Prevention of Shaken Baby Syndrome, Abusive Head Trauma, and Child Maltreatment

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Prevention of Child Maltreatment

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Prevention of Child Maltreatment

Child TRENDS

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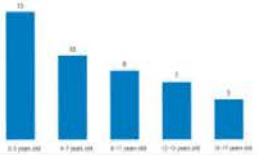
Differences by age

Young children experience higher rates of maltreatment than older children. In 2017, children 3 and younger had a maltreatment rate of 16 per 1000, compared with 10 per 1000 for children ages 4 to 7, 9 per 1000 for ages 8 to 11, 7 per 1000 for ages 12 to 15, and 5 per 1000 for children ages 16 to 17 (Appendix 2).

Child Maltreatment* Rate (Unique Victims per 1,000 Population), by Age: 2017



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Prevention of Child Maltreatment: Appropriate Guidance

- The State of Michigan manual for licensed childcare providers prohibits the following means of punishment: hitting, spanking, shaking, biting, pinching, restricting movement, and inflicting emotional or mental harm.
- Children deserve to be treated respectfully and appropriately in a positive manner. Research has linked mental and emotional stress and corporal punishment with negative effects such as learning issues and later criminal behavior.

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Prevention of Child Maltreatment: Appropriate Guidance

- Make sure the space is ready
- Model the behaviors and language you want to see
- Tell children what you want them to do
- Redirect the child to a positive choice
- Ignore behaviors when appropriate
- Remove the child from the situation

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Prevention of Abusive Head Trauma or Shaken Baby Syndrome

- Happens when a child is vigorously shaken
- Inconsolable crying is the number one cause
- Causes damage to the brain, eyes, ribs, and in severe cases, death
- No amount of shaking is safe

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Shaken Baby Syndrome

Never Shake A Baby – Tips for Parents and Caregivers

Approximately 1,200 to 1,400 children are injured or killed by shaking a baby every year in the United States.* Most of these people could never imagine harming their baby – it was an instantaneous reaction to frustration. Caregivers must be educated about Shaken Baby Syndrome (SBS).

- Although it may happen out of frustration, shaking a baby vigorously is a serious form of child abuse.

- A single shaking episode can result in death or other severe injuries such as mental retardation, speech and learning disabilities, cerebral palsy, seizure disorder, hearing loss, partial or total blindness, behavior disorders, cognitive impairment, spinal cord injury, paralysis, broken bones and dislocations.

- Caring for a baby can be difficult and frustrating. Babies cry for many reasons including:

    - Hunger
    - Need to be burped
    - Need diaper change
    - Too hot or too cold
    - Fever or pain from earache, teething, rash, or insect bite
    - Need to be held or soothed
    - Overtired
    - Over stimulated
    - Sometimes babies just need to cry!

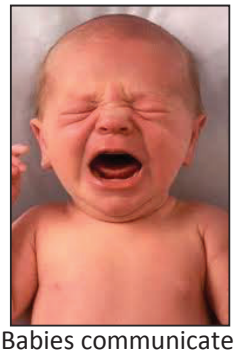
- **If you are frustrated, gently place baby in his or her crib and go to another room for a few minutes until you calm down.** Take several deep breaths, count to 100, listen to soft music, exercise, do household chores, or go for a walk (do not leave baby home alone).

- Caregivers must be educated about Shaken Baby Syndrome. Make sure they understand the dangers of shaking a baby. Provide them with the number for an alternate caregiver who can help. Also available is the Child Help USA Hotline 1-800-4-A-CHILD. Caregivers can speak to a counselor during stressful times through this free, confidential hotline.

- Reassure your caregiver and make them feel comfortable that it is OK to call you at work if baby is inconsolable.

SOURCE: Together With Baby, LLC (http://www.togetherwithbaby.com/Handouts/handout_sbs.pdf)

How to Calm A Crying Baby



Babies communicate by crying

A tight swaddle can help your baby relax

Always keep your baby safe

Step # 1: Try to figure out what is upsetting the baby

Make sure your baby:

- Is not hungry or doesn't need to burp
- Has a dry diaper
- Is in comfortable clothing
- Is not too hot or too cold
- Is not overtired or overstimulated by playing, noise, or bright lights
- Is not sick or does not have a fever
- Is not in pain

Step # 2: Try to help the baby relax

- Turn down the lights
- Wrap or swaddle the baby securely
- Rock the baby gently
- Offer the breast, a bottle, or a pacifier
- Walk with your baby
- Play some calm music
- Shhh, whisper, sing, or talk quietly to the baby
- Run the vacuum cleaner
- Take your baby for a ride in a stroller or in a car

Step # 3: Keep your baby safe

Sometimes babies cry even after all of these steps are taken. Do not take this personally. Every caregiver needs a plan to deal with a crying baby. If you feel overwhelmed, frustrated, angry, or out of control, then:

- Stop
- Take a deep breath and count to 10
- Place your baby in a safe place, such as a crib or playpen
- Leave the room and shut the door
- Find a quiet place for yourself and take a time out
- Check on your baby every 5-15 minutes
- If you are calm and in control you can repeat step #1 and #2
- Do not be afraid to ask for help

Asking for Help

Keeping your baby safe and asking for help are signs of a good parent. Stop, take time out, and call for help you can:

- Call a friend, relative, or neighbor for support and advice
- Ask another adult to take care of your baby while you take a break
- Call a crisis hotline (1-800-4-A-CHILD)
- Call your health care provider

Source: National Association of Neonatal Nurses
Karin M. Gracey, *RNC, MSN, CNNP, Column Editor &* Suzanne Franklin Carbaugh*, RN, MS, APRN, NNP*

Everyone who cares for a baby or a young child needs to be aware of the serious consequences of child shaking. For more information:

National Center On Shaken Baby Syndrome
(888)-273-0071
www.don'tshake.com
The Shaken Baby Alliance
(877)-6-END-SBS
www.shakenbaby.com

Prevention of Child Maltreatment: Have a Plan When You're Feeling Stressed

- Know it is okay to ask for help
- Have easy access to parent phone number and other support people
- Know that it is okay to let an infant or toddler cry – if the child is safe
- Step into another room and breathe

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Recognition and Reporting of Child Abuse and Neglect

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Recognition and Reporting of Child Abuse and Neglect

- As a License Exempt Provider, you are committing to understanding your role as a Mandated Reporter
- Know the signs of abuse and neglect
- Michigan Department of Health and Human Services Centralized Intake
  - Open 24 hours a day, 7 days a week
  - Report by phone or online
    - 855-444-3911

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MANDATED REPORTERS' RESOURCE GUIDE

En Masse image by Clockblock at clockblock.deviantart.com/art/En-Masse

HAVE A HAND IN PROTECTING CHILDREN

Contact the Children's Protective Services Program Office for questions at 517-335-3704.

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The Michigan Child Protection Law

The Michigan Child Protection Law, 1975 PA 238, MCL 722.621 et. seq., requires the reporting of child abuse and neglect by certain persons (called mandated reporters) and permits the reporting of child abuse and neglect by all persons. The Child Protection Law includes the legal requirements for reporting, investigating, and responding to child abuse and neglect. This document is to assist mandated reporters in understanding their responsibilities under the Child Protection Law. For copies of the Child Protection Law, contact the local Michigan Department of Health and Human Services (MDHHS) office or go to www.michigan.gov/mdhhs.

List of Mandated Reporters

Mandated reporters are an essential part of the child protection system because they have an enhanced capacity, through their expertise and direct contact with children, to identify suspected child abuse and neglect. Reports made by mandated reporters are confirmed at nearly double the rate of those made by non-mandated reporters. The list of mandated reporters may be updated based on changes to the Child Protection Law. More information on mandated reporting can be found at www.michigan.gov/mandatedreporter.

The list of mandated reporters is as follows:

- Physician
- Physician's Assistant
- Nurse
- Dentist
- Registered dental hygienist
- Law enforcement officer
- Medical examiner
- Audiologist
- Psychologist
- Member of the clergy
- School administrator
- School counselor or teacher
- Regulated child care provider
- Social worker
- Licensed professional counselor
- Marriage and family therapist
- Regulated child care provider
- Licensed master's social worker
- Licensed bachelor's social worker
- Registered social service technician
- Social service technician
- Any person licensed to provide emergency medical care
- A person employed in a professional capacity in any office of the friend of the court
- Any employee of an organization or entity that, as a result of federal funding statutes, regulations, or contracts would be prohibited from reporting in the absence of a state mandate or court order (e.g., domestic violence providers).

> Note: For individuals working or volunteering in a capacity similar to those listed professions (but not included in this list), please follow agency procedures or internal policies to ensure that your concerns regarding suspected abuse and/or neglect are reported.

The list also includes specific MDHHS personnel:

- Welfare Services Specialist
- Eligibility Specialist
- Social Services Specialist
- Social Work Specialist
- Family Independence Specialist
- Family Independence Manager
- Social Work Specialist Manager

Responsibility of Mandated Reporters

Mandated reporters are always required to report suspected child abuse and neglect to MDHHS. Specific MDHHS personnel are required to report to MDHHS Centralized Intake when child abuse and neglect is suspected during the course of employment with MDHHS.

The report must be made directly to MDHHS Centralized Intake. There are civil and criminal penalties for a mandated reporter's failure to make a report. Likewise, there is a civil and criminal immunity for someone making a report in good faith.

The Child Protection Law requires mandated reporters who have reasonable cause to suspect child abuse or neglect to make an **immediate oral report** to MDHHS – Centralized Intake (855-444-3911), followed by a **written report within 72 hours** (see page 3). The reporter is not expected to investigate the matter, know the legal definitions of child abuse and neglect, or even know the name of the perpetrator. The Child Protection Law is intended to make reporting simple and places responsibility for determining appropriate action with the Children's Protective Services (CPS) division of MDHHS. The authority and actions of CPS are based on requirements in the Child Protection Law.

Mandated reporters who are staff of a hospital, agency, or school shall notify the person in charge of that agency. They shall include their findings and make the written report available to the person in charge. This notification to the person in charge does not relieve mandated reporters of the obligation to report child abuse or neglect to MDHHS – Centralized Intake. Mandated reporters should also confirm with their individual agencies regarding any internal procedures their agency may have in addition to the state requirement for reporting.In addition to those persons required to report child abuse or neglect under section 3, a person, including a child, who has reasonable cause to suspect child abuse or neglect may report the matter to the department or a law enforcement agency.

Child's Disclosure: The Role of Mandated Reporters

Mandated reporters often have an established relationship with child clients, patients, students, etc., which may give them the advantage of being able to have a conversation with a child using terms the child will understand. When child abuse and/or neglect is suspected, mandated reporters need to only obtain enough information to make a report.

If a child starts disclosing information regarding child abuse and/or neglect, mandated reporters should proceed by moving the child into a private environment. This may limit distraction of the child and provide privacy for a potentially sensitive conversation.

During disclosure, mandated reporters should maintain eye contact and avoid displaying any signs of shock or disapproval. Mandated reporters should only ask open-ended questions (mainly "how" and "what" types of questions) that allow the child to freely discuss the incident without being led during the conversation. For example, *"How did you get that bruise?"* Again, these discussions should only proceed to the point needed to determine whether a report needs to be made to MDHHS.

Children may want to tell what has happened but may also want to maintain loyalty to their parent(s). If a report is going to be made, maintain the trust with the child by explaining the reporting process, if appropriate.

The Verbal Report

The information in a CPS report needs to be provided by the individual who actually has observed the injuries or had contact with the child regarding the report. It is helpful, but not necessary, for the MDHHS intake worker to have the information listed below. Contact MDHHS – Centralized Intake for Abuse and Neglect at 855-444-3911 to make the verbal report.

Intake personnel will want the following information, if available:

- Primary caretaker's (parent and/or guardian) name and address.
- Names and identifying information for all household members, including the alleged victim and perpetrator, if known.
- Birth date and race of all members of the household, if known.
- Whether the alleged perpetrator lives with and/or has current access to the child.
- The address where the alleged incident happened, if different than the home address.
- Statements of the child's disclosure and context of the disclosure. For example, was the child asked about the injury or did the child volunteer the information?
- History of the child's behavior.
- Why child abuse and/or neglect is suspected.

See Appendix for specific questions that may be asked during the intake process.

The Written Report

Within 72 hours of making the verbal report, mandated reporters must file a written report as required in the Child Protection Law. MDHHS encourages the use of the DHS-3200, Report of Suspected or Actual Child Abuse or Neglect form, which includes all the information required under the law. Mandated reporters must also provide a copy of the written report to the head of their organization. One report from an organization will be considered adequate to meet the law's reporting requirement.

Mandated reporters cannot be dismissed or otherwise penalized for making a report required by the Child Protection Law or for cooperating with an investigation. Even though the written process may seem redundant, the written report is used to document verbal reports from mandated reporters. Any necessary or beneficial documentation may be included with your written report and will be electronically attached to your referral upon receipt. This could include, but is not limited to, medical reports, police reports, written letters, or photographs.

See pages 14 and 15 for a copy of the DHS-3200 or access the form online, under the *Resources* section, at www.michigan.gov/mandatedreporter.

Forward the written report to:

Michigan Department of Health and Human Services
Centralized Intake for Abuse and Neglect
5321 28th Street Court S.E.
Grand Rapids, MI 49546

or email to:

MDHHS-CPS-CIGroup@michigan.gov

Fax: 616-977-1154 | 616-977-1158 | 616-977-8050 | 616-977-8900

Reporting Process for Mandated Reporters

VERBAL REPORT

Contact CPS immediately.

→ Call Centralized Intake for Abuse and Neglect at 855-444-3911

WRITTEN REPORT

Submit a written report within 72 hours.

→ Forward your written report to:
Department of Health & Human Services Centralized Intake for Abuse and Neglect
5321 28th Street Court S.E.
Grand Rapids, MI 49546
or email to:
MDHHS-CPS-CIGroup@michigan.gov
Fax: 616-977-1154 | 616-977-1158 | 616-977-8050 | 616-977-8900

NOTIFICATION

Notify the head of the organization of the report.

→ If the reporting person is a member of the staff of a hospital, agency, or school, the reporting person shall notify the person in charge of the hospital, agency, or school of his or her finding and that the report has been made, and shall make a copy of the written or electronic report available to the person in charge. A notification to the person in charge of a hospital, agency, or school does not relieve the member of the staff of the hospital, agency, or school of the obligation of reporting to the department as required by 722.623 Sec. 3. (1) (a)

Definitions of Child Abuse/Neglect

Physical Abuse
Physical abuse is a non-accidental injury to a child. Physical abuse may include, but is not limited to, burning, beating, kicking and punching. There may be physical evidence of bruises, burns, broken bones or other unexplained injuries. Internal injuries may not be readily apparent.

Sexual Abuse
Sexual abuse can encompass several different types of inappropriate sexual behavior including, but not limited to:

- Sexual contact which includes but is not limited to the intentional touching of the victim's or alleged perpetrator's intimate parts or the intentional touching of the clothing covering the immediate area of the victim's or alleged perpetrator's intimate parts, if that touching can be reasonably construed as being for the purposes of sexual arousal, gratification, or any other improper purpose.
- Sexual penetration which includes sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body.
- Accosting, soliciting, or enticing a child to commit, or attempt to commit, an act of sexual contact or penetration, including prostitution.

Child Maltreatment
Child maltreatment is defined as the treatment of a child that involves cruelty or suffering that a reasonable person would recognize as excessive. Possible examples of maltreatment are:

- A parent who utilizes locking the child in a closet as a means of punishment.
- A parent who forces his or her child to eat dog food out of a dog bowl during dinner as a method of punishment and/or humiliation.
- A parent who responds to his or her child's bed-wetting by subjecting the child to public humiliation by hanging a sign outside the house or making the child wear a sign to school which lets others know that the child wets the bed.

Mental Injury
A pattern of physical or verbal acts or omissions on the part of the parent and/or person responsible for the health and welfare of the child that results in psychological or emotional injury/impairment to a child or places a child at significant risk of being psychologically or emotionally injured/impaired (e.g., depression, anxiety, lack of attachment, psychosis, fear of abandonment or safety, fear that life or safety is threatened, etc.).

Neglect
Child neglect encompasses several areas:

- *Physical Neglect*. Negligent treatment, including but not limited to failure to provide or attempt to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child, excluding those situations solely attributable to poverty.
- *Failure to Protect.* Knowingly allowing another person to abuse and/or neglect the child without taking appropriate measures to stop the abuse and/or neglect or to prevent it from recurring when the person is able to do so and has, or should have had, knowledge of the abuse and/or neglect.
- *Improper Supervision.* Placing the child in, or failing to remove the child from, a situation that a reasonable person would realize requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and results in harm or threatened harm to the child.

Definitions of Child Abuse/Neglect (continued)

- *Abandonment*. The person responsible for the child's health and welfare leaves a child with an agency, person or other entity (e.g., MDHHS, hospital, mental health facility, etc.) without:

  - Obtaining an agreement with that person/entity to assume responsibility for the child.
  - Cooperating with the department to provide for the care and custody of the child.
  - Medical Neglect - Failure to seek, obtain, or follow through with medical care for the child, with the failure resulting in or presenting risk of death, disfigurement or bodily harm or with the failure resulting in an observable and material impairment to the growth, development or functioning of the child.

Threatened Harm

A child found in a situation where harm is **likely** to occur based on:

- A current circumstance (such as home alone, domestic violence, drug house).
- A historical circumstance (such as a history of abuse/neglect, a prior termination of parental rights or a conviction for crimes against children) unless there is evidence found during the investigation that past issues have been **successfully** resolved.

Person Responsible

A person responsible for a child's health or welfare is any of the following:

- A parent, legal guardian, or person 18 years of age or older who resides for any length of time in the same house in which the child resides.
- A nonparent adult. A nonparent adult is a person 18 years of age or older and who, regardless of the person's domicile, meets ***all*** of the following criteria in relation to the child:

  - Has substantial and regular contact with the child;
  - Has a close personal relationship with the child's parent or with another person responsible for the child's health or welfare; and
  - Is not the child's parent or a person otherwise related to the child by blood or affinity to the third degree (parent, grandparent, great-grandparent, brother, sister, aunt, uncle, great aunt, great uncle, niece, nephew).

- A nonparent adult who resides in any home where a child is receiving respite care. **Note**: This includes nonparent adults residing with a child when the complaint involves sexual exploitation (human trafficking).
- An owner, operator, volunteer, or employee of one or more of the following:

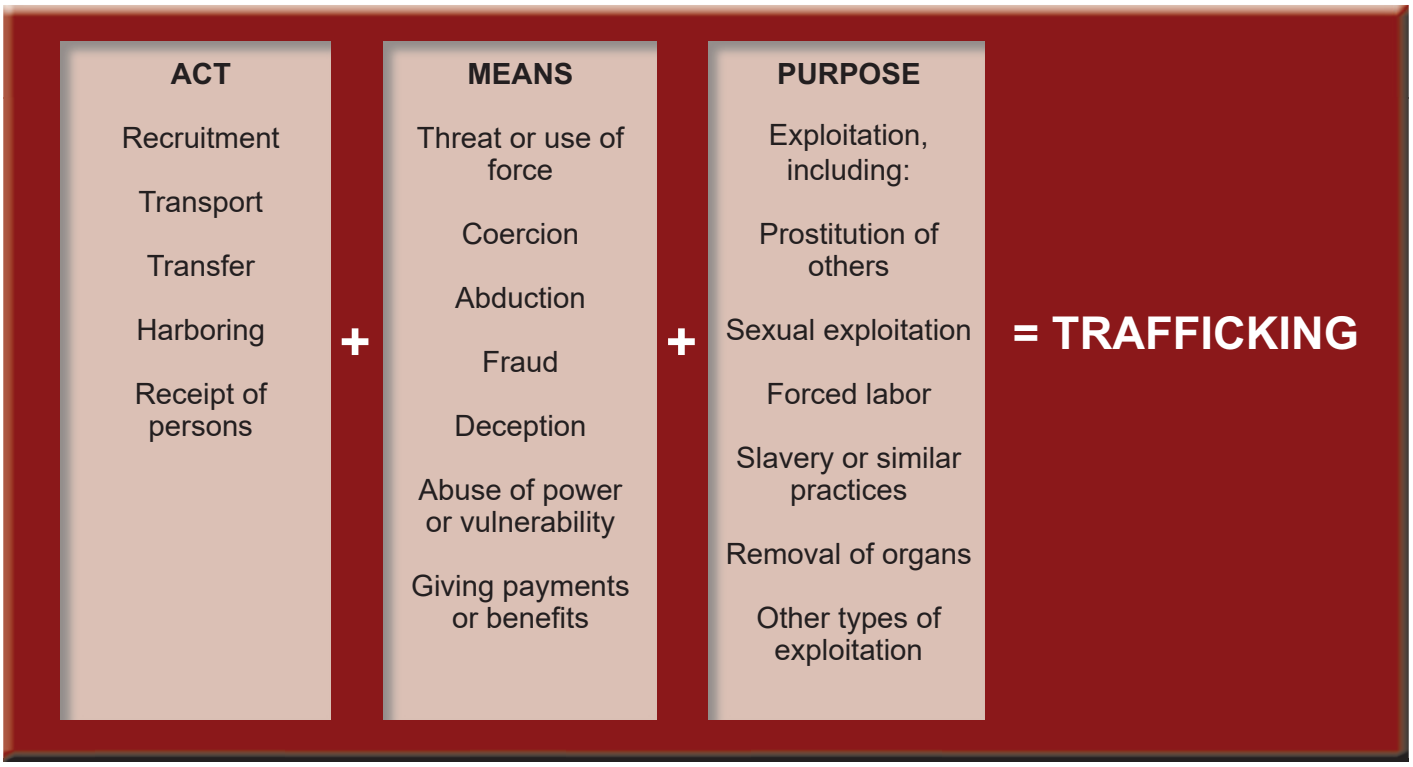
  - A licensed or registered child care organization.
  - A licensed or unlicensed adult foster care family home or adult foster care small group home.
  - Child care organization or institutional setting.

Human Trafficking (Sex trafficking victim)

A sex trafficking victim is defined as an individual subject to the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purposes of a commercial sex act or who is a victim of a severe form of trafficking in persons in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induces to perform the act is under 18 years old.

Labor Trafficking Victim

Labor trafficking is the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.



See Appendix for specific questions that may be asked when reporting each type of abuse and neglect.

Indicators of Child Abuse/Neglect

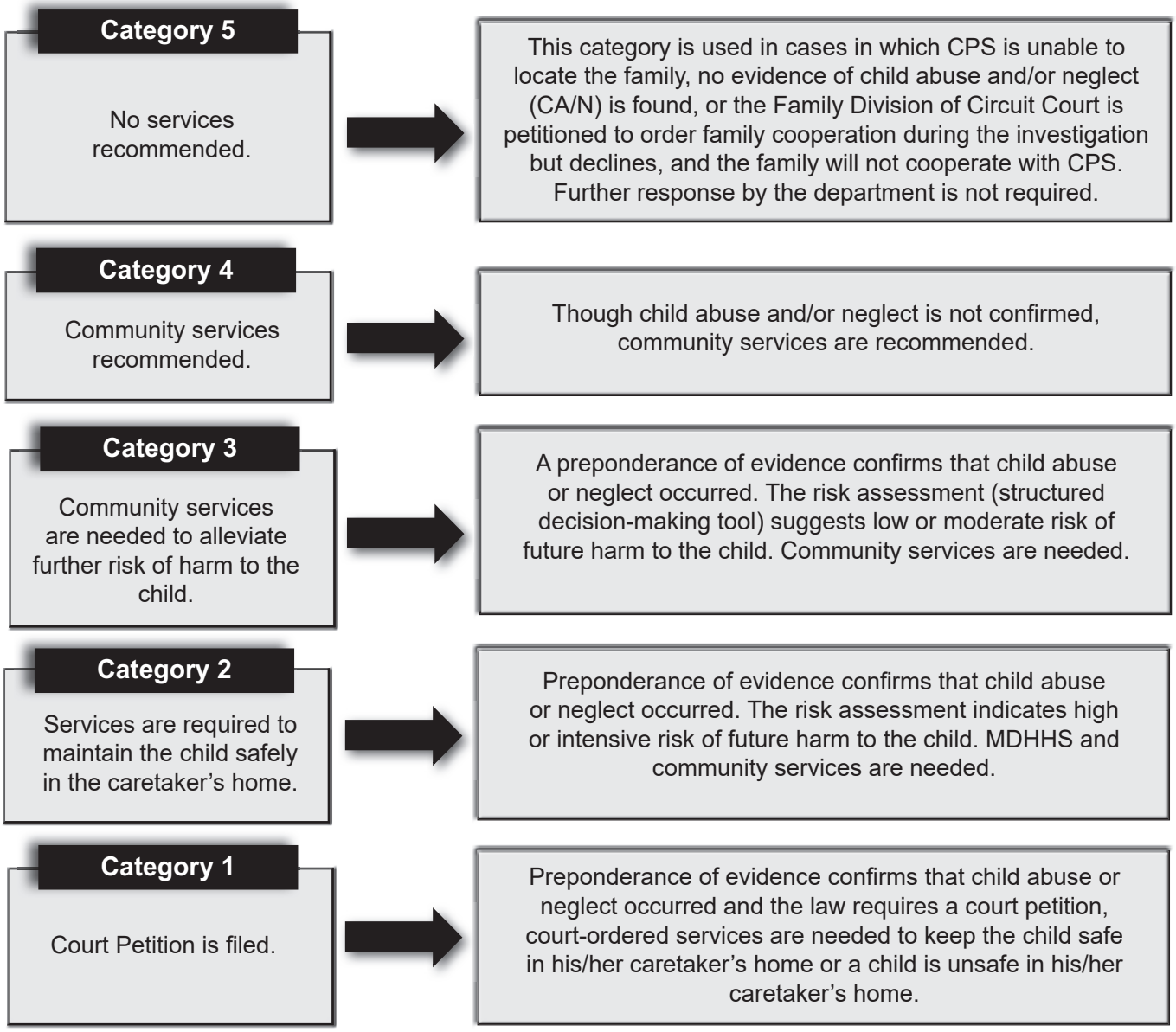
Determining when to report situations of suspected child abuse/neglect can be difficult. When in doubt, contact MDHHS for consultation. Below are some common physical and behavioral warning signs associated with various forms of child abuse and neglect. **Note that the physical and behavioral indicators below, are not the only indicators of child abuse and neglect and, if present, do not necessarily mean a child is being abused and neglected.**

Category	Physical Indicators	Behavioral Indicators
Physical Abuse	• Bruises more numerous than expected from explanation of incident. • Unexplained bruises, welts or loop marks in various stages of healing. • Adult/human bite marks. • Bald spots or missing clumps of hair. • Unexplained fractures, skin lacerations, punctures, or abrasions. • Swollen lips and/or chipped teeth. • Linear/parallel marks on cheeks and/or temple area. • Crescent-shaped bruising caused by pinching. • Puncture wounds that resemble distinctive objects. • Bruising behind the ears.	• Self-destructive/self-mutilation. • Withdrawn and/or aggressive-behavior extremes. • Uncomfortable/skittish with physical contact. • Repeatedly arrives at school late. • Expresses fear of being at home. • Chronic runaway (adolescents). • Complains of soreness or moves uncomfortably. • Wears clothing inappropriate to weather to cover body. • Lacks impulse control (e.g., inappropriate outbursts). • Is frequently absent from school • Abuses animals or pets
Physical Neglect	• Distended stomach, emaciated. • Unattended medical needs. • Lack of supervision. • Consistent signs of hunger, inappropriate dress, poor hygiene. • Sudden or unexplained weight change.	• Regularly displays fatigue or listlessness; falls asleep in class. • Steals, hoards or begs for food. • Reports that no caretaker is at home. • Is frequently absent from school • Abuses animals or pets
Sexual Abuse	• Pain or itching in genital area. • Bruises or bleeding in genital area. • Frequent urinary or yeast infections. • Sudden or unexplained weight change. • Becomes pregnant or contracts a venereal disease, particularly if the child is under the age of 14.	• Withdrawal, chronic depression. • Sexual behaviors or references that are unusual for the child's age. • Seductive or promiscuous behavior. • Poor self-esteem, self-devaluation, lack of confidence. • Suicide attempts. • Habit disorders (sucking, rocking). • Experiences a sudden change in appetite. • Runs away. • Attaches very quickly to strangers or new adults in their environment.

Indicators of Child Abuse/Neglect (continued)

Category	Physical Indicators	Behavioral Indicators
Medical Neglect	• Developmental delays. • Failure to Thrive. • Untreated serious physical injury.	• Social withdrawal or a loss of interest or enthusiasm in daily activities. • Somatic complaints. • Frequent absence from school. • Frequently missed medical appointments.
Maltreatment	• Habit disorders (sucking, biting, rocking, etc.). • Conduct disorders (antisocial, destructive, etc.). • Neurotic traits (sleep disorders, speech disorders, inhibition of play). • Has scars or marks from self-harm. • Shows extreme behaviors (overly compliant or demanding, extreme passivity and/or aggression. • Is delayed in physical and emotional development. • Reports lack of attachment to the parent.	• Behavior extremes such as compliant/passive or aggressive/ demanding. • Overly adaptive behavior such as inappropriately adult or infant. • Developmental delays (Physical, mental, and emotional). • Depression and or/suicide attempts. • Over sensitive to light, noise. • Has attempted suicide. • Acts inappropriately as an adult by parenting other children. • Acts inappropriately infantile by frequently rocking or head banging.
Human Trafficking	• Minors have contracted sexually transmitted diseases. • Minors have symptoms of post-traumatic stress including anxiety, depression, addictions, panic attacks, phobias, paranoia or hyper vigilance, or apathy. • Avoids eye contact. • Lacks health care. • Appears malnourished and/or always hungry. • Shows signs of physical and/or sexual abuse, physical restraint, confinement or torture.	• Minor may not identify themselves as a victim. • Victims and perpetrators are often skilled at concealing their situations. • Minors live with other unrelated youth and with unrelated adults. • Minors have significant and unexplained gaps in school attendance. • Minors are not in control of their own identification documents. • Minors do not live with their parent(s) or know the whereabouts of their parent(s).

Outcomes of CPS Investigations



When CPS conducts a field investigation and there is a preponderance of evidence to confirm child abuse or neglect, the case may be opened and monitored by CPS. When a case is denied, the worker is required to provide the family with a list of available community services to assist the family. Community services, including, but not limited to, substance abuse treatment, emotional/mental health treatment, domestic violence services or other identified services, are provided by CPS on a voluntary basis and the family is encouraged to seek out and utilize those services. The worker may also address underlying concerns which may not rise to the level of child abuse or neglect.

When CPS conducts a field investigation and there is a preponderance of evidence to confirm child abuse or neglect, the case is opened and monitored by CPS. The family are referred for services to address the concerns identified by the worker and family. The worker utilizes a structured decision making tool to 1) assess risk of future abuse/neglect in the home and 2) to assist with determining the services provided to the family. In these cases, the ongoing CPS worker conducts monthly face to face visits with the children to ensure safety and assess progress being made with the provision of services. The case is reviewed every 90 days to assess child safety and determine if risk of harm has been reduced.

Miscellaneous Issues

Head Lice Issues
An allegation of neglect based solely on a child having head lice is not appropriate for a CPS investigation. This condition could arise in any number of ways and is not, in and of itself, an indicator of neglect.

Therapy Issues
There are times when a child's behavior is a concern and may need further evaluation by a medical professional. If mandated reporters determine psychological help may be needed for a child, they should provide that information to the parent. It is up to the parent and/or guardian to make an appropriate decision for their child.

Medical Issues
- Immunizations - CPS is not authorized to investigate complaints that allege parents are failing or refusing to obtain immunizations for their children. The Michigan Public Health Code provides for exceptions to the immunization requirements.
- Medication - CPS is not responsible for investigating complaints that allege parents are failing or refusing to provide their children with psychotropic medication such as Ritalin.

School Truants and Runaways
Routine complaints on school truants and runaways are not appropriate for CPS. Truancy and running away are not in themselves synonymous with child abuse or neglect.

Multiple Allegations of Chronic Abuse and/or Neglect Suspected
If a mandated reporter reports a suspicion of child abuse/neglect and then a new allegation occurs, the mandated reporter must make another verbal and written report of suspected abuse and/or neglect to MDHHS. It is important to treat each suspected incident of abuse and/or neglect independently as it occurs. Each allegation of suspected child abuse and/or neglect could uncover patterns the CPS investigator would analyze during the intake and investigation process.

Miscellaneous Issues (continued)

Making the Report

- **Centralized Intake is not an emergency responder.** If the situation you are reporting requires immediate attention by law enforcement or medical responders, please call 911 first and then contact Centralized Intake to make your report. Although emergency responders are Mandated Reporters as well, you would still need to contact Centralized Intake to make your report to fulfill your reporting obligations.

  Example: Parents driving while intoxicated with the child in the car, a child in the middle of road, a child hanging out of a second story window, a domestic violence situation that is occurring at the time that the call is being made, a young child found unsupervised, etc.

- **Call Immediately**. The Child Protection Law states that the verbal report should be made immediately once a Mandated Reporter has reasonable cause to suspect child abuse and/or neglect.

  Examples: Do not wait until the morning to call Centralized Intake when the allegations are that the caretaker left the children alone in the middle of the night. The caretaker will usually be back home and it will be difficult to prove. Call when the children are still alone.

  Do not wait a week to report and say that there was no food in the home last week. There may be food in the home now and it will be difficult to prove. Call as soon as you can.

  Do not wait a week to call in concerns when a child has an injury. The injury may heal prior to CPS contact if the report is called in several days after being seen.

  It is understood that some professions and situations prevent the Mandated Reporter from stopping what they are doing to make the call to Centralized Intake immediately; however it is important to know that the report should be made as soon as possible once the Mandated Reporter suspects abuse/neglect towards a child.

  Example: Teachers may not be able to walk out of a classroom, leaving students unattended; however once the class has ended, or the teacher is on a break (lunch, the class is at gym, recess, at the end of the school day, etc.) or once the teacher is able to secure another teacher to relieve them, they would then need to make the call to Centralized Intake.

- **24/7 Availability.** Centralized Intake is available 24 hours a day, 7 days a week.

- **Be Prepared.** It is important to have as many details as possible (about the situation, concerns and the family) when making the report; however Centralized Intake will still take the report if not all the information is known.

- **Know Your Environment**. Be mindful of your surroundings when calling in the report. Do not make the call to Centralized Intake with the child present. Be sure to have gathered all the necessary information from the child prior to calling Centralized Intake.

REPORT OF ACTUAL OR SUSPECTED CHILD ABUSE OR NEGLECT

Michigan Department of Health and Human Services

Was Complaint Phoned to MDHHS?

☐ Yes ☐ No ▶ If yes, Intake ID # _____ ▶ If no, contact Centralized Intake (855-444-3911) immediately

INSTRUCTIONS: REPORTING PERSON: Complete items 1-19 (20-28 should be completed by medical personnel, if applicable). Send to Centralized Intake at the address listed on page 2.

1. Date

2. List of Child(ren) Suspected of Being Abused or Neglected. **To insert additional rows, tab at the end of last row to create a new row.**

NAME	BIRTH DATE	SOCIAL SECURITY #	SEX	RACE
"Click Here and Type"				

3. Mother's Name			
4. Father's Name			
5. Child(ren)'s Address (No. & Street)	6. City	7. County	8. Phone No.
9. Name of Alleged Perpetrator of Abuse or Neglect	10. Relationship to Child(ren)		
11. Person(s) The Child(ren) Living With When Abuse/Neglect Occurred	12. Address, City & Zip Code Where Abuse/Neglect Occurred		

13. Describe Injury or Conditions and Reason for Suspicion of Abuse or Neglect

14. Source of Complaint (Add reporter code below)

01 Private Physician/Physician's Assistant	11 School Nurse	42 MDHHS Facility Social Worker
02 Hosp/Clinic Physician/Physician's Assistant	12 Teacher	43 DMH Facility Social Worker
03 Coroner/Medical Examiner	13 School Administrator	44 Other Public Social Worker
04 Dentist/Register Dental Hygienist	14 School Counselor	45 Private Agency Social Worker
05 Audiologist	21 Law Enforcement	46 Court Social Worker
06 Nurse (Not School)	22 Domestic Violence Providers	47 Other Social Worker
07 Paramedic/EMT	23 Friend of the Court	48 FIS/ES Worker/Supervisor
08 Psychologist	25 Clergy	49 Social Services Specialist/Manager (CPS, FC, etc.)
09 Marriage/Family Therapist	31 Child Care Provider	56 Court Personnel
10 Licensed Counselor	41 Hospital/Clinic Social Worker	

15. Reporting Person's Name	Report Code (see above)	15a. Name of Reporting Organization (school, hospital, etc.)			
15b. Address (No. & Street)		15c. City	15d. State	15e. Zip Code	15f. Phone Number
16. Reporting Person's Name	Report Code (see above)	16a. Name of Reporting Organization (school, hospital, etc.)			
16b. Address (No. & Street)		16c. City	16d. State	16e. Zip Code	16f. Phone Number
17. Reporting Person's Name	Report Code (see above)	17a. Name of Reporting Organization (school, hospital, etc.)			
17b. Address (No. & Street)		17c. City	17d. State	17e. Zip Code	17f. Phone Number
18. Reporting Person's Name	Report Code (see above)	18a. Name of Reporting Organization (school, hospital, etc.)			
18b. Address (No. & Street)		18c. City	18d. State	18e. Zip Code	18f. Phone Number
19. Reporting Person's Name	Report Code (see above)	19a. Name of Reporting Organization (school, hospital, etc.)			
19b. Address (No. & Street)		19c. City	19d. State	19e. Zip Code	19f. Phone Number

TO BE COMPLETED BY MEDICAL PERSONNEL WHEN PHYSICAL EXAMINATION HAS BEEN DONE

20. Summary Report and Conclusions of Physical Examination (Attach Medical Documentation)		
21. Laboratory Report	22. X-Ray	
23. Other (specify)	24. History or Physical Signs of Previous Abuse/Neglect ☐ YES ☐ NO	
25. Prior Hospitalization or Medical Examination for This Child		
DATES	**PLACES**	
26. Physician's Signature	27. Date	28. Hospital (if applicable)

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.	AUTHORITY: P.A. 238 of 1975. COMPLETION: Mandatory. PENALTY: None.

INSTRUCTIONS

GENERAL INFORMATION:
This form is to be completed as the written follow-up to the oral report (as required in Sec. 3 (1) of 1975 PA 238, as amended) and mailed to Centralized Intake for Abuse & Neglect. Indicate if this report was phoned into MDHHS as a report of suspected CA/N. If so, indicate the Log # (if known). The reporting person is to fill out as completely as possible items 1-19. Only medical personnel should complete items 20-28.

Mail this form to:
Centralized Intake for Abuse & Neglect
5321 28th Street Court, SE
Grand Rapids, MI 49546

OR

Fax this form to 616-977-8900 or 616-977-8050 or 616-977-1158 or 616-977-1154
OR
email this form to MDHHS-CPS-CIGroup@michigan.gov

1. Date – Enter the date the form is being completed.
2. List child(ren) suspected of being abused or neglected – Enter available information for the child(ren) believed to be abused or neglected. Indicate if child has a disability that may need accommodation.
3. Mother's name – Enter mother's name (or mother substitute) and other available information. Indicate if mother has a disability that may need accommodation.
4. Father's name – Enter father's name (or father substitute) and other available information. Indicate if father has a disability that may need accommodation.

5.-7. Child(ren)'s address – Enter the address of the child(ren).

8. Phone Number – Enter phone number of the household where child(ren) resides.
9. Name of alleged perpetrator of abuse or neglect – Indicate person(s) suspected or presumed to be responsible for the alleged abuse or neglect.
10. Relationship to child(ren) – Indicate the relationship to the child(ren) of the alleged perpetrator of neglect or abuse, e.g., parent, grandparent, babysitter.
11. Person(s) child(ren) living with when abuse/neglect occurred – Enter name(s). Indicate if individuals have a disability that may need accommodation.
12. Address where abuse / neglect occurred.
13. Describe injury or conditions and reason of suspicion of abuse or neglect – Indicate the basis for making a report and the information available about the abuse or neglect.
14. Source of complaint – Check appropriate box noting professional group or appropriate category.

Note: If abuse or neglect is suspected in a hospital, also check hospital.

15.-19 - Reporting person's name - Enter the name and address of person(s) reporting this matter.

Michigan's Safe Delivery Law

Under Michigan's Safe Delivery of Newborns law, Michigan law (MCL 701.1 et. seq., 750.135, and 722.628) a parent(s) can anonymously surrender an unharmed newborn, from birth to 72 hours of age, to an Emergency Service Provider (ESP). An ESP is a uniformed or otherwise identified, inside-the-premises, on-duty employee or contractor of a fire department, hospital or police station, or a paramedic or an emergency medical technician responding to a 911 call.

According to the law, the parent has the choice to leave the infant without giving any identifying information to the ESP. While a parent may remain anonymous, the parent is encouraged to provide family and medical background that could be useful to the infant in the future.

Once a newborn is in the custody of an ESP, the infant is taken to a hospital for an examination. If there are no signs of abuse and/or neglect, temporary protective custody is given to a private adoption agency for placement with an approved adoptive family. If the examination reveals signs of abuse and/or neglect, hospital personnel will make a complaint to CPS.

Mandated Reporters Information Line

Phone: **877-277-2585**

Email: MDHHS-MRCIcontact@michigan.gov

The Mandated Reporters Information Line (877-277-2585) is available to respond to mandated reporters who have concerns about the actions taken on a specific complaint of child abuse or neglect they have reported to Centralized Intake. This line should not be used to report abuse or neglect.

The Mandated Reporters Information Line is staffed from 9:00 a.m. to 5:00 p.m., Monday through Friday, excluding holidays. Mandated reporters must provide the Intake ID Number given to them at the time they made their complaint to Centralized Intake in order to obtain information regarding their complaint. The Centralized Intake specialists staffing this information line will verify the caller's identity to ensure confidentiality. For example, mandated reporters could be asked to send an email to the information line from their agency or business address for comparison to contact information in the department's system.

Examples of reasons to call the Mandated Reporters Information Line:

- More than five business days have passed from the date of your complaint and you have not received a notification letter from Centralized Intake to inform you that the complaint was rejected and no CPS worker in the county has contacted you to investigate the complaint.
- You received a letter from Centralized Intake informing you that the complaint you made was rejected or transferred and you would like to speak with a Centralized Intake supervisor to discuss that action.
- A worker in the county is actively involved with the family and you are unable to contact that worker or your calls to the worker have not been returned.
- You would like to provide additional information or documentation related to a complaint you have already made.

Note: If you are reporting new allegations of suspected child abuse or neglect, please call Centralized Intake at 855-444-3911.

Training

MDHHS will provide training to mandated reporters regarding their requirement to report suspected child abuse and/or neglect. Contact information for your local MDHHS office can be found online at www.michigan.gov/contactMDHHS.

Appendix

Specific questions need to be answered during the complaint process to provide the most complete and comprehensive description of the alleged abuse or neglect.

The following is a guide for what information reporting persons should have available when placing a call to Centralized Intake. In many cases not all of the questions can be answered, but gather as much information as possible; it will enable Centralized Intake to make an informed decision as to whether or not to assign the complaint for investigation. Be alert to the following specific information, but do not complete an interview of the child(ren).

- What is the name and contact information of the non-custodial parent(s)?
- What is the visitation schedule between the child(ren) and the non-custodial parent(s)?
- How did you learn this information?
- If you learned this information from a different source, would you be willing to provide that source's name and contact information? Would that individual be willing to speak with someone from Centralized Intake regarding these concerns?
- What is the location of the child (at the time that complaint is being made)?
- What school/daycare does the child(ren) attend?
- What time does the school start? What time does the school end?
- Does the child/victim have a disability?
- Does any household member have Native American Heritage?
- Does the family reside on a Native American Reservation or Trust Land?
- Are there any safety issues or concerns for the worker to know about (weapons/pets/violent people)?
- Have the police ever been contacted regarding this family?
- Does the family have any language barriers?
- Is there anyone else who would have additional information regarding these concerns?
- Is anyone in the home a licensed foster care provider, licensed day care provider or relative provider?

I. Physical Neglect

A. If the allegations involve a ***dirty house***, describe how the house is dirty. **Be very specific**.
   - When was the last time you were in the house?
   - Describe what you see when you walk in the house.
   - The words "dirty" or "filthy" are vague and have different meanings to different people. "Garbage on the floor" or "animal feces throughout the house" would be more specific and descriptive.
   - Does the home have an odor?
   - What does the kitchen look like?
   - Are there open containers of food lying around?
   - Is there furniture in the home?
   - Do the children have beds? If so, do the mattresses have bedding on them?
   - Is there running water in the home?

B. If the allegations are regarding a child not being fed properly:
   - Is there any food in the home right now? How do you know?
   - When was the last time you saw food in the home?
   - What exactly is in the refrigerator and cupboards?
   - Do the children complain about being hungry?

- Does anybody else buy food for the home?
- Is there less food during specific times of the month?

C. If your concerns are regarding a child's hygiene (including oral hygiene):
- Is the child generally clean? If he/she is dirty, describe how he/she is dirty.
- How often is he/she dirty--twice a week, four or five times a week, every day, etc.?
- Does the child bathe on a regular basis?
- Is his/her clothes and/or body dirty?
- Does he/she have an odor?
- Does the family have animals?
- Are the animals indoor pets?
- Does the home have bugs or rodents (cockroaches, flies, mice, etc.)?
- How does this effect the child's peer-to-peer relationships? - Do others notice and/or treat the child differently due to the odor or hygiene issues?
- Does the child have any unmet dental needs?
- Is the child currently reporting any tooth/mouth pain?
- Does the child have any broken, discolored or missing teeth?

D. If the allegations are concerning **no water or heat in the home**:
- How are you aware of the situation?
- How long has the water and/or heat been off?
- Do the parents have a plan to have the water and/or heat turned back on?
- Does the family have access to water?
- Is the family bringing water into the home?
- Are the children sleeping at the residence or staying elsewhere at night?
- Are the children bathing elsewhere?

E. If the allegations involve **parental drug use**:
- How does the parent's drug use affect the care of the children?
- How do you know the parents are using drugs?
- What kind of drugs are they using?
- Does the parental use of substances in front of the child impact the child's safety and well-being?
- Are the parents selling drugs out of the home?
- Are the parents allowing other people to use drugs in the home or to sell drugs out of the home?

II. Medical Neglect
- What type of injury or medical need does the child have?
- What type of care does the child require?
- How has the parent failed to meet the child's needs?
- If the child has missed medical appointments, how many?
- When is the last time the child was seen by a doctor?
- How has the parent's failure to provide medical care affected the child?
- Any identifying information about the child's health care provider would be extremely helpful in these types of situations.

III. Failure to Protect
- How has the child been abused or neglected?
- How do you know that the parent is aware of the abuse/neglect?
- Has the parent taken any steps to protect the child?

- Has the parent threatened the child not to talk about the abuse/neglect?
- Did the abuse occur in the past and the parent continued to allow the alleged perpetrator to have contact with the child?
- What type of emotional tie does the parent have with the alleged perpetrator?

IV. Improper Supervision

- If the child is being left home alone, how old is he/she?
- How often is he/she left home alone?
- Is he/she left alone during the daytime or in the evenings?
- How long is he/she usually left alone?
- Is there a phone in the home?
- Does the child know what to do in case of emergency?
- Are any of the children in the home mentally or physically handicapped?
- Has the child ever been left alone overnight?
- Is the child home alone right now?

Please note: According to the Child Protection Law, there is no legal age that a child can be left home alone. It is determined on a case-by-case basis, but as a general rule, a child 10 years old and younger is not responsible enough to be left home alone. A child over the age of 10 and under the age of 12 will be evaluated, but the case may not always be assigned for a CPS investigation.

V. Abandonment

- If a parent leaves the child with the non-custodial parent without making prior arrangements, an assessment will be made to determine if that parent is willing or able to assume responsibility for the child.

VI. Physical Abuse

A. If the allegations involved physical abuse:
   - How is the child being abused?
   - Who is abusing the child?
   - With what is the child being abused?
   - Has the child ever had marks and/or bruises?
   - Has the child ever had any other type of injuries from the abuse?
   - When is the last time you observed the child having marks and/or bruises?

B. If the child currently has marks or bruises:
   - How does the child explain them?
   - What do the marks look like (burns, welts, scalds, etc.)?
   - What color, size, and shape are they?
   - Was the skin broken?
   - When does the child say he/she was last struck?
   - Is the child afraid to go home?
   - Did the parent threaten to hit the child again?
   - Is the child complaining of pain and/or discomfort?

VII. Sexual Abuse

- Be specific as to why you suspect sexual abuse.
- What has the child done or said to make you suspect sexual abuse?
- When and to whom did the child disclose the sexual abuse?
- Who is the suspected perpetrator?

Appendix (continued)

- Does the perpetrator live in the home?
- Does the perpetrator still have access to the child?
- Is a parent aware?
- What action has the parent taken to protect the child if he/she is aware?
- Has the parent sought medical attention for the child?

Confidentiality

Strict *state and federal* confidentiality laws govern CPS investigations. The identity of a reporting person is confidential under the law. The identity of a reporting person is subject to disclosure only with the consent of that person, by judicial process, or to those listed under Section 5 of the Child Protection Law (MCL 722.625). The alleged perpetrator may infer from the information in the report who made the complaint and confront mandated reporters, however, CPS will not disclose the identity of a reporting person.

The amount and type of information to provide the reporting person is based on the following principles:

- The child's and family's confidentiality must be protected.
- The child's and family's safety must be protected.
- Regular care providers need information which will help them enhance the child's physical and emotional well-being.
- Person's providing diagnoses and treatment to a child or member of a child's household need information which will help them enhance the child's and family's physical and emotional well-being.
- The role of the reporting person must be respected and acknowledged. In some cases, it is appropriate to ask the reporting person to work with CPS to help protect the child.
- The protection and safety of the child is enhanced by close working relationships between CPS and members of the community.

Due to federal laws and regulations, domestic violence providers and substance abuse agencies can only provide the information required for reporting by the Child Protection Law unless the client signs a concern for release of information to MDHHS for a CPS investigation.

Substance abuse agencies must comply with the Child Protection Law by reporting suspected child abuse and/or neglect and subsequently filing a written report. Complaints of suspected child abuse or neglect received from substance abuse treatment agencies may be investigated by the department. However, stringent federal confidentiality regulations govern the handling of information received from a substance abuse agency. Federal regulations apply to licensed substance abuse agencies in the state. The department must comply with these regulations when information is received from a substance abuse agency.

All law enforcement documents, reports, materials and records pertaining to an **ongoing** law enforcement investigation of suspected child abuse or neglect must be considered confidential and must not be released by MDHHS.

A perpetrator's conviction or circuit court finding (including termination of parental rights) is of public record. This information must be used when disclosing perpetrator history to the parent. Only information from a criminal conviction or circuit court finding can be shared. If a perpetrator has been placed on the central registry **only**, this information cannot be shared.

Medical information obtained during an open CPS investigation may only be released to the prosecuting attorney, law enforcement agencies, or the court in order to investigate child abuse or neglect. Information may only be released to a court when contained in a petition and relevant to the allegations made in the petition. In all other cases, confidential medical records may not be released without client consent, valid court-issued subpoena or court order.

Confidentiality (continued)

Federally assisted substance abuse treatment records that are a part of a children's services case record may only be shared with the person(s) identified in a properly executed DHS-1555-CS or court order. This information may not be used to criminally investigate or prosecute a patient. Federally assisted treatment records may only be released if there is: (1) a properly executed DHS-1555-CS; (2) a court order authorizing (but not compelling) release and subpoena or (3) a court order compelling release.

Mental Health Treatment Records (that have been obtained to determine whether child abuse or neglect has occurred, to gauge risk to children and to provide appropriate services) can be released to 1) a legally mandated public or private child protective agency; (2) a police or law enforcement agency; (3) a person legally authorized to place a child in protective custody when the information is necessary to determine whether or not to place a child in protective custody; (4) a person, agency or organization authorized to diagnose, care for, treat or supervise a child or family that is the subject of a report or record under the child protection law; (5) to others only in response to the client's consent, a valid court-issued subpoena or a court order in order to investigate a report of known or suspected child abuse or neglect.

HIV/AIDS/ARC Records can be released to CPS if the information is part of a report required under the Child Protection Law. Information regarding a child with HIV/AIDS can be released to the director or licensee of a family foster home, family foster group home, child caring institution or child placing agency for the purpose of placing the child or to licensed foster parents and child care organization staff (1) to care for or protect the child or (2) to prevent a reasonably foreseeable risk of transmission to other children or staff.

Prevention of Sudden Infant Death Syndrome and the Use of Safe Sleep Practices

27

Recognition and Reporting of Child Abuse and Neglect

28

Prevention of Sudden Infant Death Syndrome and the Use of Safe Sleep Practices

- Alone on back
- In crib, bassinet or pack-n-play
- On a firm mattress with a tightly fitted sheet
- No pads, blankets, wedges, or positioners
- In the same room as an adult

29

What Does A **Safe Sleep Environment** Look Like?

The image below shows a safe infant sleep environment.

Baby's sleep area is in the same room, next to where parents sleep.

Use a firm and flat sleep surface, such as a mattress in a safety-approved crib*, covered by a fitted sheet.

Baby should not sleep in an adult bed, on a couch, or on a chair alone, with you, or with anyone else.

Do not smoke or let anyone else smoke around your baby.

Do not put pillows, blankets, sheepskins, or crib bumpers anywhere in your baby's sleep area.

Keep soft objects, toys, and loose bedding out of your baby's sleep area. Make sure nothing covers the baby's head.

Dress your baby in sleep clothing, such as a wearable blanket. Do not use a loose blanket, and do not overbundle.

Always place your baby on his or her back to sleep, for naps and at night.

NIH *Eunice Kennedy Shriver* National Institute of Child Health and Human Development

SAFE TO SLEEP®

* A crib, bassinet, portable crib, or play yard that follows the safety standards of the Consumer Product Safety Commission (CPSC) is recommended. For information on crib safety, contact the CPSC at **1-800-638-2772** or http://www.cpsc.gov.

Safe Sleep For Your Baby

Reduce the Risk of Sudden Infant Death Syndrome (SIDS) and Other Sleep-Related Causes of Infant Death

- Always place baby on his or her back to sleep, for naps and at night, to reduce the risk of SIDS.
- Use a firm and flat sleep surface, such as a mattress in a safety-approved crib*, covered by a fitted sheet with no other bedding or soft items in the sleep area.
- Share your room with baby. Keep baby in your room close to your bed, but on a separate surface designed for infants, ideally for baby's first year, but at least for the first 6 months.
- Do not put soft objects, toys, crib bumpers, or loose bedding under baby, over baby, or anywhere in baby's sleep area.

To reduce the risk of SIDS, women should:

- Get regular prenatal care during pregnancy.
- Avoid smoking, drinking alcohol, and using marijuana or illegal drugs during pregnancy or after the baby is born.
- Do not smoke during pregnancy, and do not smoke or allow smoking around your baby or in your baby's environment.
- Think about giving your baby a pacifier for naps and nighttime sleep to reduce the risk of SIDS.
- Do not let your baby get too hot during sleep.

For more information about the Safe to Sleep® campaign, contact us:

Phone: 1-800-505-CRIB (2742) | **Fax:** 1-866-760-5947
Email: SafetoSleep@mail.nih.gov
Website: http://safetosleep.nichd.nih.gov
Mail: 31 Center Drive, 31/2A32, Bethesda, MD 20892-2425
Federal Relay Service: Dial 7-1-1

Breastfeed your baby to reduce the risk of SIDS. Breastfeeding has many health benefits for mother and baby. If you fall asleep while feeding or comforting baby in an adult bed, place him or her back in a separate sleep area as soon as you wake up.

- Follow guidance from your health care provider on your baby's vaccines and regular health checkups.
- Avoid products that go against safe sleep recommendations, especially those that claim to prevent or reduce the risk for SIDS.
- Do not use heart or breathing monitors in the home to reduce the risk of SIDS.
- Give your baby plenty of tummy time when he or she is awake and someone is watching.

* A crib, bassinet, portable crib, or play yard that follows the safety standards of the Consumer Product Safety Commission (CPSC) is recommended. For information on crib safety, contact the CPSC at **1-800-638-2772** or http://www.cpsc.gov.

NIH Pub. No. 18-HD-5759 | April 2018

Prevention of Sudden Infant Death Syndrome and the Use of Safe Sleep Practices: Choking

30

Prevention of Sudden Infant Death Syndrome and the Use of Safe Sleep Practices

Three Ways Infants Can Suffocate in Inclined Sleepers

Head turns into side padding | Baby rolls over | Head falls forward

31

Break

Please return in 5 minutes

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Building and Physical Premises Safety

33

Building and Physical Premises Safety: Serious Injury

"Unintentional injuries—such as those caused by burns, drowning, falls, poisoning and road traffic—are the leading cause of morbidity and mortality among children in the United States."

-Center for Disease Control (CDC)

34

Building and Physical Premises Safety: Supervision

- Children under age six should always be supervised directly by sound and sight
- Even when children are napping, make visual checks

35

What hazards do you see?

Activity

GSQ

36

Building and Physical Premises Safety: Indoor Hazards

GSQ

37

Building and Physical Premises Safety: Outdoor Play

- Anchors children to the real world
- Social interactions
- STEM skills
- Taking appropriate risks
- New context for learning
- Opportunities for collaboration
- Promotes better sleep

GSQ

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Building and Physical Premises Safety:
Outdoor Hazards
Sun protection
Animal bites
Water safety
GSQ

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Building and Physical Premises Safety:
Outdoor Hazards
Traffic, driveways, and parking lots
Weather
Playground
GSQ

40