HAUTE AUTORITÉ DE SANTÉ

Guidance Leaflet
Child abuse: identification and action to be taken

October 2014

Key points

- Give frequent thought to the following:
  - Child abuse is more common than generally believed,
  - It exists within all social classes,
  - We need to think about it during consultations even if the signs are non-specific.
- Do not keep your doubts to yourself; know how to get help.
- Protecting the child is a medical procedure and a legal obligation:
  - The doctor or other healthcare professional does not have to be certain about the abuse nor have proof of it in order to alert the competent authority

Introduction

Abuse is defined as non-respect for the rights and fundamental needs of children (health; safety; morality; education; physical, emotional, intellectual and social development) (see article 375 of the Civil Code, Appendix 1.1). The Act of 5 March 2007, reforming child protection, has replaced the concept of abuse with that of danger (which includes abuse).

This guidance leaflet "Child abuse: identification and action to be taken" is concerned with children who are abused as well as those at risk of being abused. This guidance leaflet follows on from work already undertaken by HAS on interpersonal violence and its impact on health. It addresses all healthcare professionals who perform clinical observations of children, with a special emphasis on the place of doctors given their decision-making role. It thus concerns: general practitioners, paediatricians, psychiatrists; doctors and nursery nurses in maternal and child protection centres (PMI); school doctors and nurses; hospital doctors and paramedical staff (especially those working in the emergency, paediatric and radiological departments); midwives; doctors and paramedical staff in services for young children, and the medico-social services.

More than 80% of ill-treatment is inflicted within the family. The abuse is characterised by its early onset and chronic nature.

The difficulty and complexity of these situations, as well as the strong sense of isolation felt by professionals, explain the need to make clear and precise information available to professionals so as to assist them in the identification of violence against children.

This guidance leaflet is made up of three parts:

- identification of the abuse and the decisions that arise from this;
- the documents already produced by HAS concerning three specific situations: sudden unexpected death in infancy, shaken baby syndrome, sexual abuse within the family;
- two appendices: 1: the legislative and regulatory aspects; 2: the template for alerts drawn up by the French National Board of Physicians, Ministry of Justice, Ministry of Health and the Family and the child protection societies

What could suggest child abuse is occurring?

The situation

The situations associated with a risk of abuse include in particular:

→ in the child:

- prematurity,
- developmental and/or behavioural disorders,
- disability;

→ in the parents:

- any event that makes early bonding with the newborn child difficult (neonatal separation, postpartum depression, etc.),
- personal history of abuse experienced in childhood,
- domestic violence,
- addiction,
- social and above all moral isolation,
- psychopathological disturbances.

The lack of identification of one or more risk factors should not eliminate a diagnosis of abuse.

Case history

The following should be suggestive of abuse:

→ with infants: cases where parents report the baby is crying inconsolably and say that they are suffering from nervous exhaustion;

→ at any age if:

- the abuse of a child or adolescent is disclosed by the victim, by a parent or by a third party,
- there is an injury for which:
  - there is a discrepancy between the injury observed, the age, level of development of the child, the mechanism invoked,
  - the explanation supplied changes at different times or with the person being questioned,
- there is a delay in seeking treatment,
- there are recurrent physical complaints without a clear aetiology (abdominal pain, headache),
- there is a history of repeated domestic accidents,
- there has been one or more suicide attempts,
- there has been incidents of running away and risky behaviour,
- there has been a deterioration in school results or even dropping out from school,
- there is abuse in the siblings.

Physical signs

Bruises

The following are suggestive of abuse:

→ bruises on a child who is not independently mobile (crawling and then walking);

→ bruises on concave parts of the body (ears, cheeks, neck etc.) and on areas of the skin that are not usually exposed, such as the inner arms and thighs;

→ multiple bruises of various ages;

→ large bruises;

→ bruises with the shape of an object or hand,

Contusions (bruises and haematomas) are suspicious in the absence of a reported injury, regardless of their location.

Burns

The following are suggestive of abuse:

→ burns with a sharp edge that could be the result of immersion (shaped like gloves or socks);

→ contact burns with the shape of the causative agent (domestic appliance, cigarette);

→ burns extending into the body creases;

→ burns located on regions normally protected by clothes (buttocks, perineum);

→ abrasions (can mimic burns) of the wrists and ankles (restraint by means of bonds).

Physical signs (continued)

Bites

Generally the imprint of a bite appears as a circular or oval mark, 2 to 5 cm in size, consisting of opposing concave arcs, with or without central bruising

Fractures

Certain characteristics of fractures are suggestive of abuse:

→ in an infant:

- any fracture is suspicious in the absence of a high-energy injury (traffic accident, fall from a great height);

→ at any age:

- multiple fractures of different ages, fractures showing specific characteristics on imaging (see below)

Injuries to organs

Nausea, vomiting, acute abdomen, signs of internal bleeding (particularly pallor) should be a warning.

Any finding on clinical examination indicating injury of a solid organ (particularly the liver and pancreas) or of a hollow internal structure, for which the circumstances of occurrence are not clear or for which the alleged mechanism of occurrence is incompatible with the seriousness of the injury, should be suggestive of abuse.

Combination of injuries of different types (bites, scratches, burns, bruises, etc.)

Signs of extreme neglect

Neglect may relate to: diet, rhythm of sleep, hygiene, medical care, education, safety within or outside the home.

Extreme neglect has serious consequences for the child's physical and psychological development (malnutrition, low height and weight, psychosocial short stature). Neglect may be the cause of physical injuries due to inadequate supervision and even result in the death of the child.

Signs of psychological abuse

→ in an infant: problems with early interactions, behavioural disorders associated with a lack of bonding;

→ at any age: discontinuity of interactions, repeated humiliation, insults, excessive demands, control, paradoxical commands.

Behavioural signs in the child

→ any change in the child's usual behaviour in all the places where he/she spends his/her life (at home, with peers, at school, in activities outside school) for which no clear explanation exists;

→ behaviour of a fearful child, withdrawn, avoiding eye contact;

→ sleep disorders, nightmares;

→ eating disorders (anorexia, bulimia);

→ oppositional behaviour, aggressiveness or, on the contrary, seeking contact or affection without discernment, excessive politeness with strangers including healthcare professionals;

→ labile or unpredictable behaviour/emotional state.

Behavioural signs in persons close to the child

→ with respect to the child:

- intrusive parent or adult imposing themselves on the medical consultation, speaking in place of the child,
- or, notable indifference from the adult regarding the child (absence of eye contact, gestures, speech),
- parent or adult with exaggerated or inappropriate physical proximity to the child,
- parents or adults who refuse the obligatory vaccines or who apply diets that cause deficiencies, despite repeated medical advice;

→ with respect to the people intervening:

- minimising, trivialising or disputing the symptoms or what is said by the child,
- denigrating or accusing the child,
- refusal to permit medical tests or any social follow-up without giving a valid reason,
- or excessive recourse to care,
- aggressive or defensive attitude to healthcare professionals.

What to look for and how?

During the clinical examination

This is a complete clinical examination of the undressed child and includes:

- measurement of growth parameters (cranial circumference, height, weight) and their location on standard curves;
- evaluation of the child's psychomotor development and capabilities;
- close examination of the skin to look for traces of violence over the whole body;
- examination of the mucosae, particularly within the buccal cavity, to look for dental and mucosal injuries;
- generalised palpation to look for signs of fracture, internal bleeding due to organ damage (abdominal guarding, pain, masses, etc.);
- observation of the behaviour of the child and persons close to the child during the clinical examination.

During the interview with persons close to the child

An interview should take place with the family or others close to the child, where open questions should be asked non-judgementally. The objective is to collect information about:

- personal and familial medical histories;
- life events that could have affected the child;
- the child's usual behaviour and environment in which he/she lives;
- the family environment (number of children, including half-brothers and half-sisters; stability of the couple, educational rules; domestic violence; history of abuse of the parents when they were children);
- the parent-child relationship (favourable, hostile or indifferent).

During the interview, it should be borne in mind that the person accompanying the child (parent or adult close to the child) may be the alleged perpetrator or a passive witness.

During the interview with the child

The child should be interviewed on his/her own, provided he/she is of an appropriate age and agrees, and

- the interview should start with general questions (about school, conditions of life at home, hobbies, relationships with the family, friends);
- give the child the possibility of spontaneous expression, by avoiding any reformulation or interpretation of what he/she says, respecting silences and favouring open questions, and by showing that you believe what he/she says.

The objective is to clarify the origin of the observed injuries and to look for any discrepancies between the observed injuries and the explanations provided.

In the imaging studies performed in a hospital environment

Certain characteristics of fractures seen on X-rays are suggestive of abuse:

- in an infant (X-ray of whole skeleton):
  - rib fractures, particularly of the middle and posterior ribs (the baby has been strongly squeezed or shaken),
  - fractures of the extremities (toes, fingers: due to torsion);
- at any age:
  - metaphyseal fractures: avulsion fractures caused by torsion and traction movements,
  - complex fractures of the cranium (potentially with brain damage),
  - epiphyseal detachments (distal and proximal humerus, femur),
  - periosteal reactions (due to torsion),
  - diaphyseal fractures of the long bones due to a direct blow (transverse) or by torsion (oblique or spiral)

Notes in the patient's file and health record book

All the data obtained during the clinical examination should be entered into the patient's file. Statements made by the child and family are to be transcribed word for word, enclosed in quotation marks, just as they were heard or observed, avoiding any commentary, interpretation or personal opinion. The various injuries may be drawn on a diagram. Whenever possible, they should be photographed.

Only objective data concerning the development of the chid and the observed pathology are recorded in the health record book (a tool for liaison between various healthcare professionals).

Possible decisions to protect the child

Some fundamental rules

→ The doctor is bound to protect the child (Articles 43 and 44 of the Code of Medical Practice) (Appendix 1.2).

There are situations when immediate hospitalisation is necessary:

- when the child is an infant;
- when there is a major, even life-threatening, medical risk;
- when the child has to be placed into care.

→ The doctor may have to produce an initial medical certificate (ITT) [total temporary incapacity] which will establish the rights to compensation.

Possible decisions

In an emergency situation

→ In a case of life-threatening emergency, the medical emergency service (SAMU centre 15) is called in order to take the child to the hospital, and it is the hospital that has to complete the alert form.

→ In the event of major danger, when it is necessary to place the child into care immediately (strong suspicion of abuse by a presumed perpetrator in the child's home), it is necessary to:

- hospitalise the child without delay: warn the senior emergency doctor and ensure the efficient arrival of the child;
- inform the public prosecutor by telephone and send the alert by fax and letter, keeping one copy (Appendix 2). The alert is made, after consultation, either by the doctor dealing with the child or by the hospital.

In non-emergency situations

→ Due to the complexity of situations of children in danger and at risk of danger, there should be a collective discussion, particularly with the school doctor and/or the doctor from the maternal and child protection centre (PMI).

→ These situations come under the jurisdiction of the Departmental Council and should be the subject of an "information of concern" sent to the departmental unit of collection, evaluation and processing of information of concern (CRIP) by telephone and fax and/or letter.

→ The CRIP also provides advice to healthcare professionals who are questioning or expressing doubts about a specific child's situation.

Whatever the level of urgency, inform the parents about your concerns with respect to the child, unless this is against the greater interest of the child.

In advance of danger

Before the birth: attention should be paid to risk situations that have been detected, particularly during the early antenatal interview (systematic identification of factors of physical, social and psycho-emotional vulnerability) (see GPG Préparation à la naissance et à la parentalité [Preparation for birth and for parenting] – HAS 2005) and to directing the families to existing mother-baby support structures (maternal and child protection centre (PMI), centre for early medical-social action (CAMSP), medico-psycho-pedagogic centre (CMPP), medico-psychological centre (CMP), social services).

Obligations of and risks for the doctor

Like any citizen, the doctor is bound to assist the child and non-assistance does not mean "not speaking but rather not acting" (to protect the child). This applies to professionals and non-professionals with no exceptions. If there is any doubt, the doctor can ask for advice by telephoning the departmental CRIP or the departmental advisory service of the French National Board of Physicians. If the doctor is faced with abuse and without the means to place the child into care immediately, he/she MUST alert the juridical authorities, namely the public prosecutor (see Appendix 1.2).

No prosecution or sanctions are possible if the alert is made according to the rules: statement and description of the injuries without interpretation regarding their origin, the speech of the various protagonists reported in quotation marks, potential use of the conditional tense, no accusation of anyone, no names mentioned (see the model reporting certificate presented in Appendix 2).

Special cases

Sudden unexpected death in infancy (SUDI) (link GPG HAS Prise en charge en cas de mort inattendue du nourrisson (moins de 2 ans) [GPG HAS Management of a case of sudden unexpected death in infancy (aged less than 2 years)]

Deaths by homicide, particularly those during the first year of life (infanticides) are, according to the international literature, greatly underestimated in all countries. It is not rare that, when the death is certified, there is confusion between homicide, accident and SUDI, this last diagnosis covering a multitude of situations.

Action to be taken at the time of the first telephone contact with the family

In the event of suspected or confirmed death of an infant, and if the persons who found the infant to be dead, have not themselves directly alerted the medical emergency centre (Centre 15):

- the healthcare professional (general practitioner, emergency doctor, etc.) or the rescue services (firemen, etc.) receiving the telephone call should immediately contact a doctor at the medical emergency centre (Centre 15).

Actions to be taken by the first person intervening at the site

While at the site of the intervention, in an emergency, the following should be done:

- perform a complete examination of the unclothed child (note injuries of the skin and mucosae, lividity, fontanelle pressure, temperature, signs of dehydration or malnutrition, etc.);
- speak with each of the persons present (interview to be conducted by the same person if possible, looking for any discrepancies or contradictions);
- perform a detailed examination of the place of death;
- organise routine medical care for the child and parents;
- complete an intervention form (link GPG HAS Prise en charge en cas de mort inattendue du nourrisson (moins de 2 ans)) [link GPG HAS Management of a case of sudden unexpected death in infancy (aged less than 2 years)] in order to collect all the information noted at the site;
- organise the transport of the child's body to a SUDI reference centre (local doctor or medical emergency centre (Centre 15) in agreement with the parents;
- collect the child's health record book and recent prescriptions.

When should the juridical authority be alerted?

The question of making an alert may arise at any moment during the management of the event if any doubt arises regarding a natural cause of death, regardless of the place of death (home or at the house of a third party, etc.).

Certain signs (multiple bruises or bruises of different ages, bites, cigarette burns, extreme thinness) are immediately strongly suggestive of abuse and the juridical authorities must be alerted immediately (call to the public prosecutor).

In such a case, it is important to inform the parents (or third party) of the action that has been initiated and to explain to them the observations that led to an alert being made.

In other cases, the situation is evaluated on a case-by-case basis either at the place of death or at the hospital, in the light of the results of the first medical investigations (including the autopsy).

Drawing up the death certificate

In this specific context, the death certificate must be drawn up in two stages.

- When death is established, complete a death certificate to send to the registrar:
  - administrative section: if the death is not suspicious, tick the box "samples to investigate the cause of death", if the death is suspicious tick the box "medico-legal obstacle" (article 81 of the Civil Code);
  - medical section: mention the most probable cause of death.
- A supplementary medical death certificate will be filled in after the diagnostic tests have been completed.

Shaken baby syndrome (link audition publique Syndrome du bébé secoué – Recommandations) [link Public Hearing on Shaken Baby Syndrome - Recommendations)]

Shaken baby syndrome is cranial trauma caused by shaking.

Most of the time it occurs in infants aged less than 1 year, often aged less than 6 months.

The rate of recurrence of shaking is high: more than 50% of babies were shaken between 2 and 30 times (on average 10 times). The first signs of violence must be detected as soon as possible.

In the most serious cases, the child is found dead (link GPG HAS Management of a case of sudden unexpected death in infancy (aged less than 2 years).

Signs indicative of neurological damage:

- → severe malaise, impaired alertness up to the stage of coma, severe apnoea, seizures, hypotonia, extreme pallor, fixed upward gaze suggesting serious damage with acute intracranial hypertension, even herniation;
- → other signs: poorly responsive, child has decreased competency.

Non-specific signs of neurological damage:

- → altered behaviour (irritability, changes in sleep or feeding patterns), vomiting without fever or diarrhoea, often wrongly classified as gastroenteritis, respiratory pauses, pallor, infant in pain.

Clinical examination:

(complete, on the unclothed infant, including palpation of the fontanelle: measurement of the cranial circumference, which should be plotted on a curve to see if there is a change in slope, search for bruises over the whole body including the scalp, face, behind the ears, inside the mouth, the neck, the axillary cavities)

- → major importance of the combination of certain signs:
  - the combination of vomiting with a tense fontanelle, seizures, axial hypotonia, impaired alertness;
  - the combination of seizures with axial hypotonia, a tense fontanelle;
  - tense fontanelle with a break up towards the top of the curve of the skull.

Case history:

- → no symptom-free interval: in the majority of cases the shaking immediately results in symptoms; however there may be a delay between the shaking and the consultation;
- → a delay in seeking treatment,
- → no explanations given for the signs, or the explanations are incompatible with the clinical picture or the child's stage of development, or the explanations keep changing;
- → spontaneously reported history of minor cranial trauma;
- → previous consultations for crying or any type of injury;
- → history of unexplained death(s) of siblings.

Actions to be taken urgently:

- → let the parents know of your concern about the child's condition;
- → say that emergency hospital admission is indicated so that tests can be performed;
- → contact the hospital team before sending the child there;
- → make sure that the parents take the baby to the hospital;
- → once the clinical examinations and laboratory tests have been completed, send the alert to the prosecutor with a copy to CRIP.

Sexual abuse within the family (lien GPG HAS Repérage et signalement de l'inceste par les médecins) [link GPG HAS Identification and reporting of incest by doctors]

Sexual abuse of a minor is defined as forcing or encouraging the minor to take part in a sexual activity with or without physical contact and/or exploiting a minor sexually.

The disclosure made by the minor

- The facts mentioned may be current or they may be older facts being disclosed after they stopped.
- This could be a chance disclosure, due to a need to confide in a third party or it could be a premeditated revelation.
- Sometimes the disclosure is inconsistent (the minor may retract it or change what is said), which is why it is important to be on alert to think of it regardless of the context of the revelation.

Warning signs

- None of the warning signs listed below is characteristic of sexual abuse. These signs are all the more suggestive when they are combined, recurrent, long-term, and have no rational explanation.
- **General signs**: very varied non-specific manifestations of this type of abuse, for example: eating disorders, sleep disorders, difficulties at school, or non-specific physical and functional symptoms (isolated abdominal pain, headache, etc.).
- **Signs in the anogenital region**
  - Certain signs may be suggestive: if they are observed in a prepubertal child (these signs are less suggestive in adolescents); if no medical cause is found; or if no medical pathology is diagnosed; the more so if they recur.
  - The most suggestive signs are: bleeding, genital discharges; genital irritation or pruritus; genital or anal pain; problems with urination; recurrent urinary infections in prepubertal girls.
- **Behaviour of the minor**: there are no specific manifestations of sexual abuse.
- **Behaviour of persons close to the child**: pay attention to the behaviour of the adult towards the child, towards the healthcare professional and to the attitudes shown by the adults to each other.

Mental examination

The objective is to look for signs that are suggestive but non-specific:

- a psychotraumatic syndrome:
  - signs of intrusion of the traumas (recurrent nightmares, recurrent flashbacks of the assaults, which are either spontaneous or triggered by events, etc.),
  - avoidance behaviour (to avoid thoughts, activities, places associated with assaults, feelings of detachment and/or restrained emotions, etc.),
  - neurovegetative symptoms: sleep disorders, hypervigilance, spontaneous startle reflexes, irritability, outbursts of anger, problems concentrating, etc.;
- and also: depressive state; problematic behaviour (concerning sexual matters, relationships, school); behavioural disorders; impaired intellectual and emotional development of the minor.

Physical examination

- This must be adapted to the doctor's manner of practice and experience, the means available and the circumstances of the discovery. It is also adapted to the age of the minor and is based on the warning signs and the statements made by the minor.
- The absence of signs on physical examination does not exclude an assault of a sexual character even if the data from the examination do not correlate with what is said by the minor.
- An genital and anal examination is performed if the doctor considers this to be useful. Normal findings in the genital and anal examination do not exclude the possibility of sexual abuse (highly suspicious injuries are very rare, sexually transmitted infections are the exception in children and rare in adolescents in these situation).
- The situations that justify an urgent examination are:
  - *medico-legal*: if the assault occurred less than 72 hours ago and involved a form of penetration: to look for recent injuries;
  - *medico-surgical*: severe physical or psychological signs (surgical wounds, acute psychological disturbance, etc.).

Where there is a strong presumption of sexual abuse and there is permanent or frequent contact with the assailant: ensure immediate protection of the at-risk child (alert with or without hospitalisation).

Appendix 1 Legislative and regulatory aspects

Appendix 1.1.1 Article 375 of the Civil Code

"**If the health, security or morality of an unemancipated minor** are threatened, or if the conditions of his/her **education or his/her physical, emotional, intellectual and social development** are seriously endangered, measures of educational assistance may be judicially ordered on request of the father and mother jointly, or of either one of them, of the person or body to whom the child was entrusted or of the guardian, of the minor himself or of the State Prosecutor. In the cases where the State Prosecutor has been advised by the president of the general council, he ensures that the situation of the minor is within the purview of Article L. 226-4 of the Family and Social Action Code. Exceptionally, the judge may intervene of his own accord."

Appendix 1.2. Juridical framework for alerts by a healthcare professional concerning **child abuse**

Violation of professional secrecy is punishable in accordance with Article 226-13 of the Penal Code. However, the derogations from this article permit healthcare professionals to report any deprivation and abuse they find.

- Article 226-14 of the Penal Code permits secret information to be divulged:
  - "1° to a person who informs a judicial, medical or administrative authority of deprivation or abuse, including sexual abuse or mutilation, of which he/she has knowledge and which has been inflicted on a minor or a person unable to protect himself/herself because of his/her age, or due to physical or psychological incapacity;
  - 2° to a doctor who, with the consent of the victim, brings to the knowledge of the public prosecutor instances of deprivation or abuse, either physical or psychological, that he/she has observed in the exercise of his profession that cause him/her to believe that physical, sexual or psychological violence of any sort has been committed. Where the victim is a minor or a person unable to protect himself/herself because of his/her age, or due to physical or psychological incapacity, his/her consent is not necessary.
- Article 226-2-1 of the Family and Social Action Code has the provision that: "[...] persons implementing the child protection policy defined in Article L.112-3 as well as those contributing to it will, in conformity with Article L. 226-3, transmit without delay to the president of the general council or to a person designated by the president any information of concern on a minor in danger or at risk of danger as defined in Article 375 of the Civil Code. When this information is subject to professional secrecy, its transmission shall be ensured in accordance with Article L. 226-2-2 of this code [...]"

  This transmitted information must be strictly limited "to that which is necessary to accomplish the task of child protection [...]" (Article L. 226-2-2 of the Code on Social Action and Families).

By virtue of Article 226-14 of the Penal Code, a healthcare professional will not incur any penal or disciplinary sanctions relating to disclosure of information subject to professional secrecy if the alert has been made under the conditions provided for in this article.

Furthermore, Articles 43 and 44 of the Code of Medical Practice stipulate that:

- the doctor must be the child's advocate when he/she considers that the interests of the child's health are poorly understood or poorly upheld by those close to the child (Article 43);
- when a doctor determines that a minor is a victim of abuse or deprivation "he/she alerts the juridical or administrative authorities, unless there are special circumstances of which he/she is aware" (art. 44).

Finally, a healthcare professional is obliged to provide assistance to a person in danger (Article 223-6 of the Penal Code).

Appendix 2. Standard template for an alert

In order to assist the doctor in this procedure, a template for alerts has been produced through the collaboration of the Ministry of Justice, the Ministry of Social Affairs, Health, Women's Rights, the State Secretariats of Family and Disabled Persons, the French National Board of Physicians, and the child protection societies.

The alert must be sent directly by the doctor to the public prosecutor.

If, due to urgency, the alert is made by telephone or fax, it will be confirmed by a written, dated and signed document. The doctor must ensure it has been received and keep a copy.

Doctor's
stamp

ALERT

(Please use printed letters)

I certify that I have examined on this day (written out in full):

- date (day of the week and numerical day of the month):
- year:
- time:

The child:

- surname:
- forename:
- date of birth (written out in full):
- gender:
- address:
- nationality:

Accompanied by (note whether this person is an adult or a minor, if possible give contact details for this person and indicate any relationship to the child):

- the accompanying person has told us that:

"_____
_____
_____
_____
_____"

- the child has told us that:

"_____
_____
_____
_____
_____"

Doctor's
stamp

Clinical examination performed in the presence of the accompanying person:

Yes
No

(delete as appropriate)

- description of the child's behaviour during the consultation:

- description of any lesions that are present (note the location and characteristics without prejudging the origin)
  -
  -
  -
  -
  -
  -
  -

In light of the foregoing and in accordance with the law, I am sending this alert to you.

Alert sent to the public prosecutor

At_____, on

Signature of the doctor who examined the child:

To find out more

- Maltraitance chez l'enfant : repérage et measures de protection – Rapport d'élaboration – HAS 2014 [Child abuse: identification and measures for protection - Draft report - HAS 2014]
- Protection de l'enfance. La cellule départementale de recueil, de traitement et d'évaluation. Ministère de la Santé et des Solidarités – Guide pratique - 2011
- Agir contre la maltraitance - Guide juridique à l'usage des professionnels de l'enfance - Enfance et Partage Association - 2014

List of guidelines

- Syndrome du bébé secoué – Audition publique – HAS 2011 [Shaken baby syndrome - Public hearing - HAS 2011]
- Repérage et signalement de l'inceste par les medecins : reconnoitre les maltraitances sexuelles intrafamiliales chez le mineur – Recommandation de bonne pratique – HAS 2011 [Identification and reporting of incest by doctors: recognising sexual abuse of minors within the family - Good Practice Guideline - HAS 2011]
- Prise en charge en cas de mort inattendue du nourrisson (moins de 2 ans) – Recommandation de bonne pratique – HAS 2007 [Management in the event of unexpected death in infancy (aged less than 2 years) - Good Practice Guideline - HAS 2007]
- *When to suspect child maltreatment - Clinical Guideline - National Institute for Health and Care Excellence - 2013*

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