Chapter 18
Mandatory Reporting of Child Abuse and Neglect by Health Professionals

Debbie Scott and Jennifer Fraser

The role of Australian health professionals in reporting child abuse and neglect, in particular medical and nursing personnel, has increased substantially during the past two decades. This chapter discusses key issues related to the recognition and reporting of child abuse and neglect by health professionals in Australia. The responsibilities of not only recognising but reporting all forms of child maltreatment by doctors and nurses are introduced. Health professionals, like teachers, police and other professional groups, are variously obligated through policy and legislation to report their knowledge or suspicion of child maltreatment. As well, health services impose policies in line with the legislation specific to their jurisdiction to assist clinical staff in responding when they know of, or have a reasonable suspicion of, harm being caused to a child. In most Australian states and territories, if doctors and nurses know or suspect that a child is, has been or is likely to suffer significant harm, then they have a legal obligation to report this to designated authorities.

The Australian Institute of Family Studies (AIFS) is committed to the creation and dissemination of research-based information on family functioning and wellbeing. Views expressed here are those of individual authors and may not reflect those of the Australian Institute of Family Studies or the Australian Government.

D. Scott (✉)
Australian Institute of Family Studies (AIFS),
485 La Trobe Street, Melbourne, VIC, Australia
e-mail: Debbie.Scott@aifs.gov.au

J. Fraser
Sydney Nursing School, The University of Sydney, Sydney, NSW, Australia

B. Mathews, D.C. Bross (eds.), *Mandatory Reporting Laws and the Identification of Severe Child Abuse and Neglect*, Child Maltreatment 4,
DOI 10.1007/978-94-017-9685-9_18

A Case Study: Sarah's Dilemma

In the case study below, we provide a scenario that is typical of the experience of health professionals working in Australian hospital emergency departments. The case study is used to illustrate the issues that they face and that are discussed throughout the chapter:

> Sarah is a Registered Nurse working a Saturday afternoon shift in the emergency department of a busy regional hospital in Australia. In the State in which she works, Sarah has a legal obligation to report knowledge or suspicion of child abuse and neglect in her professional role when she has a reasonable suspicion that a child has been, is being, or is likely to be, significantly harmed.[1] Sarah has been to all the training sessions offered by the hospital regarding reporting of child maltreatment and is aware of her responsibilities.
>
> At 5 pm, three year old Brittany presented to the hospital with her mum, Julie, and step-father, Garry for treatment of a laceration on her forehead, caused when she fell against the coffee table. This was the fifth time Brittany had been brought to the hospital for an injury. None of the previous physical injuries had been considered significant and she had never been admitted to the hospital for ongoing treatment of her injuries. Nevertheless, Sarah was concerned about a pattern emerging. She became suspicious of the previous injuries and concerned about future harm to the child. Sarah was concerned for a number of reasons. Garry, like many men in the district, had a well-paid position at the mine site within the district. He was known in the community as a heavy drinker. Each of Brittany's injuries had occurred when Garry was at home and not while he was away at work. While explaining to Sarah how Brittany sustained the injury, Julie consistently deferred to her partner Garry's version of events. While she would initiate an explanation, she seemed to be watching his reactions carefully and would be silent when he interrupted her. Brittany did not go to Garry for comfort and cried if Julie left the cubicle.
>
> Sarah was aware of her obligations to report her suspicions but was unsure if reporting would be the right thing to do for this family. Sarah's own father was an alcoholic and she grew up with him. Occasionally he was abusive to her mother and herself and she feels she has turned out well despite this. She feels she knows the family well and has a very good rapport with Julie in particular. Garry is away much of the time and Julie is a good mum to Brittany. The town they live in is small and many of the men who work on the mine drink heavily while at home. Garry behaves in much the same way socially as any of the other workers. Sarah is concerned that if she makes a notification of child abuse it might affect her relationship not just with this family but with others in the community, violating a trust that has developed. She is also concerned that it will only exacerbate the home situation and inflame Garry who will blame Julie for the situation, and may even discover that Sarah is the one who reported the abuse. She is not confident that her identity will be protected and worries about the consequences of reporting. She is not sure if she should confer with her colleagues.

[1] In the Queensland mandatory reporting legislation applying to nurses (the *Public Health Act 2005* (Qld)), a nurse must make a report if she or he 'becomes aware or reasonably suspects, during the practice of his or her profession, that a child has been, is being or is likely to be harmed' (s 191). 'Harm' is defined in s 158 as 'any detrimental effect on the child's physical, psychological or emotional wellbeing—(a) that is of a significant nature; and (b) that has been caused by physical, psychological or emotional abuse or neglect; or sexual abuse or exploitation'.

Health Professionals and Child Protection

Access to Families with Children, Especially in the Early Years

Health professionals play an important role in recognising and reporting child maltreatment in Australia. The health system including community and hospital services provides a first point of contact capable of intervening in child abuse and neglect. Until a child starts school or an early childhood education programme, they spend their time at home. The outside world may be largely unaware of what occurs within families. This magnifies the responsibility of the health professional in terms of identifying, documenting and reporting child maltreatment.

Few, if any, children would start formal education without having contact with a health professional at some stage prior to that time. In Australia, there is a robust Community Child Health Service in all states and territories. Community child health nurses are well trained in screening for child abuse and neglect risk indicators. Mechanisms through which child maltreatment occurs and is maintained within families generally include developmental history, personality factors, cultural expectations, familial interactions and child characteristics (Daro 1993; Zeanah et al. 1997). At the same time, it is difficult to recognise child maltreatment even for children like Brittany who present numerous times in early life for injuries. It is estimated that one in six children presented to an emergency department for physical injury and that between 1 and 10 % of these children have actually suffered physical abuse (Benger & Pearce, 2002). Children under the age of 12 months are more likely than older children to be admitted to the hospital for injuries sustained through maltreatment. Unfortunately, they are also more likely to die from their injuries (McKenzie and Scott 2011; O'Donnell et al. 2011).

Perceived Role/Reporting Practice

In Australia, reports by health professionals accounted for only 13.5 % of all reports to statutory child protection authorities. This is compared to 24.6 % from police and 15.1 % from schools (Australian Institute of Health and Welfare 2013). In Canada, other professional groups report more child abuse and neglect than health-care professionals do. In that country, school personnel, police and social workers all report more child abuse and neglect than health-care professionals (Tonmyr et al. 2009). Further research is needed to disentangle the underlying reasons for these figures. It may be that health professionals are primarily exposed to children who present with physical injury or illness. Unfortunately though, there is still the possibility that they may not view child protection as part of their role to the same extent as police, social workers and others.

A survey of the General Practitioners in Queensland, Australia, revealed that even though 97 % were aware of their legal requirement to report child maltreatment, and 69 % had done so at some stage, 26 % had decided, at least once, against reporting their knowledge or suspicion of abuse or neglect (Schweitzer et al. 2006). Unfortunately, it was beyond the scope of this particular study to be able to elicit which forms of maltreatment were less likely to have been reported. Results did reveal that if the doctor thought this was a one-off presentation of maltreatment and not likely to be repeated, then a report, they said, would not be made. Further harm to the child was thought to be very unlikely.

Similarly in their study of Queensland nurses, Fraser et al. found that of the 930 registered nurses they surveyed, 21.1 % had never reported maltreatment. Of those who had made reports in their professional role, 26.6 % had also decided not to report maltreatment on at least one occasion (Fraser et al. 2010), despite mandatory reporting requirements. These studies reveal that despite the legal obligation placed on doctors and nurses to report suspicion or knowledge of child maltreatment, sometimes they do not. The reasons are quite well known, as will be discussed in this chapter. The way forward in improving these rates is less clear.

Recognition

Diagnosis

Based on the studies reviewed above, there appears to be a number of impediments to health professionals reporting child maltreatment. The first of these that we will discuss is recognition of past, current and future abuse and neglect. Before clinical staff can respond and report, they must first make the connection that what they are seeing *is* child maltreatment. In the case of physical abuse, discerning whether a presentation such as the lacerated forehead from a fall, as in our case study, or a broken arm is due to falling down a flight of stairs or being pushed down those stairs is not easy.

There is quite a significant and well-enough understood literature about the injury type and the relationship of injury presentations and physical and sexual abuse in particular. Certain physical injury presentations are more likely to have resulted from maltreatment. Any fracture in a preambulatory child is concerning; however, fractures of the femur (Leventhal et al. 2007), rib fractures, bucket handle or corner fractures (caused by twisting forces), skull fractures or a combination of a skull and long bone fractures are immediately associated with abuse (Bandyopadhyay and Yen 2002). Head injury is the most common cause of abusive injury-related death in children (King et al. 2006), and abused children are more likely to sustain a head injury than other children, particularly in those under 2 years of age (Berkowitz 1995; DiScala et al. 2000).

Head injury in infants is commonly associated with acceleration-deceleration injuries that point to the infant having been shaken, potentially a shaken baby syndrome.

When considering the causes of injury, it is not enough to undertake a physical assessment of injury and risk alone. Shaken baby syndrome often presents with subdural or subarachnoid bleeds, cerebral oedema, long bone and/or rib fractures, retinal bleeds and little or no craniofacial trauma (Cadzow and Armstrong 2000; Kairys et al. 2001; Reece and Sege 2000). These injuries can be difficult to diagnose as patients may not exhibit any external signs of trauma, and the symptoms may mimic gastrointestinal symptoms (Jenny et al. 1999; Kairys et al. 2001; Keenan et al. 2004).

When a child presents for treatment of an injury and the parents/caregivers cannot explain how that occurred, it should be a cause of concern (Scott 2012; Scott et al. 2012). Other injuries may result as an unintended consequence of corporal punishment, for example, a child attempting to avoid being struck and falling.

In the case study presented herein, Brittany's presentation makes the diagnosis much less certain. Her parents don't seem to be telling the same story of how the injury occurred, her father appears to have been drinking, and the mother appears to be worried about saying too much.

A family approach to assessment including psychosocial risk needs to be employed. Child abuse and neglect are known to be associated with parental alcohol or drug misuse, domestic violence, mental health issues, inadequate housing, financial stress and social isolation, and all of these issues need to be considered when assessing for abuse and neglect. Understanding the context of what is occurring at home and how that impacts on the family can provide a greater understanding of a child's wellbeing within that family (Scott 2013) and inform health professionals in their decisions about reporting abuse and neglect. At the same time, it is necessary for the emergency department staff to recognise the risks of abuse and neglect and make a report of suspicion. That is, they are not making a decision to substantiate the suspicion, rather linking the risk indicators to confirm that a report is necessary based on the seriousness of the harm or the potential harm to the child.

The Impact of Training in Recognition of Abuse-Related Injury

In interviews with Australian doctors, nurses and child protection liaison officers, Scott et al. (2012) hoped to better understand factors that influence them identifying, documenting and reporting child protection issues in emergency departments. The majority of the nurses and doctors clearly understood the procedures for reporting child maltreatment. However, they reported that training in recognising maltreatment had only ever occurred during their university courses. For many, no training had ever been undertaken (Scott 2012).

Health professionals are not confident in recognising and reporting maltreatment in New South Wales (NSW) hospitals (Raman et al. 2012). There is a considerable variation across Australian jurisdictions relating to the level and types of harm that require a report to child protection authorities. At one end of the spectrum, doctors and nurses in Western Australia must only report sexual abuse. Near the other end

of the spectrum, in South Australia, doctors and nurses must report situations of physical abuse, sexual abuse, emotional abuse or neglect where a child 'has suffered, or is likely to suffer, physical or psychological injury detrimental to the child's wellbeing; or the child's physical or psychological development is in jeopardy' (Mathews and Scott 2013). The complexity of the principles and the ambiguity of the terms used to describe the level of harm which activates the reporting duty – such as 'injury detrimental to the child's wellbeing' – can cause concern and confusion for some health professionals. Because of this, some doctors and nurses are inclined to report all maltreatment, regardless of the level of harm, making them liable to report cases that do not meet the threshold (Fraser et al. 2010; Scott 2012). There is a confusion around what to report, and nurses in particular may feel they are obliged to report all maltreatments as mandated reporters, while others appear to be uncertain about what level meets the reporting threshold and so report because they are concerned about the consequences for the child and for themselves professionally if they do not (Fraser et al. 2010; Scott 2012). Nurses in the Queensland study made comments like '*It's almost come to a point that we want to protect ourselves and anything that can just even come back at you … we just report, so it's almost protecting ourselves*' (Scott 2012 Page 186) and '*it's better to over report than under-report*' and '*better to be safe than sorry*' (page 191). Mathews et al. (2008) noted that this could be due to the ambiguous language in legislation that is open to personal interpretation of what constitutes an incident that meets a reportable threshold. This reporting is reliant on health professionals forming a 'reasonable' suspicion of 'significant' harm now or 'in the future'. This lack of clarity on what constitutes harm at a reportable level requires training and appears to be lacking in the training received by health professionals.

Fear of Consequences

Damage to Therapeutic Relationship

Doctors and nurses often develop strong bonds with the families they treat, and there is a fear that reporting child maltreatment may damage that relationship (Flaherty and Sege 2005; Nayda 2002, 2004; Schweitzer et al. 2003; Scott 2012; Van Haeringen et al. 1998). In the Queensland study by Scott (2012), some doctors were concerned that a record of what may end up being an unsubstantiated report of maltreatment on a medical record could prejudice the treatment of the family in the future. Indeed, they feared that if they reported the family, the family may not seek treatment for the child if there was a future injury. Nurses interviewed by Scott (2012) were reluctant to report maltreatment for families they knew well. They reported that they believed the maltreatment was not serious enough to report, sometimes not recognising the maltreatment at all. One nurse commented '*If the nurse knows the family that makes it hard. If they're family friends, especially being*

a small town…they don't think that they should report, you know, family friends. They don't think that it's happening' (Page 182). In other research, this has also been noted in workers facing child neglect. As the social worker deals with the family, they are 'drawn into' the family's situation. They can be reluctant to report the maltreatment when the family is already dealing with a disadvantage and other issues, feeling it will only exacerbate the problems, or their perception changes and they become 'acclimatised' over time – failing to see the level of harm occurring to that child (Tanner and Turney 2003).

Health professionals were also concerned with damaging the relationship they had with adults in their care who were parents. If a parent's capacity is diminished by, for example, a mental illness or substance abuse disorder, the health professional may be conflicted as to whether or not to report. In the Scott (2012) study, they revealed some concern that reporting is a violation of confidentiality with the potential to exacerbate the parent's condition.

Fear of Being Identified as the Reporter

Health professionals have also mentioned a fear of retaliation from the family if the identity of the reporter is revealed and of knowing a family and therefore not wanting to 'see' the maltreatment and 'not wanting to get involved', particularly if there were issues of domestic violence in the home (Nayda 2002; Schweitzer et al. 2003; Van Haeringen et al. 1998). Scott (2012) found similar concerns, particularly in regional and remote centres. Health professionals were very concerned that there could be repercussions for them or their families. Despite laws protecting the identity of the reporter, those health professions were concerned that other health workers, who were related to the family, may note the report in the child's medical record. Comments from a child protection worker in the Queensland study included, '*I think it's very difficult … raising reports, particularly when you live in a community and there's often retribution when Child Safety is involved and things can get pretty nasty*' and a child protection liaison officer speaking about nurses who had come back to her after a report included, '*I do have a couple of occasions where people have come back to me and said, Oh I wish I didn't put that in because the family have found out that they were the ones to initially raise the concerns; and there'd been repercussions from that*' (Page 183).

Poor Medical Documentation

The fear of being identified may go some way to explain why there is reluctance to explicitly document concerns in the medical record. Health professionals frequently rely on verbal communication rather than written documentation to relay information regarding potential maltreatment. Despite the fact that the medical record is a record

of patient care and can be used as evidence in court proceedings, documentation specific to maltreatment is often lacking (McKenzie and Scott 2012; Scott 2012). One study found that fewer than 7 % of emergency department medical records complied with the recommended documentation (McKenzie and Scott 2010; Scott 2012). Emergency department nurses seldom document concerns of child abuse, instead allowing doctors and inpatient paediatric nurses, who were perceived as the experts, to take this role. When patients were transferred from the emergency department to the ward, nurses would exchange information at handover that did not use the word 'abuse' but suggested the admission was 'suspicious'. Nayda (2004, p. 194) described one nurse in South Australia saying 'We do a lot of talking and thinking and handing over…a lot of talking is going on but not documentation', and she noted that nurses were reluctant to document a thorough assessment of cases of maltreatment particularly in an emergency department, where encounters with violent patients were a commonplace. By communicating orally and not documenting the maltreatment, nurses were able to remove themselves from the immediate picture and therefore minimise their responsibility for the situation (Nayda 2004).

Medical Context: Professional Culture and Hierarchy

The medical system has traditionally included a hierarchical structure, and health professionals continue to adhere to this structure. Where differences of opinion occur between doctors about whether a child protection report should be made, the senior staff member's decision is generally adhered to, despite requirements to report all concerns to child protection authorities (Scott 2012). Nurses are reluctant to document concerns or generate a report to child protection authorities in circumstances where a doctor disagrees with the nurse's assessment of the situation. In her research, Nayda (2004) identified the subservient position of nurses as an issue in identifying and reporting maltreatment, with most nurses unwilling to speak up against a doctor who determined a patient was or was not a victim of maltreatment. Similarly, Alvarez et al. (2004) noted that where there is conflict with a supervisor about whether or not a report to child protection is necessary can result in a lack of confidence and frustration. Research in the Queensland study (Scott 2012) identified similar issues with one doctor saying '*So if the senior medical officer disagrees with the junior medical officer – the senior medical officer wins*' (Page 187). Interestingly, one of the child protection liaison officers noted that mandatory reporting was a way to deal with this medical hierarchy saying '*That's the greatest thing about mandatory reporting …if they are suspicious and the senior staff disagree, they are still obliged to report*' (Page 187).

The medical model of practice in an emergency department also plays a role in the reporting of child maltreatment. In Scott's 2012 study, clinicians noted that the processes for managing child maltreatment in an emergency department are quite different to managing other conditions. The emergency department is typically a place where the injury or disease of a patient is identified and their condition

stabilised, and then the care is referred to specialists who ensure ongoing care and referral. Emergency departments are busy, high-stress environments, and the workload in a busy emergency department was considered an impediment to reporting. There is a significant time required for the completion of the reporting process, and when the department is busy, the focus has to be on the clinical wellbeing of patient care, so the paperwork required for reporting maltreatment takes a lower priority. This can occasionally lead to inadequate documentation. One doctor said that there was inadequate access to specialists and that where maltreatment was considered to be a possibility, it should not be up to the emergency department staff to gather information needed to make a report to child protection; instead, a specialist team should be called who would undertake an assessment and respond accordingly. This, he argued, would put managing child maltreatment into the same paradigm as other conditions in the emergency department. While there was an acknowledgement that there are health professionals with this expert training available in specialist paediatric hospitals and to a smaller degree during 'office hours' in regional and remote hospitals, this is not the case in smaller, less well-resourced regional and remote hospitals. Access to such expertise would contribute positively to the identification, documentation and reporting of child maltreatment in emergency departments, particularly in regional and remote hospitals (Scott 2012).

Child Protection System Responses

Practitioner Perceptions of Systemic Failure to Respond to Reports and Influence on Reporting Attitudes and Practice

For the most part, child protection system responses only occur in Australia both when there is evidence of significant harm for a child *and* where a parent is unable/unwilling to protect a child from that significant harm. Reports may be made that do not meet the threshold or are dealt with by means other than an investigation and subsequent child protection intervention. This may lead to a perception that child protection workers are failing to respond to reports by health professionals or that health professionals are reporting more cases than necessary to child protection systems (Flaherty and Sege 2005; Nayda 2002; Scott 2012). Nayda (2002) noted that some community nurses feared reporting in case the report was not substantiated, and so families might 'disappear' from the system, leaving no one able to support them and monitor the wellbeing of the children. Scott (2012) found that for some health staff, this perceived lack of action on behalf of child protection was an incentive to continue to report minor incidents or report the same incident in the hope that a multitude of reports would influence some sort of action.

As well as serving as a barrier to reporting, the lack of understanding of the different frameworks led to some professional tension, with both groups feeling undervalued by the other. Health staff felt that a perceived lack of action by child protection

workers devalued their professional assessment of the need for intervention; and child protection caseworkers commented that health staff did not value their professional assessment and the fact that their investigation may reveal more than was immediately known by health staff. Child protection case workers, however, clearly valued the input from health professionals and acknowledged that in some circumstances a report from health professionals was an incentive to act more quickly than others (Scott 2012).

Perceptions of Child Protection System Responses

Scott's research (2012) highlighted the concerns of health professionals in relation to reporting child abuse and neglect. On the one hand, it is considered a tool for protecting children from harm through the implementation of family support, that is, an early intervention and protection strategy. On the other hand, it is seen as punitive with punishment for perpetrators when cases are substantiated. In the Scott (2012) study, some health professionals were reluctant to report because they feared the caseworkers would respond by removing children from their homes. Conversely, others commonly said that they didn't see a point in reporting because the child protection authorities 'never did anything anyway'; this was particularly true in cases of chronic, low-level neglect.

Sites with strong relationships that allowed for informal consultation also seemed more willing to share information. This resulted in health professionals receiving feedback on the outcomes of reports. These sites also appeared to have a better understanding of the issues the other agency faced. On the other hand, sites where the only communication was through formal documentation, health staff felt undervalued and that the child protection workers didn't respond to their concerns. At the same time, child protection workers felt that the health professionals didn't understand their priorities, and they felt undervalued by health professionals.

Interagency Alliances

The variable nature of relationships between individuals and departments in the hospital and the two agencies (health and child protection) was also a central theme that emerged in Scott's 2012 study. Clinical staff valued verbal consultation and found learning from each other's experiences. Some child protection offices noted a cooperative atmosphere whereby both agencies relied on the support and expertise of the other to make informed decisions for the wellbeing of children. In contrast, in other regions, the atmosphere was almost adversarial with all information requests having to flow through official channels and a refusal to deal one-on-one

with professionals from the other agency due to years of entrenched distrust. In one site this had come about from an informal comment made by a health professional that was used in formal documentation by a child protection worker. The health professional felt she had been misrepresented and risked being identified by the family. Despite both staff members subsequently leaving their employment, this mistrust and fear of being misrepresented continued (Scott 2012).

The time they spend with children and families in their care, the intimate nature of their work, their knowledge of child health and development and the position of trust they hold places doctors and nurses in a strong position to detect child maltreatment. Skilled health professionals can identify the more subtle signs of emotional maltreatment as well as the more obvious signs of physical or sexual assault. The way in which medical and nursing staff respond to children such as Brittany, as presented in our case study at the start of this chapter, can influence how the family is supported to provide an optimal parenting environment for her and reduce the risk of further injury. Despite the potential barriers to protecting children detailed in this chapter, children like Brittany are very likely to be identified as at risk within the Australian health-care system. Where community support systems are in place, it is likely that such families will be followed up and supported. Early intervention and prevention services can be provided but only when the situation is recognised, assessed and referred to the appropriate community support networks. In the following section, we discuss the way forward in improving this potential.

What Can Be Done to Improve Culture, Education and Practice?

Identification and confidence in reporting for health may improve with better access to training for health professionals (Scott 2012). Health professionals working with children should have a comprehensive understanding of the nature and context of different types of child abuse and neglect, when to be concerned about child protection matters, how to diagnose abuse-related injury, what should be documented in the medical record, the nature of the legal reporting duty, the reporting process involved in alerting child protection authorities to a child in need of protection, what to expect after a report is made and how best to support the child and family. This training should not only occur at the pre-vocational level but needs to be maintained during the working life of the health professional. Scott (2012) identified that interdisciplinary training would be most useful. Child protection and health professionals, police, teachers and other community workers involved in protecting children and the care for their welfare could share training sessions and thereby improve their understanding of the needs and restrictions of other workers in the field and to build relationships that would facilitate future informal consultation and information sharing.

Summary

The legal obligation to report suspicion and knowledge of child abuse and neglect in Australia is well established, though perhaps not well understood. There are numerous strategies and policies in place to assist health professionals to report their concerns, and yet many children still do not benefit because their injuries are not reported and investigated. When they are reported, it is because the abuse has become so severe the child may not survive the injuries. Early identification and prevention is the goal of mandatory reporting of child abuse and neglect, and health professionals have a legal and ethical responsibility to act to protect children from all forms of harm. To do so, they need to be well supported with training in the recognition of child abuse and neglect presentations and be committed to the practice of reporting knowledge or suspicion of all forms of violence experienced by children.

References

Alvarez, K. M., Kenny, M. C., Donohue, B., & Carpin, K. M. (2004). Why are professionals failing to initiate mandated reports of child maltreatment, and are there any empirically based training programs to assist professionals in the reporting process? *Aggression and Violent Behavior, 9*(5), 563–578.

Australian Institute of Health and Welfare. (2013). Child protection Australia: 2011–2012. In *Child Welfare Series*. Canberra: AIHW.

Bandyopadhyay, S., & Yen, K. (2002). Non-accidental fractures in child maltreatment syndrome. *Clinical Pediatric Emergency Medicine, 3*(2), 145–152.

Benger, J. R., & Pearce, A. V. (2002). Simple intervention to improve detection of child abuse in emergency departments. *British Medical Journal, 324*(7340), 780–782.

Berkowitz, C. (1995). Pediatric abuse. *Emergency Medical Clinics of North America, 13*, 321–342.

Cadzow, S. P., & Armstrong, K. L. (2000). Rib fractures in infants: Red alert! The clinical features, investigations and child protection outcomes. *Journal of Paediatrics and Child Health, 36*(4), 322–326.

Daro, D., Jones, E., & McCurdy, K. (1993). *Preventing child abuse: An evaluation of services to high-risk families*. Philadelphia: William Penn Foundation.

DiScala, C., Sege, R., Li, G., & Reece, R. M. (2000). Child abuse and unintentional injuries: A 10-year retrospective. *Archives of Pediatrics & Adolescent Medicine, 154*(1), 16–22.

Flaherty, E., & Sege, R. (2005). Barriers to physician identification and reporting of child abuse. *Pediatric Annals, 34*(5), 349–356.

Fraser, J. A., Mathews, B., Walsh, K., Chen, L., & Dunne, M. (2010). Factors influencing child abuse and neglect recognition and reporting by nurses: A multivariate analysis. *International Journal of Nursing Studies, 47*(2), 146–153. doi: 10.1016/j.ijnurstu.2009.05.015. S0020-7489(09)00173-4 [pii].

Jenny, C., Hymel, K. P., Ritzen, A., Reinert, S. E., & Hay, T. C. (1999). Analysis of missed cases of abusive head trauma. *JAMA, 281*(7), 621–626.

Kairys, S., Alexander, R., Block, R., Everett, D., Hymel, K., & Jenny, C. (2001). Shaken baby syndrome: rotational cranial injuries – Technical report. *Paediatrics, 108*(1), 206–210.

Keenan, H., Runyan, D., Marshall, S., Nocera, M., & Merten, D. (2004). A population-based comparison of clinical and outcome characteristics of young children with serious inflicted and non-inflicted traumatic brain injury. *Pediatrics, 114*(3), 633–639.

King, W., Kiesel, E., & Simon, H. (2006). Child abuse fatalities – Are we missing opportunities for intervention? *Pediatric Emergency Care, 22*(4), 211–214.

Leventhal, J. M., Larson, I. A., Abdoo, D., Singaracharlu, S., Takizawa, C., Miller, C., Goodman, T. R., Schwartz, D., Grasso, S., & Ellingson, K. (2007). Are abusive fractures in young children becoming less common?: Changes over 24 years. *Child Abuse & Neglect, 31*(3), 311–322.

Mathews, B., & Scott, D. (2013, July). Mandatory reporting of child abuse and neglect. *Resource sheets*. Retrieved 20 September, 2013, from http://www.aifs.gov.au/cfca/pubs/factsheets/a141787/

Mathews, B., Fraser, J., Walsh, K., Dunne, M., Kilby, S., & Chen, L. (2008). Queensland nurses' attitudes towards and knowledge of the legislative duty to report child abuse and neglect: Results of a state-wide survey. *Journal of Law and Medicine, 16*(2), 288–304.

McKenzie, K., & Scott, D. (2011). Using routinely collected hospital data for child maltreatment surveillance: Issues, methods and patterns. *BMC Public Health, 11*, 7.

McKenzie, K., & Scott, D. (2012). Quantity of documentation of maltreatment risk factors in injury-related paediatric hospitalisations. *BMC Public Health, 12*, 563.

McKenzie, K., Scott, D., Fraser, J., & Dunne, M. (2010). *Quality of child abuse information for measurement and surveillance: Linking hospital and child welfare data.* Paper presented at the Safety 2010, London.

Nayda, R. (2002). Influences on registered nurses' decision-making in cases of suspected child abuse. *Child Abuse Review, 11*, 168–178.

Nayda, R. (2004). Registered nurses' communication about abused children: Rules, responsibilities and resistance. *Child Abuse Review, 13*(3), 188–199.

O'Donnell, M., Nassar, N., Jacoby, P., & Stanley, F. (2011). Western Australian emergency department presentations related to child maltreatment and intentional injury: Population level study utilising linked health and child protection data. Jan; 48(1), 57–65.

Raman, S., Holdgate, A., & Torrens, R. (2012). Are our frontline clinicians equipped with the ability and confidence to address child abuse and neglect? *Child Abuse Review, 21*(2), 114–130.

Reece, R. M., & Sege, R. (2000). Childhood head injuries: Accidental or inflicted? *Archives of Pediatrics & Adolescent Medicine, 154*(1), 11–15.

Schweitzer, R., Buckley, L., Harnett, P., & Loxton, N. (2003). *Suspected child abuse and neglect reporting behaviour*. Brisbane: Abused Child Trust.

Schweitzer, R., Buckley, L., Harnett, P., & Loxton, N. (2006). Predictors of failure by medical practitioners to report suspected child abuse in Queensland. *Australian Health Review, 30*(3), 298–304.

Scott, D. (2012). *Improving the measurement and surveillance of child maltreatment in Queensland Emergency Departments.* Doctor of Health Science, Queensland University of Technology, Brisbane.

Scott, D. (2013). *Meeting children's needs when the family environment isn't always 'good enough': A systems approach*. Retrieved December 20, 2013, from http://www.aifs.gov.au/cfca/pubs/papers/a144433/cfca14.pdf

Scott, D., Higgins, D., & Franklin, R. (2012). *The role of supervisory neglect in childhood injury.* Retrieved December 20, 2013, from http://www.aifs.gov.au/cfca/pubs/papers/a142582/

Tanner, K., & Turney, D. (2003). What do we know about child neglect? A critical review of the literature and its application to social work practice. *Child and Family Social Work, 8*, 25–34.

Tonmyr, L., Li, A., Williams, G., Scott, D., & Jack, S. (2009). Patterns of reporting to child protection services in Canada by healthcare and non-healthcare professionals. *Paediatrics & Child Health, 15*(8), 25–32.

Van Haeringen, A., Dadds, M., & Armstrong, K. (1998). The child abuse lottery – Will the doctor suspect and report? Physician attitudes towards and reporting of suspected child abuse and neglect. *Child Abuse & Neglect, 22*(3), 159–169.

Zeanah, C. H., Boris, N. W., & Scheeringa, M. S. (1997). Psychopathology in infancy. *Journal of Child Psychology and Psychiatry, 38*(1), 81–99.