American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

September 2025
Volume 6, Issue 3

Newsletter of the Council on Child Abuse & Neglect

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Hello from the Co-Editors in Chief

Hello,

Happy fall and welcome to the latest edition of our newsletter! In this issue, we highlight a deeply important topic within our community: abusive head trauma.

This newsletter features contributions from a talented group of writers. Drs. Vincent Palusci and Brooke Starn explore educating medical students on abusive head trauma, particularly the role of media in shaping perceptions of this complex issue. Drs. Margaret Russell and Tagrid Ruiz bring us the invaluable voices of families who have experienced AHT. Katie Synder presents a case study that highlights the real-world implications of AHT in clinical settings. Additionally, we have our regular EC update to keep you informed of the latest initiatives and developments in the field.

Thank you for joining us in this crucial conversation.

Angela Doswell and Natasha Jouk

Eye on Equity

Understanding Abusive Head Trauma Through the Lens of Family: A Commentary on Research, Practice, and Lived Experience

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Abusive head trauma (AHT) affects an estimated 1,300 children in the United States per year and is not a diagnosis made lightly.[1] As acknowledged in the American Academy of Pediatrics' Technical Report on AHT, medical providers are acutely aware of the profound social and legal implications of an AHT diagnosis and are not immune to the emotional distress inherent to these cases.[2] Despite the challenges posed by these cases, Child Abuse Pediatricians (CAPs) remain committed to making accurate, evidence-based diagnoses and advocating for the welfare of the child, including policy development and prevention efforts.[3-10] Ensuring a child's safety may entail involvement of a child welfare or law enforcement agency. For those providing care to a child and family, it also warrants awareness of how the lives of our patients—and their families—may be altered across emotional, relational, developmental, and sometimes legal domains. The impact of AHT is far more than physical injury alone.

Understanding what life looks like after a diagnosis of AHT requires engaging with families not only as recipients of care but as essential sources of perspectives that are not captured by quantitative analyses of large databases. The lived experiences of the families navigating an AHT diagnosis and its repercussions are invaluable for pediatricians as we seek to care for the patient and the patient's family.

There are challenges to research involving lived experiences regarding AHT and its aftermath. Victims of this form of maltreatment are unable to be interviewed due to their age at the time of the injury.[2] The associated morbidity, such as developmental delay, or death related to AHT confers limitations to exploring the lived experience of victims in the years following their trauma.[11] Recruitment of alleged perpetrators similarly has limitations, with their disclosures having ramifications for ongoing investigations or legal proceedings. The existing literature on perpetrator disclosures of physical abuse includes case reports and case series of confessions insofar as they shed light on mechanisms and pathophysiology of AHT, drawn largely from investigations and judicial confessions.[12-16]

The experience of the non-offending caregiver (NOC) emerges as a source of rich information that avoids inherent limitations to engaging with victims or alleged perpetrators. While NOC perspectives have been used to inform care in child sexual abuse literature, they remain under-utilized in studies pertaining to child physical abuse.[17-20] When a child survives AHT, the NOC is faced with nearly impossible decisions, such as what contact a child will have with an alleged perpetrator moving forward, and their perspectives can shed light on the impact of an AHT diagnosis on the family. In cases with few physical sequelae, the NOC's decisions about family life and caregiving may be the most impactful factor in shaping the experience of a child moving forward. AHT impacts a NOC as well, and understanding this impact is essential to providing appropriate support.

As a researcher exploring the NOC's perspective, speaking with these caregivers has changed my clinical approach and highlighted opportunities for improvement in our care of a child and their family. These are some reflections informed by my interactions with NOCs—lessons that may meaningfully inform clinical practice for those involved in the evaluation and care of children with suspected AHT.

1. In our information-gathering, we often rely on the caregiver for medical information and context. Yet in AHT cases, **the caregiver with whom we speak**—whose report we elicit to understand a child's medical history and with whom we discuss prognosis—**may know no more about the circumstances of the child's injury than we do**. In fact, they may know less. A trauma-informed approach requires that we consider this possibility from the outset rather than assume intentional omission.

2. **There are gaps in our support for families impacted by AHT.** Families interface with many medical teams following AHT; of those, interactions with CAPs are finite and, at times, fraught. Understanding the experiences of NOCs, however, may facilitate support by other medical providers or community support networks. Existing post-AHT literature supports comprehensive subspecialty follow-up and has begun to explore parenting interventions that aid in a child's recovery.[11,21] It should also include an understanding of changes in family dynamics and ways a medical system, be that a Primary Care Provider or subspecialist with longitudinal involvement, can support caregivers following an AHT diagnosis.

As we work to improve our practice, the insights of NOCs can be essential to building a trauma-informed approach to caregivers of children with suspected AHT. While challenges to this work exist, the potential benefits of qualitative research on physical abuse, particularly

AHT, are substantial. These caregivers' perspectives are complex, and in integrating qualitative research into our policies, practices, and quality improvement efforts we can begin to fill large gaps in care of children and their families.

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Focus On

Misinformation in the Media: Educating Medical Students about Abusive Head Trauma

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Abusive head trauma (AHT) is a well-accepted diagnosis by the vast majority of the medical community; yet, the media perpetuates significant misinformation regarding AHT, falsely claiming that the diagnosis is discredited, alternative theories explain patient presentations, and studies disprove the possibility of shaking as a mechanism. This portrayal of AHT is not new; there are articles dating back over a decade that misrepresent AHT to readers. However, the renewed scrutiny this topic has received recently is concerning. Since most medical school curricula on AHT generally focus on recognition and management without directly addressing common inaccuracies, medical students often lack formal education on AHT misconceptions and how to interpret statements in the popular media.

As the evaluation and management of AHT require a multidisciplinary clinical team, it is imperative that medical students, regardless of future specialty, are equipped with accurate information. A curriculum was developed for medical students aimed at reviewing and correcting common misconceptions presented in the popular media. This curriculum was presented to two student groups at New York University Grossman School of Medicine: (1) a 15-minute version for pediatric clerkship students in conjunction with an existing lecture on child abuse pediatrics that included an overview of AHT, and (2) a 45-minute version for first-year and post-clerkship students in the Pediatrics Interest Group that included additional background information on the clinical presentation and work-up of AHT.

The curriculum directly reviewed 10 common claims in the media, assessed their validity in the scope of current literature, and provided students with the origin of some of these misconceptions. Throughout the presentation, we integrated a review of students' evidence-based medicine (EBM) curriculum to highlight how students can apply EBM concepts when confronted with uncertainty regarding the validity of media claims. Students were given the option to participate in pre- and post-presentation surveys to ensure learning objectives of the curriculum were met and to gather feedback on the presentation as part of a quality improvement initiative. The survey assessed students' perception of the media's accuracy in general, AHT myths in the media, AHT epidemiology, and AHT differential diagnosis. Table 1 includes survey questions and answers.

Table 1: Survey questions

Question topic	Question	Correct Answer
General media accuracy	TRUE or FALSE: News media always present accurate medical information about the science of AHT.	False
AHT myths	Which of the following are true? Select all that apply. A. The quantity, location, and characteristics of retinal hemorrhages are important to note when considering AHT on a differential diagnosis. B. Many AHT cases have been overturned in recent years, corresponding with misinformation being presented in the popular media. C. The forces required to cause neurologic impairment through shaking an infant would also cause damage to the infant's spine. D. Biomechanics studies can accurately replicate an infant's head and neck, and consistently demonstrate that shaking can cause the pattern of injuries generally seen in AHT. E. Injuries from AHT are devastating for both patients and families.	A, E
AHT epidemiology	TRUE or FALSE: Death from a short distance fall is exceedingly rare, occurring in less than 1 / 1,000,000 children under 5yo, while AHT occurs in roughly 30 / 100,000 infants under 1yo.	True
AHT differential diagnosis	Which of the following are often (**incorrectly**!) used to explain findings concerning for AHT? Select all that apply. A. Rebleeding from birth trauma B. Vaccinations C. Severe coughing D. Cerebral Sinovenous Thrombosis	A, B, C, D

We analyzed the results by topic area and by student level; these results are included in tables 2 and 3 below. All 18 students who participated correctly answered the question about the accuracy of the media on both the pre- and post-presentation surveys, demonstrating an appropriately weary view of the popular media as a source of medical information before the presentation. Each of the other three questions, which were about AHT specifically, saw an increase in correct responses from the pre- to post-presentation surveys. The average score on the pre-presentation survey was 2.2/4, which increased to 3.5/4 on the post- presentation surveys, leading to an average score increase of 1.3 ($p<0.05$ on paired t-test analysis). Additionally, students' written feedback was positive, with students requesting more time or resources to learn about this topic in greater depth. One student reported having previously heard of the controversies surrounding AHT and was glad to have dedicated time to review the misconceptions in the media.

Table 2: Survey results by topic.

Question topic (all students, n = 18)	% of students with correct responses on pre-test	% of students with correct responses on post-test
General media accuracy	100%	100%
AHT myths	0%	61%
AHT epidemiology	89%	100%
AHT differential diagnosis *	33%	89%

* Difference between pre- and post-test is significant on McNemar's test with $p < 0.05$.

Table 3: Survey results by training level.

Class year (n)	Average score on pre-test	Average score on post-test
Pre-clinical (5) **	2.4	3.8
In clerkship (10) **	2.1	3.3
Post-celerkship (3)	2.3	3.7
All (18) **	2.2	3.5

** Difference between pre- and post-test is significant on paired t-test with $p < 0.05$.

In our small sample of students, a short, introductory presentation about the misinformation in the popular media regarding AHT was an effective means of increasing their content knowledge as demonstrated by an increase in scores on a test given after the lesson. Students also expressed a desire to learn more about this topic, suggesting that similar discussions could be integrated into other standard curricula. Limitations of this project include inability to generalize findings to other groups of students due to the small sample size. The most appropriate level for this type of information has not yet been determined. All students can benefit, but the most substantial gains may be during the preclinical years.

Despite these limitations, the results from this project are encouraging. It may also be best delivered as part of an evidence-based medicine curriculum that specifically addresses interpreting findings in the popular media. With the growing distrust of "scientific evidence" presented in the popular media, it is imperative that future physicians are equipped with accurate information regarding AHT and the skills to critically assess the validity of those claims.

Overview On

New AAP technical report can help counter misinformation about abusive head trauma

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An internal medicine physician approaches you at a social function and says, "I just read an article in The New York Times *about a father who lost custody of his children and could face prison time after his infant son was hospitalized with subdural hematomas. The article indicated that shaken baby syndrome is now considered a controversial medical diagnosis. I was not aware of that!"*

Legal cases of shaken baby syndrome highlighted in the media offer sensational narratives of wrongfully convicted individuals who spend years fighting for justice. These stories often ignore the nuanced, multifactorial nature of abusive head trauma (AHT) and oversimplify a complex medicolegal issue. As a result, they give rise to misconceptions about the causes, effects and science underpinning this serious condition.

Over the last several decades, much has been published on various aspects of the AHT diagnosis, and it can be difficult for pediatric providers to keep up with the volume and complexity of the science. A new AAP technical report provides a comprehensive review of the evidence-based literature surrounding AHT, which can help pediatricians communicate scientific information to child welfare agencies, the courts and others.

The report *Abusive Head Trauma in Infants and Children* was authored by a multidisciplinary group of experts from the AAP Council on Child Abuse and Neglect, Section on Ophthalmology, Section on Radiology and Section on Neurological Surgery; Society for Pediatric Radiology; American Association of Certified Orthoptists; American Association for Pediatric Ophthalmology and Strabismus; and American Academy of Ophthalmology. It is available at https://doi.org/10.1542/peds.2024-070457 and will be published in the March issue of *Pediatrics*.

Consequences of controversy

While the media and legal community have questioned whether shaken baby syndrome is real, the AAP and at least 18 international professional medical societies consider it a valid diagnosis under the broader diagnosis of AHT.

The AAP adopted the term AHT in 2009 in recognition that shaking is just one of a variety of biomechanical forces that can cause inflicted head injury in children. The change in terminology has been misinterpreted by some, including those in the court system, as an indication that shaking no longer is a valid cause of injury.

A recent medicolegal study found that the rate of conviction reversals of AHT cases in the U.S. appellate system increased four-fold in the prior decade (Narang SK, et al. *Child Abuse Negl*. 2021;122:105380).

Additionally, recent high-level state court decisions including State of New Jersey v. Darryl Nieves have described AHT as an "article of faith" diagnosis that rests on "discredited science."

This background and the increasing volume and complexity of AHT science make it challenging for pediatric providers to educate interdisciplinary colleagues such as child welfare agencies and courts about the diagnosis.

How technical report can support pediatricians

Although not conducted in a formalized systematic review method, the technical report, with 72 pages and 684 references, offers many supports for the pediatric provider.

First, unlike large books or chapters in books, the technical report is openly available, readily accessible and includes up-to-date scientific information.

Second, it provides an appendix of standardized definitions. Various medical terms encountered in the AHT diagnosis (i.e., acute subdural hematoma/hemorrhage, chronic subdural hematoma/hemorrhage, short distance fall, subdural hygroma, etc.) have had some definitional variance throughout the medical literature. The technical report endeavors to provide consistency by utilizing the National Institutes of Health Common Data Elements for Traumatic Brain Injury.

Finally, the technical report is organized into scientific subsections such as epidemiology, risk factors, evaluation, diagnosis, team approach to management and prevention. Takeaway points are listed at the end of each subsection. These scientific summary statements offer succinct, evidence-based responses to counter misinformation. Following are examples of some takeaway points:

- An absent trauma history, in the presence of traumatic findings, has high specificity and positive predictive values for AHT.
- Sentinel injury research has identified bruising as a key sentinel finding in babies and young infants, occurring in upwards of 28% of "definite" abuse cases.
- Bruising in the TEN-4-FACESp distribution has high sensitivity and specificity for abusive injury. This refers to torso, ear, neck (TEN), frenulum, angle of jaw, cheeks (fleshy), eyelids, subconjunctivae (FACES), patterned (p), and the 4 represents any bruising anywhere to an infant 4.99 months or younger. Thus, in general, bruising in such locations, absent a clear and consistent accidental history, warrants an evaluation for possible abuse.
- Retinal hemorrhages that are numerous, present in multiple layers of the retina and extend peripherally beyond the posterior pole are highly specific (94%) for severe head trauma and particularly AHT. Nontraumatic causes of retinal hemorrhages usually occur in patterns different from head trauma.
- Short distance falls rarely result in fatality in children.
- There is an evidence base among multiple initiatives that demonstrate AHT prevention programs improve caregiver knowledge on infant crying, the consequences of shaking an infant and AHT in general.

The controversy surrounding AHT likely will continue in legal and media realms. The emotional and psychological toll on families accused of abuse is significant. Pediatric providers stand in the unique position to counterbalance sensationalistic propositions with the sound, measured, evidence-based information provided in the technical report.

Dr. Narang is a lead author of the technical report and a member of the AAP Council on Child Abuse and Neglect.

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Case Presentation

Toddler vs. Car

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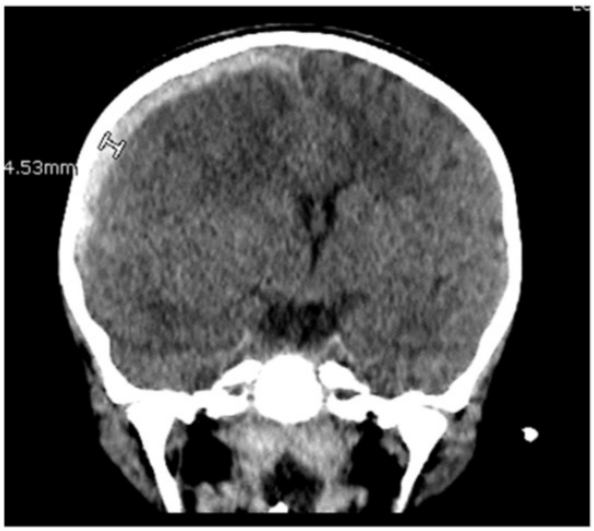
Patient is a 20 month old male who was noted by mother's boyfriend (MBF) to have vomiting and seizure-like activity while he was caring for him. MBF dropped the patient off at mother's workplace, shortly after which, the patient vomited and became unresponsive. Mother called EMS. EMS reports that the patient was not moving his left side in the ambulance, and his oxygen saturations fluctuated requiring supplemental oxygen administration.

Upon arrival in the ED, the patient was noted to be unresponsive, with limited movement of the left side of his body, sluggishly reactive pupils bilaterally with intermittent right-sided eye deviation, a GCS of 7, "contracting" of the right sided extremities, a large hematoma to the frontal area, and an abrasion under his left eye. The patient was breathing spontaneously. On subsequent examinations, the patient was identified as having multiple scars to his extremities, torso, buttocks, and posterior neck. The patient was intubated, sent for a head CT without contrast and sent to the PICU.

The head CT without contrast showed an acute 6 mm right convexity subdural hemorrhage (SDH) with 6 mm of right to left midline shift with a minimal amount of SDH on the falx and tentorium. A CT without contrast of the cervical spine was negative.
Skeletal Survey showed a subacute fracture of the left posterior 9th and 10th ribs and the right posterior 9th rib as well as transverse sclerosis to the proximal diaphysis of the right 1st and 4th metatarsals and possibly the left 4th and 5th metatarsals raising the question for chronic healing fractures.

The patient was noted to have transaminitis with an ALT of 558 and an AST of 366. An abdominal/pelvic CT without contrast was completed identifying nondisplaced subacute fractures of the left posterior 9th and 10th ribs, a subacute fracture of the right posterior lateral 9th rib.

Initially laboratory evaluation revealed an elevated white blood cell count of 22.4, a low hemoglobin of 9.4 and hematocrit of 28.4, and a platelet count of 319. Coagulation workup including PT, PTT, INR, factor VIII, factor IX, and vW panel were normal with the exception of an elevated PT of 15.7. A CMP was notable for an elevated glucose of 184 and the transaminitis. Urine toxicology screen was positive for benzodiazepines related to previously given medication during the course of medical intervention.



Coronal View on Initial Head CT without contrast

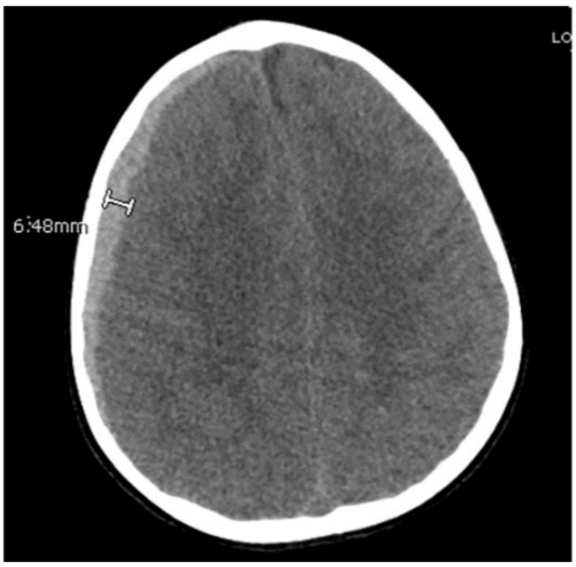
Metabolic bone labs showed a normal calcium, phosphorous, alkaline phosphatase, and bioactive PTH. 25-hydroxy-vitamin D was low at 8.5.

Pediatric ophthalmology noted bilateral retinal hemorrhages in all four quadrants that extended to the periphery, were multilayer and too numerous to count, as well as left-sided retinoschisis.

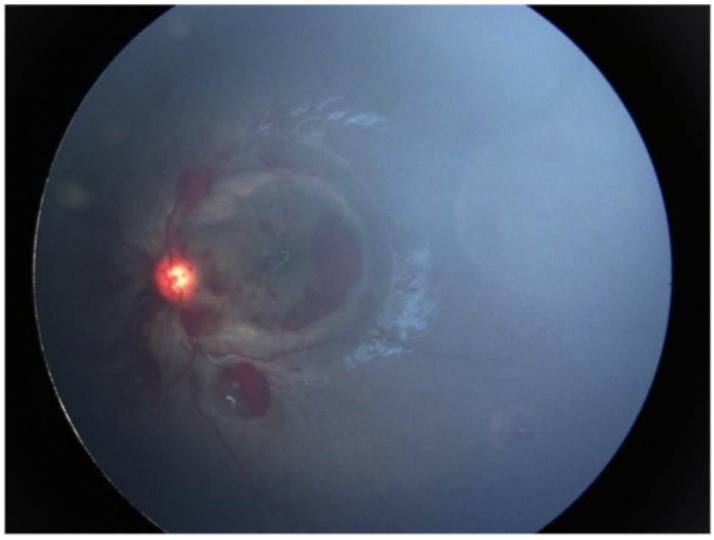
The patient required emergent craniotomy, subdural evacuation, and EVD placement.

Brain MRI with and without contrast was completed showing post-operative changes. A MRI of the cervical spine without contrast was completed and was unremarkable; a whole spine MRI was not completed.

Case Presentation cont'd



Axial View of Initial Head CT without contrast



Retcam Photo

At the time of EMS arrival and presentation to the hospital, mother and MBF denied a history of any type of trauma. The following day, MBF said the patient was trying to get out of his carseat in the car and MBF slammed on his breaks to teach the patient a lesson; the patient hit his head on the armrest of the front seat. Mother was reportedly in the car at the time. Neither adult in the car was injured. This was the only reported history of trauma.

Later in the investigation, MBF reported that he had made up the history of the incident in the car. MBF then stated that the patient was sitting on his lap in the car and threw up on him. MBF reported he became frustrated and threw the child across the car where his head and face impacted the door.

A follow-up skeletal survey was completed 2-3 weeks later and the patient was noted to have sclerosis of the right 1stand 4th metatarsals and chronic healing fractures of the left lateral 7th rib and posterior 9th and 10th ribs, and lateral right 9th rib. In reviewing the original abdominal/pelvic CT with pediatric radiology, they were able to identify the left 7th rib fracture and the right lateral 9th rib fracture in that study.

News from the Executive Committee

Update from the EC

Tagrid Ruiz-Maldonado, MD, MS, FAAP
Program Chair, COCAN Executive Committee

Hello Fellow COCAN members,

Summer is quickly fading and your Executive Committee is hard at work preparing for the Academy's National Conference & Exhibition (NCE) in Denver, CO at the end of September. Your Executive Committee has planned some exciting educational sessions, including our annual H Program which will focus on Abusive Head Trauma and the media this year. We will also have sponsored sessions on recognizing child physical abuse, pediatrician's role in preventing child maltreatment, using data to address child deaths from intimate partner violence, best practices in child sexual abuse, and so much more!

We've put together a detailed schedule for council members who are attending NCE below. We look forward to seeing you in Denver in a few weeks!

Thank you all for everything you do for children!

Tagrid

Friday, September 26, 2025			
SESSION	**TIME (MDT)**	**LOCATION**	**SPEAKERS**
I1352: Trauma, Tantrums and Treatment: Distinguishing and Treating Trauma	1:00-2:30 PM	Colorado Convention Center, Meeting Room 301/302	Wynne Morgan, MD (she/her/hers) Heather Forkey, MD, FAAP
S1424: Helping Families Stay Together by Putting Families First and Implementing Plans of Safe Care	2:30-3:30 PM	Colorado Convention Center, Meeting Room 505/506	Steven Chapman, MD, FAAP
S1523: Enhancing Access to Care for American Indian and Alaska Native Children	4:00-5:00 PM	Colorado Convention Center, Meeting Room 102/104/106	Allison Empey, MD, FAAP (she/her/hers) Jason Deen, MD, FAAP

Saturday, September 27, 2025			
SESSION	**TIME (MDT)**	**LOCATION**	**SPEAKERS**
S2221: Case-Based Guide to Recognizing Child Physical Abuse	9:00-10:00 AM	Colorado Convention Center, Bluebird Ballroom 2B-D	Tagrid Ruiz-Maldonado, MD, MS, FAAP (she/her/hers)
I2302: Trauma, Tantrums and Treatment: Distinguishing and Treating Trauma	2:00-3:30 PM	Colorado Convention Center, Meeting Room 303	Wynne Morgan, MD (she/her/hers) Heather Forkey, MD, FAAP
S2328: Pediatrician's Role in Preventing Child Maltreatment	2:00-3:00 PM	Colorado Convention Center, Bluebird Ballroom 2GH	John Stirling, MD FAAP (he/him/his)
S2428: Novel Approach to Improve Health of Youth Involved With Child Welfare	3:30-4:30 PM	Colorado Convention Center, Meeting Room 102/104/106	Amanda Bird H. Gilmartin, MD, FAAP (she/her/hers) Erin Baker, MSW
S2521: Beyond Buzzword: Science of Trauma-Informed Care	5:00-6:00 PM	Colorado Convention Center, Meeting Room 503/504	Heather Forkey, MD, FAAP
S2524: Intimate Partner Violence Fatalities: Using National Data to Address Child Deaths	5:00-6:00 PM	Colorado Convention Center, Meeting Room 505/50	Francis T. Pleban, PhD

Sunday, September 28, 2025			
SESSION	**TIME (MDT)**	**LOCATION**	**SPEAKERS**
H0312: Council on Child Abuse and Neglect Program When My Case Report Becomes a News Report!	8:00 AM-12:00 PM	Colorado Convention Center, Mile High Ballroom 4A/4B	Leigh Bishop, JD Jennifer Nimke Dhvani Shanghvi, MD, Med, FAAP (she/her/hers) Vincent J. Palusci, MD, MS, FAAP (he/him/his)
S3325: Implementing Trauma-Informed Care in Your Pediatric Practice	2:00-3:00 PM	Colorado Convention Center, Meeting Room 505/506	Amanda Bird H. Gilmartin, MD, FAAP (she/her/hers)
Fostering Health Book Launch	6:00-7:30 PM	Colorado Convention Center, Meeting Room 111/113	Mary V. Greiner, MD, MS, FAAP Camille Broussard, MD, MPH, FAAP Kristine Fortin, MD, MPH, FAAP Moira Szilagyi, MD, PhD, FAAP

Monday, September 29, 2025			
SESSION	**TIME (MDT)**	**LOCATION**	**SPEAKERS**
H0425: Joint Program: Council on Foster Care, Adoption, and Kinship Care and Council on Healthy Mental and Emotional Development Promoting Mental and Emotional Development of Youth in Foster Care	8:30 AM-4:25 PM	Colorado Convention Center, Mile High Ballroom 1A/1B	Jeremy Harvey (he/him/his) Brooks Keeshin, MD, FAAP, DFAACAP Brenda Jones Harden, MSW, PhD (she/her/hers) Diane Lanni Macon Stewart, MSW

Tuesday, September 30, 2025			
SESSION	**TIME (MDT)**	**LOCATION**	**SPEAKERS**
S5223: How Can We Bolster the Pediatrician Workforce?	9:00-10:00 AM	Colorado Convention Center, Meeting Room 103/105	Kimberly A. Boland, MD (she/her/hers)
S4321: Best Practices When Sexual Abuse Is Suspected	2:00-3:00 PM	Colorado Convention Center, Meeting Room 102/104/106	Katie Johnson, MD, FAAP (she/her/hers)

For April, May, and June, the Academy is hosting an archive display featuring the history of child abuse pediatrics .

AAP Monthly Update

AAP RESOURCES & UPDATES

COCAN-Helfer Society Presents

WHAT'S HAPPENING IN AHT?

NOVEMBER 19, 2025
12:00-3:00 PM EST

Join the AAP Council on Child Abuse and Neglect and the Ray E. Helfer Society to learn more about the recent AAP Abusive Head Trauma in Infants and Children: Technical Report. You'll get an overview of the technical report, case-based discussions, and Q and A with the the lead author and experts!

$30 Registration Fee

3 CME credits for Physicians, PA/APNs, and Nurses

- AAP designates this live activity for a maximum of *3.0 AMA PRA Category 1 Credit(s)™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
- This activity is acceptable for a maximum of 3.0 AAP credits. These credits can be applied toward the AAP CME/CPD Award available to Fellows and Candidate Members of the American Academy of Pediatrics.
- PAs may claim a maximum of 3.0 Category 1 credits for completing this activity. NCCPA accepts *AMA PRA Category 1 Credit(s)™* from organizations accredited by the ACCME or a recognized state medical society.
- This program is accredited for 3.0 NAPNAP CE contact hours of which 0 hrs contain pharmacology (R_x) content, (0 related to psychopharmacology) (0 hours related to controlled substances), per the National Association of Pediatric Nurse Practitioners (NAPNAP) Continuing Education Guidelines.
- This Provider approved by the California Board of Registered Nursing, Provider Number 18014, for 3.0 contact hours.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

AAP RESOURCES & UPDATES

American Academy of Pediatrics, the Pediatric Trauma Society, and the Society of Trauma Nurses Call for Systems Approach to Prevent and Provide Care to Children with Injuries

Many hospitals are not equipped to treat children with injuries, according to health organizations seeking coordination of care at local, regional, state and national levels.

More children and youth die from injuries than from cancer, birth defects, or other early life health issues combined -- a public health concern that demands a systems approach.

A new policy statement by the American Academy of Pediatrics, the Pediatric Trauma Society and the Society of Trauma Nurses outlines the most effective ways to provide care for children with injuries. The statement, "Systems-Based Care of the Injured Child," and an accompanying technical report provides recommendations on emergency response, hospital treatment, rehabilitation therapies and follow-up care.

The statement and technical report will be published simultaneously in the September 2025 issues of Pediatrics, the Journal of Trauma and Acute Care Surgery, and Journal of Trauma Nursing. All journals will publish the policy and report online Aug. 18.

"Children are not little adults, and many hospitals aren't fully equipped to care for them in cases of injury and trauma," said Katherine T. Flynn-O'Brien, MD, MPH, FAAP, FACS, lead author of the statement. "This can lead to worse outcomes—or even preventable deaths. Children who survive serious injuries also may face long-term physical, emotional, and mental health challenges."

National and state emergency care systems must consider children's unique needs so that no matter where a child is injured, they get timely, appropriate care, according to the organizations.

"A systems-based approach to pediatric trauma care ensures that, regardless of where a child is injured, there is a reliable pathway to timely, appropriate care delivered by a capable and coordinated team," said Patricia Morrell, MHA, BSN, RN-BC, President of the Pediatric Trauma Society. "This approach is foundational in improving outcomes for injured children."

Access to care isn't equal. Some children face barriers to getting the high-quality trauma care they need, depending on where they live or other factors.

"There is an urgent need for cohesive, coordinated trauma systems that are specifically designed to meet the needs of injured children," said Elizabeth Atkins, MSN, RN, TCRN, President of the Society of Trauma Nurses. "This policy statement outlines lifesaving, evidence-based approaches that improve outcomes by addressing the unique challenges faced by pediatric patients across the full continuum of trauma care. STN fully supports its widespread adoption to ensure every child receives timely, equitable, and high-quality care—no matter where they live."

The American Academy of Pediatrics, the Pediatric Trauma Society, and the Society of Trauma Nurses also recommend:

The unique needs of injured children and their families should be integrated into trauma systems and disaster planning at the local, state, regional, and national levels.

Ongoing support from state and federal governments is needed to improve trauma systems, train providers, support families, and research better ways to care for injured children.

Emergency departments throughout the United States should refer to pediatric readiness guidelines to facilitate appropriate care for all children.

Specialized pediatric trauma centers are essential components of trauma systems and should provide support and guidance to non-pediatric and non-trauma centers as part of their outreach mission.

National organizations with a special interest in pediatric trauma should work together to ensure pediatric trauma care is multidisciplinary and collaborative to provide the highest quality of care.

Pediatric trauma care teams should actively work to provide equitable care to all injured children.

Policy statements and technical reports created by AAP are written by medical experts, reflect the latest evidence in the field, and go through several rounds of peer review before being approved by the AAP Board of Directors and published in Pediatrics.

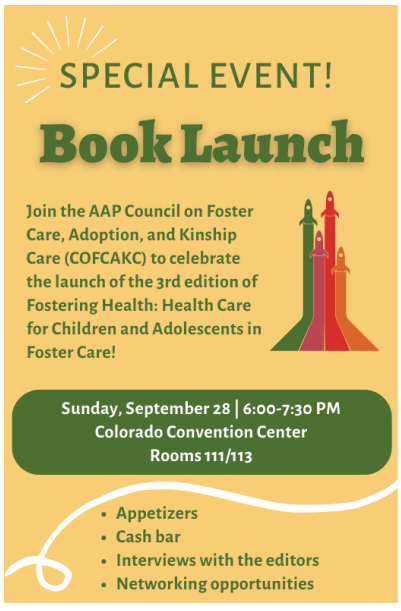
American Academy of Pediatrics is an organization of 67,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults.

Pediatric Trauma Society is a professional organization for all healthcare providers dedicated to improving outcomes for injured children through the development of optimal care guidelines, education, research and advocacy. PTS is committed to serve as the resource for both pediatric and adult trauma care providers with the goal of improving pediatric trauma care regardless of where injured children are cared for.

Society of Trauma Nurses

The Society of Trauma Nurses is a professional nonprofit organization whose mission is to promote optimal and equitable trauma care to all people through initiatives focused on trauma nurses related to prevention, education and collaboration with other healthcare disciplines. For more information, visit www.traumanurses.org.

Fostering Health Book Launch at NCE



AAP RESOURCES & UPDATES CONT

Shattering the Stigma: Trauma-Informed Care for Healthcare Heroes | September 16 @ 11:00am – 12:00pm CT

Pediatric healthcare professionals often operate under high-stress conditions, with exposure to secondary trauma, burnout, and moral distress affecting both mental health and professional longevity. This 1-hour webinar, by Dr Dena Hubbard, will explore how the principles of trauma-informed care (TIC) can be applied not just to patients, but to support the well-being of healthcare providers themselves. Participants will examine common stressors and traumatic experiences in healthcare settings and their impact on professional wellness. The webinar will also provide actionable strategies to normalize seeking mental health support within the healthcare profession and champion systemic changes that promote resilience, reduce stigma, and foster a culture of care for the caregiver. Join this webinar to better understand how adopting a trauma-informed approach can enhance individual well-being, team dynamics, and the overall health of healthcare systems. **Register here!**

New Mental Health Resources

We're excited to share a few newly released resources from the CDC-funded "Let's Talk About It" campaign, focused on reducing mental health stigma and strengthening provider-family communication.

Below are trauma-informed aligned tools we encourage you to explore and share with your pediatric teams. These resources are designed to support safe, empathetic, and stigma-free environments for youth and families navigating mental health challenges.

Mental Health is Health videos series

In these brief videos, youth share what they need from healthcare providers, parents, and peers when it comes to mental health. Videos are available in both English and Spanish, share these resources with anyone engaging in trauma informed mental health conversations.

- Mental Health is Health
  - Video in Spanish
  - Mental health is health. Healthy mental and emotional well-being is a lifelong journey, and that's why it should be part of every pediatric visit. When talking about overall health, pediatricians should include questions about their patients' thoughts and feelings. Pediatricians can provide resources and support to promote both the physical and mental health of the children and families they see.

- Doctor's Earning Trust
  - Video in Spanish
  - Feeling safe, heard and supported is essential to a young person's emotional well-being, and it begins in the exam room. During routine visits, pediatricians can foster open and honest conversations by listening attentively and showing compassion without judgment. By building strong, trusting relationships with patients, pediatricians have a powerful opportunity to support their mental health journey from the very first visit.

- What you need from providers and peers
  - Video in Spanish
  - When teens feel connected, their mental health thrives. When they feel isolated, it can have a lasting impact. Pediatricians can make a meaningful difference by asking about peer relationships and screening for social-emotional challenges during routine visits. Recognizing the role of connection, inclusion and belonging is essential to support each patient's full mental health journey.

- Going through a tough time
  - Videos in Spanish
  - Feeling seen and validated is essential to a young person's mental health, and it begins in the exam room. Pediatricians can foster open and supportive conversations by listening with empathy and reminding patients they are not alone. By affirming emotions and connecting patients with the support they need, pediatricians can promote healthy mental development at every stage.

Podcasts

Looking for resources to talk about mental health with providers and families? Check out two new podcast episodes that share practical tips and strategies to support children and youth on their lifelong mental health journey. Developed for parents, caregivers and healthcare professionals these episodes explore how to build trust, foster resilience, and promote empathy.

- HealthyChildren.org: Lighthouse Parenting: Building Resilience & Guiding Kids Through Failure
  - Dr. Ken Ginsburg joins host Dr. Bracho-Sanchez to explore lighthouse parenting. They discuss building resilience, coping with failure, equipping children with the skills to become successful adults, and the importance of taking a balanced approach to parenting.

- Pediatrics On Call: Trends in Adolescent Risky Behavior
  - In this episode Laura Sigman, MD, JD, FAAP, discusses having conversations with patients about adverse medical events. David Hill, MD, FAAP, and Joanna Parga-Belinkie, MD, FAAP, also speak with Rebekah Levine Coley, PhD, about new trends in adolescents' risky behaviors.

HealthyChildren.org Article

Check out this new HealthyChildren.org article! The article shares quick and practical strategies for families and caregivers to begin mental health conversations. This HealthyChildren.org article includes a youth written excerpt sharing their perspective on navigating mental health issues.

AAP RESOURCES & UPDATES CONT

New Resources from CPTI

The Community of Pediatrics Training Initiative (CPTI) is pleased to share several new resources and tools for practicing pediatricians, pediatric residents, and pediatric faculty on the CPTI website.

Food Insecurity Learner Workbook

- This workbook was written by the Curriculum and Assessment Pillar of CPTI with the goal of provide learners with resources, tools, and knowledge needed to understand the social and structural aspects of food insecurity (FI) and how it impacts pediatric health and healthcare.

Community Asset Mapping Tool

- While the primary audience is pediatric residents, the tool is designed for pediatricians to gain a broader understanding of child health and how communities play a critical part in overall child wellness. The activities can be applied by all pediatricians looking to make an impact on their communities.

Community Pediatrics and Advocacy Curriculum (CPAC)

- Formerly known as CHAMP, the CPAC is a peer-reviewed tool grounded in a socio-ecological model for health promotion and with a strong emphasis on health equity that links CPTI gold-standard training objectives to Entrustable Professional Activity 11 for General Pediatrics as defined by the American Board of Pediatrics. EPA 11 states that pediatricians must "promote equitable care at the level of each individual patient and the population to address racism and other contributors to health inequities".

Lunch & Learn NCE

Saturday, September 27, 2025
12:00 PM – 1:00 PM
Hyatt Regency Denver Centennial Ballroom C

Be the Pebble: Starting Ripples of Change
Learn Simple Advocacy Skills You Can Use to Impact Lasting Change for Child Health in Your Community

If you are interested in learning what easy steps you can take to address the social drivers/determinants of health impacting the families you serve, please join us! The goal of this session is to introduce the new AAP Community Advocacy Roadmap tool, demonstrate how you can use it in your local advocacy work, and provide real-world examples of pediatricians who joined forces with community partners to transform their communities.

*Thanks to the generous financial support of ByHeart, we are able to offer a FREE lunch to the first 90 people who register for this opportunity! Register here: https://www.surveymonkey.com/r/AAPNCE2025.

This is an educational opportunity held prior to the Council on Community Pediatrics H-Program. You do not need to attend the H-Program to attend this Lunch & Learn.

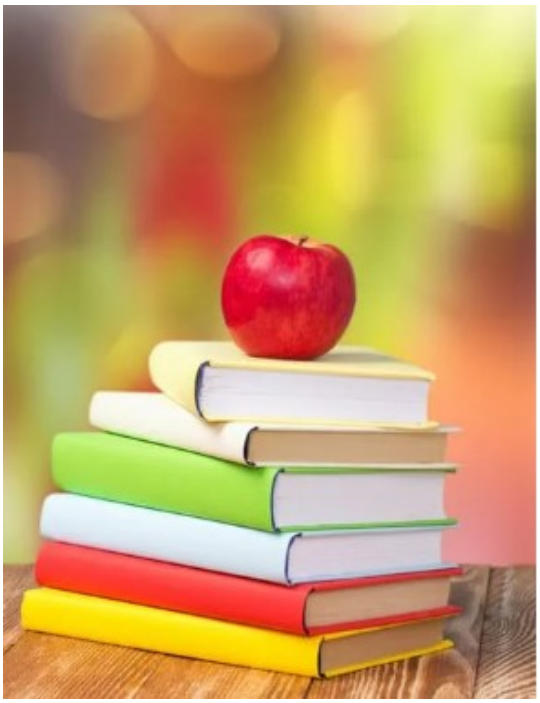
RESOURCES FROM OUR PARTNERS

New Webinar: Protecting Potential: Bridging Development, Foster Care and Courts

This webinar explores how pediatric practices can be effectively aligned with foster care and legal interventions to better support vulnerable children and families. Dr. Deb Rodriguez and Morgan Silverman will share strategies, case studies, and resources for improving outcomes for infants and toddlers involved in the foster care system. Sign up here.

Creating Pathways for Kin: A Framework for Implementing Kin-Specific Licensing Standards

Evidence has shown that children placed with relatives and kin experience greater placement stability and well-being, but many state licensing standards can create barriers to these placements. A new federal rule from the Administration for Children and Families now allows Title IV-E agencies to create separate licensing or approval standards for kinship caregivers. These standards can reduce unnecessary barriers and support access to foster care maintenance payments that help families meet the unique demands of kinship care. Chapin Hall has created a phased framework to help agencies implement kin-specific licensing standards. Kin-Specific Licensing Standards: A framework for planning, implementation, and evaluation supports agencies in initiating, refining, and scaling up kin-specific licensing policies. It also provides detailed guidance on team protocols, partner engagement, communication, and data tracking to ensure long-term success



RESOURCES FROM OUR PARTNERS CONT.

How is Your State Funding Child Welfare?

Many funding sources are available to child welfare agencies, and each has its own unique purposes, eligibility requirements, and limitations, creating a complex financing structure that is challenging to understand and administer. Each state's unique funding composition impacts what services are available to children and families and how child welfare agencies operate. Child Trends has produced factsheets on each state's child welfare agency expenditures with data from our Child Welfare Financing Survey SFY 2022.

InterCAP 2026: In-Person Course

Date: 18-21 May 2026
Location: Paris, France

InterCAP is designed for all healthcare professionals who work with children and adolescents. This four-day in-person course covers broad content related to child abuse and neglect identification, management, and prevention.
Course Highlights:
- Teaching delivered by international leaders in the field
- Didactic talks, workshops, and small group sessions
- Opportunities for discussion and collaboration on challenging issues
- Networking opportunities with international colleagues and faculty

Where Child Welfare Spending Goes

In the child welfare field, data and research show we achieve better outcomes for children and families if we prioritize the prevention of child maltreatment and prevent unnecessary out-of-home placement. However, state and local child welfare agencies must contend with many demands on their resources, as well as different sets of rules and regulations on what they can do with their various sources of funding.

An updated national survey of child welfare funding—conducted by Child Trends and funded by the Annie E. Casey Foundation and Casey Family Programs—shows that the greatest percentage of spending goes toward out-of-home placement such as foster care (44%), followed by adoption and guardianship (19%), child protective services (17%), and preventive services (15%). Read the full report to see all the data on funding sources, the uses of this funding, and profiles of how each state allocates its dollars.

"It's not about us anymore": after the Le Scouarnec case

Joël Le Scouarnec sexually assaulted hundreds of patients in his care. His victims are now calling for institutional changes in the wake of his conviction. Marianne Guenot reports. This article is free with registration. Read it here.

New Webinar from Child Abuse Clinical Decision Support

This webinar is free and open to both Consortium members and colleagues.

System Agnostic Child Abuse Clinical Decision Support (CA-CDS) for All
Dr. Eric Whitebay
Thursday 9/25 1-2pm Eastern

The efforts of major healthcare software companies like Epic, Oracle, and others in developing built-in support for Child Abuse Clinical Decision Support (CA-CDS) have been invaluable in improving child abuse detection and responses. However, the benefits of these integrated systems are often inaccessible to smaller, independent, and less-resourced organizations, such as rural hospitals and safety net organizations serving vulnerable populations.

For these organizations, a different approach is needed: interoperable CA-CDS software that can seamlessly integrate with *any* existing healthcare software system, regardless of the vendor**.** This presentation will explore how such vendor-agnostic CA-CDS software functions, national and internation policies and laws supporting interoperability, widely adopted parallels in healthcare and public health, and opportunities system agnostic software brings to organizations nationally and internationally.

Register here:
https://events.teams.microsoft.com/event/6f7f8822-cc5e-40c0-a7ba-cfca63f90dbd@8b3dd73e-4e72-4679-b191-56da1588712b

Safer Child Protective Services Reporting—the BEST Timeout Model

Every day at hospitals around the country, patients are wheeled into surgery, saying goodbye to loved ones and hoping for successful operations. Much of that success relies on the surgical team's ability to provide high-fidelity, precise care without mistakes. Similarly critical interventions are made daily in other areas of medicine, including deciding when to report to Child Protective Services (CPS). Read more here.

The Quarterly Child Abuse Medical Update

The quarterly is a publication from the Ray E. Helfer Society. Scan the link below for more information and for access to current and past issues. Click here for a sneak peak at one of the articles.