagnose the existence of lesions, but doctors cannot diagnose causation. When medical providers assume abusive causation, it can:
  - Prevent or delay diagnosis and treatment of underlying medical disorders, which can cause unnecessary suffering for the child and can even lead to potentially life-threatening outcomes;
  - Prevent consideration of accidental injuries;
  - Lead to wrongful allegations of abuse, wrongful removal of children from loving homes, and wrongful convictions; and
  - Waste limited child welfare resources that could be invested in the identification and prevention of actual abuse.
- **Allowing child abuse pediatricians to lead research efforts compromises the objectivity of medical examinations and diagnoses.** This bill paints the picture of an array of medical specialists working together to increase the identification of abuse, when in fact the individuals who would be involved in this study would be almost exclusively child abuse pediatricians, child welfare caseworkers, law enforcement officers, and prosecutors. This is not a neutral set of fact finders—it is effectively a prosecutorial team that is more likely to find abuse and less likely to consider an array of alternative medical possibilities. This method of establishing policies and protocols for assessment of "sentinel injuries" slants the system in favor of false positives. The failure to include treating physicians, such as hematologists, dermatologists, endocrinologists, or pathologists makes this new system for earlier detection of abuse a recipe for biased determinations that exclude genuine medical causes of marks on young children.
- **The retrospective study on which the bill relies is inadequate to support policies that the bill calls for.** More research is needed, not implementation of policies on the basis incorrect inferences from the data. The study cited in Section 2 (4) was led by Lynn Sheets, Medical Director of Child Advocacy and Protection Services at the Children's Hospital of Wisconsin. The study was a retrospective analysis that looked into the medical records of children who were considered to be a victim of abuse. If the child's records showed a history of an unexplained cutaneous or oral lesion, that lesion was retrospectively labeled a "sentinel" injury." Retrospective studies are considered by researchers to be problematic in that they are prone to bias and vulnerable to the impact of confounding variables. [1]
- **The assumption that we know how to predict future abuse from early citing of cutaneous and oral lesions is false.** It is premature to adopt more entrenched protocols before research provides a better approach that will wean false positives from the underreported cases.

NOT ALL UNEXPLAINED MARKS ON INFANTS ARE EMBLEMMATIC (OR PATHOGNOMIC) FOR ABUSE

- **Research shows that many medical conditions resulting in cutaneous and oral lesions can be mistaken for child abuse.** Such diagnostic errors stem from unusual disease presentations, the presence of a rare condition, or because of the medical provider's failure to consult with board-certified treating specialists. Certain populations are especially vulnerable to medically-based wrongful allegations of abuse, including racial and ethnic minorities, the economically disadvantaged, undocumented immigrants, and LGBTQ parents. For this reason, it is urgent that those tasked with identifying the cause of cutaneous and oral lesions are knowledgeable about the conditions that mimic child abuse and rely on board-certified treating specialists experienced in differentiating between medical conditions, accidental injury, and abuse.
  - **Cutaneous lesions, including bruises in pre-mobile infants, are not pathognomonic for child abuse.** Potential causes include Mongolian spots, fungal/viral/bacterial infections, vasculitis, vascular malformations, petechia, immune thrombocytopenic purpura, idiopathic thrombocytopenic purpura, Von Willebrand disease, hemophilia, Berard-Soulier syndrome, Glanzmann thrombasthenia, storage pool disease, May-Hegglin anomaly, Wiskott-Aldrich syndrome, hemorrhagic telangiectasia, EpisAXIS, cryoglobulinemia, pulmonary-renal involvement, malignancies, Ehlers Danlos syndrome, osteogenesis imperfecta, dermatomysitis, phytophotodermatitis, hemangiomas, meningococcemia, incontinentia pigmenti, erythema multiforme, digitform parapsoriasis, pyoderma gangrenosum, erythema marginatum, eczema, nutritional deficiencies, striae, skin staining from dyes, incontientia pigmenti, Cushing's Disease, Marfan's Syndrome, use of medications (heparin, steroids, NSAIDS, etc), pressure (from clothing and child restraint fasteners), and accidental injuries.
  - **Oral lesions, including frenulum tears in pre-mobile infants, are not pathognomonic for child abuse.** Potential causes include cysts, osteomyelitis, herpes simplex virus, candidiasis, mucocele, ranula, Riga-Fede disease, breastfeeding keratosis, intubation attempts, neonatal pemphigus, hemangioma, lymphangioma, Langerhans cell histiocytosis X, congenital epulis, melanotic neuroectodermal tumors, epignathus, oral choristomas, and salivary gland neoplasms.
- **Research clearly indicates that pre-mobile children are at risk for a number of accidental injuries.** A 2001 study of 11,466 children under 6 months of age, found that 2,554 experienced falls. Of these children, 14% reported a visible injury, 56% of which were bruises.[2] Common accidents between 0-7 months includes caregiver-related accidents (such as dropping the infant or tripping while holding the infant), sleeping on top of a hard object, rolling off furniture, tipping from a sitting position, injuries from pets, injuries from siblings, carpet burns (from rolling or creeping), and more. Some common equipment can also result in cutaneous lesions, such as car seats, bouncy seats, high chairs, and infant carriers. Even the most attentive parents may not realize these injuries occurred or may not notice them promptly enough to give accurate reports to prosecutorial-focused individuals when questioned. Vulnerable minorities who are already at high risk for child protection intervention are likely to become the targets of more invasive investigations and risk losing custody based on false positive reports made

and supported by child abuse pediatricians, without having access to neutral medical experts.

MEDICALLY-BASED WRONGFUL ALLEGATIONS HARM CHILDREN

- **By promoting the idea that all unexplained cutaneous and oral lesions are suspicious for abuse, SB 1009 could harm, not help children.** By filling child protection investigators' caseloads and the courts with an ever-increasing number of cases, the child welfare system is at risk of unnecessarily harming children— both through wrongful allegations of abuse and through the failure to detect actual abuse. When agencies and court systems are flooded with cases, hearings to determine the merits of individual cases are further delayed. Unharmed children may be wrongfully removed from loving homes while vulnerable children needing protection may be left in harmful homes.
- **Wrongful allegations are extremely traumatizing to children— even young infants.** Being separated from parents may cause grief, terror, and feelings of abandonment, as well as compromise a child's ability to form secure emotional attachments. [10]

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Movement for Family Power
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And others in formation.

Notes:

1. Viswanathan M, Berkman ND, Dryden DM, et al. Assessing Risk of Bias and Confounding in Observational Studies of Interventions or Exposures: Further Development of the RTI Item Bank [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2013 Aug.

2. Warrington SA, Wright CM, Team AS. Accidents and resulting injuries in premobile infants: data from the ALSPAC study. Archives of Disease in Childhood 2001;85:104-107.

3. Chill, Paul, "Burden of Proof Begone: The Pernicious Effect of Emergency Removal in Child Protectice Proceedings" (2004). University of Connecticut School of Law Articles and Working Papers. 55.
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