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“Abusive Head Trauma”

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- I and my immediate family have neither financial relationships with nor significant direct investment in related commercial entities.
- I do not plan to discuss off-label uses of pharmaceuticals or medical equipment.
- The findings and conclusions in this presentation are those of the author and do not necessarily represent the official position of the AAP, APSAC, or the U.S. Centers for Disease Control and Prevention.
Objectives

Upon completion of this activity, participants will:

- Understand current scientific knowledge about abusive head trauma and shaken baby syndrome.
- Review a consensus statement from the Society of Pediatric Radiology, APSAC and other national organizations which addresses significant misconceptions about the diagnosis of Abusive Head Trauma (AHT).
- Learn about the activities of the APSAC Center for Child Policy related to AHT.
History & Current Science
MULTIPLE FRACTURES IN THE LONG BONES OF INFANTS SUFFERING FROM CHRONIC SUBDURAL HEMATOMA*

By JOHN CAFFEY, M.D.
NEW YORK CITY

Fractures of the cranium are not infrequently associated with infantile subdural hematoma but fractures in the long bones have rarely been reported as complications of this intracranial lesion. An old fracture of the radius is mentioned by Sherwood in his fifth case. Ingraham and Heyl demonstrated greenstick fractures roentgenographically in the radius and ulna of both forearms of one infant (Case 4) in whom there were neither clinical signs of fracture nor history of injury. Dr. Ingraham has written me that in his extensive experience with more than 100 cases of infantile subdural hematoma, fractures were also found in the humerus of one patient; in the femur of another; and in six ribs of a third.

Convulsion which lasted for one-half hour, after which the infant was weak and listless for three days and strabismus with stare developed. During this period fever was present and vomiting was frequent. The mother, who had been with the infant continuously, had not observed injury to the head or extremities. Physical examination disclosed a tense bulging anterior fontanel, internal strabismus and exaggerated deep reflexes. There were no signs of meningeal irritation. The bones of the left forearms were thickened to palpation and this finding raised the question of an old fracture with callus. Roentgenograms of the extremities were not made at this time. Forty-five cubic centimeters of cerebrospinal fluid were withdrawn from the lumbar subarachnoid space; the pressure was increased but the fluid was normal chemically and microscopically. Following lumbar puncture, the signs and symptoms disappeared; the
SIGNIFICANCE OF SKELETAL LESIONS IN INFANTS RESEMBLING THOSE OF TRAUMATIC ORIGIN

Paul V. Woolley Jr., M.D.
and
William A. Evans Jr., M.D., Detroit

In every clinic caring for a volume of children there are seen, from time to time, infants with skeletal lesions resembling those due to trauma but unaccompanied by readily volunteered and adequate account of injury. While such cases would appear to be of interest to a variety of disciplines, discussion of the present paper has been chiefly by roentgenologists. Caffey\(^1\) first emphasized the frequent association of chronic subdural hematoma and fractures of the long bones in 1946, but, since he was unable to obtain histories of violence in the material he considered, no conclusion as to the nature of this complex was advanced. He was also the first to point out the frequency with which defects in the metaphyses, as contrasted to the shafts of bones, were encountered. Smith,\(^2\) in Canada, two groups in France,\(^3\) and Lis and Frauenberger,\(^4\) in this country, noted the same relationship in single infants but, likewise, advanced no valid explanation. Later Astley\(^5\) in England described six babies with metaphyseal discontinuity of bone similar to that described by Caffey and was so impressed by this feature as to subtitle his publication "Metaphyseal Fragility of

by Silverman is supported—that fractures in infancy are primarily due to trauma regardless of history and independent of the anatomic areas of bone involved,—then it is necessary to ask still a third question; what is the nature of the injury-prone environment that predisposes to skeletal lesions without history of violence and, especially, of that ménage in which the various defects accumulate episodically or continuously?

MATERIAL AND PROCEDURES

The material available at the Children's Hospital of Michigan for examination has included all infants admitted or treated in the emergency section because of injury during the period 1946-1954 as well as those with roentgenologic or clinical findings resembling those usually associated with trauma, even though no supportive history was obtained. In addition all x-ray films representative of various forms of bone pathology encountered during infancy were restudied in order to determine where confusion in interpretation might arise between them and examples known to be due purely to adverse lines of
The Battered-Child Syndrome

C. Henry Kempe, M.D., Denver, Frederic N. Silverman, M.D., Cincinnati, Brandt F. Steele, M.D., William Droegemueller, M.D., and Henry K. Silver, M.D., Denver

The battered-child syndrome, a clinical condition in young children who have received serious physical abuse, is a frequent cause of permanent injury or death. The syndrome should be considered in any child exhibiting evidence of fracture of any bone, subdural hematoma, failure to thrive, soft tissue swellings or skin bruising, in any child who dies suddenly, or where the degree and type of injury is at variance with the history given regarding the occurrence of the trauma. Psychiatric factors are probably of prime importance in the pathogenesis of the disorder, but knowledge of these factors is limited. Physicians have a duty and responsibility to the child to require a full evaluation of the problem and to guarantee that no expected repetition of trauma will be permitted to occur.

cidence of this syndrome in a one-year period. Among 71 hospitals replying, 302 such cases were reported to have occurred; 33 of the children died; and 85 suffered permanent brain injury. In one-third of the cases proper medical diagnosis was followed by some type of legal action. We also surveyed 77 District Attorneys who reported that they had knowledge of 447 cases in a similar one-year period. Of these, 45 died, and 29 suffered permanent brain damage; court action was initiated in 46% of this group. This condition has been a particularly common problem in our hospitals; on a single day, in November, 1961, the Pediatric Service of the Colorado General Hospital was caring for 4 infants suffering from the parent-inflicted battered-child syndrome. Two of the 4 died of their central nervous system trauma; 1 subsequently died suddenly in an unexplained manner 4 weeks after discharge from the hospital while under the care of its parents, while the fourth is still enjoying good health.
Infantile Subdural Haematoma and its Relationship to Whiplash Injuries

A. N. Guthkelch

British Medical Journal, 1971, 2, 430-431

Summary

Subdural haematoma is one of the commonest features of the battered child syndrome, yet by no means all the patients so affected have external marks of injury on the head. This suggests that in some cases repeated acceleration/deceleration rather than direct violence is the cause of the haemorrhage, the infant having been shaken rather than struck by its parent. Such an hypothesis might also explain the remarkable frequency of the finding of subdural haemorrhage in battered children as compared with its incidence in head injuries of other origin, and the fact that it is so often bilateral.

Introduction

Subdural haematoma is a commoner complication of head injury in infancy than at any other age. Lewin (1966) reported 47 cases of subdural haemorrhage in an unselected series of 1,750 head injuries occurring in patients of all ages—an incidence of about 2.7%—but Hendrick et al. (1964) found 5.2% in a large series of head-injured children ranging in age from birth to 15 years, the excess over Lewin’s series being entirely accounted for by a greatly increased frequency in infants aged 0-1 years. More recently Ommaya and Yarnell (1969) published two well-documented cases of subdural haematoma, in both of which the subject sustained a whiplash injury to the neck as a result of an automobile accident, the head itself not being injured at all. There was no immediate loss of consciousness and it was not until several days later that cerebral signs developed.

It is now submitted that the conditions which are known to exist in many cases of the battered child syndrome are particularly favourable to the production of subdural haematoma in infants by an essentially similar mechanism. Kempe et al. (1962) noted that in their experience the extremities of the child are often used as handles during an episode of rough treatment; “sometimes an arm is pulled to jerk a reluctant child to his feet, sometimes the legs are held while the tiny body is swung in a punitive way.” In one of Caffey’s (1946) cases of subdural haematoma the history is given in the following words: “Baby rolled off a table and his mother grabbed him by the forearm and jerked him in the air to prevent his fall.” It seems clear that the relatively large head and puny neck muscles of the infant must render it particularly vulnerable to whiplash injury in this sort of situation. Moreover, since one would expect that the child is often grasped more or less symmetrically by chest or limbs the rotation-acceleration strains on the brain would tend to occur fairly symmetrically also, in an anteoposterior direction. This may be the reason why infantile subdural...
On the Theory and Practice of Shaking Infants
Its Potential Residual Effects of Permanent Brain Damage and Mental Retardation

John Caffey, MD, Pittsburgh

In the first modern discussion in 1946 of the parent-infant stress syndrome (PITS), or battered baby syndrome, I described six infants, 13 months or younger, who suffered from the combination of subdural hematomas and characteristic bone lesions. During the last 25 years substantial evidence, both manifest and circumstantial, has gradually accumulated which suggests that the whiplash-shaking and jerking of abused infants are common causes of the skeletal as well as the cerebrovascular lesions; the latter is the most serious acute complication and by far the most common cause of early death.

Today we invite your attention to the evidence which supports our con...
The shaken baby syndrome

A clinical, pathological, and biomechanical study

Ann-Christine Duhaime, M.D., Thomas A. Gennarelli, M.D.,
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Because a history of shaking is often lacking in the so-called “shaken baby syndrome,” diagnosis is usually based on a constellation of clinical and radiographic findings. Forty-eight cases of infants and young children with this diagnosis seen between 1978 and 1985 at the Children’s Hospital of Philadelphia were reviewed. All patients had a presenting history thought to be suspicious for child abuse, and either retinal hemorrhages with subdural or subarachnoid hemorrhages or a computerized tomography scan showing subdural or subarachnoid hemorrhages with interhemispheric blood. The physical examination and presence of associated trauma were analyzed; autopsy findings for the 13 fatalities were reviewed. All fatal cases had signs of blunt impact to the head, although in more than half of them these findings were noted only at autopsy. All deaths were associated with uncontrollably increased intracranial pressure.

Models of 1-month-old infants with various neck and skull parameters were instrumented with accelerometers and shaken and impacted against padded or unpadded surfaces. Angular accelerations for shakes were smaller than those for impacts by a factor of 50. All shakes fell below injury thresholds established for subhuman primates scaled for the same brain mass, while impacts spanned concussion, subdural hematoma, and diffuse axonal injury ranges. It was concluded that severe head injuries commonly diagnosed as shaking injuries require impact to occur and that shaking alone in an otherwise normal baby is unlikely to cause the shaken baby syndrome.

“Shaken Impact Syndrome”

SPOTLIGHT ON PRACTICE

THE WHIPLASH SHAKEN INFANT SYNDROME:
HAS CAFFEY’S SYNDROME CHANGED OR
HAVE WE CHANGED HIS SYNDROME?

STEPHEN LAZORITZ AND SANDRA BALDWIN

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Abusive Head Trauma in Infants and Children

Cindy W. Christian, MD, Robert Block, MD, and the Committee on Child Abuse and Neglect

ABSTRACT
Shaken baby syndrome is a term often used by physicians and the public to describe abusive head trauma inflicted on infants and young children. Although the term is well known and has been used for a number of decades, advances in the understanding of the mechanisms and clinical spectrum of injury associated with abusive head trauma compel us to modify our terminology to keep pace with our understanding of pathologic mechanisms. Although shaking an infant has the potential to cause neurologic injury, blunt impact or a combination of shaking and blunt impact cause injury as well. Spinal cord injury and secondary hypoxic ischemic injury can contribute to poor outcomes of victims. The use of broad medical terminology that is inclusive of all mechanisms of injury, including shaking, is required. The American Academy of Pediatrics recommends that pediatricians develop skills in the recognition of signs and symptoms of abusive head injury, including those caused by both shaking and blunt impact, consult with pediatric subspecialists when necessary, and embrace a less mechanistic term, abusive head trauma, when describing an inflicted injury to the head and its contents. Pediatrics 2009;123:1409–1411
Diagnosis

- Subdural hematomas (SDHs), with concomitant brain injury, and retinal hemorrhages (RHs), with or without additional injury, including spinal, skin, and skeletal injuries, are the hallmarks of child abuse and AHT, although individually these findings are not specific for the diagnosis.
Legal Controversies
The diagnosis of Shaken Baby Syndrome is based on the triad of subdural bleeding, retinal bleeding, and brain injury.

It has been overapplied in the legal system, resulting in erroneous conviction and imprisonment.

The theory is in a state of flux and previous “truths” are now known to be untrue or unproved and new “truths” rise on a regular basis.
Traumatic shaking
The role of the triad in medical investigations of suspected traumatic shaking
A systematic review

The systematic review showed the following graded results:

- There is limited scientific evidence that the triad and therefore its components can be associated with traumatic shaking (low quality evidence).
- There is insufficient scientific evidence on which to assess the diagnostic accuracy of the triad in identifying traumatic shaking (very low quality evidence).

Limited scientific evidence (low quality evidence) represents a combined assessment of studies of high or moderate quality which disclose factors that markedly weaken the evidence. It is important to note that limited scientific evidence for the reliability of a method or an effect does not imply complete lack of scientific support.

Insufficient scientific evidence (very low quality evidence) represents either a lack of studies, or situations when available studies are of low quality or show contradictory results.

Evaluation of the evidence was not based on formal grading of the evidence according to GRADE but on an evaluation of the total scientific basis.
Consensus Statement
Consensus statement on Abusive Head Trauma in infants and young children.

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Organizations

- Society for Pediatric Radiology (SPR)
- European Society of Pediatric Radiology (ESPR)
- American Society of Pediatric Neuroradiology (ASPNR)
- European Society of Neuroradiology (ESNR)
- American Academy of Pediatrics (AAP)
- American Professional Society on the Abuse of Children (APSAC)
- Swedish Paediatric Society
- Norwegian Pediatric Association
- Japanese Pediatric Society
Purpose

- This consensus document addresses significant misconceptions about the diagnosis of abusive head trauma (AHT) in infants and children.
- It builds on 15 major national and international professional medical societies and organization’s consensus statements confirming the validity of the AHT diagnosis.
- The statement also exposes the fallacy of simplifying the diagnostic process to a “triad of findings” — a legal argument and not a medically valid term.
- We hope that this consensus document will reduce confusion by recommending to judges and jurors, the tools necessary to distinguish genuine evidence-based opinions of the relevant medical community from legal argument or etiological speculation unwarranted by the clinical findings, medical evidence and evidenced-based literature.
Abusive Head Trauma (AHT) is the leading cause of fatal head injuries in children under 2 years.

The diagnosis is established by a multidisciplinary team based on history, physical examination, imaging, and laboratory findings.

Since the etiology of the injury is multifactorial (shaking, shaking and impact, impact, etc.), the current best and inclusive term is AHT.

There is no controversy concerning the medical validity of the existence of AHT with multiple components including subdural hematoma, intracranial and spinal changes, complex retinal hemorrhages as well as rib and other fractures inconsistent with the provided mechanism of trauma.
Outline

1. Etiology of head trauma in infants and young children and nomenclature of abusive head trauma (AHT)
2. What are the presenting features of AHT?
3. How is the diagnosis of AHT made?
   - History
   - Physical examination and importance of ocular findings
   - Laboratory studies and imaging
4. Unsubstantiated alternative theories proffered in the court
5. Multidisciplinary assessment and long-term outcome
6. What are the issues that allow misconceptions to perpetuate in the courtroom?
   - *The Medical Expert Witness*

7. What can be done to provide the court accurate information about the state of medical knowledge in AHT?
   - *The admissibility of expert evidence*
   - *Professional society consensus statements*
   - *Accurate medical evaluation versus non evidence based opinions*
   - *AHT is a medical diagnosis not a legal finding of murder*
The diagnosis of AHT is a medical diagnosis made by a multidisciplinary team of pediatricians and pediatric subspecialty physicians, social workers and other professionals based on consideration of all the facts and evidence.

AHT is a scientifically non-controversial medical diagnosis broadly recognized and managed throughout the world.

When diagnosed, it signifies that accidental and disease processes cannot plausibly explain the etiology of the infant/child’s injuries.

A diagnosis of AHT is a medical conclusion, not a legal determination of the intent of the perpetrator or, in the false hyperbole of the courtroom and sensationalistic media, “a diagnosis of murder.”
Diagnosis

- No single injury is diagnostic of AHT.
- Rather the multiplicity of findings including evidence of intracranial and spinal involvement, complex retinal hemorrhages, rib and other fractures inconsistent with the provided mechanism of trauma, as well as the severity and age of the findings provide clues to the diagnosis.
- Subdural hematoma is the most frequently identified intracranial lesion but brain parenchymal injury is the most significant cause of morbidity and mortality in this setting.
- There is a high incidence of ligamentous cervical spine injury among victims of inflicted injury. However, it is important to emphasize that absence of ligamentous injury doesn’t exclude AHT. In suspected cases of AHT, alternative diagnoses must be considered and when appropriate explored.
- The question to be answered is “Is there a medical cause to explain all the findings or did this child suffer from inflicted injury?”
Alternative theories

- The work-up must exclude those medical diseases that can mimic AHT.
- However, the courtroom has become a forum for speculative theories that cannot be reconciled with “generally accepted” medical literature.
- There is no reliable medical evidence the following processes are causative in the constellation of injuries of AHT: cerebral sinovenous thrombosis, hypoxic ischemic injury, lumbar puncture, or dysphagic choking/vomiting.
- There is no substantiation, at a time remote from birth, that an asymptomatic birth related subdural hemorrhage can result in rebleeding and sudden collapse.
Mimics

- Despite courtroom arguments by defense lawyers and their retained physician witnesses, there is no reliable medical evidence that the following processes are precise mimics or causative in the constellation of injuries characteristic of AHT:
  - cerebral sinovenous thrombosis
  - hypoxic ischemic injury, lumbar puncture or dysphagic choking/vomiting
  - There is also no substantiation, at a time remote from birth, of the proposal that birth-related subdural hemorrhages can result in sudden collapse, coma or death due to acute rebleeding into a previously asymptomatic chronic collection
  - In addition, subdural hematoma is uncommonly seen in the setting of benign enlargement of the subarachnoid spaces (BESS) and when present, AHT should be considered
Legal Controversy

- The question in civil and criminal court cases involving allegations of unwitnessed abuse is the quality of the medical evidence and the integrity and expertise of the medical witness’s testimony.
- Over the past decade, the courtroom has become a forum for medical opinions on the etiology of infant/child head injuries that runs the gamut from the well-founded evidence-based conclusions of multidisciplinary medical teams to speculative theories that cannot be reconciled with the medical evidence generally accepted in the relevant medical community.
- When pivotal medical testimony is contradictory, the message to the courts, the media and the general public about infant injuries and safe caregiving is often confusing and inaccurate.
Harm

- Defense attorneys and few medical witnesses who promulgate scientifically unsubstantiated theories about abuse “mimics” in an effort to manufacture a scientifically-sounding controversy, run afoul of professional norms and standards, can distort the view of the relevant medical community and create a grave public health risk by promulgating dangerous misinformation regarding safe infant and childcare (i.e., infant shaking is safe).

- As professional medical societies continue to issue evidence-based consensus statements to help courts, the media and the public to address these issues, we anticipate that they will also play a greater role in curbing and sanctioning members whose testimony impedes the goals of scientific, adjudicative and public health accuracy.
Conclusions - 1

1. Abusive head trauma (AHT) is the current, most appropriate and inclusive diagnostic term for infant and young children who suffer from inflicted intracranial and associated spinal injury. This does not negate the mechanisms of shaking or shaking with impact as a significant mechanism of injury but merely indicates that the term “shaken baby” is not all inclusive.

2. Lack of history, changing history or the incompatibility of history (i.e. short falls) with the severity of injury raise concerns for possible AHT.

3. Relatively few infants with AHT have isolated intracranial injury without retinal hemorrhages, fractures or other manifestations of child abuse. These children need a comprehensive evaluation to rule out other diseases. However, isolated intracranial injuries occur in a small percentage of children with AHT.

4. There is no single injury that is diagnostic of AHT. It is a compilation of injuries most often including SDH, complex retinal hemorrhage and/or retinoschisis, rib, metaphyseal or other fractures and soft tissue injury which leads to the diagnosis.

5. Each infant must be further evaluated for other diseases, that may present with similar findings. The question to be answered is “Is there a medical cause to explain the findings and did this child suffer from inflicted injury?”
Conclusions -2

6. There is no reliable medical evidence that the following processes cause the constellation of injuries associated with AHT: Cerebral sinovenous thrombosis, isolated hypoxic ischemic injury, lumbar puncture and dysphagic choking/vomiting. There is no reliable evidence to support speculation that long term consequences of birth related subdural can result in later collapse, coma or death due to acute rebleeding into a previously asymptomatic chronic subdural. In addition, subdural hematoma is uncommonly seen in the setting of benign enlargement of the subarachnoid space and when present, AHT should be considered in the differential diagnosis.

7. After medical diagnosis, in many hospitals, a multidisciplinary team provides comprehensive assessment and services to the family, based on consideration of all the facts.

8. There is no controversy about the methodology used to diagnose AHT as a medical disease.

9. AHT is a medical diagnosis unrelated to the legal determination by a judge or jury of a charge of murder. The term “triad” is a legal convention that falsely mischaracterizes a complex AHT diagnosis process.

10. A professional medical society’s consensus statement educates judicial factfinders, the media and the public about “general acceptance”, what is accurate medical information and what are non evidence, speculative, or professionally irresponsible etiological hypotheses.

11. The professional society’s consensus statement on AHT should help the court recognize unsubstantiated medical expert testimony.
Consensus statement on Abusive Head Trauma in Infants and Young Children.

- To be published in Pediatric Radiology by Springer-Verlag GmbH Germany, part of Springer Nature, 2018
- Free “open access” has been arranged for a limited time: 1 June to 15 July, 2018
- The link for the article once published will be: http://dx.doi.org/10.1007/s00247-018-4149-1
- Please contact the publisher for additional access options
APSAC Center for Child Policy
ABOUT THE CENTER FOR CHILD POLICY

Why do we need the Center for Child Policy?

- Research may not exist on critical program or practice areas. Practitioners must make decisions on how to keep children safe without supporting data.
- If research does exist, not all data is equally valid. The poor quality of some research should invalidate it from being used for decision-making.
- The child maltreatment field is comprised of many different professions, and cross-professional research is hard to come by. Child maltreatment requires a multi-professional response. Each profession has its own vocabulary, ethical guidelines, and set of professional responsibilities. Professionals are left struggling with research that contains vocabularies, methods, and procedures that are not necessarily applicable to their profession.
- In areas of controversy, there is often research from multiple perspectives and opposing viewpoints. Instead of tuning out the dialogue and dismissing contradicting research findings as “differences of opinion,” it’s important to thoroughly understand all viewpoints in order to make the best decision based on the research.

Our Mission

We translate the best available research findings into useable resources that promote best practices in all professions involved with child maltreatment.

All professionals working with children and families involved in child maltreatment need access to quality information, based on the best available data, that they can translate into useable solutions to solve their most critical practice issues.

The Center for Child Policy will help professionals working in all child maltreatment-related fields to access, translate, and to implement the best available research into effective practice.
ABUSIVE HEAD TRAUMA

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APSAC – CCP - AHT

- Subcommittees
  - 1. Legal Aspects
  - 2. Prevention

- Objectives
  - Review current evidence for best practices
  - Develop policy and white papers
Lend Your Expertise - Become a Member of the Policy Analysis Committee on Abusive Head Trauma

APRIL 5, 2017 | KELLI NICOLE HUGHES

The APSAC Center for Child Policy is looking for subject matter experts and professionals with specific interest in the topic of Abusive Head Trauma to serve as an expert on the Policy Analysis Committee for this critical issue.

Learn how to become a member of the committee and to help solve critical issues related to this topic.

We need your input on the most critical issues in the field of child maltreatment.
Thank You!

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