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Willful Child Abuse and State Reporting Statutes

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WILLFUL CHILD ABUSE AND STATE REPORTING STATUTES

BARBARA DALY*

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I. INTRODUCTION

The phenomenon of child abuse dates back, no doubt, to the beginnings of mankind and to the first parent who punished his child in an overly severe manner. The advent of civilization did little to protect the child from its parents, and, under Roman law, a parent was fit to punish the child as he wished. This was based on the assumption that since the parent had given life to the child, he also had the right to take it away. While this may have reduced behavioral problems, it also left the child at the mercy of a parent who might be unbalanced, unfit and ready to inflict severe or fatal punishment for even an imagined wrong.

The common law took a more solicitous view towards children, giving

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the parent the right to discipline his children, but prohibiting him from inflicting what society believed to be abuse. Society's definition of abuse has no doubt changed with the times and today is defined by Webster as "physical ill treatment or injury." Even this definition is not overly helpful in many cases since what may be considered as an acceptable mode of punishment in rural areas may be thought of as abusive in a large metropolis. The age of the child may also be a point of differentiation. Statutes prohibiting child abuse have been common for years, but they speak in the same general terms. Being criminal in nature, they ultimately leave the definition to the trier of fact. While this lack of a specific definition may cause problems for those attempting to study or write about the phenomenon, it seems to benefit ultimately both the child and society by setting no arbitrary limits which might later be regarded as unfortunate. Society knows what abuse is, even without a specific definition, and may thus approach the problem with the individual characteristics and the best interests of the child as the primary considerations.

The first reported case of abuse occurred in 1874 in New York City. The child involved, a girl named Mary Ellen, was eventually taken in by the Society for the Prevention of Cruelty to Animals after individuals concerned by her plight convinced the Society that she was a member of the animal kingdom. The Society for the Prevention of Cruelty to Children was formed a year later.¹

The problem of child abuse has been realistically recognized only in the last twenty years. It was not until 1946 that the first article appeared in a medical journal attributing traumatic injury to children to possible parental abuse.² Slow progress was made for the next fifteen years with an increasing amount of publication and study on the problem. In the early 1960's, the term "battered child syndrome" was coined and nationwide interest followed.³ The mass media soon responded and the problem became the subject of magazine and newspaper articles as well

1. Fontana, *The Neglect and Abuse of Children*, 64 N.Y.S.J. OF MED. 215-16 (1964).

2. Caffey, *Multiple Fractures in the Long Bones of Infants Suffering from Chronic Subdural Hematoma*, 56 AM. J. OF ROENTGENOLOGY 163-73 (1946).

3. There is no generally accepted definition of the battered child syndrome. Those which have been formulated have usually been aimed at selecting cases to be included in a study and lack universal appeal. Delsordo's explanation has a somewhat more general application and states:

The "battered child" syndrome takes its name from the fact that the child's injuries are the result of twisting, throwing, knocking around or some other form of "battering" by the abusive person. The injuries include bruises, hematoma, and one or a combination of fractures of the arms, legs, skull or ribs.

Delsordo, *Protective Casework for Abused Children*, 10 CHILDREN 214 (1963). A somewhat more extensive definition and explanation is given by Connell:

In its most useful concept, definition of the battered child should include all degrees of violent person-to-child physical assault, and not just those in which bones or vital organs are damaged, or hospitalization required. Nor should the term be limited to a child whose aggressor admits inflicting the injuries. Confessions of this import are rarely made to the physician.

Connell, *The Devil's Battered Children*, 64 J. KAN. MED. SOC'Y 385-86 (1963).

as television dramas.⁴ In response to an enlightened public outcry, legislatures acted, often without regard to party lines, and within four years all fifty states, the District of Columbia and the Virgin Islands had enacted statutes requiring cases of child abuse to be reported to the authorities.

II. THE BATTERED CHILD SYNDROME

A. *Characteristics of the Child*

child was hospitalized at age five months with extensive burns . . . after having been fed boiling milk. Following recovery, the infant was separated temporarily from the parents and placed in a foster home. The child was returned shortly thereafter by court order, and at age eight months was admitted to another hospital with cerebral concussion, skull fracture and nutritional anemia. The silent, suffering child was unable to protest the inadequacies of our protective laws and suffered the inevitable consequence, death, at age three.⁵

In another case, a six-week-old child was admitted to the hospital with a swelling of the right thigh of four days duration. The mother stated that the child had fallen from his crib and struck his leg on the floor. X-rays revealed a fracture of the right thigh and the child was discharged two weeks later in good condition with a cast on his hip. A few weeks later he was admitted to another hospital with multiple contusions and abrasions. It was learned that the father had thrown the child on the floor, shattering the cast and inflicting serious head injuries. When last seen, the child was blind, mentally retarded and showed multiple signs of brain damage.⁶

These cases are only an indication of the injuries which may be suffered by children who are the victims of parental rage, frustration or inadequacy. While the child is subject to a wide range of trauma inflicted by numerous means, certain characteristics repeatedly present themselves to the extent that their existence in a given case often leads to a proper diagnosis in situations where the uninformed might never suspect abuse.

The battered child is typically young. While various studies come to

4. Articles that appeared are Cole, *Terror-Struck Children*, *The New Republic*, May 30, 1964; David, *The Shocking Price of Parental Anger*, *GOOD HOUSEKEEPING*, March 1964, at 181-86; DeFrancis, *Parents Who Abuse Children*, *PTA MAGAZINE*, Nov. 1963, at 16-18; Earl, *Ten Thousand Children Battered and Starved*, *Today's Health*, Sept. 1965, at 24-31; Flata, *Parents Who Beat Children*, *SATURDAY EVENING POST*, Oct. 6, 1962, at 30-35; and Oettinger, *Protecting Children from Abuse*, *PARENTS*, Nov. 1964, at 12. Numerous stories have also appeared in the *New York Times*. Both the "Ben Casey" and "Dr. Kildare" television series have included programs set around the battered child.

5. Gillespie, *The Battered Child Syndrome: Thermal and Caustic Manifestations*, 5 *J. OF TRAUMA* 523, 529 (1965).

6. Fontana, Donovan & Wong, *The "Maltreatment Syndrome" in Children*, 269 *N. ENG. J. MED.* 1389-90 (1963).

slightly different results, most agree that he is almost certain to be of pre-school age and often substantially younger.⁷ One study included an infant who suffered abuse on his first day of life,⁸ and others found that the majority of their cases involved children a year old or less.⁹ It would seem obvious from these findings that the children involved could hardly have provoked their parents intentionally, or even that they were capable of any substantial amount of mischief.

Cases of abuse are most frequently discovered when the child is taken to a private physician or hospital for treatment, although some are reported to the authorities by neighbors, relatives, and even the non-abusing parent.¹⁰ The physical injuries inflicted cover a broad range, but injuries to the arms, legs and head are most common.¹¹ Bruises such as lacerations, old and new abrasions, welts, choke marks and bites are not uncommon,¹² and thermal injuries have been found in a number of

7. Cameron, Johnson & Camps, *The Battered Child Syndrome*, 6 MED. SCI. & L. 2 (1966); Elmer, *Identification of Abused Children*, 10 CHILDREN 183 (1963); Galdston, *Observations on Children Who Have Been Physically Abused and Their Parents*, 122 AM. J. OF PSYCHIATRY 440 (1965); Gillespie, *supra* note 5, at 523; Ireland, *A Registry on Child Abuse*, 13 CHILDREN 115 (1966); Kempe, Silverman, Steele, Droegemueller & Silver, *The Battered-Child Syndrome*, 181 J.A.M.A. 17 (1962). See also, Merrill, *Physical Abuse of Children—An Agency Study, Protecting the Battered Child* (Children's Division, American Humane Association) (1962); Comment, *The Child Abuse Problem in Iowa*, 53 J. IOWA MED. SOC'Y 692 (1963).

Ireland found that in 247 of 363 cases reported the abused child was under five years of age. Gillespie's study of 19 burned children indicated their average age to be 20 months, while Cameron's study involving 29 children subjected to various kinds of abuse in England found 79% to be less than two years old and the mean age to be 14.3 months. In Galdston's study of abused children seen at Children's Hospital Medical Center in Boston over a five year period, the largest group fell between the ages of six and 18 months, while the range extended from three months to three and a half years. The battered child is usually less than three years old, although Elmer states that the peak incidence is reached at age two to three. Merrill, somewhat to the contrary, notes that half of the 180 children referred to the American Humane Association in 1960 were aged seven or under.

8. Gillespie, *supra* note 5, at 523.

9. Barta & Smith, *Willful Trauma to Young Children—A Challenge to the Physician*, 2 CLINICAL PEDIATRICS 545 (1963); Cameron, *supra* note 7; McHenry, Girdany & Elmer, *Unsuspected Trauma with Multiple Skeletal Injuries During Infancy and Childhood*, 31 PEDIATRICS 903 (1963).

In a study by McHenry of 50 children conducted at Children's Hospital in Pittsburgh, 60% were found to be under nine months and over half less than six months old. The peak age of incidence was three months, although the children's ages ranged from one month to eight years. Ten children ranged in age from nine to 15 months. Cameron's study reported 55% of the children to be less than a year old. In this connection, Elmer states that the normal incidence of accidents is minimal among children less than nine months old.

10. Merrill, *supra* note 7, at 3.

11. Cameron, *supra* note 7, at 9-10; Kempe, *supra* note 7, at 21-22.

Injuries to the arms and legs are most common and are usually present even if the most severe injury is located elsewhere. This is due largely to the fact that these extremities are easiest for an abuser to grab, and the yanking, jerking, twisting motions that follow produce injuries. Bruises on the head, face and neck have also been found in a substantial number of cases. Injuries around the mouth have been seen as efforts to make a child stop crying, while those on the cheeks or side of the head have been explained as inflicted with an open hand or fist. Skull injuries are consistent with blows against hard objects such as furniture.

12. Shepherd, *The Abused Child and the Law*, 22 WASH. & LEE L. REV. 182 (1965); Gillespie, *supra* note 5, at 523-24.

cases.¹³ Safety pins, paper clips and coins may be found in the gastrointestinal tract.¹⁴ Fractures are often distributed about the body, and x-rays of the skeleton may show previous fractures, some still not yet fully healed.¹⁵ "To the informed physician, the bones tell a story the child is too young or too frightened to tell."¹⁶

The parents are likely to have a variety of explanations for the child's condition. Seldom do they immediately admit inflicting the injuries, instead blaming an accident such as a fall or the aggression of a sibling.¹⁷ Some claim that the child injured himself or that he just simply "bruised easily." If no new injuries occur during hospitalization, it is difficult to believe that "bruising easily" explanation, and it is more difficult to believe that a small child would intentionally burn himself repeatedly with cigarettes, pour scalding water on his buttocks or constantly inflict other painful injuries on himself.¹⁸ Masochism is simply not common in infants and toddlers.

While authorities believe that many cases of abuse go unreported, it is probably more correct to say that a large number of cases are not properly diagnosed. Faced with a child who has been severely beaten, physicians often refuse to believe that an adult could inflict such harm.¹⁹ In many cases, the parents may show outward signs of devotion to the child which induce the physician to fail to consider the possibility of abuse.²⁰ When the parent gives a reasonably plausible explanation, they may be too willing to accept it rather than to probe further. Some young doctors, similarly unwilling to consider wilful abuse, attempt to explain the bruises and fractures as symptoms of some rare disease.²¹

The ever-increasing number of articles in the medical literature should help the physician to be more aware of the possibility of abuse when examining children, but this alone will not solve the statistical

13. Gillespie, *supra* note 5, at 525.

Burns are most often caused by scalding liquids, usually coffee or water. Of the 19 children included in the study, two were forced by their parents to wash their mouths out with drain cleaner, one was burned with cigarettes and cremation of one child was attempted. Two children were frostbitten as a result of being forced to take a bath outside in slush and snow and remain outdoors.

14. Shaw, *The Surgeon and the Battered Child*, 119 SURGERY, GYNECOLOGY AND OBSTETRICS 355 (1964).

15. Shepherd, *supra* note 12, at 192; Fontana, *supra* note 1, at 1390.

16. Kempe, *supra* note 7, at 18.

17. Connell states that: "In our experience, the majority of parents deny any knowledge of willful trauma, though they often recall falls in which the child—though seldom the adult—may have been injured. Not infrequently a toddling sibling too young to talk is implicated; the impossibility of prosecuting such a defendant is obvious to everyone, including the parents." Connell, *supra* note 3, at 386.

18. Gillespie, *supra* note 5, at 528; Comment, *The California Legislative Approach to Problems of Willful Child Abuse*, 54 CALIF. L. REV. 1805 (1966).

19. CALIF. L. REV., *supra* note 18, at 1809; Kempe, *supra* note 7, at 19; Bain, Commentary, *The Physically Abused Child*, 31 PEDIATRICS 895-96 (1963).

20. Fontana, *supra* note 1, at 1392.

21. Bain, *supra* note 19, at 896.

problem. The fact remains that many physicians who might see abused children fail to report and many who have substantial reason to believe that a child has been battered fail to act. A survey of physicians in the Washington metropolitan area disclosed that "a fifth of the nearly 200 physicians questioned said that they rarely or never considered the 'battered child syndrome' when seeing an injured child and a fourth said that they would not report a suspected case even if protected by law against legal action by the parents."²² The reasons for this are numerous. Some, unsure of their diagnosis, feel that an accusation would be out of place on the basis of their evidence. As battering parents seldom take the child to the same doctor or hospital twice, the examining physician is unable to see any pattern.²³ Other physicians feel that their duty is medical rather than social and consider their job finished when the child has been treated.²⁴ Still others fear civil litigation stemming from an accusation of abuse or are reluctant to take part in a criminal proceeding that might result from a report to the authorities.²⁵ Unfortunately, it is the child who ultimately ends up paying, sometimes with his young life, for the missed diagnosis or hesitation of these practitioners.

The symptoms of the battered child syndrome should sound a loud alarm to physicians treating a child exhibiting them. While not all abused children will show all of these symptoms, presence of four or more should raise a strong suspicion. The symptoms include age of the child, a distribution of fractures, a disproportionate amount of soft tissue injury, injuries in different stages of healing, the cause of the recent trauma, a suspicious family history, and the absence of any new lesions during the period of hospitalization.²⁶

A physician needs to have a high level of suspicion of the diagnosis of the battered-child syndrome in instances of subdural hematoma, multiple unexplained fractures at different stages of healing, failure to thrive, when soft tissue swellings or skin

22. Wasserman, *The Abused Parent of the Abused Child*, 14 CHILDREN 175 (1967).

23. Hansen, *Child Abuse Legislation*, 52 A.B.A.J. 734, 736 (1966); *but see* Ireland, *supra* note 7, at 115.

24. Bain, *supra* note 19.

25. *Id.*

26. Cameron, *supra* note 7, at 7; Connell, *supra* note 3, at 391; Delsordo, *supra* note 3, at 214; Elmer, *supra* note 7, at 182; Ireland, *supra* note 7, at 115; Shepherd, *supra* note 12, at 192.

The increasing importance of fractures in making the diagnosis of abuse has been noted by Elmer, who states that:

multiple bone injuries, especially in a very young child, are now clinically recognized as a flagrant sign of danger in the child's environment. Without a glimpse of the family or a word of history, the clinician who is confronted with them knows that family factors are of primary importance for the understanding of the child and his injuries.

Further, Ireland found in one study that beatings and fractures accounted for two-thirds of the abuse reported. However, a caveat must be added to this: Fontana has warned that the physician must consider the possibility that skeletal manifestations are due to a prolonged and difficult labor at birth. Fontana, *supra* note 6, at 1391.

bruising are present, or in any other situation where the degree and type of injury is at variance with the history given regarding its occurrence or in any child who dies suddenly.²⁷

In most cases the child has been well fed and cared for, indicating that the parent has at least some sense of responsibility.²⁸

The battered child, upon admission to the hospital, exhibits a personality shaped by his previous treatment. While he is unlikely to be mentally retarded or physically defective, his relationship with the abusive parent is often understandably poor. He cries unceasingly while being treated or examined, but very little at other times. He does not look at his parents for assurance and shows no real expectation of being comforted. He is wary of physical contact initiated by anyone, may manifest fright by whimpering or attempting to hide under the sheets, and tends to over-react to hostility. He becomes apprehensive when other children cry and are approached by an adult, yet watches the situation with curiosity. He seems to seek safety in sizing up the situation rather than from his parents whom he fears. He is constantly on the alert for danger, yet is less afraid when admitted to a ward than other children and settles in quickly. He is constantly asking in words or actions what will happen next. His personality is depressed and generally passive and, if old enough to speak, asks when he is going home or states that he does not want to go home. When informed of his impending release, he exhibits a disinterested look and retreats into himself. In some of the more severe cases the child may show a profound apathy to the point of stupor, a condition resembling cases of "shell-shock" in adults. He may show little external manifestation of inner life and instead, lie or sit motionless and unresponsive to all attempts to evoke some recognition of the world around him. He differs from the schizophrenic or autistic child in that his behavior is not bizarre, but rather his inner life seems to be completely suspended.²⁹ "In general, cared-for children turn to their parents for safety in life. Neglected and battered children endure life as if they are alone in a dangerous world with no real hope of safety."³⁰

B. Characteristics of the Abusive Parent

The battering parent presents a personality pattern as unique as that of his child. Studies show that mothers and fathers are equally likely to be abusive, and that children of both sexes are equally likely to be victims. However, the parent is more likely to batter a child of

27. Merrill, *supra* note 7, at 4.

28. Cameron, *supra* note 7, at 4; Merrill, *supra* note 7, at 4.

29. Morris, Gould & Matthews, *Toward Prevention of Child Abuse*, 11 CHILDREN 59 (1964); *Legislation: The Battered Child: Florida's Mandatory Reporting Statute*, 18 FLA. L. REV. 503, 506 (1965); Merrill, *supra* note 7, at 6.

30. Morris, *supra* note 29.

the same sex.³¹ One author reported twenty-one percent of the abusive mothers to be pregnant at the time of the assault.³² Studies vary on patterns of abuse, some finding that one child in the family is singled out while others reporting that abuse is more evenly distributed among several or all of the offspring.³³ In some cases, the youngest child is battered methodically, escaping only by the birth of another.³⁴

Battering seems to occur in both white and colored families³⁵ and at all levels of society and education, but is more easily concealed by the more affluent. Even among those with a good education and stable financial and social backgrounds, it would appear that there is a flaw in character structure which permits aggressive impulses to be too freely expressed.³⁶ As a result, the typical abusive parent is thought of as undereducated and from a lower financial and social level.³⁷ In most cases, the abused child was unwanted. Often he was illegitimate, conceived out of wedlock or at a time deemed inconvenient by the parents.³⁸ The intelligence of these parents has often been judged to be low. One British study found that only thirty percent of the fathers and seven percent of the mothers were of average intelligence, while the intelligence of eighteen percent of the fathers and thirty-four percent of the mothers was classified as very low. In accordance with this, the parents' occupations were found to usually require little mental ability.³⁹

31. Cameron, *supra* note 7, at 18; Merrill, *supra* note 7, at 4.

32. Cameron, *supra* note 7, at 18.

33. Cameron, *supra* note 7, at 11; Kempe, *supra* note 7, at 18-19; Merrill, *supra* note 7, at 6.

Cameron reported that in 32% of the cases in which a child died after abuse, another child in the family had previously been abused.

34. Cameron, *supra* note 7, at 14-15.

35. Cameron, *supra* note 7, at 16-17; Adelson, *Slaughter of the Innocents—A Study of Forty-Six Homicides in Which the Victims Were Children*, 264 N.E. J. MED. 1345 (1961).

Cameron found that colored children were more likely to be abused than white children, but Adelson found that the incidence of homicides among the two races was in proportion to their percentage of the population. Neither study is thought to be conclusive of the battering problem in this country as Cameron's study was conducted in England and Adelson's dealt with homicides in a variety of circumstances rather than just in cases of abuse.

36. Kempe, *supra* note 7, at 18.

37. Barta, *supra* note 9, at 553; Galdston, *supra* note 7, at 441; Kempe, *supra* note 7, at 18; McCoid, *The Battered Child and Other Assaults Upon the Family: Part One*, 50 MINN. L. REV. 18 (1965); Morris, *supra* note 29, at 441; Rubin, *The Need for Intervention*, 24 PUB. WELFARE 231 (1966); Wasserman, *supra* note 22, at 176.

While upper class ability to conceal abuse contributes to findings that a large number of cases involve poorly-educated parents, another factor to be considered is that the location of a hospital conducting a study may greatly influence the type of family who uses it. A hospital in a poor section of town is far more likely to come in contact with disadvantaged families than hospitals located in more affluent areas.

38. Cameron, *supra* note 7, at 14; Delsordo, *supra* note 3, at 216; Gillespie, *supra* note 5, at 527; Kempe, *supra* note 7, at 18; *contra*, Comment, *The Child Abuse Problem in Iowa*, *supra* note 7, at 692.

Cameron found that 66% of the abused children studied were either illegitimate, conceived before marriage or stated to be unwanted. However, an Iowa study involving 71 children found all but one to be legitimate.

39. Cameron, *supra* note 7, at 16-18; *accord*, Harper, *The Physician, the Battered Child and the Law*, 31 PEDIATRICS 899 (1963); Kempe, *supra* note 7, at 18.

Marital instability is present in the majority of cases⁴⁰ and conflict among the abusive parent and other family members has often been noted.⁴¹ In some cases, the non-abusive parent has taken the child and left the battering parent, but such separations are seldom permanent and, unless the underlying cause of the abuse is found and treated, any improvement in the child's environment is temporary.

Studies have consistently shown that alcoholism, sexual promiscuity, minor criminal activities, impulsiveness, hypersensitivity, poorly controlled tempers, self-centeredness and immaturity are common among these parents.⁴² Most of them married young⁴³ with the abused child often born soon thereafter.⁴⁴ In some other cases, the abusive parent is physically disabled or mentally retarded.⁴⁵ While serious financial difficulties or real ignorance were not present in most of the cases,⁴⁶ the youth and lack of education of most parents can be seen to have possibly produced stresses with which they were unable to cope successfully.⁴⁷ Older abusive parents had usually lived in the area for years and were self-supporting, but were reported to be poorly integrated with or accepted by the community as evidenced by the fact that ninety percent were felt to have serious social problems.⁴⁸ "Rarely is child abuse the product of wanton, willful or deliberate acts of cruelty, but usually is the result of emotional immaturity and lack of capacity for coping with the pressures and tensions of modern living."⁴⁹ In many instances, the child becomes the scapegoat for these problems⁵⁰ and, unable to retaliate ef-

To this must be added the previously mentioned caveat. Those with average or better intelligence are in a better position to avoid becoming part of the studies dealing with abuse.

40. Cameron, *supra* note 7, at 17; Delsordo, *supra* note 3, at 214-16; Kempe, *supra* note 7, at 18; McCoid, *supra* note 37, at 18-19; McHenry, *supra* note 9, at 907; Wasserman, *supra* note 22, at 176.

41. Wasserman, *supra* note 22, at 176.

42. Cameron, *supra* note 7, at 17; DeFrancis, *Child Abuse—The Legislative Response*, 44 DENVER L.J. 3, 6 (1967); Gillespie, *supra* note 5, at 527; Harper, *supra* note 39, at 899; Kempe, *supra* note 7, at 18; McCoid, *supra* note 37, at 18; McHenry, *supra* note 9, at 907; Comment, *The Child Abuse Problem in Iowa*, *supra* note 7, at 693.

To the contrary, Merrill states that most parents had never had serious trouble with the law, although some had displayed some socially disapproved behavior. Barta, in addition, noted that only one abusive mother in his study had previously been known to a law enforcement or social welfare agency. Merrill, *supra* note 7, at 6; Barta, *supra* note 9, at 553.

43. Cameron, *supra* note 7, at 14; Delsordo, *supra* note 3, at 216; Galdston, *supra* note 7, at 441; Kempe, *supra* note 7, at 18; Merrill, *supra* note 7, at 4; Comment, *The Child Abuse Problem in Iowa*, *supra* note 7, at 693.

44. Merrill, *supra* note 7, at 3.

45. McHenry, *supra* note 9, at 907.

46. Galdston, *supra* note 7, at 441.

47. McHenry, *supra* note 9, at 907.

48. Older abusive parents had usually lived in the area for years and were self-supporting, but were reported to be poorly integrated with or accepted by the community as evidenced by the fact that 90% were felt to have serious social problems. Merrill, *supra* note 7, at 3.

49. DeFrancis, *supra* note 42, at 6.

50. McCoid, *supra* note 37, at 19; Comment, *The Child Abuse Problem in Iowa*, *supra* note 7, at 693.

fectively to the situation, provides an ideal target. One author has referred to the child in these circumstances as a "hostility sponge."⁵¹

Authorities differ on the existence of serious mental illness in these parents; some feel them to be psychopathic or schizophrenic,⁵² while others report little psychosis but rather a marked inability to set up a genuine relationship with another human being.⁵³ Parents who were reported to be non-psychotic were often found to be unable to sympathize with the feelings of others. While they showed little remorse for their actions and were often unconcerned with their child's welfare, they could be very much concerned about the results their actions might bring from those in authority.⁵⁴

It is interesting to note that many abusive parents were themselves emotionally deprived or battered as children.⁵⁵ It thus seems that the problem is one that is largely passed from generation to generation. It is understandable that the abused and rejected child might easily turn into an insecure and unstable adult. This may serve to explain why the child is sometimes perceived by these parents as a competitor for the attention and affection of others.⁵⁶ In some cases the parents seem to recognize the seriousness of their acts and some authorities feel that they are actually seeking help for themselves as much as for the injured child when they take him for medical treatment.⁵⁷ One author states that:

parents who neglect and batter their children are actually speaking their parental incapacities in action language and are asking to be stopped in behaving as they do. Why else do they bring their children to hospitals and so run a high risk of punishment? We think that parents run this risk because the risk of total, internal, personality disintegration is even more terrifying—a risk they run in continuing the care of their children.⁵⁸

In other cases, the act of abuse itself may be the parent's plea for help that he is too proud or too embarrassed to make in any other way. While the battering parent needs help and understanding, his actions towards hospitals, law enforcement authorities, social workers and the courts are often calculated to bring about the opposite treatment. Provocation directed at these potentially helpful sources may result in rejection

51. Wasserman, *supra* note 22, at 177.

52. Delsordo, *supra* note 3, at 214; Gillespie, *supra* note 5, at 527; Harper, *supra* note 39, at 899; Kempe, *supra* note 7, at 18; McHenry, *supra* note 9, at 907; Comment, *The Child Abuse Problem in Iowa*, *supra* note 7, at 693.

53. Wasserman, *supra* note 22, at 177.

54. *Id.*

55. Harper, *supra* note 39, at 899; Kempe, *supra* note 7, at 18; McCoid, *supra* note 37, at 6; McHenry, *supra* note 9, at 907; Morris, *supra* note 29, at 60.

56. Delsordo, *supra* note 3, at 216.

57. Wasserman, *supra* note 22, at 177.

58. Morris, *supra* note 29, at 56.

similar to that suffered as a child and may possibly satisfy the parent's inner sense of a need of punishment for his guilt.⁵⁹

Attempts have been made to catalogue the types of abuse inflicted and the differing backgrounds that seem to produce it. While there seems to be no substantial amount of agreement on these views, they produce an interesting picture of the situation.

A British study of 29 abused children attempted to subdivide the syndrome into four classes based largely on the state of mind of the abusive parent.⁶⁰ The first subdivision included cases that were clearly murder and which were intended as such by the parent. The second included cases where frequent acts of violence ultimately terminated in the child's death. The actual intent to kill the child seems to be missing here, but the pattern of apparently intentional abuse carried out methodically has achieved the same result. The third subdivision dealt with cases where acts of violence took place on the spur of the moment, resulting in death. These acts often occurred when the parent was drunk or consumed by a fit of temper. There seems to have been no preconceived plan to kill the child and the death was more the result of the parent's inability to control himself. The fourth category was composed of cases involving children who were abused by foster parents. Other studies have shown that natural parents commit the abusive acts in the majority of cases⁶¹ and this category is thought to be a catch-all for foster parents because the number of cases was too small to justify further subdivision. It was further reported that differentiation between the second and third categories was aided by the fact that children subjected to frequent intentional abuse tended to be underweight while those who suffered from spur of the moment acts of violence were usually of normal weight and size.⁶²

Another study attempted to group abusive parents according to "clusters of personality characteristics."⁶³ The first cluster was composed mainly of mothers with internal conflicts. They were hostile, aggressive and constantly angry. This was thought to be related to severe emotional rejection and deprivation suffered by the mother as a child. The few fathers who fell within this group were likely to express their feelings outside the home as well, their behavior sometimes producing serious

59. Wasserman, *supra* note 22, at 179.

60. Cameron, *supra* note 7, at 18.

61. Adelson, *supra* note 35, at 1346; Ireland, *supra* note 7, at 115; Merrill, *supra* note 7, at 4.

Ireland reported that parents inflicted the abuse in approximately two-thirds of the cases studied. Merrill's study indicates that parents were the abusers in 86% of the cases and that these abusive parents usually lived with the children. Adelson found that the 46 children whose deaths he studied had been killed by 41 persons, 36 of whom were parents or stood in loco parentis. However, the implications of this finding in a pure abuse situation are uncertain as some of the children included in his study were the victims of attempts by the parent to wipe out the entire family, rather than of the battered child syndrome.

62. Cameron, *supra* note 7, at 18.

63. Merrill, *supra* note 7, at 4-5.

consequences. The second cluster was filled with parents with rigid and compulsive personalities who lacked warmth, reasonableness and pliability in their thinking and beliefs. They defended their acts of abuse and the mothers often openly rejected their children. These mothers were primarily concerned with their own pleasures and were unable to feel love or protection for their children. Oftentimes the children were blamed by the parents for their various difficulties. The third cluster was comprised of parents with passive and dependent personalities. They often competed with their children for their spouse's love, and were generally depressed, sad, moody, unresponsive and unhappy. They lacked maturity and seemed uncertain of what they wanted in life. This uncertainty extended to their desire to be married, to have children, and to have a home of their own. The fourth cluster was composed mainly of fathers unable to work because of a physical disability. The mothers supported the family in these cases but the father exerted strong discipline and control in a home where the atmosphere was often rigid and controlled. These fathers were often young and intelligent and felt an acute loss of pride and status due to their disabilities.

The same role-reversal found in the fourth cluster has been noted in other studies but with different effects.⁶⁴ In these reports the wives who worked were quite masculine in appearance and demeanor while their husbands were passive and retiring. The careers of these mothers have often been found to be a means of withdrawal from the child, whose behavior they interpreted as deliberate and intentional. The actual abuse in these cases often followed a breakdown of this arrangement which required the mother to remain at home with her children and made further withdrawal impossible. In these situations the mother was the abusive parent, and it seems that where role-reversal is present, the dominant and controlling parents is likely to be the abuser.

A third study attempted to classify abuse according to the emotional difficulties that caused it.⁶⁵ This study was based on investigation of cases involving 80 abused and battered children. Four of the children in this study were abused by parents with actual mental illness, two of whom were unwed mothers. In the other two cases, the father was the abuser and the home showed severe marital conflict. The method of abuse in these cases was ritualistic rather than impulsive, and this would seem to accord with the second subdivision of the British report. Thirteen cases resulted from what was termed "overflow abuse" from parents, usually mothers, who were unable to cope with responsibility. Over half of the homes lacked a father and those with two parents were marked by a history of severe marital conflict. The children who suffered this abuse were usually over five years of age, somewhat older than the

64. Galdston, *supra* note 7, at 442; Comment, *The Child Abuse Problem in Iowa*, *supra* note 7, at 693.

65. Delsordo, *supra* note 3, at 214-16.

typical battered child. These parents were diagnosed as having "inadequate personalities." Eight cases were classified as "battered child abuse." In two of the families involved, more than one child was abused. The case histories of these families showed conflict either between the parents or between the abusing parent and a significant relative. The child was perceived as a competitor or a burden to be destroyed or made to suffer. Twelve of the cases were termed "disciplinary abuse." Most of the children involved were adolescents, and only one child was under age seven. The abuser was usually rigid and unfeeling and the abuse commonly followed failure to comply with parental expectations or commission of a forbidden act. Five of the abusers were parent substitutes who cared for the child because of parental default rather than by their own choice. The abuse in these cases was not restricted to one child and usually took the form of beatings with a strap, rope, stick or similar article. This classification would seem to be a combination of the fourth subdivision of the British study and the third personality cluster in the previous study. Forty-three cases were classified as "misplaced abuse." The child in these cases was often illegitimate, conceived before marriage, brain damaged, or a pawn in a marital conflict. In some cases, the child's behavior leading to the abuse was attributed to the birth of a sibling. The children involved in these batterings were seldom found to be in danger of death and their parents often showed remorse, making a solution for the problem more possible. The fathers, usually the abusers in these situations, were often mismatched with their wives, a fact probably aided by premarital conception and which contributed to the marital conflict. In some instances there was a history of the child having been cared for by a parent substitute. Only one child was normally beaten in multiple child families, and most of these children were aged five or over. The abuse was usually administered by fists or a strap and was possibly brought on by bed-wetting, truancy, fire-setting or withdrawal evidenced by a number of these children.

Once the battered child is taken to the hospital for treatment, the parents are likely to display a set of characteristics, reactions and attitudes as distinctive as those exhibited by the child. They do not volunteer information about the child's injury and are evasive or contradict themselves regarding the circumstances under which it occurred. They become irritable when asked how the child's symptoms developed. They seem critical of the child, angry at him for being injured, and give no indication of any feeling of guilt or remorse regarding his condition. They either show no concern about his injury or are overly inquisitive, solicitous and prying, but often disappear from the hospital while the child is being examined or shortly after he is admitted. They tend not to visit the child while he is hospitalized and, during any visits which may occur, seldom touch or look at him. They do not involve themselves in the child's care or inquire about his discharge and ask to take him home

only when frightened by interrogation. They do not ask about post-hospital care. Their concern seems to be mainly what will happen to themselves and others responsible for the child's injury. They maintain that the child injured himself and act as though his injuries are an assault on them. They either fail to respond to the child or respond inappropriately and give no indication of having any perception of how the child could feel, physically or emotionally. They constantly criticize the child and never mention the existence of any good quality in him. They show no understanding of the rights of others and are preoccupied with themselves and the concrete things in life, although they are often neglectful of their own physical health. They exhibit violent feelings. They reveal that such a pattern of violence surrounded them as children and that they are concerned about having been abandoned and punished by their parents. They may exhibit a longing for their mothers. Perhaps the most telling of all characteristics exhibited is their overwhelming feeling that both they and their children are worthless.⁶⁶

These characteristics of the syndrome must be understood in order to deal effectively with the abuse problem and the possible solutions which may be available. It is easy for the uninformed to state that punishment of the parent is an expedient and simple remedy. Such feelings stem from a natural repugnance experienced by those who know only of the injuries inflicted on the child. These people cannot understand what causes an adult to inflict serious injuries on a defenseless child. The facts remain, however, that some children are more difficult to handle than others and that biological parenthood is no guarantee of fitness to raise any child, let alone one who may present problems. In this connection, it must be decided whether punishment of the abusive parent or solving the larger problem of getting to the reason for the abuse is to be the main objective, although it is admitted that, in some instances, punishment may be warranted as one means of bringing about a solution.

If the improper decision is made, serious and sometimes fatal consequences may ensue for the child. "Knowledgeable professional persons now believe that a child with multiple bone injuries has a 50-50 chance of being reinjured should he return to his usual habitat following hospitalization."⁶⁷ Furthermore, studies have shown that approximately 10 percent of the children who survive long enough to receive medical attention later die, either from the injuries that first brought them to the physician or hospital or from subsequently inflicted trauma.⁶⁸ A

66. Connell, *supra* note 3, at 391; Galdston, *supra* note 7, at 440; McHenry, *supra* note 9, at 907; Morris, *supra* note 29, at 56-57.

67. Elmer, *supra* note 7, at 181.

68. Elmer, *supra* note 7, at 183; Gillespie, *supra* note 5, at 527; Kempe, *supra* note 7, at 17; McHenry, *supra* note 9, at 906; Comment, *The Child Abuse Problem in Iowa*, *supra* note 7, at 692.

Elmer and McHenry reported that of 50 children seen at Children's Hospital in

number of those who survive suffer permanent brain damage or are seriously crippled.⁶⁹

III. SOLVING THE FAMILY PROBLEM

A. *The Punishment-Rehabilitation Conflict*

Modern legal theory is making greater and more rapid inroads in the area of family law than perhaps in any other field. This is readily visible in the area of child abuse, which contains components of both criminal and family law. Abusing a child is a statutory offense in all states, and criminal penalties are provided. However, the modern trend is to reduce use of these sanctions except in the more severe and aggravated cases and to attempt to prevent further incidents of a similar nature through concentrated social casework. This is a significant departure from the normal criminal case in which the defendant may, with luck, be placed on probation after a first offense but will likely be far more severely punished for a second infraction.

This departure is probably due, in large part, to the almost overwhelming sentiment in favor of keeping the family intact. This is especially true when reports of child abuse come to the primary attention of social welfare agencies or juvenile courts rather than law enforcement authorities. The former are more likely to feel that prosecution is unwise or unnecessary if the problem can be solved in other ways. Studies have shown that decisions not to prosecute are made in a number of cases,⁷⁰ due either to a preference for maintaining the family unit or the difficulty of obtaining a conviction. Additionally, if prosecution is unsuccessful, the child may remain with parents who feel justified in continuing abuse, and the publicity that attends the prosecution may make it more difficult to work with the parents.⁷¹

Pittsburgh, two died in the hospital and five others died after release under suspicious circumstances. Kempe surveyed 71 hospitals which reported 302 cases of abuse in one year in which 33 children died. He further found that 77 district attorneys had knowledge of a total of 447 cases in a year in which 45 children died. A study of child abuse in Iowa covering 71 children found that seven died of their injuries. Gillespie's study of 19 burned children reported a far higher mortality rate. Six of the children died of injuries existing at the same time as the burns and another died after being returned to his family. It is possible that the difference is due to the nature of the injuries suffered.

69. Elmer, *supra* note 7, at 183; Kempe, *supra* note 7, at 17.

Kempe's survey of hospitals and district attorneys found that 85 of the 279 surviving children seen by hospitals suffered permanent brain injury and that 29 of the 402 surviving cases known to district attorneys resulted in similar permanent damage to the child. Elmer reported that three of the 43 surviving children studied were permanently crippled by their injuries and that four more showed serious physical defects when next seen at the hospital. Four other children were seriously mentally retarded, although it was unknown whether the retardation preceded or resulted from the injuries.

70. Cameron, *supra* note 7, at 18; Kempe, *supra* note 7, at 17.

Kempe found that prosecution was undertaken in only a third of the cases reported by hospitals and in 46% of those known to the district attorneys. Cameron reported that legal action was taken against the father in 34% of the cases and against the mother in 21%.

71. Rubin, *supra* note 37, at 234.

Contrary positions can easily be taken on this matter. There are those who would argue that deterrent value of criminal sanctions and the fact that in no other area of criminal law is simple emotional instability a defense. If the battering parent is clearly insane by whatever rule a given jurisdiction has adopted, there is no problem, but it is doubtful that this is true in any substantial number of cases. Further, emotional instability is still not a defense to child abuse but often simply results in a decision not to prosecute in situations where it is thought that temporary removal of the child from the home or social casework will provide a solution. Ultimately, in a majority of cases this refusal to prosecute has the same effect as providing a defense. Perhaps the saddest commentary on this situation is the fact that, while prosecutions for child abuse are relatively rare as compared to incidence, prosecutions for murder or manslaughter are increasingly common. The tragedy of this is accentuated by the fact that a number of these children who were battered to death had been abused previously.⁷² It is only fair to note, however, that convictions in child abuse cases may be difficult to obtain because of the nature of the offense. Not only are physicians often reluctant to testify in criminal proceedings, but abuse is commonly committed in the privacy of the home with no one except possibly the abuser's spouse knowing the circumstances of the child's injury. The child is usually too young or too frightened to tell the story, and if the husband-wife privilege is not abrogated by statute, evidence is likely to be wholly circumstantial absent a confession. The difficulty of showing guilt beyond a reasonable doubt becomes obvious in these cases. Moreover, a jury may have the same trouble believing that an adult would severely injure a defenseless child as physicians do.

In most cases it is far more helpful to bring proceedings on behalf of the children in juvenile court than to prosecute a parent in a criminal action. Not only are criminal charges in child abuse cases difficult to prove, but punishing the parent does not help to change his behavior, nor do threats of punishment seem to deter him from further acts of abuse.⁷³

The opposing view of the punishment problem stresses the primary interest in the welfare of the child. It is undisputed that imprisonment of the battering parent will not heal the child's injuries or negate the retardation that may be attributed to them. If the premise of serving the best interests of the child can be accepted as a guideline for all problems raised by an abuse situation, the argument against punishment may be quite strong in many cases. If preservation of the family unit is considered to be of paramount importance, as it is by a

72. Cameron found that 90% of the children who died had suffered previous abuse. Cameron, *supra* note 7, at 11.

73. Rubin, *supra* note 37, at 234.

number of authorities, more weight is added to the case against punishment. There is no question but that this is an extremely modern means of attempting to deal with a problem that is largely criminal in nature. Rehabilitation has long been accepted as a primary consideration in criminal cases and an elaborate probation system has evolved as one means of dealing with this problem, but seldom has the rehabilitative process been left solely to actual social casework with no participation by the criminal courts. The impact of this innovation can be realized more fully when it is considered that most criminals have some kind of emotional or psychiatric problems which lead them to allow their behavior to deviate from the boundaries set by society. In cases involving the better known criminal offenses, rehabilitation is often attempted largely within a punitive framework. Emotional or psychiatric problems are then dealt with within that setting. Imprisonment of a parent, whether for shoplifting, larceny or child abuse, will have at least some disruptive effect on the family, and while extensive counseling might be sufficient to prevent further offenses in any of these situations, it is not generally considered as a sole answer in the first two. Why should a young parent who fractures his child's skull be treated any differently than a young parent who steals a television set? The only answer is that, if enlightened, socially-oriented methods of rehabilitation are accepted, they should be extended to cover other crimes. The more modern provisions for rehabilitation of battering parents should not be condemned if results are achieved which would be comparable to those of a prison. The advantages are numerous: reduced cost to the state, maintenance of the family, and very possibly a solution to the battering parent's underlying problem which contributed to or brought about the abuse and which might possibly be difficult to solve in a prison setting where time and individual attention are often severely limited.

B. *The Social Casework Method*

The social casework method of dealing with abusive parents combines medical and sociological efforts to preserve the family unit. Its primary objective is to protect the child and to attempt to restructure the home to remove the element of danger to him. Ideally, it is initiated while the child is still hospitalized. The home atmosphere and backgrounds of the parents are scrutinized by a trained social worker. Neighbors, relatives and others who know the parents may be interviewed. The parents are interviewed at length on their attitudes toward the child, each other, their home, and other pertinent subjects. While premature or hostile accusations of child abuse may be detrimental to all concerned and may retard efforts to learn of the reason for the child's injuries,⁷⁴ these interviews may bring the first admissions of abuse from

74. Elmer, *Hazards in Determining Child Abuse*, 45 CHILD WELFARE 28 (1966).

parents who have previously denied all responsibility for the child's condition. Along with the admission is likely to come a flood of reasons or explanations for the abuse that may lead to the heart of the problem. The social worker may then attempt to help the abusive parent deal with the problem effectively, providing the moral support that often makes the difference between success and failure. In some cases, showing the young and harried mother how to care for her child properly or helping her set up a workable routine may enable her to cope with day to day difficulties that might previously have resulted in abuse to a child who cried at the wrong time. In other cases, the parent may be a victim of community exclusion, deeply in need of inclusion to break the battering cycle.⁷⁵ Helping him to readjust and to seek inclusion in acceptable ways may relieve the frustration that was previously taken out on the child. If psychiatric problems are presented, counseling may be arranged. Oftentimes, however, the greatest need of the parent is an understanding friend who can be relied on for help and moral support. Once a relationship of trust is established, the social worker may be able to allay the parents' fears about themselves and their often imagined inadequacies.

Upon the release of the child from the hospital, a decision must be made whether to let him return to the home. "Under no circumstances should such a child be returned to his original environment until after definite proof of its improvement has been given."⁷⁶ If it is felt that the home atmosphere is still dangerous for the child, a petition may be made to the juvenile court to remove the child from the home temporarily. Such a temporary removal would be for an indefinite period of time and would be terminated only when the home is found to be safe for the child. In the meantime, the child would be placed in a foster home under the supervision and custody of the juvenile court. If the home were considered reasonably free from danger, the child would be returned to his parents.

After the child's return to the home, social casework continues to make sure that the adaptive process continues. The parent who seems to recognize, understand and be able to cope with his problems while the child is hospitalized may be subject to relapses in time of stress. Preventing this stress may be impossible, but providing the parent with the means to cope with it may save the child from further abuse. With a parent who has a basic and genuine underlying interest in and love for the child, help in understanding the situations and crises which lead to abuse of the child may help him to recognize the danger they present and to attempt to control his impulses more effectively.

Periodic visits from a trained nurse constitute another segment of the over-all casework. The nurse can easily examine the child to see if

75. Wasserman, *supra* note 22, at 179.

76. Barta, *supra* note 9, at 553.

subsequent traumatic episodes have occurred. While gross instances of abuse might be readily visible to the social worker, a nurse is able to detect subtle indications of trauma and to determine if these are consistent with the normal bumps and bruises suffered by an active child. The fact that a medically oriented investigator will call periodically may also have a sobering effect on the parents in times of stress. Knowing that their misdeeds are more likely to be discovered, they may exert a greater degree of self-control.

Over a period of time, need for the periodic visits of both the nurse and social worker diminish. Having become more able to control themselves and having a better understanding of their problems, the parents are less likely to strike out at the child. As the child becomes older, he outgrows the characteristics which make him prone to abuse. As he learns to talk, the parents realize that it is then impossible to continue battering him without this coming to the attention of others. There may, of course, still be moments of discipline which some authorities might regard as harsh, but discipline, within reasonable limits, is a matter of parental discretion and, if within these limits, should not be construed as abuse simply because the parent had battered the child previously. It is also possible that the passage of time will bring maturity and responsibility to young parents and enable them to cope more successfully with the adult world that they were not previously prepared to enter.

Of course there are instances when social casework will be to no avail. In some cases, the child will be truly unwanted. In others, the parent's problems will be too great to be solved without long-range psychiatric treatment and possibly hospitalization or institutionalization. "In families where a mentally ill parent is physically abusing a child, the mental illness soon becomes so apparent and predictable that separation of abusive parent and child is imperative."⁷⁷ In still others, the parents will be unwilling to cooperate with the caseworker or refuse to accept help. In these cases, a number of solutions are possible. Sometimes the non-abusive parent leaves the abuser and takes the child. Divorce may follow in some cases and there is little doubt that the court will consider the abusive parent unfit to have custody of the child. The problem here is that, in separation cases, the abusive parent may beg for the return of the spouse and child, asking forgiveness and promising not to repeat the abuse. These promises are sometimes forgotten after the return and further injuries are inflicted on the child. In these situations, the caseworker must be alert to the possible results of the return and recommend removal of the child from the home if it cannot otherwise be protected.

Little difficulty is encountered in cases where the child is obviously unwanted or both parents have severe emotional or psychiatric problems. In such a situation the child should seldom if ever be returned to the

77. Delsordo, *supra* note 3, at 213.

family following hospitalization. Where the child is unwanted, the parents are likely to have little objection to its placement in a foster home. However, some seriously disturbed parents may have a strong desire to have the child returned to them. One writer has stated that "where parents are unable to admit their abusive attacks on children and where there is definite evidence of assaultive behavior (fractures, subdural hematoma, etc.), we should be predisposed to seek removal of the child from the home immediately to prevent further damage."⁷⁸ With this evidence and a critical report by the social worker, the juvenile court should give serious consideration to a petition for removal. If in doubt, there seems to be no reason why the court could not order psychiatric evaluation of the parents before returning the child to them, using the results of the evaluation along with other information in making a decision. Removal of the child from his family is a serious matter, and studies seem to indicate that this course is not taken in most situations.⁷⁹ While mistakes in judgment may be made, failure of the court to order removal should not be seen as a condemnation of the social casework effort.

In still other instances, the battered child may be close to outgrowing his period of vulnerability at the time of the attack which resulted in his hospitalization. In these cases, the social worker may see the child through what remains of his period of greatest danger and then consider the problem solved. If no siblings have been born in the meantime, it is possible that a solution actually has been achieved. However, the birth of a sibling may simply shift the problem to the younger child. In such a situation, it is important for the social worker and visiting nurse to check the new baby's progress to guard against a simple transfer of the abuse. If both children progress satisfactorily, the need to visit may lessen over a period of time. It may seem that seeing each child through his infancy is a somewhat ambitious program simply because one child has been abused. However, saving a child from severe injuries and maintaining the family intact are objectives worthy of this effort. "Preventing neglect and battering depends in the long run on preventing transmission of the kind of social deprivation which takes children's lives, damages their physical health, and retards their minds, and which contributes through those who survive to a rising population of next generation parents who will not be able to nurture children."⁸⁰

78. Merrill, *supra* note 7, at 13.

79. Merrill, *supra* note 7, at 6-7; Comment, *The Child Abuse Problem in Iowa*, J. IOWA MED. SOC'Y, *supra* note 7, at 692.

Merrill found that court action was initiated to remove the child from the home in only 8% of the cases studied, while structural family change occurred in 26% and the family remained intact and received casework treatment in the remaining cases. The Iowa study reported that 17 of the 64 children studied who survived the abuse inflicted were removed from their parents by court action, although the attempt was made to improve conditions so that the child could remain with the family wherever possible.

80. Morris, *supra* note 29, at 60.

IV. THE LEGISLATIVE RESPONSE

Alerted by a growing amount of information and sentiment, the legislatures of all fifty states, the District of Columbia and the Virgin Islands have acted to meet the problem.⁸¹ It was apparent to them that statutes prohibiting abuse were insufficient and that the true extent of the problem was largely unknown.⁸² Until instances of child abuse came to the attention of the authorities, it was evident that little could be done either to protect the children involved or to deal with the perpetrators of the abuse.

The solution was found in reporting statutes, similar to those enacted for cases of gunshot wounds. The first state to pass such legislation was California in 1963, and its lead was quickly followed. Support for such bills was almost universal and disagreement among members of different parties was largely restricted to who would receive credit for them or whose wording would be used. Committees were formed in a number of states to investigate the problem and formulate the legislation. These committees were often broad-based and included businessmen, civic leaders and others whose concerns were not primarily political.⁸³ Unfortunately, for all the fervor that existed, the results often did not meet the needs. This was due, no doubt, in part to a lack of certainty as to just what the needs were. While these hastily enacted statutes have supplied a starting point, it is clear that a number of them are in need of revision to reflect the lessons learned over the last five years.

A. *The Purpose Clause*

A number of the statutes enacted start with purpose clauses. These are advantageous for the obvious reason that the court is given direction in statutory construction should this be needed. While legislative history is available in some states, it is not in others. A purpose clause would be far more necessary in these latter states, but certainly nothing is lost by including such a clause in other states. The purpose clause further defines the aims of the various statutes and some indicate what action should be taken. Ten states⁸⁴ limit this clause to the aim of the legisla-

81. Both the District of Columbia and the Virgin Islands will be treated as states for statistical purposes.

82. In the first nine months of 1962, newspapers reported 378 cases of abuse involving 446 children and 109 fatalities in 47 states. It seems obvious that these cases are only a small minority as newspapers would be unlikely to know of or report the less serious cases or cases which were not extraordinary. Jacobziner, discussing Fontana, *The Neglect and Abuse of Children*, 64 N.Y.S.J. OF MED. 215, 221 (1964).

83. Paulsen, Parker & Adelman, *Child Abuse Reporting Laws—Some Legislative History*, 34 GEO. WASH. L. REV. 482 (1966).

84. [Statutes will be cited according to the date of passage.] DEL. CODE ANN. tit. 16, § 1001 (1965); IOWA CODE ANN. § 235A.1 (1965); KAN. STAT. ANN. § 38-716 (1965); MINN. STAT. ANN. § 626.554(1) (1967); MONT. REV. CODE ANN. § 10-901 (1965); NEV. REV. STAT. § 200.501 (1965); N.H. REV. STAT. ANN. § 571:25 (1965); N.J. STAT. ANN. § 9:6-8.1 (1964); OKLA. STAT. ANN. tit. 21, § 845 (1966); W. VA. CODE § 49-6A-1 (1965).

tion, generally stating that it is for the protection of children who have had injuries inflicted on them. Six states⁸⁵ add a somewhat limited aim of stating an intent that protective services of the state be used to protect the child's welfare and prevent further abuse. The clauses from the statutes in these states are similar to the provision of the Model Act recommended by the Children's Division of the U.S. Department of Health, Education and Welfare.⁸⁶ While the intent is no doubt laudatory, it is thought that somewhat stronger and more definite language might be desirable. This objection is largely overcome by the language used in ten states which provides that protective services shall be made available to prevent further abuse, enhance the welfare of the child and preserve the family wherever possible.⁸⁷ It is obvious that such a clause gives

85. ARK. STAT. ANN. § 42-801 (1965); IND. STAT. ANN. tit. 52, § 1419 (1965); KY. REV. STAT. ANN. § 199.335(1) (1966); VT. STAT. ANN. tit. 13, ch. 26, § 1351 (1965); WASH. REV. CODE ANN. § 26.44.010 (1965); V.I. CODE ANN. tit. 19, § 171.

86. The Model Act is as follows:

1. PURPOSE

The purpose of this Act is to provide for the protection of children who have had physical injury inflicted upon them and who are further threatened by the conduct of those responsible for their care and protection. Physicians who become aware of such cases should report them to appropriate police authority thereby causing the protective services of the State to be brought to bear in an effort to protect the health and welfare of these children and to prevent further abuses.

2. REPORTS BY PHYSICIANS AND INSTITUTIONS

Any physician, including any licensed doctor of medicine, licensed osteopathic physician, intern and resident, having reasonable cause to suspect that [a] child under the age of — (the maximum age of juvenile court jurisdiction) brought to him or coming before him for examination, care or treatment has had serious physical injury or injuries inflicted upon him other than by accidental means by a parent or other person responsible for his care, shall report or cause reports to be made in accordance with the provisions of this Act; provided that when the attendance of a physician with respect to a child is pursuant to the performance of services as a member of the staff of a hospital or similar institution he shall notify the person in charge of the institution or his designated delegate who shall report or cause reports to be made in accordance with the provisions of this Act.

3. NATURE AND CONTENT OF REPORT; TO WHOM MADE

An oral report shall be made immediately by telephone or otherwise, and followed as soon thereafter as possible by a report in writing, to an appropriate police authority. Such reports shall contain the names and addresses of the child and his parents or other persons responsible for his care, if known, the child's age, the nature and extent of the child's injuries (including any evidence of previous injuries), and any other information that the physician believes might be helpful in establishing the cause of the injuries and the identity of the perpetrator.

4. IMMUNITY FROM LIABILITY

Anyone participating in good faith in the making of a report pursuant to this Act shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed. Any such participant shall have the same immunity with respect to participation in any judicial proceeding resulting from such report.

5. EVIDENCE NOT PRIVILEGED

Neither the physician-patient privilege nor the husband-wife privilege shall be a ground for excluding evidence regarding a child's injuries or the cause thereof, in any judicial proceeding resulting from a report pursuant to this Act.

6. PENALTY FOR VIOLATION

Anyone knowingly and willfully violating the provisions of this Act shall be guilty of a misdemeanor.

U.S. DEPT. H.E.W., *THE ABUSED CHILD* (1965).

87. COLO. REV. STAT. ANN. § 22-13-1 (1963); D.C. CODE tit. 2, § 2-161 (1966); FLA. STAT. § 828.041(1) (1965); GA. CODE ANN. § 74-111(d) (1965); SESS. LAWS OF HAWAII, Act 261 § 1 (1967); IDAHO CODE § 16-1624 (1965); ME. REV. STAT. ANN. tit. 22, § 3851

more direction to those concerned with implementation of the statute. This language seems to imply that protective services will be established to deal with the problem if they do not already exist, rather than simply stating, as the Children's Division proposal seems to do, that those which exist be made available to deal with the problem. It further states as an objective the preservation of the family, and this may be interpreted as recommending that social casework be used if possible rather than punishment. The statutes of 11 states⁸⁸ contain no purpose clause, and the remainder espouses an intent regarding a variety of other problems, many of which are covered in the body of statutes in other states.

In this context it should be noted that a direction to make protective services available is by no means a panacea. While these statements sound commendable, the fact remains that if such services do not exist at the time of passage of the statute, they must be established, and this requires money. While some states have directed that services be made available, they have neglected to appropriate the necessary funds, thus emasculating the provision. In only two states have funds actually been appropriated;⁸⁹ this seems to be an exceptionally poor record, even granting that the agencies may already exist in some states. It is imperative that statutory provision be made for the investigation of reports of child abuse and funds should be appropriated to carry them out,⁹⁰ for it is doubtless true that "no law can be better than its implementation, and its implementation can be no better than its resources permit."⁹¹

B. *Making the Report*

The next clause generally deals with who is required to report and under what conditions. There is great dissimilarity among the states on this matter, almost every one having inserted its own special provisions. The situation is further complicated by the fact that some states have enacted permissive rather than mandatory legislation. While permissive statutes, generally allowing a physician to report if he pleases, are better than none at all, it is questionable whether they are very much better. It seems in these cases that the aim is more to protect the physician than the child. Such statutes allow physicians to make a medical judgment their first concern rather than the social policy.⁹² Even with a manda-

(1965); N.M. STAT. ANN. § 13-9-12 (1965); R.I. GEN. LAWS § 40-13.1-1 (1965); UTAH CODE ANN. § 55-16-1 (1965).

88. ALA. CODE tit. 27, ch. 4, §§ 21-25 (1965); ARIZ. REV. STAT. ANN. § 13-842.01 (1965); CONN. GEN. STAT. ANN. § 17-38a (1965); LA. REV. STAT. ANN. § 14:403 (1964); MICH. COMPILED LAWS ANN. § 722.571 (1968); MO. ANN. STAT. § 210.105 (1965); N.Y. PEN. CODE § 483-d (1964); PA. STAT. ANN. tit. 18, § 4330 (1965); S.C. CODE § 20-302 (1965); S.D. SESSION LAWS OF 1964, ch. 90; TEX. CIV. STAT. art. 695c-2 (1965).

89. DeFrancis, *supra* note 42, at 21.

90. Paulsen, *Legal Protections Against Child Abuse*, 13 CHILDREN 46 (1966).

91. Paulsen, *Child Abuse Reporting Laws: The Shape of the Legislation*, 67 COLUM. L. REV. 1, 49 (1967).

92. Paulsen states that "[w]hether cases of suspected abuse should be brought to the

tory statute, the physician would still have to make a medical judgment, but subordination to social policy would not occur.⁹³ Further, the argument has been made that existence of a mandatory statute may make parents hesitate to seek medical treatment for abused children until they realize that the child is seriously injured or fear impending death.⁹⁴ In some cases, abused children brought to hospitals have been dead for hours.⁹⁵ In at least one reported instance, a mother stated that she delayed taking her child to a physician for fear of having his injuries reported. The two-and-a-half-year-old child subsequently died.⁹⁶ However, there is no assurance that the same problem would not exist with a permissive statute, and the parent is less apt to be resentful if the statute requires a report.⁹⁷ Additionally, permissive reporting is almost certain to produce statistical distortion, gaps and inaccuracies.⁹⁸ "To make the law permissive emasculates its intent and purpose. It results only in suiting the convenience of the reporting source and, too often, may fail to bring protection to children in grave hazard."⁹⁹ Permissive statutes have been enacted in six states,¹⁰⁰ and it is interesting to note that two¹⁰¹ of these statutes contain no purpose clause, whereas better than four out of five mandatory statutes contain purpose clauses. The fact remains that society's interest should be primarily that of protecting the child in these cases and that permissive statutes are likely to fail miserably in this regard.

1. MANDATORY REPORTERS

Reporting by physicians is permitted or required by all the statutes, although 36 states provide that if a physician attends a child while performing his duties as a staff member of a hospital that he must notify the person in charge of the hospital or a designated delegate of such a person who is then required to make the report.¹⁰² Six states limit coverage to

attention of the authorities responsible for child protection is not a medical question, but a question of social policy, properly answered by a legislature." Paulsen, *supra* note 91, at 47.

93. Paulsen, *supra* note 91, at 8.

94. Cameron, *supra* note 7, at 3; Fontana, *supra* note 6, at 1390; Paulsen, *supra* note 91, at 9.

95. Cameron, *supra* note 7, at 3.

96. *People v. Forbs*, 62 Cal. 2d 847, 402 P.2d 825, 44 Cal. Rptr. 753 (1965).

97. Paulsen, *supra* note 91, at 8-9.

98. *Id.* at 8.

99. DeFrancis, *supra* note 42, at 21.

100. ALASKA STAT. §§ 11.67.010 to .070 (1965); MO. ANN. STAT. § 210.105 (1965); N.M. STAT. ANN. §§ 13-9-13 (1965); N.C. GEN. STAT. § 14-318.2 (1965); TEX. CIV. STAT. ART. 695c-2 (1965); WASH. REV. CODE ANN. §§ 26.44.030 (1965).

101. MO. ANN. STAT. § 210.105 (1965); TEX. CIV. STAT. ART. 695c-2 (1965).

102. ARIZ. REV. STAT. ANN. § 13.842.01(A) (1965); ARK. STAT. ANN. § 42-802 (1965); CONN. GEN. STAT. ANN. § 17-38a(a) (1965); DEL. CODE ANN. tit. 16, § 1002 (1965); D.C. CODE tit. 2, § 2-162 (1966); FLA. STAT. § 828.041(2) (1965); GA. CODE ANN. § 74-111(a) (1965); SESS. LAWS OF HAWAII, Act 261 § 2 (1967); ILL. ANN. STAT. ch. 23, § 2042 (1965); IND. STAT. ANN. tit. 52, § 1420 (1965); IOWA CODE ANN. § 235A.3 (1965); KAN. STAT. ANN. § 38-717 (1965); KY. REV. STAT. ANN. § 199.335(2) (1966); LA. REV. STAT. ANN. § 14:403(B) (1964); ME. REV. STAT. ANN. tit. 22, § 3852 (1965); MD. ANN. CODE, art. 27,

“any physician”¹⁰³ (two of them permissively¹⁰⁴), and one¹⁰⁵ requires reporting by “every physician.” The remainder include at least one other person or institution and oftentimes a substantial number of others. Osteopaths are required to report in 25 states,¹⁰⁶ and permitted to report in one.¹⁰⁷ Dentists are covered in 14 states;¹⁰⁸ social or welfare workers in 13;¹⁰⁹ chiropractors in ten;¹¹⁰ school teachers in ten;¹¹¹ and pharmacists or druggists in four.¹¹² Ten statutes¹¹³ include nurses in any capac-

§ 11A(c) (1963); MICH. COMPILED LAWS ANN. § 722.571(1) (1968); MISS. CODE ANN. § 7185-05 (1966); MO. ANN. STAT. § 210.105.1 (1965); MONT. REV. CODE ANN. § 10-902 (1965); NEV. REV. STAT. § 200.502 (1965); N.H. REV. STAT. ANN. § 571:26 (1965); N.J. STAT. ANN. § 9:6-8.3 (1964); N.M. STAT. ANN. § 13-9-13 (1965); OHIO REV. CODE ANN. § 2151.421 (1966); OKLA. STAT. ANN. tit. 21, § 846 (1966); ORE. REV. STAT. § 146.750(1) (1965); R.I. GEN. LAWS § 40-13.1-3(2) (1965); S.D. SESS. LAWS OF 1964, ch. 90; UTAH CODE ANN. § 55-16-2 (1965); V.I. CODE ANN. tit. 19, § 172 (1966); VT. STAT. ANN. tit. 13, ch. 26, § 1352 (1965); VA. CODE § 16.1-217.1 (1968); WASH. REV. CODE ANN. § 26.44.030(2) (1965); W. VA. CODE § 49-6A-2 (1965); WYO. STAT. § 14-28.1 (1963).

103. ARIZ. REV. STAT. ANN. § 13.842.01(A) (1965); D.C. CODE tit. 2, § 2-162 (1966); MICH. COMPILED LAWS ANN. § 722.571(1) (1968); MO. ANN. STAT. § 210.105.1 (1965); ORE. REV. STAT. § 146.750(1) (1965); TEX. CIV. STAT. art. 695c-2 (1965).

104. MO. ANN. STAT. § 210.105.1 (1965); TEX. CIV. STAT. art. 695c-2 (1965).

105. MASS. ANN. LAWS ch. 119, § 39A (1964).

106. ARK. STAT. ANN. § 42-802 (1965); COLO. REV. STAT. ANN. § 22-13-2 (1963); DEL. CODE ANN. tit. 16, § 1002 (1965); FLA. STAT. § 828.041(2) (1965); GA. CODE ANN. § 74-111(a) (1965); SESS. LAWS OF HAWAII, Act. 261 § 2 (1967); ILL. ANN. STAT. ch. 23, § 2042 (1965); IND. STAT. ANN. tit. 52, § 1420 (1965); IOWA CODE ANN. § 235A.2 (1965); KAN. STAT. ANN. § 38-717 (1965); KY. REV. STAT. ANN. § 199.335(2) (1966); LA. REV. STAT. ANN. § 14:403(A) (1964); ME. REV. STAT. ANN. tit. 22, § 3852 (1965); NEV. REV. STAT. § 200.502(a) (1965); N.H. REV. STAT. ANN. § 571:26 (1965); N.J. STAT. ANN. § 9:6-8.3 (1964); N.Y. PEN. CODE § 483-d (1964); N.D. CENT. CODE § 50-25-01 (1965); OKLA. STAT. ANN. tit. 21, § 846 (1966); PA. STAT. ANN. tit. 18, § 4330 (1965); R.I. GEN. LAWS § 40-13.1-2(1) (1965); S.D. SESS. LAWS OF 1964, ch. 90; VT. STAT. ANN. tit. 13, ch. 26, § 1852 (1965); V.I. CODE ANN. tit. 19, § 172 (1966); WYO. STAT. § 14-28.1 (1963).

107. WASH. REV. CODE ANN. § 26.44.030 (1965).

108. ARK. STAT. ANN. § 42-802 (1965); CALIF. PEN. CODE § 11161.5 (West 1963); SESS. LAWS OF HAWAII, Act 261 § 2 (1967); ILL. ANN. STAT. ch. 23, § 2042 (1965); IOWA CODE ANN. § 235A.2 (1965); KAN. STAT. ANN. § 38-717 (1965); MD. ANN. CODE art. 27, § 11A(b)1 (1963); MISS. CODE ANN. § 7185-05 (1966); NEV. REV. STAT. § 200.502(a) (1965); N.Y. PEN. CODE § 483-d (McKinney 1964); OKLA. STAT. ANN. tit. 21, § 846 (1966); S.D. SESS. LAWS OF 1964, ch. 90; WASH. REV. CODE ANN. § 26.44.020(3) (1965); WIS. STAT. ANN. § 48.981(1) (1965).

109. ALA. CODE tit. 27, ch. 4, § 21 (1965); ALAS. STAT. § 11.67.010(b) (1965); CONN. GEN. STAT. ANN. tit. 17-38a(a) (1965); GA. CODE ANN. § 74-111(a) (1965); KAN. STAT. ANN. § 38-717 (1965); MD. ANN. CODE art. 27, § 11A(c) (1963); MONT. REV. CODE ANN. § 10-902 (1965); NEV. REV. STAT. § 200.502(d) (1965); N.M. STAT. ANN. § 13-9-13 (1965); N.C. GEN. STAT. § 14-318.2 (1965); OHIO REV. CODE ANN. § 2151.421 (1966); W. VA. CODE § 49-6A-2 (1965); WIS. STAT. ANN. § 48.981(1) (1965).

110. CAL. PEN. CODE § 11161.5 (West 1963); ILL. ANN. STAT. ch. 23, § 2042 (1965); IND. STAT. ANN. tit. 52, § 1420 (1965); IOWA CODE ANN. § 235A.2 (1965); KAN. STAT. ANN. 38-717 (1965); ME. REV. STAT. ANN. tit. 22, § 3852 (1965); N.D. CENT. CODE § 50-25-01 (1965); S.D. SESS. LAWS OF 1964, ch. 90; VT. STAT. ANN. tit. 13, ch. 26, § 1352 (1966); WASH. REV. CODE ANN. § 26.44.020(3) (1965).

111. ALA. CODE tit. 27, ch. 4, § 21 (1965); ALAS. STAT. § 11.67.010(b) (1965); CONN. GEN. STAT. ANN. § 17-38a(a) (1965); MONT. REV. CODE ANN. § 10-902 (1965); NEV. REV. STAT. § 200.502(d) (1965); N.M. STAT. ANN. § 13-9-13 (1965); N.C. GEN. STAT. § 14-318.2 (1965); OHIO REV. CODE ANN. § 2151.421 (1966); ORE. REV. STAT. § 146.750(3) (1965); W. VA. CODE § 49-6A-2 (1965).

112. ALA. CODE tit. 27, ch. 4, § 21 (1965); ARK. STAT. ANN. § 42-802 (1965); MINN. STAT. ANN. § 626.554(2) (1967); WYO. STAT. § 14-28.1 (1963).

113. ALA. CODE tit. 27, ch. 4, § 22 (1965); ALAS. STAT. § 11.67.010(a) (1967); ARK.

ity or in a number of capacities, and five¹¹⁴ more require reporting by a nurse only if attending a child in the absence of a health practitioner. Eight states¹¹⁵ qualify the types of nurses required to report, limiting coverage to registered, visiting or public health nurses. Seven states¹¹⁶ specifically include surgeons as well as physicians, although this would seem to be redundant as surgeons are just specialized physicians. Other medical personnel, such as interns,¹¹⁷ residents,¹¹⁸ laboratory technicians,¹¹⁹ podiatrists,¹²⁰ optometrists,¹²¹ hospital staff members,¹²² U.S. medical officers on duty in the state,¹²³ superintendents or managers of various medical institutions¹²⁴ and others authorized to engage in the practice of healing¹²⁵ are covered in the statutes of as many as five states. Hospitals are included in two states,¹²⁶ one of which further includes clinics and sanatoriums.¹²⁷ Four states¹²⁸ go so far as to require reports from "any person" or "any other person," but one¹²⁹ limits this to those called on to render aid or medical assistance. Five states¹³⁰

STAT. ANN. § 42-802 (1965); MINN. STAT. ANN. § 626.554(2) (1965); MONT. REV. CODE ANN. § 10-902 (1965); N.C. GEN. STAT. § 14-318.2 (1965); ORE. REV. STAT. § 146.750(13) (1965); VA. CODE § 16.1-217.1 (1968); WIS. STAT. ANN. § 48.981(1) (1965); WYO. STAT. § 14-28.1 (1963).

114. IOWA CODE ANN. § 235A.2 (1965); KAN. STAT. ANN. § 38-717 (1965); MD. ANN. CODE art. 27, § 11A(b)1 (1963); NEV. REV. STAT. § 200.502(c) (1965); OKLA. STAT. ANN. tit. 21, § 846 (1966).

115. Georgia and North Dakota require public health nurses to report. GA. CODE ANN. § 74-111(a) (1965); N.D. CENT. CODE § 50-25-01 (1965). The Connecticut, Hawaii and Mississippi statutes cover only registered nurses in this category, and the statutes of New Mexico, Ohio and West Virginia cover both registered and visiting nurses. CONN. GEN. STAT. ANN. tit. 17-38a(a) (1965); SESS. LAWS OF HAWAII, Act 261 § 2 (1967); MISS. CODE ANN. 7185-05 (1966); N.M. STAT. ANN. § 13-9-13 (1965); OHIO REV. CODE ANN. § 2151.421 (1966); W. VA. CODE § 49-6A-2 (1965).

116. ALA. CODE tit. 27, ch. 4, § 21 (1965); CALIF. PEN. CODE § 11161.5 (West 1963); CONN. GEN. STAT. ANN. § 17-38a(a) (1965); ILL. ANN. STAT. ch. 23, § 2042 (1965); IOWA CODE ANN. § 235A.2 (1965); S.D. SESS. LAWS OF 1964, ch. 90; WIS. STAT. ANN. § 48.981(1) (1965).

117. ARK. STAT. ANN. § 42-802 (1965); FLA. STAT. § 828.041(2) (1963).

118. ARK. STAT. ANN. § 42-802 (1965); FLA. STAT. § 828.041(2) (1963).

119. ARK. STAT. ANN. § 42-802 (1965); WYO. STAT. § 14-28.1 (1963).

120. ILL. ANN. STAT. ch. 23, § 2042 (1965); IOWA CODE ANN. § 235A.3 (1965).

121. IOWA CODE ANN. § 235A.2 (1965).

122. S.C. CODE § 20-302.1 (1965).

123. S.C. CODE § 20-302.1 (1965).

124. ARK. STAT. ANN. § 42-802 (1965); N.Y. PEN. CODE § 483-d (McKinney 1964); PA. STAT. ANN. tit. 18, § 4330 (1965); WIS. STAT. ANN. § 48.981(1) (1965).

125. SESS. LAWS OF HAWAII, Act 261 § 2 (1967); MD. ANN. CODE art. 27, § 11A(c) (1963); MINN. STAT. ANN. § 626.554(2) (1967); VA. CODE § 16.1-217.1 (1968); W. VA. CODE § 49-6A-2 (1965).

126. ALA. CODE tit. 27, ch. 4, § 21 (1965); IDAHO CODE § 16-1641 (1965).

127. ALA. CODE tit. 27, ch. 4, § 21 (1965).

128. ALA. CODE tit. 27, ch. 4, § 21 (1965); NEB. REV. STAT. § 28-481 (1965); TENN. CODE ANN. § 37-1202 (1966); UTAH CODE ANN. § 55-16-2 (1965).

Iowa and Maryland specifically permit but do not require reporting by any other person. IOWA CODE ANN. § 235A.3 (1965); MD. ANN. CODE art. 27, § 11A(d) (1963).

129. ALA. CODE tit. 27, ch. 4, § 21 (1965).

130. CONN. GEN. STAT. ANN. § 17-38a(a) (1965); SESS. LAWS OF HAWAII, Act 261 § 2 (1967); MD. ANN. CODE art. 27, § 11A(c) (1963); NEV. REV. STAT. § 200.502(d) (1965); N.C. GEN. STAT. § 14-318.2 (1965).

include school authorities, and four¹³¹ cover religious personnel although one¹³² limits this to Christian Science practitioners. Another¹³³ covers only ordained ministers of established churches. Coroners¹³⁴ are included in the statutes of two states, and attorneys,¹³⁵ social workers,¹³⁶ and mental health workers¹³⁷ are each required to report by one state. Law enforcement officers are covered in four states.¹³⁸ Seven states¹³⁹ provide that those who are required to report need do so only when acting in an official capacity.

These provisions specifying who shall report are especially interesting considering the current debate in the literature regarding whether mandatory reporting statutes should be confined to physicians and institutions. Those favoring restriction cite the fact that a physician, by virtue of his special training, is in a far better position to make a diagnosis and determine whether the injuries suffered are consistent with abuse. Nurses are excluded on this basis because they are considered unqualified to form an opinion as to how the injury occurred. One authority who favors limiting required reporting to physicians has explained his position by stating:

The physician more than any other individual is able to determine whether the child's injuries are consistent with the parent's recital of a history of non-traumatic events or of minor "accidental" injuries. It is the physician who is best able to discover the evidence of multiple injuries in various stages of healing which have come to be recognized as "signs" of the battered child syndrome. Indeed, the very fact that the medical profession has seen fit to describe the problem as the battered child syndrome, or the "maltreatment syndrome" and to emphasize the role of the medical practitioner in its detection may explain why legislators have looked to the medical profession as the class most likely to make disclosures of child abuse.¹⁴⁰

Some of the writers who support this position add, however, that the statute does not prohibit reporting by others¹⁴¹ but simply does not make it mandatory. A 1960 study, prior to the enactment of any reporting

131. CALIF. PEN. CODE § 11161.5 (West 1963); ILL. ANN. STAT. ch. 23, § 2042 (1965); NEV. REV. STAT. § 200.502(d) (1965); N.M. STAT. ANN. § 13-9-13 (1965).

132. ILL. ANN. STAT. ch. 23, § 2042 (1965).

133. N.M. STAT. ANN. § 13-9-13 (1965).

134. ARK. STAT. ANN. § 42-802 (1965); SESS. LAWS OF HAWAII, Act 261 (1967).

135. NEV. REV. STAT. § 200.502(d) (1965).

136. SESS. LAWS OF HAWAII, Act 261 § 2 (1967).

137. MD. ANN. CODE art. 27, § 11A(c) (1963).

138. MD. ANN. CODE art. 27, § 11A(c) (1963); MICH. STAT. ANN. § 14.564(1) (1965); ORE. REV. STAT. § 146.750(3) (1965); S.D. SESS. LAWS OF 1964, ch. 90.

139. SESS. LAWS OF HAWAII, Act 261 § 2 (1967); MONT. REV. CODE ANN. § 10-902 (1965); N.M. STAT. ANN. § 13-9-13 (1965); N.C. GEN. STAT. § 14-318.2 (1965); OHIO REV. CODE ANN. § 2151.421 (1966); VA. CODE § 16.1-217.1 (1966); W. VA. CODE § 49-6A-2 (1965).

140. McCoid, *supra* note 37, at 28.

141. *Id.*; Comment, *Legislation as Protection for the Battered Child*, 12 VILL. L. REV. 313 (1967).

statutes, seems to point up the necessity of requiring medical personnel to report. Of 180 children who were abused within 155 families, it noted that 24% of the referrals on these cases came from relatives, 23% from legal authorities and 22% from neighbors. Physicians and hospitals accounted for only 9% of the reports although they had had contact with 30% of the cases.¹⁴² This would seem to indicate that those other than physicians will report without a statute but that the medical profession needs at least a little prodding.¹⁴³ The American Humane Association has recommended that mandatory statutes be directed at physicians and hospital personnel,¹⁴⁴ and the Model Act includes only physicians, osteopaths, interns and residents. The position taken by those who favor restricted legislation is aptly summed up by Professor Monrad Paulsen of Columbia:

The case for confining mandatory reporting to physicians is a strong one. The mandate speaks to the problems which doctors face in particular and which are likely to inhibit reporting. The rest of us are not bound by similar concerns about professional responsibility. However, some of us might fail to speak for fear of facing a successful tort action based on libel, slander, or an invasion of the right to privacy. Therefore, there is much to commend a scheme which requires physicians to report, but clothes every reporter who acts in good faith with immunity from civil and criminal liability.¹⁴⁵

Those who favor broader coverage sometimes cite the fact that an abused child might not be taken to a physician or hospital.¹⁴⁶ Even Professor Paulsen admits that existence of a statute requiring physicians and institutions to report may deter parents from seeking treatment

142. Merrill, *supra* note 7, at 3.

143. The American Humane Association proposal was limited to physicians as it was felt that they were the ones who had failed to report in the past. Merrill, *supra* note 7, at 3-4.

144. The American Humane Association has made the following proposals for mandatory reporting of cases of child abuse.

1. That such legislation be directed to medical practitioners and hospital personnel coming in contact with children for the purpose of examination and treatment of injuries sustained allegedly from accidental or other cause.
2. That doctors and hospital personnel have mandatory responsibility for reporting all cases of child injury where medical diagnosis and findings are incompatible with alleged history of how injuries were sustained and the syndrome leads to the inference of "inflicted injuries."
3. That doctors and hospital staff members reporting cases of suspected inflicted injuries be made immune to possible civil or criminal action for the disclosure of matters which might be considered confidential because of the doctor-patient relationship.
4. That all reports of cases of suspected inflicted injuries be made to the public or voluntary Child Welfare service which carries the Child Protective function in the community.

CHILDREN'S DIVISION, THE AMERICAN HUMANE ASS'N, TO PROTECT THE BATTERED CHILD.

145. Paulsen, *supra* note 91, at 7-8.

146. McCoid, *supra* note 37, at 36; *Legislation Notes, Privileged Communications—Abrogation of the Physician-Patient Privilege to Protect the Battered Child*, 15 DE PAUL L. REV. 453 (1966).

for their child, but states that the true extent of this problem is unknown.¹⁴⁷ In these situations, others who come in contact with the child, teachers, nurses and social workers in particular, would be inclined to notice maltreatment in some circumstances. A requirement that they report would have the effect of giving the child the protection that his parents had denied him by their failure to have his injuries treated. Additionally, information as to instances of child abuse might become known to attorneys, clergy, and, to a lesser extent, some social workers who deal primarily with adults and have little if any contact with children. The problem of confidential communications might easily arise if such classes of people obtained their information solely from an abusive parent, and it is understandable that some might feel an obligation not to disclose such matters.¹⁴⁸ The same problem could also exist with marriage counselors if included as a group required to report as some recommend.¹⁴⁹ While there is no difficulty in stating that an examining physician's first obligation is to the child, there is considerable doubt as to the primary obligation of professionals having a confidential relationship with the parents. With marriage counselors and the clergy in particular, perhaps the duty is to the family as a whole rather than to any individual member. While this view allows consideration of the best interests of the family, the attempt by and desire of the parents to solve the problem without outside intervention, and the likelihood of future abuse, it is an entirely unsatisfactory criterion to use to determine if a report should be required. While the solution begs the question, it seems advisable to allow attorneys, clergy and marriage counselors to report if they wish but avoid imposing a mandatory statutory duty on them. This seems to be the view taken by most states at present.

While some reports from non-medical sources would no doubt cover injuries not resulting from abuse, such a requirement pertaining to nurses, school teachers and social workers would afford greater and more broad-based protection to the child. No class of reporters can guarantee complete accuracy and it has been shown that even physicians sometimes err in deciding whether a child's injuries are due to abuse. One study indicated that a surprising number of cases originally classified as resulting from abuse had actually involved no maltreatment at all, but these findings were made only after a subsequent investigation of the explanation given by the parents.¹⁵⁰ One author has further suggested that teachers, nurses and social workers need not be covered by the statute because they have an obligation to report due to the governmental positions they hold.¹⁵¹ However, this obligation seems to be largely un-

147. Paulsen, *supra* note 91, at 9.

148. *Legislation Notes, supra* note 146; Comment, *Legislation as Protection for the Battered Child, supra* note 141, at 320.

149. McCoid, *supra* note 37, at 29.

150. Elmer, *supra* note 75, at 29-30.

151. McCoid, *supra* note 37, at 28-29.

written, and if it is admitted that it exists, it is difficult to see how it can be argued that they are unqualified to report. If the obligation exists, there should be no objection to reducing it to statutory form. Even the American Medical Association has recommended that reporting requirements be extended beyond physicians and hospitals.¹⁵² This seems to indicate recognition of the fact that others may be qualified to suspect abuse and that the medical profession cannot handle the job alone. Suggested legislation by the Medical Society of the County of New York¹⁵³ would

152. Editorial, *Battered Child Legislation*, 188 J.A.M.A. 386 (1962).

153. The New York County Medical Society has made the following proposal for legislation on child abuse:

REASON FOR LEGISLATION. To provide for the protection of children whose health and welfare are adversely affected or threatened by those responsible for their care and protection.

PARAGRAPH I—Any person who wilfully causes or permits any child to suffer or who inflicts thereon unjustifiable physical pain or mental suffering, and whoever, having the care or custody of any child, causes or permits the life or limb of such child to be endangered, or the health of such child to be injured, and any person who wilfully causes or permits such child to be placed in such situations that its life or limb may be injured, or its health likely to be injured is guilty of a misdemeanor.

PARAGRAPH II—**REPORTS BY PHYSICIANS AND INSTITUTIONS.** Every person, firm or corporation conducting any hospital or pharmacy in the state, or the managing agent thereof, or the person managing or in charge of such hospital or pharmacy, or in charge of any ward or part of such hospital to which any child suffering from any wound or any injury inflicted by the act of another shall report the same immediately both by telephone and in writing to the Child Protective Agency, The Society for Prevention of Cruelty to Children or the sheriff if such hospital or pharmacy is located outside the incorporated limits of the city, town or other municipal corporation. The report shall state the name of the injured person, if known, his whereabouts, the character and extent of his injuries and the person who inflicted such injuries, if known.

PARAGRAPH III—Every physician or surgeon, doctor of medicine including any licensed interne or resident, and licensed osteopathic physician who has under his charge or care any child suffering from any wounds or injury inflicted in the manner described in Paragraph I, shall make a report of the kind specified in Paragraph II and to the appropriate agencies named in Paragraph II.

PARAGRAPH IV—The reporting individual should submit such to the Child Protective Agency, based on sound medical diagnosis and suspicion that the injuries were inflicted. The following items should be considered before reporting cases of maltreatment:

1. Characteristic age, usually under two years.
2. General health of child indicative of serious neglect.
3. Characteristic distribution of fractures.
4. Disproportionate amount of soft tissue injury.
5. Evidence that injuries occurred at different times; are in different stages of resolution.
6. Cause of recent trauma in question.
7. Suspicious family history.
8. History of previous episodes.
9. No new lesions occurring during child's hospitalization.

PARAGRAPH V—**IMMUNITY FROM LIABILITY.** The reporting agent is relieved from civil liability when making reports pursuant to the law. This immunity from civil liability extends into every stage of the procedures up to and including testimony presented in court relevant to the issues being tried as the direct result of the report.

PARAGRAPH VI—**EVIDENCE NOT PRIVILEGED.** This physician-patient privilege shall not be a ground for excluding evidence regarding children's injuries or the cause thereof in any judicial procedures resulting from a report pursuant to this Act.

PARAGRAPH VII—**PENALTY FOR VIOLATION.** Any person, firm or corporation violating any provision of this article is guilty of a misdemeanor and is

extend coverage beyond physicians and hospitals to "persons, firms or corporations conducting a pharmacy," which is at least a minor advance. Perhaps the most convincing argument in favor of extended reporting is the fact that the legislatures of 31 states have seen fit to include at least one group besides physicians, hospitals, osteopaths and surgeons in their provisions. While the wisdom of legislators is sometimes subject to question, the fact that 31 states could reject the major proposals indicates that sentiment favors statutory guarantees of more broad-based protection for children.

2. GROUNDS REQUIRING A REPORT

The second clause in most reporting statutes further defines the circumstances under which a report is required. In 39 states¹⁵⁴ these statutes order a report to be made if the reporter "has cause to believe," "has reasonable cause to believe," "has cause to suspect" or similar language stating that there is evidence which supports an opinion of abuse. Nine states¹⁵⁵ provide that compliance is necessary if the reporter "believes," "determines by medical findings," etc., that a child has been abused. Two states¹⁵⁶ require reporting if the reporter "believes" or "has reason to believe." While the language of the different statutes may seem to differ only slightly, it is clear that most states take a rather objective view and are more concerned with what could or should be derived from the child's condition rather than what the individual reporter actually thinks. It is obvious that this objective test offers greater protection to the child and that a physician or other person who failed to report can-

punishable by imprisonment in the county jail not exceeding six months or by a fine not exceeding \$500, or by both.

64 N.Y.S.J. OF MED. 22 (1964).

154. ALAS. STAT. § 11.67.010 (a,b) (1965); ARK. STAT. ANN. § 42-802 (1965); COLO. REV. STAT. ANN. § 22-13-3 (1963); CONN. GEN. STAT. ANN. § 17-38a(a) (1965); DEL. CODE ANN. tit. 16, § 1002 (1965); D.C. CODE tit. 2, § 2-162 (1966); FLA. STAT. § 828.041(2) (1965); GA. CODE ANN. § 74-111(a) (1965); SESS. LAWS OF HAWAII, Act 261 § 2 (1967); ILL. ANN. STAT. ch. 23, § 2042 (1965); KAN. STAT. ANN. § 38-717 (1965); KY. REV. STAT. ANN. § 199.335(2) (1966); LA. REV. STAT. ANN. § 14:403(A) (1964); ME. REV. STAT. ANN. tit. 22, § 3852 (1965); MASS. ANN. LAWS, ch. 119, § 39A (1964); MISS. CODE ANN. § 7185-05 (1966); MO. ANN. STAT. § 210.105.1 (1965); MONT. REV. CODE ANN. § 10-902 (1965); NEB. REV. STAT. § 28-481 (1965); NEV. REV. STAT. § 200.502 (1965); N.H. STAT. ANN. § 571:26 (1965); N.J. STAT. ANN. § 9:6-8.3 (1964); N.M. STAT. ANN. § 13-9-13 (1965); N.Y. PEN. CODE § 483-d (McKinney 1964); N.D. CENT. CODE § 50-25-01 (1965); OHIO REV. CODE ANN. § 2151.421 (1966); OKLA. STAT. ANN. tit. 21, § 846 (1966); ORE. REV. STAT. § 146.750(1) (1965); R.I. GEN. LAWS § 40-13.1-3(1-2) (1965); S.C. CODE, § 20-302.1 (1965); S.D. SESS. LAWS OF 1964, ch. 90; UTAH CODE ANN. § 55-16-2 (1965); VT. STAT. ANN. tit. 13, ch. 26, § 1352 (1965); V.I. CODE ANN. tit. 19, § 171 (1966); W. VA. CODE § 49-6A-2 (1965); WIS. STAT. ANN. § 48.981(1) (1965); WYO. STAT. § 14-28.1 (1963).

155. ALA. CODE tit. 27, ch. 4, § 21 (1967); ARIZ. REV. STAT. ANN. § 13-842.01(A) (1965); CALIF. PEN. CODE § 11161.5 (West 1963); IND. STAT. ANN. tit. 52, § 1420 (1965); MICH. COMPILED LAWS ANN. § 722.571(1) (1968); MINN. STAT. ANN. § 626.554(2) (1965); PA. STAT. ANN. tit. 18, § 4330 (1965); N.C. GEN. STAT. § 14-318.2 (1965); TEX. CIV. STAT. art. 695c-2 (1965).

156. IOWA CODE ANN. § 235A.3 (1965); MD. ANN. CODE art. 27, § 11A(c) (1963).

not use his individual opinion as a shield if most others would have had reason to suspect abuse. While such a provision may result in reports of injuries that are later satisfactorily explained, it may be expected to turn up some questionable cases where fairly well concealed abuse has been perpetrated on the child. Where the statute covers both "believing" and "having reason to believe," added protection results. While it may seem advisable for the reporter to have "reasonable cause" to believe, it is suggested that an immunity provision linked to good faith may provide all the safeguards necessary in this area, at least where reporting is required only of professional or quasi-professional people such as physicians, teachers, nurses and social workers. These people are unlikely to make good faith reports that are totally unsupported by evidence, and a malicious and unsupportable report would strip them of their immunity. If the statute requires reporting by "any person," then reasonable cause might well be required.

At least two sources recognize that a determination of abuse may be difficult even for a physician, especially when the evidence seems marginal or abuse is not clearly indicated.¹⁵⁷ These sources feel that the reporter should not be required to give an opinion indicating abuse, but rather that his duty to report should encompass all cases where "medical diagnosis and findings are incompatible with alleged history of how injuries were sustained," or where "injuries differ from those likely by the explanation." One writer would include situations involving accidental injuries that seem to be the result of parental indifference.¹⁵⁸ The advantage of wording of this nature is that it relieves the reporter of the necessity of forming an opinion as to whether or not abuse was responsible for the trauma. However, in some instances the explanation given might be plausible, but the reporter might still have reason to suspect battering. It also seems that this wording would not require a report if the parent admitted inflicting the injuries. While such a construction may be deemed to be too literal, addition of only a few words to the statute would solve the problem.

The various pieces of proposed legislation show no similarity in this area. The Model Act uses the test of "reasonable cause to suspect." The American Humane Association recommends the language "where medical diagnosis and findings are incompatible with alleged history of how injuries were sustained and the syndrome leads to the inference of 'inflicted injuries,'" a rather objective position. The New York County Medical Society proposal recommends a subjective standard which is somewhat limited as it applies to "wounds or injuries inflicted by the act of another," a phrase that implies that actual knowledge on the part of the reporter as to the cause of the trauma is required.

157. Paulsen, *supra* note 91, at 11.

158. *Id.*

3. AGE AS A LIMITATION

The age of the child is also important in determining whether a report is required. While the typical battered child is quite young, legislators have recognized that older children may similarly be endangered by their environment and set age limits high enough to protect almost all children. Eighteen states¹⁵⁹ require reports if the child is under 16, and another state¹⁶⁰ protects children under 16 or reasonably presumed to be so. Eighteen states¹⁶¹ cover children under 18 in their provisions. Four states provide for reporting only if the child is under 12,¹⁶² and three states¹⁶³ set the age as under 17. The ages of under 15¹⁶⁴ and under 19¹⁶⁵ are used in one state each. Four states¹⁶⁶ require reporting if the abused individual is a "minor," but their statutes do not specify further. Two states¹⁶⁷ require compliance in cases involving a "child," and one of these states¹⁶⁸ also covers instances involving "any incompetent or disabled person." Both the recommendations of the American Humane Association and the New York County Medical Society speak only in terms of children without specifying an age limit, although the latter provides that one item to be considered before reporting cases of maltreatment is the age of the child, which it states to be characteristically under two. This seems to be an unfortunate provision in that it may deny some protection to a substantially older child who has been subjected to abuse. The Model Act proposes that the maximum age of juvenile court jurisdiction in each state be used.

159. ALA. CODE tit. 27, ch. 4, § 21 (1967); ALAS. STAT. § 11.67.070(2) (1965); ARIZ. REV. STAT. ANN. § 13-842.01(E) (1965); ARK. STAT. ANN. § 42-802 (1965); FLA. STAT. § 828.041(2) (1963); ILL. ANN. STAT. ch. 23, § 2042 (1965); IND. STAT. ANN. tit. 52, § 1420 (1965); KAN. STAT. ANN. § 38-717 (1965); ME. REV. STAT. ANN. tit. 22, § 3852 (1965); MD. ANN. CODE art. 27, § 11A(c) (1963); MASS. ANN. LAWS ch. 119, § 39A (1964); N.H. REV. STAT. ANN. § 571:26 (1965); N.M. STAT. ANN. § 13-9-13 (1965); N.Y. PEN. CODE § 483-d (McKinney 1964); N.C. GEN. STAT. § 14-318.2 (1965); S.C. CODE, § 20-302.1 (1965); VT. STAT. ANN. tit. 13, ch. 26, § 1352 (1965); VA. CODE § 16.1-217.1 (1968).

160. TENN. CODE ANN. § 37-1202 (1966).

161. CONN. GEN. STAT. ANN. § 17-38a(a) (1965); DEL. CODE ANN. tit. 16, § 1002 (1965); D.C. CODE tit. 2, § 2-162 (1966); IDAHO CODE § 16-1641 (1965); IOWA CODE ANN. § 235A.3 (1965); KY. REV. STAT. ANN. § 199.335(2) (1966); MISS. CODE ANN. § 7185-05 (1966); MONT. REV. CODE ANN. § 10-902 (1965); NEV. REV. STAT. § 200.502 (1965); N.J. STAT. ANN. § 9:6-8.3 (1964); N.D. CENT. CODE § 50-25-01 (1965); OHIO REV. CODE ANN. § 2151.421 (1966); PA. STAT. ANN. tit. 18, § 4330 (1965); R.I. GEN. LAWS § 40-13.1-3 (1965); S.D. SESS. LAWS OF 1964, ch. 90; TEX. CIV. STAT. Art. 695c-2 (1965); WASH. REV. CODE ANN. § 26.44.030 (1965); W. VA. CODE § 49-6A-2 (1965).

162. COLO. REV. STAT. ANN. § 22-13-3 (1963); GA. CODE ANN. § 74-111(a) (1965); MO. ANN. STAT. § 210.105.1 (1965); ORE. REV. STAT. § 146.750(1) (1965).

163. LA. REV. STAT. ANN. § 14:403(A) (1964); MICH. COMPILED LAWS ANN. § 722.571(1) (1968); OKLA. STAT. ANN. tit. 21, § 846 (1966).

164. V.I. CODE ANN. tit. 19, § 172 (1966).

165. WYO. STAT. § 14-28.1 (1963).

166. CALIF. PEN. CODE § 11161.5 (West 1963); SESS. LAWS OF HAWAII, Act 261 § 2 (1967); MINN. STAT. ANN. § 626.554(2) (1965); UTAH CODE ANN. § 55-16-2 (1965).

167. NEB. REV. STAT. § 28-481 (1965); WIS. STAT. ANN. § 48-981(1) (1965).

168. NEB. REV. STAT. § 28-481 (1965).

While the abuse problem is mainly limited to younger children, it would seem advantageous and in the best interest of the child to protect it as long as it comes under the jurisdiction of the juvenile court. The fact that a child has attained the age of 12 or 15 years is no guarantee that it is not subject to abuse although the method used to inflict the injuries may be different and the child may be more capable of protecting himself. If the aim of the statutes is to protect juveniles from abuse, then it should protect all of them and not simply those thought to be most likely to need protection.

4. IDENTITY OF THE ABUSER

While reporting is required in 27 states¹⁶⁹ regardless of the identity of the perpetrator, the remaining states have provided for reporting only when the abuse is inflicted by certain classes of persons. Parents are singled out in 24 states¹⁷⁰ with good reason: it has been shown that they are responsible for two-thirds of the incidents.¹⁷¹ A variety of others who have some responsibility for the child have also been named in a number of statutes: step-parents in two states,¹⁷² legal guardians or custodians in seven states,¹⁷³ caretakers in four states,¹⁷⁴ "other persons responsible for" the child's care in 18 states,¹⁷⁵ a person standing in

169. ALA. CODE tit. 27, ch. 4, § 21 (1967); ALAS. STAT. § 11.67.020 (1965); ARIZ. REV. STAT. ANN. § 13-842.01(A) (1965); CALIF. PEN. CODE § 11161.5 (West 1963); D.C. CODE tit. 2, § 2-162 (1966); ILL. ANN. STAT. ch. 23, § 2042 (1965); IOWA CODE ANN. § 235A.3 (1965); KAN. STAT. ANN. § 38-717 (1965); MD. ANN. CODE art. 27, § 11A(c) (1963); MINN. STAT. ANN. § 626.554(2) (1965); MONT. REV. CODE ANN. § 10-902 (1965); NEV. REV. STAT. § 200.502 (1965); N.M. STAT. ANN. § 13-9-13 (1965); N.Y. PEN. CODE § 483-d (McKinney 1964); N.D. CENT. CODE § 50-25-01 (1965); OHIO REV. CODE ANN. § 2151.421 (1966); OKLA. STAT. ANN. tit. 21, § 846 (1966); ORE. REV. STAT. § 146.750(1) (1965); PA. STAT. ANN. tit. 18, § 4330 (1965); TENN. CODE ANN. § 37-1202 (1966); TEX. CIV. STAT. Art. 695c-2 (1965); UTAH CODE ANN. § 55-16-2 (1965); VA. CODE § 16.1-217.1 (1968); WASH. REV. CODE ANN. § 26.44.030 (1965); W. VA. CODE § 49-6A-2 (1965); WIS. STAT. ANN. § 48.981(1) (1965).

170. ARK. STAT. ANN. § 42-802 (1965); COLO. REV. STAT. ANN. § 22-13-3 (1963); CONN. GEN. STAT. ANN. § 17-38a(a) (1965); DEL. CODE ANN. tit. 16, § 1002 (1965); FLA. STAT. § 828.041(2) (1963); GA. CODE ANN. § 74-111(a) (1965); IDAHO CODE § 16-1641 (1965); IND. STAT. ANN. tit. 52, § 1420 (1965); KY. REV. STAT. ANN. § 199.335(2) (1966); LA. REV. STAT. ANN. § 14:403(A) (1964); ME. REV. STAT. ANN. tit. 22, § 3852 (1965); MASS. ANN. LAWS ch. 119, § 39A (1964); MISS. CODE ANN. § 7185-05 (1966); MO. ANN. STAT. § 210.105.1 (1965); NEB. REV. STAT. § 28-481 (1965); N.H. REV. STAT. ANN. § 571:26 (1965); N.J. STAT. ANN. § 9:6-8.3 (1964); N.C. GEN. STAT. § 14-318.2 (1965); R.I. GEN. LAWS § 40-13.1-3 (1965); S.C. CODE § 20-302.1 (1965); S.D. SESS. LAWS OF 1964, ch. 90; VT. STAT. ANN. tit. 13, ch. 26, § 1352 (1965); V.I. CODE ANN. tit. 19, § 172 (1966); WYO. STAT. § 14-28.1 (1963).

171. Ireland, *supra* note 7, at 115.

172. COLO. REV. STAT. ANN. § 22-13-3 (1963); N.C. GEN. STAT. § 14-318.2 (1965).

173. COLO. REV. STAT. ANN. § 22-13-3 (1963); IDAHO CODE § 16-1641 (1965); MISS. CODE ANN. § 7185-05 (1966); NEB. REV. STAT. § 28-481 (1965); N.J. STAT. ANN. § 9:6-8.3 (1964); N.C. GEN. STAT. § 14-318.2 (1965); R.I. GEN. LAWS § 40-13.1-3 (1965).

174. FLA. STAT. § 828.041(2) (1963); GA. CODE ANN. § 74-111(a) (1965); ME. REV. STAT. ANN. tit. 22, § 3852 (1965); WYO. STAT. § 14-28.1 (1963).

175. ARK. STAT. ANN. § 42-802 (1965); COLO. REV. STAT. ANN. § 22-13-3 (1963); CONN. GEN. STAT. ANN. § 17-38a(a) (1965); DEL. CODE ANN. tit. 16, § 1002 (1965); IND. STAT. ANN. tit. 52, § 1420 (1965); KY. REV. STAT. ANN. § 199.335(2) (1966); LA. REV. STAT. ANN. § 14:403(A) (1964); MASS. ANN. LAWS ch. 119, § 39A (1964); MICH. COMPILED LAWS ANN.

loco parentis in one state,¹⁷⁶ and an agent or employee of an institution having the authority of a parent or guardian in one state.¹⁷⁷ No state specifically provides for reporting of abuse inflicted by siblings, although this explanation is often tendered by parents and is no doubt sometimes true. The recommendations of neither the American Humane Association nor the New York County Medical Society place any limits on the identity of the perpetrator, but the Model Act would limit reporting to cases in which a "parent or other person responsible" for the child's care could be or was suspected of having inflicted the abuse.

This issue has also provoked some amount of discussion in the literature. The argument has been made that reporting of abuse by persons other than parents or caretakers is unnecessary because the parent will protect the child from torts occurring outside the family setting.¹⁷⁸ This is probably true in most cases, but what if the parent does not care or blames the injuries he has inflicted on the child on someone outside of the family? The only solution to these problems is to require a report to be made regardless of the identity of the purported abuser. To allow a loophole of this nature to remain is to deny the very protection that was intended to result and to promote fabrication by a battering parent who is already likely to be looking for a way out.

The same authority who contends that reporting should not be required unless the injury is attributed to the neglect or abuse of the parent or caretaker also states that the reporter should not be called on to guess at the identity of the perpetrator.¹⁷⁹ As a practical matter, how could such a reporter determine whether or not a report was required without guessing at the abuser's identity? Reliance on the parent's explanation would seem to be a poor solution as it might promote shifting of the blame while the true nature of the attack could be disclosed so as to correspond with the injuries. It is thought that a better solution would be to require the report regardless of the assailant's identity, including the explanation for the injuries given by the parents, and then let those in charge of investigating the reports delve into the identity problem. That at least partial acceptance of this solution exists is evidenced by the statutes of the 22 states¹⁸⁰ which make no mention of the perpetrator

§ 722.571(1) (1968); MISS. CODE ANN. § 7185-05 (1966); MO. ANN. STAT. § 210.105.1 (1965); N.H. REV. STAT. ANN. § 571:26 (1965); N.J. STAT. ANN. § 9:6-8.3 (1964); R.I. GEN. LAWS § 40-13.1-3 (1965); S.C. CODE § 20-302.1 (1965); VT. STAT. ANN. tit. 13, ch. 26, § 1352 (1965); V.I. CODE ANN. tit. 19, § 172 (1966).

176. N.C. GEN. STAT. § 14-318.2 (1965).

177. *Id.*

178. Paulsen, *supra* note 91, at 11.

179. Paulsen, *supra* note 91, at 10-11; *accord*, DeFrancis, *supra* note 42, at 17-18; McCoid, *supra* note 37, at 44-45.

180. ALA. CODE tit. 27, ch. 4, § 21 (1967); ALAS. STAT. § 11.67.010 (1965); ARIZ. REV. STAT. ANN. § 13-842.01(A) (1965); ILL. ANN. STAT. ch. 23, § 2042 (1965); IOWA CODE ANN. § 235A.3 (1965); KAN. STAT. ANN. § 38-717 (1965); MD. ANN. CODE art. 27, § 11A(c) (1963); MINN. STAT. ANN. § 626.554(2) (1965); MONT. REV. CODE ANN. § 10-902 (1965); NEV. REV. STAT. § 200.502 (1965); N.M. STAT. ANN. § 13-9-13 (1965); N.Y. PEN. CODE § 483-d

and those of the three states¹⁸¹ which require reporting of abuse inflicted on a child by "any person."

5. NATURE OF THE INJURIES

The statutes further attempt to give a general definition of the nature of the injuries which must be reported. Twenty-four states¹⁸² require reporting only when the injuries are "serious" or "severe," and this follows the recommendation of the Model Act. The problem with such a specification is that it leaves a substantial amount of discretion to the reporter as to what constitutes "serious" injuries. An objection has also been made on the basis that reporting of injuries that may not be considered severe may prevent later injuries which might be permanent or fatal.¹⁸³ However, one authority states that the limitation is justified by limited state resources and that family privacy should not be invaded without grave reason.¹⁸⁴ Reporting of all injuries which are or could reasonably be believed to be the result of abuse, whether deemed severe or not, provides greater protection for children and is thought to justify the possible increased cost and invasion of privacy.

The invasion of privacy contention may be raised in a number of areas related to child battering. There is no doubt that investigation of parental fitness and methods of discipline may constitute some invasion, but this must be balanced against the state's interest in the welfare of the child. This interest should be particularly strong where the abuse has led to a brain-damaged or permanently crippled child, the one more likely to be unable to support and maintain himself if he survives to become an adult. Protection of individual children is essentially a parental function, but where the parents not only refuse to assume this responsibility but actively prey on the child's characteristic defenselessness, society must assume the role of protector, and must do so even

(McKinney 1964); N.D. CENT. CODE § 50-25-01 (1965); OHIO REV. CODE ANN. § 2151.421 (1966); OKLA. STAT. ANN. tit. 21, § 846 (1966); ORE. REV. STAT. § 146.750(1) (1965); TENN. CODE ANN. § 37-1202 (1966); TEX. CIV. STAT. art. 695c-2 (1965); UTAH CODE ANN. § 55-16-2 (1965); VT. STAT. ANN. tit. 13, ch. 26, § 1352 (1966); WASH. REV. CODE ANN. § 26.44.030 (1965); W. VA. CODE 49-6A-2 (1965).

181. CALIF. PEN. CODE § 11161.5 (West 1963); PA. STAT. ANN. tit. 18, § 4330 (1965); WIS. STAT. ANN. § 48.981(1) (1965).

182. ARK. STAT. ANN. § 42-802 (1965); CONN. GEN. STAT. ANN. § 17-38a(a) (1965); DEL. CODE ANN. tit. 16, § 1002 (1965); D.C. CODE tit. 2, § 2-162 (1966); KAN. STAT. ANN. § 38-717 (1965); KY. REV. STAT. ANN. § 199.335(2) (1966); LA. REV. STAT. ANN. § 14:403(A) (1964); MASS. ANN. LAWS, ch. 119, § 39A (1964); MO. ANN. STAT. § 210.105.1 (1965); MONT. REV. CODE ANN. § 10-902 (1965); NEB. REV. STAT. § 28-481 (1965); NEV. REV. STAT. § 200.502 (1965); N.H. REV. STAT. ANN. § 571:26 (1965); N.J. STAT. ANN. § 9:6-8.3 (1964); N.M. STAT. ANN. § 13-9-13 (1965); N.Y. PEN. CODE § 483-d (McKinney 1964); N.C. GEN. STAT. § 14-318.2 (1965); N.D. CENT. CODE § 50-25-01 (1965); OKLA. STAT. ANN. tit. 21, § 846 (1966); S.D. SESS. LAWS OF 1964, ch. 90; VT. STAT. ANN. tit. 13, ch. 26, § 1352 (1965); VA. CODE § 16.1-217.1 (1968); V.I. CODE ANN. tit. 19, § 172 (1966); W. VA. CODE § 49-6A-2 (1965).

183. McCoid, *supra* note 37, at 50-51; Paulsen, *supra* note 91, at 12.

184. Paulsen, *supra* note 91, at 12.

though some invasion of family privacy might result. It was never intended that the right to privacy should be a shield for those who would cripple and kill their children.

The statutes of 26 states¹⁸⁵ specify that the injury must be thought to have been suffered "other than by accidental means" to require a report. This again calls for some guesswork on the part of the reporter as information of this sort is likely to be beyond his reach. Injuries resulting from battering are often explained as accidental by those responsible for them and the problem is apt to ultimately boil down to one of whether the reporter believes the parents' story. Professor Paulsen has suggested that a report be required if the child's injuries differ from those likely from the explanation.¹⁸⁶ This proposal has the weakness of allowing the parents to blame someone else for the injuries, thus offering a satisfactory explanation and avoiding the reporting requirement. It would seem preferable to require a report whenever the injuries could reasonably be believed to accord with the symptoms of the battered child syndrome, an opinion well within the physician's area of competence. As a number of the characteristics are not entirely medical, it is thought that this phraseology would pose no substantial problem for nurses, teachers and social workers. A determination of whether the trauma was accidental could then be left to those better qualified and in a better position to make it.

Paulsen has further recommended that accidental injuries be reported if they seemed to result from parental indifference.¹⁸⁷ This proposal has obvious merit on its face, but it is difficult to see how Paulsen can contend that a reporter should not be required to determine whether injuries are intentional and then, practically in the same breath, recommend that accidental injuries resulting from indifference be reported. It may well be true in some cases that there is no doubt, but it seems that, particularly with small children who are unable to offer any explanation,

185. ARK. STAT. ANN. § 42-802 (1965); CALIF. PEN. CODE § 11161.5 (West 1963); COLO. REV. STAT. ANN. § 22-13-3 (1963); CONN. GEN. STAT. ANN. § 17-38a(a) (1965); DEL. CODE ANN. tit. 16, § 1002 (1965); D.C. CODE tit. 2, § 2-162 (1966); FLA. STAT. § 828.041(2) (1963); GA. CODE ANN. § 74-111(a) (1965); ILL. ANN. STAT. ch. 23, § 2042 (1965); IND. STAT. ANN. tit. 52, § 1420 (1965); KY. REV. STAT. ANN. § 199.335(2) (1966); LA. REV. STAT. ANN. § 14:403(A) (1964); ME. REV. STAT. ANN. tit. 22, § 3852 (1965); MINN. STAT. ANN. § 626.554(2) (1965); MISS. CODE ANN. § 7185-05 (1966); MO. ANN. STAT. § 210.105.1 (1965); N.H. REV. STAT. ANN. § 571:26 (1965); N.J. STAT. ANN. § 9:6-8.3 (1964); R.I. GEN. LAWS, § 40-13-3 (1965); S.C. CODE, § 20-302.1 (1965); S.D. SESS. LAWS OF 1964, ch. 90; VT. STAT. ANN. tit. 13, ch. 26, § 1352 (1966); V.I. CODE ANN. tit. 19, § 172 (1966); WASH. REV. CODE ANN. § 26.44.030 (1965); WIS. STAT. ANN. § 48.981(1) (1965); WYO. STAT. § 14-28.1 (1963).

186. Paulsen, *supra* note 91, at 11.

It is interesting to note that Paulsen subsequently recommended that a physician be required to report only if he believed the injuries to have been inflicted other than by accidental means, rather than if he had reason to believe. *Id.* at 13. This would require a guess as to the perpetrator's state of mind and is a seeming contradiction with the proposal that a report be required only if the injuries differ from those likely by the explanation given.

187. Paulsen, *supra* note 91, at 11.

it will be impossible to tell in many cases whether the mother let the child play at the top of an unguarded staircase or gave him a shove down. Further, many injuries which might result from indifference could also occur simply because no mother, no matter how good or concerned, can watch a child all the time and curious, inquisitive toddlers are often prone to a variety of injuries which are largely unpreventable. Again, determination of parental indifference should be left to trained investigators as should that of the asserted accidental nature of the injury.

Eighteen states¹⁸⁸ further define the injury as one resulting from or indicative of abuse, maltreatment or neglect. One state¹⁸⁹ requires compliance in cases of "neglect or sexual abuse" and another¹⁹⁰ stipulates that the abuse inflicted must be "unusual or unreasonable." It should not be difficult for reporters, particularly those in the medical profession, to form an opinion as to whether the child's injuries were indicative of abuse or neglect. Paulsen has recommended that the words "abuse" and "neglect" be left undefined to include all forms of physical injuries.¹⁹¹ Use of both words could be construed to comprehend both intentionally and accidentally inflicted injuries by a court which chose to follow the spirit of the law. This should afford maximum protection to the child endangered either by indifference or willful conduct. A disjunctive provision requiring a report whenever the child's injuries accorded with the symptoms of the battered child syndrome or when they were or could be believed to have resulted from abuse or neglect would seem to provide for all contingencies. Provisions limiting themselves to sexual abuse or "unusual or unreasonable" abuse should be modified to include all abuse situations. Any abuse which would come to the attention of an outsider or require treatment by a physician would be highly unlikely to be unreasonable and it is thought that qualifying the duty to report by such wording might ultimately have the effect of raising controversies that would better be avoided. Further, a limitation to

188. ALA. CODE tit. 27, ch. 4, § 21 (1967); ALAS. STAT. § 11.67.070(1) (1965); SESS. LAWS OF HAWAII, Act 261 § 2 (1967); IDAHO CODE § 16-1641 (1965); IOWA CODE ANN. § 235A.3 (1965); KAN. STAT. ANN. § 38-717 (1965); MD. ANN. CODE art. 27, § 11A(c) (1963); MINN. STAT. ANN. § 626.554(2) (1965); MONT. REV. CODE ANN. § 10-902 (1965); NEV. REV. STAT. § 200.502 (1965); N.M. REV. STAT. ANN. § 571:26 (1965); N.Y. PEN. CODE § 483-d (McKinney 1964); N.C. GEN. STAT. § 14-318.2 (1965); OHIO REV. CODE ANN. § 2151.421 (1966); OKLA. STAT. ANN. tit. 21, § 846 (1966); TENN. CODE ANN. § 37-1202 (1966); TEX. CIV. STAT. art. 695c-2 (1965); W. VA. CODE § 49-6A-2 (1965).

189. VA. CODE § 16.1-217.1 (1968).

190. UTAH CODE ANN. § 55-16-2 (1965).

191. Paulsen, *supra* note 91, at 11-12.

However, Paulsen further recommends that neglect be excluded from abuse statutes because, with the exception of cases of severe malnutrition, which he would include, it is generally beyond the physician's scope. While neglect is not within the purview of this paper, it is admitted that severe neglect could result in injuries to the child and that this could be a form of abuse. For instance, injuries resulting from parental indifference, which Paulsen would deem reportable as abuse, could no doubt be construed as having been caused by neglect.

situations involving sexual abuse or neglect would have little or no application to the characteristic battered child unless "neglect" was given an extremely strained interpretation. If the object of these statutes is to protect children from abuse, then the draftsmen should so provide without the necessity of a forced construction.

In four states,¹⁹² the statutes require that the injuries be the result of abuse or neglect and additionally that they be inflicted other than by accidental means. Wording such as this provides a large loophole as it seemingly disclaims coverage of abusive incidents where the injuries are stated to have been accidental. It has the added defect of requiring an opinion on the part of the reporter as to whether the trauma was accidental or intentional.

Two states¹⁹³ provide for reporting if the injuries were "intentionally inflicted" and another¹⁹⁴ requires it if the injuries were "inflicted in violation of the law." The former necessitates the previously discussed formation of an opinion as to the state of mind of the perpetrator. The latter seems commendable at first glance, but it must be remembered that many would-be reporters are unlikely to be familiar with all the statutory provisions and accompanying constructions which would result in a report being required in a given case. It is thought that it would be better to leave a determination of this sort to those best equipped to make it and require a report in terminology likely to have more meaning to those affected by it.

It is interesting to note that while the statutes call for reporting of abusive injuries sustained by a child, they fail to require a report in situations where the child dies. At first glance this seems to be a tremendous oversight, but it is thought that the vast majority of cases require a report even in the absence of such a provision. The number of children who succumb to abuse is relatively small, and most of them have received medical treatment prior to death. In such cases, a report concerning the child's injuries would be necessary even if death occurred only shortly after arrival at the hospital as the physician would have seen a battered child. The only difficulty comes in cases where the child is dead on arrival or dies before being seen by a person charged with the duty to report. Some provision should be made for these relatively rare situations, even though the matter will probably be referred to law enforcement authorities. While nothing more can be done for the fatally injured child, it is possible that there are other children in the home who remain in danger. The inclusion of a disjunctive provision in the statute requiring a report in the case of injury or death would cover all possibilities and result in

192. ARK. STAT. ANN. § 42-802 (1965); ILL. ANN. STAT. ch. 23, § 2042 (1965); MISS. CODE ANN. § 7185-05 (1966); WASH. REV. CODE ANN. § 26.44.030 (1965).

193. MICH. COMPILED LAWS ANN. § 722.571(1) (1968); ORE. REV. STAT. § 146.750(1) (1965).

194. PA. STAT. ANN. tit. 18, § 4330 (1965).

protection both to the child who survives the abuse and to siblings of those who are not so fortunate.

C. *Identity of the Recipient*

The question of to whom to report has almost as many solutions as there are states. In most cases, either a county welfare agency, district state or county attorney, juvenile court or law enforcement agency will be designated, but more than one are enumerated in many statutes and a number of states have added other specifications. Ten states¹⁹⁵ provide for a report solely to a law enforcement agency, eight¹⁹⁶ for a report solely to a welfare agency, five¹⁹⁷ for a report solely to the county or district attorney, and five¹⁹⁸ for reporting only to the juvenile or family court. One state¹⁹⁹ requires that its reports be made solely to the medical investigator. From here, the variation is seemingly endless.

A number of states give the reporter a choice of recipients. In five states²⁰⁰ it may be a law enforcement agency or welfare agency offering child protective services. One state²⁰¹ requires reports to be made to law enforcement authorities or the district attorney, and another²⁰² adds a welfare agency to this list. A third state²⁰³ provides a choice between juvenile court and law enforcement officers, while a fourth²⁰⁴ allows a choice between juvenile court and welfare authorities with a direction to report to law enforcement personnel if the former do not exist. Another state²⁰⁵ similarly provides for reporting to a law enforcement agency only if no welfare agency exists in the vicinity, but directs such law enforcement agencies to immediately forward the information received to the nearest welfare agency. One state²⁰⁶ gives a broad choice of the

195. ARIZ. REV. STAT. ANN. § 13-842.01(A) (1965); ARK. STAT. ANN. § 42-803 (1965); COLO. REV. STAT. ANN. § 22-13-3 (1963); D.C. CODE tit. 2, § 2-163 (1966); LA. REV. STAT. ANN. § 14:403(B) (1964); MO. ANN. STAT. § 210.105.2 (1965); NEV. REV. STAT. § 200.502 (1965); OHIO REV. CODE ANN. § 2151.421 (1966); V.I. CODE ANN. tit. 19, § 173 (1966); WASH. REV. CODE ANN. § 26.44.030 (1965).

196. SESS. LAWS OF HAWAII, Act 261 § 2 (1967); IDAHO CODE § 16-1641 (1965); MASS. ANN. LAWS ch. 119, § 39A (1964); N.Y. PEN. CODE § 483-d (McKinney 1964); N.C. GEN. STAT. § 14-318.2 (1965); R.I. GEN. LAWS § 40-13.3 (1965); VT. STAT. ANN. tit. 13, ch. 26, § 1353 (1965); WYO. STAT. § 14-28.2 (1963).

197. MONT. REV. CODE ANN. § 10-902 (1965); NEB. REV. STAT. § 28-481 (1965); N.J. STAT. ANN. § 9:6-8.3 (1964); N.M. STAT. ANN. § 13-9-13 (1965); W. VA. CODE § 49-6A-2 (1965).

198. FLA. STAT. § 828.041(3) (1965); KAN. STAT. ANN. § 38-717 (1965); S.D. SESS. LAWS OF 1964, ch. 90; TENN. CODE ANN. § 37-1202 (1966).

199. ORE. REV. STAT. § 146.750(2) (1965).

200. ALA. CODE tit. 27, ch. 4, § 21 (1967); CONN. GEN. STAT. ANN. § 17-38a(b) (1965); IND. STAT. ANN. tit. 52, § 1421 (1965); UTAH CODE ANN. § 55-16-3 (1965); WIS. STAT. ANN. § 48.981(1) (1965).

201. CALIF. PEN. CODE § 11161.5 (West 1963).

202. OKLA. STAT. ANN. tit. 21, § 846 (1966).

203. VA. CODE § 16.1-217.1 (1968).

204. PA. STAT. ANN. tit. 18, § 4330 (1965).

205. ALAS. STAT. § 11.67.020 (1965).

206. TEX. CIV. STAT. art. 695c-2 (1965).

juvenile court, district or county attorney, law enforcement agency or county probation officer. One state²⁰⁷ that lists public health nurses and welfare workers as required reporters directs them to report to the county health officer or, if none exists, to a physician who is required to report if he concurs after examination of the child. Still another state²⁰⁸ gives a reporter a choice between a welfare agency, law enforcement agency and the county attorney.

Allowing a choice of recipients has the advantage of letting the reporter pick whichever agency he would prefer to work with or thinks should handle the case. However, this is outweighed by disadvantages such as the resultant confusion that may ensue, the difficulty of keeping statistics and the possibility that similar cases will be handled differently.²⁰⁹ To provide the most benefit "it is particularly essential to foster a cooperative working relationship between the social agencies, the courts, and law enforcement agencies. Without planned cooperative effort, there is a possibility of conflict which results in a lack of protection for the abused child."²¹⁰ If a reporter is given a choice and this cooperation is lacking, it is entirely possible that agencies whose services might be beneficial to the child might never be notified of the case. For this reason it is essential that all reports be made to one office in the city or county and that legislative guidance be given for their conduct of the case.

Some states provide for reporting to two or more recipients. There is little if any agreement between these states as illustrated by their provisions. One state²¹¹ requires reporting to the welfare agency and county attorney; another²¹² provides for triplicate reports with a copy to the prosecuting attorney, local welfare agency and state welfare agency; a third²¹³ orders the report to be made to "any person designated" by the juvenile court and to the welfare agency; a fourth²¹⁴ requires reporting to a law enforcement agency which must then notify the welfare agency, and a fifth²¹⁵ reverses this by having the report go to the welfare agency which then notifies the law enforcement authorities. A sixth²¹⁶ requires the report to be made to both law enforcement and welfare authorities with a direction that the police shall notify the welfare agency upon receipt of a report. The advantage of multiple reports is that the agencies involved receive the information first-hand and are then able to start investigating the situation. This solves the problem of one agency failing

207. GA. CODE ANN. § 74-111(b) (1965).

208. OKLA. STAT. ANN. tit. 21, § 846 (1966).

209. Paulsen, *supra* note 91, at 46.

210. Rubin, *supra* note 37, at 233.

211. ME. REV. STAT. ANN. tit. 22, § 3852 (1965).

212. MICH. COMPILED LAWS ANN. § 722.571(2) (1968).

213. MISS. CODE ANN. § 7185-05 (1966).

214. ALAS. STAT. § 11.67.020 (1965).

215. N.H. REV. STAT. ANN. § 571:27 (1965).

216. MINN. STAT. ANN. § 626.554(2) (1965).

to contact another. However, the problem of cooperation between them may still exist if not spelled out in the statute.

Three states²¹⁷ call for reporting to an authority in the county where the child resides. This limitation on the recipient is beneficial to the child as it discourages shopping for treatment in different counties by the parents. It further makes the task of investigation easier in that the home and parents are more readily available to the investigators. However, the three states having limitations of this nature show no agreement on to whom the report is to be made in the given county: one²¹⁸ prescribes the county attorney, another²¹⁹ the family court, and the third²²⁰ the welfare agency.

Two states designate the welfare agency as recipient of the reports but permit additional reports to others. One²²¹ allows a report to be made to law enforcement authorities with notice of this given to the welfare agency, and the other²²² allows a report to be made additionally to the juvenile court or state attorney if immediate action is deemed necessary. Assuming that the welfare agency would cooperate with the other authorities, a provision of this sort simply brings these other agencies into the case sooner and may afford an added degree of protection to the child who is in immediate danger of further abuse. In this context, the importance of cooperation cannot be stressed enough, as "in order to provide adequate child protection services, definite procedures must be worked out in each community so that the physicians and hospitals, law enforcement officers, social welfare agencies, and the courts are clear about their own functions as part of an over-all plan."²²³ Unfortunately, few states provide clearly for post-report investigations or define the obligations of those authorities involved.²²⁴

Perhaps the best provisions are those which require both oral and written reports. Both the Model Act and the proposal of the New York County Medical Society include such provisions. Fifteen states²²⁵ require that such an oral report be made immediately to the same authority who will receive the written report which follows and gives additional informa-

217. DEL. CODE ANN. tit. 16, § 1003 (1965); N.J. STAT. ANN. § 9:6-8.3 (1964); N.C. GEN. STAT. § 14-318.2 (1965).

218. N.J. STAT. ANN. § 9:6-8.3 (1964).

219. DEL. CODE ANN. tit. 16, § 1003 (1965).

220. N.C. GEN. STAT. § 14-318.2 (1965).

221. ILL. ANN. STAT. ch. 23, § 2043 (1965).

222. N.D. CENT. CODE § 50-25-01 (1965).

223. Rubin, *supra* note 37, at 233.

224. McCoid, *supra* note 37, at 52.

225. COLO. REV. STAT. ANN. § 22-13-3 (1963); D.C. CODE tit. 2, § 2-163 (1966); SESS. LAWS OF HAWAII, Act 261 § 2 (1967); IND. STAT. ANN. tit. 52, § 1421 (1965); LA. REV. STAT. ANN. § 14:403(B) (1964); KY. REV. STAT. ANN. § 199.335(3) (1966); MINN. STAT. ANN. § 626.554(3) (1965); MO. ANN. STAT. § 210.105.2 (1965); N.H. REV. STAT. ANN. § 571:27 (1965); OHIO REV. CODE ANN. § 2151.421 (1966); ORE. REV. STAT. § 146.750(2) (1965); R.I. GEN. LAWS § 40-13.1-3 (1965); UTAH CODE ANN. § 55-16-3 (1965); VT. STAT. ANN. tit. 13, ch. 26, § 1353 (1965); WYO. STAT. § 14-28.2 (1963).

tion. Two states²²⁶ which require the written report to be made to a welfare agency and a state or county attorney provide that the oral report is to be made to the welfare agency and also to a law enforcement authority if the child is deemed to be in immediate danger. The use of oral and written reports promotes quicker attention for the child's problems and yet gives a permanent record to be relied upon. The oral report need not have great depth²²⁷ and will usually be made by telephone, enabling investigation to begin before the child is released from the hospital or soon thereafter. This may easily result in a saving of two or three days' time which may protect the child from further abuse. The written report can then be filled out later giving as much information as possible, and sent to the designated recipient,²²⁸ the time element in this process thus being substantially shorter. Where such a system exists, it has been found that the written reports have followed up the oral ones in 90% of the cases.²²⁹

Discussions of to whom a report should be made have been the subject of much literature. Most authorities seem to agree that the welfare agencies are the most desirable recipients, but many note that some difficulty may arise because they are not available on a 24-hour basis in many communities.²³⁰ In such cases, law enforcement authorities may be the only available recipients, especially of oral reports. It is this problem that may have prompted some states to require reporting either to the law enforcement agencies alone or to the welfare agencies. The reluctance of physicians to report to a punitive agency has been noted by one writer who feels that physicians would understandably be more willing to help protect the child than to become involved in a criminal proceeding to punish the parents.²³¹ While reporters may prefer the recipient to be a social rather than a legal agency, cooperation between these agencies will no doubt result in a certain amount of prosecution no matter who receives the report. The fact must also be recognized, however, that some people are more willing to cooperate with social workers than with police, and this is undoubtedly true of parents.²³² An accusatorial tone is likely to reduce whatever willingness to cooperate which may have existed and make it more difficult to get the actual facts.²³³ For these reasons, it seems advisable to use social workers wherever pos-

226. IOWA CODE ANN. § 235A.4 (1965); MD. ANN. CODE art. 27, § 11A(d) (1963).

227. McCoid, *supra* note 37, at 51; Comment, *Legislation as Protection for the Battered Child*, *supra* note 141, at 321.

228. *Id.*

229. Ireland, *supra* note 7, at 115.

230. Paulsen, *supra* note 91, at 44-45; Am. Acad. of Pediatrics Committee on Infants and Pre-School Children, *Maltreatment of Children—The Physically Abused Child*, 37 PEDIATRICS 380 (1966); McCoid, *supra* note 37, at 55; Comment, *Legislation as Protection for the Battered Child*, *supra* note 141, at 320.

231. McCoid, *supra* note 37, at 55; Paulsen, *supra* note 91, at 44-45.

232. Rubin, *supra* note 37, at 234.

233. Elmer, *supra* note 22, at 33.

sible and let the legal authorities take over only if no social welfare agency exists or if a decision to prosecute has been made based on the social workers' findings.

Little has been written about the merits of having reports made to family or juvenile courts. Where such courts are well developed, this could be an ideal solution. The juvenile court is more likely to operate around the clock than the welfare agencies, and its position as a protector of children has long been recognized. It has both social and legal components and could provide a framework for dealing with investigation and other matters which might ultimately have a bearing on custody or dependency of the child. If the investigation disclosed little chance of keeping the family together as a unit, it could recommend prosecution of the parents. The family court has all the advantages of the juvenile court and additionally could deal with all the problems relating to the parents instead of referring them to other courts.²³⁴ By requiring reports to whichever of these courts existed in the county, benefits to and protection of the child could be maximized without the disadvantages inherent in reporting to a purely legal recipient such as law enforcement authorities or a prosecutor.

The proposed legislation in this area shows a lack of uniformity. The American Humane Association recommends that reports be made "to the public or voluntary Child Welfare service which carries the child protective function in the community." The New York County Medical Society proposal calls for oral and written reports to be made "to the Child Protective Agency, The Society for Prevention of Cruelty to Children, or the sheriff . . ." if the reporting institution is located outside the town or city limits. The Model Act calls for both oral and written reports to be made to "an appropriate police authority," leaving it to each state to designate such an authority.

D. *Contents of the Report*

The contents of the report usually supply some or all of the information proposed by the Model Act. This includes:

the names and addresses of the child and his parents or other persons responsible for his care, if known, the child's age, the nature and extent of the child's injuries (including any evidence of previous injuries), and any other information that the physician believes might be helpful in establishing the cause of the injuries and the identity of the perpetrator.

The American Humane Association has made no recommendations in this area. The proposed legislation of the New York County Medical Society would simplify the contents, including only "the name of the injured person, if known, his whereabouts, the character and extent of his

234. Comment, 45 ORE. L. REV. 114, 123 (1966).

injuries and the person who inflicted such injuries, if known." It is thought that the Model Act proposal is preferable because of the greater breadth of the report. While it is admitted that it may be impossible to obtain all of this information in some cases, it should be available in most and would provide the investigative agency to whom the report is made with a more complete picture of the situation.

E. Immunities Granted to Reporters

As an incentive to reporting, all of the states have included immunity provisions in their statutes, some more complete than others. Only six states²³⁵ provide a totally unqualified immunity, the majority requiring good faith in reporting. Thirty-seven states²³⁶ impose this good faith provision, but ten²³⁷ have a presumption of good faith, statutory or otherwise. One state²³⁸ achieves basically the same result as the "good faith" states by providing immunity if the report is made without malice. One state²³⁹ grants immunity to anyone acting "on reasonable cause" and another²⁴⁰ with the same provision adds the good faith requirement. One state²⁴¹ provides immunity from criminal liability only and then only if the report is made in good faith. The remaining states give an unqualified immunity, but limit it to certain circumstances. Five states²⁴² provide this immunity but make no mention

235. ALA. CODE tit. 27, ch. 4, § 23 (1965); ARIZ. REV. STAT. ANN. § 13-842.01(C) (1965); COLO. REV. STAT. ANN. § 22-13-6 (1963); NEB. REV. STAT. § 28-481(2) (1965); N.J. STAT. ANN. § 9:6-8.6 (1964); OHIO REV. CODE ANN. § 2151.421 (1966).

236. ALAS. STAT. § 11.67.050 (1965); ARK. STAT. ANN. § 42-804 (1965); CONN. GEN. STAT. ANN. § 17-38a(c) (1965); DEL. CODE ANN. tit. 16, § 1004 (1965); D.C. CODE tit. 2, § 2-164 (1966); GA. CODE ANN. § 74-111(c) (1965); SESS. LAWS OF HAWAII, Act 261 § 4 (1967); ILL. ANN. STAT. ch. 23, § 2045 (1965); IND. STAT. ANN. tit. 52, § 1423 (1965); IOWA CODE ANN. § 235A.7 (1965); LA. REV. STAT. ANN. § 14:403(c) (1964); ME. REV. STAT. ANN. tit. 22, § 3854 (1965); MASS. ANN. LAWS ch. 119, § 39A (1964); MICH. COMPILED LAWS ANN. § 722.571(3) (1968); MINN. STAT. ANN. § 626.554(5) (1965); MISS. CODE ANN. § 7185-05 (1966); MO. ANN. STAT. § 210.105.3 (1965); MONT. REV. CODE ANN. § 10-904 (1965); NEV. REV. STAT. § 200.505 (1965); N.H. REV. STAT. ANN. § 571:28 (1965); N.M. STAT. ANN. § 13-9-15 (1965); N.Y. PEN. CODE § 483-d (McKinney 1964); N.C. GEN. STAT. § 14-318.2 (1965); N.D. CENT. CODE § 50-25-04 (1965); OKLA. STAT. ANN. tit. 21, § 847 (1966); R.I. GEN. LAWS § 40-13.1-6 (1965); S.C. CODE § 20-302.3 (1965); S.D. SESS. LAWS OF 1964, ch. 90; TENN. CODE ANN. § 37-1202 (1966); TEX. CIV. STAT. § 695c-2 (1965); UTAH CODE ANN. § 55-16-4 (1965); VT. STAT. ANN. tit. 13, ch. 26, § 1354 (1966); VA. CODE § 16.1-217.1 (1968); V.I. CODE ANN. tit. 19, § 174 (1966); W. VA. CODE § 49-6A-4 (1965); WYO. STAT. § 14-28.4 (1963).

237. ARK. STAT. ANN. § 42-804 (1965); FLA. STAT. § 828.041(4) (1963); ILL. ANN. STAT. ch. 23, § 2045 (1965); MICH. COMPILED LAWS ANN. § 722.571(3) (1968); MISS. CODE ANN. § 7185-05 (1966); MONT. REV. CODE ANN. § 10-904 (1965); N.M. STAT. ANN. § 13-9-15 (1965); S.C. CODE § 20-302.3 (1965); TENN. CODE ANN. § 37-1202 (1966); W. VA. CODE § 49-6A-4 (1965).

238. KAN. STAT. ANN. § 38-718 (1965).

239. KY. REV. STAT. ANN. § 199.335(4) (1966).

240. ORE. REV. STAT. § 146.760 (1965).

241. WIS. STAT. ANN. § 48.981(2) (1965).

242. CALIF. PEN. CODE § 11161.5 (West 1963); MICH. COMPILED LAWS ANN. § 722.571(3) (1968); N.Y. PEN. CODE § 483-d (McKinney 1964); PA. STAT. ANN. tit. 18, § 4330 (1965); TEX. CIV. STAT. § 695c-2 (1965). It is uncertain whether the immunity extends to participation in judicial proceedings in Tennessee. TENN. CODE ANN. § 37-1202 (1966).

of immunity from liability resulting from participation in judicial proceedings. One state,²⁴³ taking almost the opposite position, provides unqualified immunity from civil liability only and then only to those testifying in "any proceedings under this chapter" and not thus to all reporters. Two more states²⁴⁴ simply grant the immunity from civil liability only and another²⁴⁵ does so only if the report is not made in bad faith. One state²⁴⁶ requiring good faith for other reporters grants unqualified immunity to doctors and hospital staff for any liability for disclosure of matters which might be considered confidential under a physician-patient relationship. The Model Act imposes the good faith requirement but extends this immunity to all reporters for any liability that might result therefrom. The New York County Medical Society proposal provides unqualified immunity without any requirement of good faith, but makes no mention of possible criminal liability, stating only that the immunity is from civil liability. The American Medical Association recommends that immunity be provided to all reporters acting in good faith and on reasonable evidence.²⁴⁷

An immunity provision is undoubtedly indispensable to a successful reporting statute. As one of the primary objectives of these statutes has been to discover cases of abuse through the help of the medical profession, the cooperation and assistance of these individuals and institutions could not be expected if compliance would result in liability. The most fertile grounds for suit following a report would seem to be defamation of character or malicious prosecution, both of which require proof of malicious motive.²⁴⁸ It is unlikely that a parent or other abuser would be able to meet this standard of proof in the vast majority of cases, but the addition of statutory immunity of one sort or another should erase or immensely diminish the possibility of suit, depending on the extent of immunity granted.

The biggest difference in the statutes in this area is the presence or absence of a good faith requirement. Where such a requirement exists, it is possible that suit may still be initiated and the reporter faced with the attendant inconvenience and aggravation. Even if the plaintiff should fail to prove lack of good faith or malicious motive, the reporter will have been put to considerable trouble. Especially in the case of physicians and institutions, the time element may prove quite costly. If the plaintiff is unsuccessful, the reporter might have a remedy for malicious prosecution, but this would be equally time-consuming. Furthermore, in view of the educational and economic characteristics of most abusive parents, there is some doubt as to whether they would be able to satisfy

243. IDAHO CODE § 16-1641 (1965).

244. MD. ANN. CODE art. 27, § 11A(g) (1963); WASH. REV. CODE ANN. § 26.44.060 (1965).

245. VA. CODE § 16.1-217.1 (1968).

246. IND. STAT. ANN. tit. 52, § 1423 (1965).

247. Editorial, J.A.M.A., *supra* note 150.

248. Harper, *supra* note 39, at 899.

a judgment entered against them. Inclusion of a presumption of good faith in the statute does little more than increase the plaintiff's burden of proof somewhat, and the existence of such a presumption would probably not deter an outraged parent from instituting a suit. So far, however, there seem to have been no suits based on reports made pursuant to these statutes.

The statutes which provide for complete and unqualified immunity present other objections. It is possible that a few reports in these states might be maliciously made and that the parents would be placed at the mercy of such reporters. The damaging effect of such reports on the parents can be minimized by careful and discreet investigation. Problems of this nature are more likely to arise where the classes of reporters are large, as it is unlikely that a physician or institution would report maliciously. Statutes which cover reporters only if acting in an official capacity may also reduce the problem, especially where classes of reporters are limited to those who deal with children in a professional capacity. The complete and unqualified privilege can be a genuine incentive to reporting by those with a sense of professional responsibility, and, if the class of protected reporters is limited with an eye toward this, little if any difficulty should be encountered with malicious reports.

In the states where unqualified but seemingly incomplete immunity is granted there is less of a problem than may appear. These states make no mention of immunity for statements made in judicial proceedings. The courts have held that all testimony in such proceedings provides absolute immunity, even if it is perjured or false.²⁴⁹ While this affords the protection that might seem to be lacking from the statute, the question is whether a would-be reporter would know of this. In the majority of cases such reporters probably never consider the fact that the statutory immunity is limited to the report itself. For those who might notice the absence, it is thought that it would be wiser to spell out the extent of the immunity in the statute, rather than allowing some possible uncertainty to exist in the minds of those affected by it. Similarly, the immunity granted should extend to all reporters regardless of whether they testify in a judicial proceeding, and this should be clearly stated. It is ridiculous to allow a suit to be brought against a reporter simply because those investigating felt that prosecution was not needed to protect the child. As it is likely that many investigations confirming the abuse will not result in prosecution, it is more important to clearly immunize the reporter than the witness in court who is protected without specific statutory provision.

F. *Abrogation of Evidentiary Privileges*

Closely related to immunity provisions are those which abrogate certain evidentiary privileges, mostly those between physician and pa-

249. W. PROSSER, TORTS 797 (3d ed. 1964).

tient and husband and wife. The physician-patient privilege specifically cannot be raised in 34 states,²⁵⁰ although it is unlikely that it would have any application if the attempt was made. The existence of the privilege is based on the confidential relationship which is necessary for the physician to be able to give the patient the best treatment. While it is unquestionably beneficial to the parents to have an injured child receive competent and informed medical aid, the physician, especially in abuse cases, must remember that the child is his patient rather than the parents, and that the act of beating a child is not a privileged communication. "The moral responsibility of the examining physician is to the maltreated child; he must be aware that over 50 percent of these children are liable to secondary injuries or death if appropriate steps are not taken to remove them from their environment."²⁵¹ For this reason, the physician who sees the abused child in private practice should attempt to have him hospitalized to evaluate his injuries and provide protection. A court order may be obtained if the parents refuse to allow hospitalization.²⁵² Hospitalization of the child further allows the physician time to obtain consulting opinions without jeopardizing the child's welfare by returning him to abusive parents.²⁵³ The privilege thus seems to be unavailable to parents seeking to prevent dissemination of the facts regarding the cause of their child's injuries. However, statutory abrogation of the privilege makes an argument of this sort unnecessary and is likely to encourage reporting from a profession which has a history steeped with protection of confidential communications.

The husband-wife privilege has also been abrogated in 20 states;²⁵⁴

250. ALA. CODE tit. 27, ch. 4, § 24 (1967); ALAS. STAT. § 11.67.060 (1965); ARIZ. REV. STAT. ANN. § 13-842.01(C) (1965); ARK. STAT. ANN. § 42-805 (1965); COLO. REV. STAT. ANN. § 22-13-6 (1963); DEL. CODE ANN. tit. 16, § 1005 (1965); FLA. STAT. § 828.041(5) (1963); SESS. LAWS OF HAWAII, Act 261 § 6 (1967); ILL. ANN. STAT. ch. 23, § 2046 (1965); IND. STAT. ANN. tit. 52, § 1425 (1965); IOWA CODE ANN. § 235A.8 (1965); KAN. STAT. ANN. § 38-719 (1965); KY. REV. STAT. ANN. § 199.335(5) (1966); LA. REV. STAT. ANN. § 14:403(D) (1964); MICH. COMPILED LAWS ANN. § 722.571(4) (1968); MINN. STAT. ANN. § 626.554(6) (1965); MO. ANN. STAT. 210.105.4 (1965); MONT. REV. CODE ANN. § 10-905 (1965); NEB. REV. STAT. § 28-482 (1965); NEV. REV. STAT. § 200.506 (1965); N.H. REV. STAT. ANN. § 571:29 (1965); N.M. STAT. ANN. § 13-9-16 (1965); N.C. GEN. STAT. § 8-53.01 (1965); N.D. CENT. CODE § 50-25-05 (1965); OHIO REV. CODE ANN. § 2151.421 (1966); OKLA. STAT. ANN. tit. 21, § 848 (1966); ORE. REV. STAT. § 146.770 (1965); PA. STAT. ANN. tit. 18, § 4330 (1965); S.D. SESS. LAWS OF 1964, ch. 90; UTAH CODE ANN. § 55-16-5 (1965); VA. CODE § 16.1-217.1 (1968); V.I. CODE ANN. tit. 19, § 175 (1966); WASH. REV. CODE ANN. § 26.44.060 (1965); WYO. STAT. § 14-28.5 (1963).

251. Fontana, *supra* note 6, at 1393.

252. Am. Acad. of Pediatrics Committee on Infant and Pre-School Children, *supra* note 230, at 379.

253. *Id.*

254. ALA. CODE tit. 27, ch. 4, § 24 (1967); ALAS. STAT. § 11.67.060 (1965); ARK. STAT. ANN. § 42-805 (1965); DEL. CODE ANN. tit. 16, § 1005 (1965); SESS. LAWS OF HAWAII, Act 261 § 6 (1967); IDAHO CODE § 16-1641 (1965); IND. STAT. ANN. tit. 52, § 1425 (1965) IOWA CODE ANN. § 235A.8 (1965); KY. REV. STAT. ANN. § 199.335(5) (1966); LA. REV. STAT. ANN. § 14:403(D) (1964); MICH. COMPILED LAWS ANN. § 722.571(4) (1968); MINN. STAT. ANN. § 626.554(6) (1965); MO. ANN. STAT. § 210.105.4 (1965); N.H. REV. STAT. ANN. § 571:29 (1965); N.D. CENT. CODE § 50-25-05 (1965); ORE. REV. STAT. § 146.770 (1965); S.D. SESS.

although one²⁵⁵ limits its scope to situations involving criminal child abuse cases. The importance of this is obvious when it is considered that abuse customarily takes place in the home when outsiders are unlikely to be present. Often only the parents know the cause of the trauma inflicted on the child. To allow the abusive spouse to batter the child and then prevent the other from telling of it is to promote activity of this sort and to further endanger the child. It was never intended that the privilege should be available as a shield for parents accused of battering their children, but since the privilege existed at common law, it must be specifically excluded in cases of this sort if the child is to be protected.

One state²⁵⁶ provides that either privilege may be abrogated in any proceeding before the juvenile court involving the welfare of the child. This would seem to imply that the privileges would be available in criminal abuse actions but not in custody proceedings. It is thought that this produces an unfortunate result as prosecution may be hindered in cases felt to require it. While custody hearings may protect the child adequately, the abusive parent may go scot free by invoking these privileges to effectively muzzle those who would be most likely to know of his conduct.

No mention is made of abrogation of any privilege in the statutes of 16 states.²⁵⁷ In some instances they have been abrogated by other statutes or case law. However, it seems that both may be in force in abuse cases in some states. While this should not be an insurmountable obstacle in the case of the physician-patient privilege, real difficulties may arise with the existence of interspousal immunity. It is thought that both the physician-patient and the husband-wife privileges should be specifically abrogated both to encourage reporting and to afford the greatest protection to the child. This proposal follows that of the Model Act. The suggested legislation of both the American Humane Association and the New York County Medical Society would limit such a provision to the physician-patient privilege.

One further problem is found in the one state²⁵⁸ that requires reporting of attorneys. While the end of protecting the child is laudable, it is questionable whether an attorney can properly be required to report and what consequences might follow if he did. Such a report would seem

LAWS OF 1964, ch. 90; VA. CODE § 16.1-217.1 (1968); V.I. CODE ANN. tit. 19, § 175 (1966); WASH. REV. CODE ANN. § 26.44.060 (1965).

255. WASH. REV. CODE ANN. § 26.44.060 (1965).

256. D.C. CODE tit. 2, § 2-165 (1966).

257. CALIF. PEN. CODE § 11161.5 (West 1963); CONN. GEN. STAT. ANN. § 17-38a (1965); GA. CODE ANN. § 74-111 (1965); ME. REV. STAT. ANN. tit. 22, §§ 3851-55 (1965); MD. ANN. CODE art. 27, § 11A (1963); MASS. ANN. LAWS, ch. 119, § 39A-B (1964); MISS. CODE ANN. § 7185-05 (1966); N.J. STAT. ANN. § 9:6-8 (1964); N.Y. PEN. CODE § 483-d (McKinney 1964); R.I. GEN. LAWS § 40-13.1 (1965); S.C. CODE § 20-302 (1965); TENN. CODE ANN. § 37-1202 to 1207 (1966); TEX. CIV. STAT. § 695c-2 (1965); VT. STAT. ANN. tit. 13, ch. 26, § 1351-55 (1965); W. VA. CODE § 49-6A-1 to -4 (1965); WIS. STAT. ANN. § 48.981 (1965).

258. NEV. REV. STAT. § 200.502 (1965).

to be in direct violation of Canon 37 of the American Bar Association's Code of Professional Ethics.²⁵⁹ As the attorney-client privilege was not abrogated in that one state requiring reporting by attorneys, it seems that an attorney who learned of child abuse committed by a client through a confidential communication could stand on this privilege with a relative degree of safety. The statute in question should be amended to provide for this problem.

G. *The Central Registry*

As abuse is often repetitive,²⁶⁰ a number of authorities have recognized the need for a compilation facility to keep track of multiple instances of battering involving the same child or family. As parents often use different physicians or hospitals each time, the physician examining the child is likely to be unaware of any previous incidents. From a medical point of view this is not a great problem in obvious cases of abuse. However, many cases raise a suspicion of abuse but still leave room for doubt.

An attempt has been made to solve this problem in five states²⁶¹ through the creation under statute of central registries. One author has even suggested that a nationwide registry might be desirable.²⁶² These registries compile the data from reports and maintain a file on the child and family. They further provide "a base for indicating the incidence of child abuse, further defining the problem, and aiding in developing and analyzing a program to deal with it."²⁶³ A telephone call regarding a questionable case will provide information as to whether the injured child or other children in the family have been the subjects of previous

259. Canon 37 states:

It is the duty of a lawyer to preserve his client's confidences. This duty outlasts the lawyer's employment, and extends as well to his employees; and neither of them should accept employment which involves or may involve the disclosure of these confidences, either for the private advantage of the lawyer or his employees or to the disadvantage of the client, without his knowledge and consent, and even though there are other available sources of such information. A lawyer should not continue employment when he discovers that this obligation prevents the performance of his full duty to his former or to his new client.

If a lawyer is accused by his client, he is not precluded from disclosing the truth in respect to the accusation. The announced intention of a client to commit a crime is not included within the confidences which he is bound to respect. He may properly make such disclosures as may be necessary to prevent the act or protect those against whom it is threatened.

260. Gillespie, *supra* note 5, at 527; McHenry, *supra* note 9, at 906; Elmer, *supra* note 7, at 183.

Gillespie reported that 12 of 13 children studied who survived the original abuse were later reinjured, while McHenry and Elmer found five of 43 surviving children suffered subsequent abuse. It has further been stated that the child who is the subject of two abuse hearings seldom lives to see a third. Hansen, *Suggested Guidelines for Child Abuse Laws*, 7 J. FAMILY L. 64-65 (1967).

261. CALIF. PEN. CODE § 11161.5 (West 1963); SESS. LAWS OF HAWAII, Act 261 § 3 (1967); ILL. ANN. STAT. ch. 23, § 2047 (1965); MD. ANN. CODE art. 27, § 11A(h) (1963); VA. CODE § 16.1-217.1 (1968).

262. Paulsen, *supra* note 91, at 25.

263. Ireland, *supra* note 7, at 115.

instances of abuse. An affirmative reply is an obvious aid to the physician in making his diagnosis. The registry can also be useful in situations where prosecution or removal of the child from the home is contemplated.²⁶⁴

Certain problems are inherent in a central registry system. First, the physician must not allow himself to be unduly swayed by the existence of previous incidents.²⁶⁵ Active children are prone to a variety of normal accidents which could be interpreted as resulting from abuse by a physician who was looking primarily for battering. Even if a post-report investigation discloses that the injuries were entirely accidental, some stigma may attach to the parents who are apt to feel outraged that their completely truthful explanation was not accepted. Secondly, reports that prove to be incorrect must be removed from the registry.²⁶⁶ If this is not done, every non-abusive injury suffered by the children in the family becomes an invitation to investigation and accusation even in cases where abuse was not seriously considered as the cause of the trauma. One authority has recommended that the registries include only those reports on which action has been taken.²⁶⁷ This seems unwise as such a provision would provide no protection for the child in cases where prosecution was declined or unsuccessful but the existence of abuse has been established. It is thus thought that reports clearly indicating abuse and those in which no determination could be made should continue to be filed to give the greatest protection to the child. As an adjunct to this, some authorities have proposed maintenance of a temporary file as well as a permanent registry.²⁶⁸ Under this scheme, a report would be placed first in the temporary file until investigation determined that it was based on fact or that doubt continued, at which time it would be transferred to the registry.

Closely connected to these problems are cases in which the physician has a suspicion of abuse but no further real evidence. Establishment of suspicion registries has been recommended to meet this problem.²⁶⁹ Such a registry would include cases in which no report was made but the possibility of abuse existed to a lesser degree. Existence of such a registry would enable different physicians who had treated the child to consult to determine whether the syndrome seemed to be present. The danger of this system is that two suspicions may add up to a case of abuse where neither, standing alone, would be sufficient.²⁷⁰ Whether the system finds acceptance depends largely on whether abuse was actually inflicted.

264. Paulsen, *supra* note 91, at 25.

265. *Id.* at 31.

266. *Id.*

267. *Id.*

268. *Id.* at 31; Am. Scad. of Pediatrics Committee on Infant and Pre-School Children, *supra* note 230, at 380.

269. Paulsen, *supra* note 91, at 26.

270. *Id.* at 31.

Those who discover actual cases of abuse by piecing together suspicions will be praised for protecting the child, while if no abuse occurred, much criticism will result.

The identity of the agency maintaining the registries varies. A welfare agency is responsible in three states,²⁷¹ a law enforcement agency in a fourth,²⁷² and the Bureau of Vital Statistics was selected by the fifth.²⁷³ The American Academy of Pediatrics Committee on Infant and Pre-School Children recommends the city or county department of health or welfare be selected.²⁷⁴ The identity is largely immaterial as long as the job is done properly, but it would undoubtedly be helpful if information was available on a 24-hour basis. Such availability contemplates use of the registry by telephone, and, if oral reports are required, the recipient might well be the one to maintain the registry. Such a system would require only one phone call to both report the abuse and discover if a previous history existed. The advantage of having the registry available around the clock lies in the fact that the physician can have the information while still treating the child and may recommend hospitalization rather than release in situations where there is reason to believe that the child's injuries are part of a continuing pattern of abuse.

In addition, maintenance of a central registry raises the problem of who should have access to the information it contains, especially in cases where the perpetrator is not conclusively known as this may well constitute invasion of privacy.²⁷⁵ While it seems unwise to open it to the public or restrict its use to physicians only, some line must obviously be drawn. If the classes of persons required to report is not too broad, the limitation could follow these lines. However, it would seem that the greatest benefit of the system would accrue to physicians, the courts and the various law enforcement agencies. These groups have sufficient reason for needing the information to justify a possible invasion of family privacy. One group recommends that access be limited to physicians, hospital administrators and social workers.²⁷⁶ The social welfare agencies might well be expected to maintain their own records as investigation of previous cases should provide this information. If the welfare agency is in charge of maintaining the registry, duplication of effort would be decreased and it is thought that this would provide the most satisfactory solution.

271. SESS. LAWS OF HAWAII, ACT 261 § 3 (1967); ILL. ANN. STAT. ch. 23, § 2047 (1965); MD. ANN. CODE art. 27, § 11A(h) (1963).

272. State Bureau of Criminal Identification and Investigation. CALIF. PEN. CODE § 11161.5 (West 1963).

273. VA. CODE § 16.1-217.1 (1968).

274. Am. Acad. of Pediatrics Committee on Infant and Pre-School Children, *supra* note 230, at 380.

275. Paulsen, *supra* note 91, at 31.

276. Am. Acad. of Pediatrics Committee on Infant and Pre-School Children, *supra* note 230, at 380.

H. *The Effect of Failure to Report*

The problem of what penalty, if any, to impose for violation of the reporting statutes is one that continues to be in dispute. No penalty is provided in the statutes of 25 states,²⁷⁷ but there is considerable divergence among the remainder. One difference in opinion involves the existence of intent. Seventeen states²⁷⁸ require that the failure to report must be "knowingly and willfully" done. Two states²⁷⁹ require only that it be done willfully and one²⁸⁰ uses only the word "knowingly." Five states²⁸¹ disregard the intent element and provide a penalty simply for "violating the statute."

The nature of the penalty also differs considerably among the states. In 11 states,²⁸² violation is stated to be a misdemeanor and the penalties for misdemeanors are applied. In one state,²⁸³ the penalty for a misdemeanor is applied if the defendant is found guilty, but the defendant who pleads guilty is subject to a fine of \$50, three months in jail, or both. A number of other states provide that the defendant may be both fined and imprisoned. One state²⁸⁴ provides for six months' imprisonment, a fine of \$500 or both; two²⁸⁵ state the penalty as \$100, ten days or both; two others²⁸⁶ provide for a fine of \$500, a year's imprisonment or both;

277. ALAS. STAT. § 11.67.010-070 (1965); COLO. REV. STAT. ANN. § 22-13-1 to -7 (1963); CONN. GEN. STAT. ANN. § 17-38a (1965); D.C. CODE tit. 2, § 2-161 to 166 (1966); GA. CODE ANN. § 74-111 (1965); SESS. LAWS OF HAWAII, ACT 261 (1967); IDAHO CODE § 16-1641 (1965); ILL. ANN. STAT. ch. 23, § 2041-2047 (1965); IND. STAT. ANN. tit. 52, § 1419-25 (1965); IOWA CODE ANN. § 235A (1965); MD. ANN. CODE art. 27, § 11A (1963); MASS. ANN. LAWS ch. 119, § 39A-B (1964); MISS. CODE ANN. § 7185-05 (1966); MONT. REV. CODE ANN. § 10-901 to -905 (1965); N.M. STAT. ANN. § 13-9-12- to -16 (1965); N.Y. PEN. CODE § 483-d (McKinney 1964); N.C. GEN. STAT. § 14-318.2, § 8-53.01 (1965); N.D. CENT. CODE § 50-25-01 to -05 (1965); OHIO REV. CODE ANN. § 2151.421 (1966); R.I. GEN. LAWS § 40-13.1 (1965); TEX. CIV. STAT. § 695c-2 (1965); VA. CODE § 16.1-217.1 (1968); WASH. REV. CODE ANN. § 26.44.010 to 060 (1965); W. VA. CODE § 49-6A-1 to -4 (1965).

278. ARK. STAT. ANN. § 42-806 (1965); DEL. CODE ANN. tit. 16, § 1006 (1965); FLA. STAT. § 828.041(6) (1963); KAN. STAT. ANN. § 38-720 (1965); KY. REV. STAT. ANN. § 199.335(6) (1966); LA. REV. STAT. ANN. § 14:403(E) (1964); ME. REV. STAT. ANN. tit. 22, § 3855 (1965); MINN. STAT. ANN. § 626.554(7) (1965); NEV. REV. STAT. § 200.507 (1965); N.H. REV. STAT. ANN. § 571:30 (1965); N.J. STAT. ANN. § 9:6-8.7 (1964); ORE. REV. STAT. § 146.990 (1965); S.D. SESS. LAWS OF 1964, ch. 90; UTAH CODE ANN. § 55-16-6 (1965); V.I. CODE ANN. tit. 19, § 176 (1966); WIS. STAT. ANN. § 48.981 (1965); WYO. STAT. § 14-28.6 (1963).

279. NEB. REV. STAT. § 28-484 (1965); PA. STAT. ANN. tit. 18, § 4330 (1965).

280. ALA. CODE tit. 27, ch. 4, § 25 (1967).

281. ARIZ. REV. STAT. ANN. § 13.842.01(D) (1965); MICH. COMPILED LAWS ANN. § 722.572(5) (1968); S.C. CODE § 20-302.4 (1965); TENN. CODE ANN. § 37-1203 (1966); VT. STAT. ANN. tit. 13, ch. 26, § 1355 (1966).

282. CALIF. PEN. CODE § 11161.5 (West 1963); FLA. STAT. § 828.041(6) (1963); KAN. STAT. ANN. § 38-720 (1965); MICH. COMPILED LAWS ANN. § 722.571(5) (1968); MINN. STAT. ANN. § 626.554(7) (1965); NEV. REV. STAT. § 200.507 (1965); N.J. STAT. ANN. § 9:6-8.7 (1964); OKLA. STAT. ANN. tit. 21, § 848 (1966); ORE. REV. STAT. § 146.990 (1965); S.D. SESS. LAWS OF 1964, ch. 90; UTAH CODE ANN. § 55-16-6 (1965).

283. TENN. CODE ANN. § 37-1203 (1966).

284. ARK. STAT. ANN. § 42-806 (1965).

285. ARIZ. REV. STAT. ANN. § 13-842.01(D) (1965); LA. REV. STAT. ANN. § 14:403(E) (1964).

286. PA. STAT. ANN. tit. 18, § 4330 (1965); V.I. CODE ANN. § 176 (1966).

and another two²⁸⁷ make the penalty a \$100 fine, six months in jail or both. Two states provide for both fine and imprisonment on an "either-or" basis. One²⁸⁸ provides for a \$500 fine or six months in jail, and the other²⁸⁹ makes the punishment \$100 or 30 days. The remaining states impose only a fine upon conviction, and the amounts show considerable variation: \$10-50,²⁹⁰ \$25,²⁹¹ \$10-100,²⁹² \$100,²⁹³ and \$500.²⁹⁴

A variety of arguments has been made for the existence or non-existence of punishment. Some feel that the objective of these statutes is solely to protect children and that granting immunity to reporters should provide incentive to report. While this view is logical, it fails to recognize that some people need more prodding than simply the absence of possible liability. The fact remains that these people would prefer to avoid the inconvenience of testifying before criminal or custody proceedings and consider this a sufficient reason not to report. A statute requiring compliance but not providing any penalty for failure to do so is a paper dragon at most.

At the other extreme it has been suggested that the penalty for a physician's failure to report should be loss of his license.²⁹⁵ There is little doubt that this would encourage compliance, but it is thought that this is a substantial penalty to extract for failure to hold the same opinion as others. There is likely to be a number of cases in which medical authorities would differ on whether the child's injuries were the result of abuse, and it seems grossly unfair to prevent a physician from practicing because of an honest and well-reasoned difference of opinion.

Even if a relatively light penalty is attached to a failure to report, considerable benefit would still result. The reporter who feels it inconvenient to go to court as a witness will not be any more eager to go as a defendant. When impressed with the importance of reporting for the child's protection and the possibility of prosecution for failure to do so, the physician is given an added reason to comply. The existence of criminal penalties for not reporting also gives the physician a strong argument to use with parents who beg for his indulgence. When the report is made, the parents are likely to feel less animosity toward the reporter.²⁹⁶ These two factors speak strongly in favor of a statute with punitive provisions.

287. WIS. STAT. ANN. § 48.981 (1965); WYO. STAT. § 14-28.6 (1963).

288. ALA. CODE tit. 27, ch. 4, § 25 (1967).

289. S.C. CODE § 20-302.4 (1965).

290. DEL. CODE ANN. tit. 16, § 1006 (1965).

291. VT. STAT. ANN. tit. 13, ch. 26, § 1355 (1965).

292. KY. REV. STAT. ANN. § 199.335(6) (1966).

293. NEB. REV. STAT. § 28-484 (1965).

294. N.H. REV. STAT. ANN. § 571:30 (1965).

295. CALIF. L. REV., *supra* note 18, at 1816.

296. Paulsen, *supra* note 91, at 9.

I. *The Child's Remedies*

Closely allied with the problem of criminal penalties is that of possible tort consequences which may result from failure to report. One author has stated that:

it seems likely that reporting statutes which require reporting and which carry criminal penalties create a cause of action in favor of infants who suffer abuse after a physician has failed to make a report respecting earlier abuse brought to his attention. Further, the failure to comply with a mandatory statute which is not supported by criminal penalties may well give rise to civil liability by analogy to the cases unholding recovery based on negligence established by a breach of the criminal law.²⁹⁷

The physician who has been granted immunity for reporting is likely to find sufficient reason to report, with or without the existence of criminal penalties, if liability may result from failure to do so. Such liability would seem to be most likely in situations where evidence of abuse was strong, and should not extend to situations where an honest, well reasoned and good faith difference of opinion existed.

In this connection it is interesting to note that though the battered child may have a cause of action against a person who fails to report, he generally does not have one against his parents for their intentional tort. The general rule in this area is that the child cannot sue his parents for intentional torts, although this rule has been relaxed somewhat with regard to step-parents and those who stand in the place of a parent.²⁹⁸ The reason for the rule is based largely on the desire to preserve peace and tranquility in the family. As tort immunity has gradually increased in other areas, inroads have been made into it in the area of parent and child. In the case of *Cowgill v. Boock*, the court stated that "we think the general rule . . . should be modified to allow an unemancipated minor child to maintain an action for damages against his parent for a willful or malicious personal tort."²⁹⁹ In explaining its reasoning, the court added, "By the wrongful conduct of the father in overstepping the bounds of the family relationship, the peace, security and tranquility of the home had already been disrupted. When the reason for the rule ceases, the rule itself ceases."³⁰⁰ In another state where the veil of parental immunity has been pierced in cases of intentional tort, the court said:

While it may seem repugnant to allow a minor to sue his parent, we think it more repugnant to leave a minor child with-

297. *Id.* at 36.

298. W. PROSSER, *supra* note 249, at 886.

299. 189 Ore. 282, 301-02, 218 P.2d 445, 453 (1950).

300. *Id.*

out redress for the damage he has suffered by reason of his parent's wilful or malicious misconduct. A child, like every other individual, has a right to freedom from such injury. Accordingly, we conclude that an unemancipated minor may sue his parent for a wilful or malicious tort. . . .³⁰¹

It should be stressed that these holdings, though they seem to indicate a trend toward abrogation of the parental immunity, represent only a small minority view.

The difficulty with cases holding that the child may sue his parents is that a total and complete breakdown of the family relationship is sometimes assumed. No doubt this is sometimes true, but the social casework method of dealing with abuse is an attempt to restructure the family, put it back together again and restore peace and tranquility. Where the parents are making a serious attempt to remedy the problems which led to abuse of the child, a tort suit based on the previous conduct may have disastrous results. It seems unrealistic to say that the suit may be maintained if the family has disintegrated and not if it remains intact and has been strengthened. As a practical matter, court calendars are extremely congested in a number of states, and it may take years before the case comes to trial, a period in which the family situation should stabilize in one way or the other. If the problems are resolved successfully, the suit can always be dismissed. However, it can be argued that only a tenuous family relationship can be held together by the threat of a lawsuit. There seems to be no one clear answer where the battered child is involved.

One additional factor must be considered, at least from a practical standpoint, where tort liability of the parents for battering their children is proposed. The average abusive parent, young and financially unstable, is not likely to be able to satisfy any sizable judgment. This is especially true if prosecution has resulted in the parent's imprisonment. While such a factor will not be present in all cases, it may effectively deprive the child of a remedy even if the cause of action is permitted. Thus abrogation of the parental immunity must be considered a hollow victory in a substantial number of cases.

V. THE FLORIDA REPORTING STATUTE

The Florida reporting statute was enacted in 1963 and has remained unchanged.³⁰² It is interesting to note that statutes involving cruelty to

301. *Emery v. Emery*, 45 Cal. 2d 421, 430, 289 P.2d 218, 224 (1955).

302. The statute, FLA. STAT. § 828.041 (1967), is as follows:

(1) PURPOSE.—The purpose of this act is to provide for the protection of children whose health and welfare are adversely affected and further threatened by the conduct of those responsible for their care and protection. This is often manifest by the infliction, other than by accidental means, of physical injury requiring the attention of a physician. It is intended that the mandatory reporting of such cases by physicians and institutions to appropriate court authority will cause the

and abuse of children are included in the same chapter with those involving cruelty to animals. It would seem that children might be considered sufficiently important to rate a chapter of their own, but no legislative action has been taken in pursuit of this end.

The statute starts with a lengthy purpose clause stating the mandatory nature of the enactment, the intention that the protective services of the state be used to protect the children involved, and the aim to preserve family life if possible. As Florida maintains no record of legislative history, this clause is the only source to which a court could refer for construction and interpretation. While the expressed purpose and intent are commendable, no appropriations to carry them out appear to have been granted. It thus seems that the funds for investigation and protection must come either from generally appropriated state funds or from county taxes. One possible explanation for this seeming lack of implementation may lie in the fact that the bill became law without the governor's signature. This apparent lack of executive commitment would possibly have doomed a bill carrying an appropriation, and the legislators may have preferred to at least get the bill passed even without needed appropriations. However, even the legislative commitment seems to have waned with the passage of time as, two governors later, nothing more has been done. The fact remains that the promise of case-finding legislation, such as reporting laws, is that when a case is found, something is done about it. The legislatures which require reporting but do not provide the means for further protective action delude themselves and neglect children.³⁰³

protective services of the state to be brought to bear on the situation in an effort to prevent further abuses, protect and enhance the welfare of these children, and preserve family life wherever possible.

(2) **REPORTS BY PHYSICIANS AND INSTITUTIONS.**—Any physician, including any licensed doctor of medicine, licensed osteopathic physician, intern and resident, having cause to believe that a child under the age of sixteen brought to him or coming before him for examination, care or treatment has had physical injury or injuries inflicted upon him, other than by accidental means, by a parent or caretaker, shall report or cause reports to be made to the appropriate juvenile judge in accordance with the provisions of this act; provided, when the attendance of a physician with respect to a child is pursuant to the performance of services as a member of the staff of a hospital or similar institution he shall notify the person in charge of the institution or his designated delegate who shall report or cause reports to be made in accordance with the provisions of this act.

(3) **NATURE AND CONTENT OF REPORT.**—Such reports shall be in writing and shall contain the names and addresses of the child and his parents or caretakers, if known, the child's age, the nature and extent of the child's injuries (including any evidence of previous injuries), and any other information that the physician believes might be helpful in establishing the cause of the injuries and the identity of the perpetrator.

(4) **IMMUNITY FROM LIABILITY.**—Anyone participating in the making of a report pursuant to this act or participating in a judicial proceeding resulting therefrom shall be presumed to be acting in good faith and in so doing be immune from any liability, civil or criminal, that might otherwise be incurred or imposed unless the person acted in bad faith or with malicious purpose.

(5) **EVIDENCE NOT PRIVILEGED.**—The physician-patient privilege shall not be a ground for excluding evidence regarding a child's injuries or the cause thereof, in any judicial proceeding resulting from a report pursuant to this act.

(6) **PENALTY.**—Anyone knowingly and wilfully violating the provisions of this act shall be guilty of a misdemeanor.

The classes of persons required to report under the statute are limited to physicians, who are defined as including licensed doctors of medicine, licensed osteopathic physicians, interns and residents. Where the examining physician is a staff member of a medical institution, the statute requires that the information concerning the child and his injuries be given to the person in charge of the institution who must then comply with the statute. This places the duty on the institution as well as on the physician.

The statute uses the objective test as to whether abuse has occurred and requires a report if there is cause to believe that the injuries were inflicted "other than by accidental means." In addition to requiring the physician to guess the intent of another, the statute then necessitates that he guess as to the perpetrator's identity as a report need be made only if the injuries were inflicted by a parent or caretaker. While it is not too difficult to interpret the word "parent," the word "caretaker" poses somewhat more of a problem. If "parent" is limited to natural and adoptive parents, then it is easy to include step-parents and foster parents under the heading of caretakers. However, a broad definition of "parents" might possibly include them and then the question of who is a caretaker becomes more difficult to answer. As no cases have arisen requiring interpretation of the statute, it is unknown how broad an interpretation will be given to various clauses and whether persons such as babysitters, older siblings who might watch the child, or others with a temporary responsibility for his welfare are included as "caretakers" under the act.

The statute further requires reporting only if the child is less than 16 years old and instructs that reports be made to the "appropriate juvenile judge." While the battered child is extremely likely to be under 16, it is interesting to note that the statutes define a child as being under 17 for juvenile court purposes.³⁰⁴ Consistency would seem to require that the age limit be the same as that used in the juvenile court definition of a child, but apparently the legislature did not feel this to be necessary. While, as a practical matter, few if any cases of abuse involving 16-year-olds would be expected, it would seem to be just as easy to require reporting to cover these children and to afford them protection in the exceptional cases that might arise.

Only a written report is required in Florida, and the statute makes no mention of an additional oral report. While it is unknown how much reliance was placed on the Model Act, it is to be noted that other provisions as to the nature and content of the report are followed almost word for word in the Florida statute. As both the Model Act and the statute first appeared in 1963, it is possible that neither had any influence on the other, but it would seem more likely that the Florida legislature

303. Paulsen, *supra* note 91, at 48-49.

304. FLA. STAT. § 39.01(6) (1963).

simply rejected the idea of oral reports and then followed the remainder of the Model Act provision.

The Florida immunity provision extends to all those making a report under the statute and includes a presumption of good faith. The immunity broadly covers any civil or criminal liability that might otherwise ensue from making the report or participating in any judicial proceeding resulting from it unless the reporter acted with bad faith or a malicious purpose.

One of the most interesting and most puzzling parts of the statute is the provision dealing with abrogation of evidentiary privileges, which dispenses with the physician-patient privilege but makes no mention of the husband-wife privilege. The unusual factor here is that neither privilege is available in Florida anyway. Abrogation of the husband-wife privilege has been accomplished by FLA. STAT. SECS. 90.04 and 932.31, which make spouses competent to testify against each other without consent in civil and criminal actions respectively. As the physician-patient privilege did not exist at common law, no statute was necessary, and the case law³⁰⁵ has specifically provided that it is not available.

This raises the question of why the reporting statute deals with the physician-patient privilege. No clear answer is available, but a number of theories are possible. First, most proposals in this area recommend abrogation of the privilege, and it is possible that the provision was included by draftsmen who were unaware of the case law. Secondly, it is possible that it was included as something of a salve for both the physician and the parent. The medical profession has a deeply ingrained tradition of confidentiality, and it may be that it was thought that a legislative mandate on the subject would promote compliance with the statute. It seems unlikely that the provision was inserted for their education as they should be aware of a law which has such an effect on a long tradition. While the privilege should not be available to the parent anyway, the physician might have difficulty explaining this to them and it would no doubt be easier and more convincing for him to be able to say that the statute compels his testimony rather than that some court decided it. Thirdly, one commentator has suggested that the provision was included just in case the privilege should later be allowed by statute or case law.³⁰⁶ While this is a possibility, there is no reason to assume that such a change will occur. The medical profession has lived without the privilege for thirty years, and it may be suggested that if the absence of it was so offensive as to require a change that this would have happened some time ago. Finally, the statute provides that knowing and willful violation is a misdemeanor.

No provision is made either for the maintenance of a central registry

305. *Fla. Power & Light Co. v. Bridgeman*, 133 Fla. 195, 212, 182 So. 911, 191 (1938).

306. *Legislation: The Battered Child: Florida's Mandatory Reporting Statute*, *supra* note 29, at 508.

or for the actual processing and investigation of reports. While the legislature may have felt it best to leave the mechanics of protecting the child to each county, it would seem better to include some mandate along these lines rather than just expressing an intent in the purpose clause that the child be protected. While available facilities may differ among the counties, some general direction could easily be included in the statute which would serve both to prod the counties to make use of the reports for the child's benefit and provide guidelines for accomplishing this result.

The Florida reporting statute is a definite step toward a commendable goal, but experience has shown that certain defects exist in its structure. The legislature should benefit from this experience and act in accordance with it for the protection of children who may not be adequately protected at present.

VI. RECOMMENDATIONS FOR IMPROVEMENT OF STATUTES

(1) The class of persons required to report should be broadened to include school teachers, nurses and social workers acting in an official capacity. These people may be in a position to see a child who has been denied medical treatment. The official capacity limitation is intended to make their duty coterminous with their positions and is similar to the limitation on physicians and other medical personnel requiring a report if the child is seen or examined.

(2) No reporter should be asked to guess at the perpetrator's identity, either to determine if a report is required or to describe the nature of the injuries. Such information should be included in the report only if an admission is made, and otherwise the only reference to identity should be in a statement reporting the explained cause of the injuries (mother states that father beat the child). Reporting the explanation given would be useful to see if the story later changed.

(3) No reporter should be required to guess whether the injuries were intentionally or accidentally inflicted to determine whether a report is required as long as the child's injuries could reasonably be believed to have resulted from abuse. This is the best left to social investigators who will be in a better position to discover the facts.

(4) The authority designated to receive reports should be located in the county where the child resides. This would serve to prevent hospital shopping across county lines and would aid in the investigative process.

(5) Central registries should be established both on the county and state level with the former maintained by an agency operating around the clock, preferably the welfare department or juvenile court. The expense of maintaining the state registry would be that of the state, and while state funding for the county registries would be preferable, this could be a county expense. The maintenance expense should be

clearly spelled out in the statute. The state registry would provide accurate and up-to-date information as well as serving as a check on families moving about the state.

(6) Oral as well as written reports should be required. If the recipient of the reports also maintained the central registry, one telephone call would serve two purposes. Additionally, protective measures could be undertaken immediately.

(7) Guidelines for inter-agency cooperation should be stated. While small counties may lack some of the facilities and services available in the larger counties, an area and duty of cooperation could be defined to provide guidance and promote the greatest protection for the child.

(8) Physicians and institutions should be granted a complete and unqualified immunity for reporting or taking part in judicial proceedings. Immunity should be granted to school teachers, nurses and social workers reporting in an official capacity in good faith, and a statutory presumption of good faith should be added. All others who choose to report but are not required to do so should be granted immunity if the report is made in good faith and with reasonable cause, but no presumption of good faith should attach.

(9) Injuries should not have to be serious or severe to be reportable. What constitutes a severe injury may be a matter of opinion in some cases, and reporting of injuries that might not be considered serious by some might well save a child from subsequent crippling or fatal attacks.

(10) Funds should be appropriated to implement statutes.

(11) Children should be protected through the age of juvenile court jurisdiction of the state.

(12) Family courts should be established to take the place of the juvenile courts and also to handle other matters pertaining to the family. Such courts could act both to protect the child and to deal with the parents in any manner that might be necessary.

(13) In custody hearings arising after cases of abuse in which the parents inflicted the trauma or the perpetrator remains unknown, the state should have the burden of proving unfitness the first time. In second and additional hearings following subsequent attacks on the child, the parents should have the burden of proving their fitness.

In view of the foregoing analysis and recommendations for improvement of child abuse reporting statutes, the following proposal is made for enactment of a statute to remedy some of the existent problems. While no statute can provide a solution without commitment on the part of those covered by it, strong legislation is a step in the right direction. In the area of child abuse, this commitment will be defeated if necessary funds for implementation are not available. It is thus urged that each state review its appropriations and provide the monies needed for the protection of children threatened by abuse. Such an appropriation will be more than repaid to the state by the preservation of the minds and

bodies of children who might otherwise grow into helpless public charges.

The proposed statute is as follows:

Section 1. PURPOSE.—*The purpose of this act is to provide for the protection of children whose health and welfare are adversely affected and further threatened by the abusive conduct of others. This is often manifest by the infliction of physical injury requiring the attention of a physician or which may come to the attention of school teachers, nurses and social workers. It is intended that the mandatory reporting of such cases by physicians, institutions, nurses, school teachers and social workers to the appropriate court authority will cause the protective services of the state to be brought to bear in an effort to prevent further abuses, protect and enhance the welfare of these children, and preserve family life wherever possible.*

Section 2. REPORTS BY PHYSICIANS, INSTITUTIONS, NURSES, SCHOOL TEACHERS AND SOCIAL WORKERS.—*Any physician, including any licensed doctor of medicine, licensed osteopathic physician, intern and resident, any school teacher, nurse or social worker, believing or having reason to believe that a child under the age of — [insert maximum age of juvenile court jurisdiction] brought to him, coming before him for examination or seen by him in performance of his official capacity, has had physical injury or injuries inflicted upon him, whether or not fatal, or whose symptoms suggest maltreatment by any person, shall report or cause reports to be made to the appropriate juvenile or family court judge in the county where the child resides in accordance with the provisions of this act; provided, when the attendance of a physician with respect to a child is pursuant to the performance of services as a member of the staff of a hospital, clinic or similar institution he shall notify the person in charge of the institution or his designated delegate who shall report or cause reports to be made in accordance with the provisions of this act.*

Section 3. CONSIDERATIONS IN REPORTING MALTREATMENT.—*The reporting individual should consider the following items in reporting cases of maltreatment:*

- a. *Characteristic age, usually under three years.*
- b. *Characteristic distribution of fractures.*
- c. *Disproportionate amount of soft tissue injury.*
- d. *Evidence that injuries occurred at different times, are in different stages of resolution.*
- e. *Cause of recent trauma in question.*
- f. *Suspicious family history.*
- g. *History of previous episodes.*
- h. *No new lesions occurring during child's hospitalization.*

Section 4. NATURE AND CONTENT OF REPORT.—*An oral report shall be made immediately by telephone or otherwise, and followed as soon thereafter as possible by a report in writing, to an appropriate juvenile*

or family court judge in the county where the child resides. Such reports shall contain the names and addresses of the child and his parents or other persons responsible for his care, if known, the child's age, the nature and extent of the child's injuries (including any evidence of previous injuries), the explanation given for the injuries, and any other information that the reporter believes might be helpful in establishing the cause of the injuries and the identity of the perpetrator.

Section 5. ESTABLISHMENT AND MAINTENANCE OF CENTRAL REGISTRIES.—Central registries shall be established and maintained by the juvenile or family court of each county and the state Department of Welfare. Each county registry shall forward copies of all reports received to the state registry after investigation has shown that the child's injuries were the result of abuse or maltreatment or if the cause remains unknown. Each registry shall contain information from reports catalogued both as to the name of the child and the name of the family, but any report shall be destroyed if subsequent investigation discloses that the child's injuries were not the result of abuse or maltreatment. Access to the information contained in the registry shall be limited to those classes of persons and institutions required to report; provided, that the juvenile or family court judge may, in his discretion, divulge such information to other persons if he deems it necessary.

Section 6. COOPERATION IN INVESTIGATION OF REPORTS.—Upon receipt of a report, the juvenile or family court judge shall cause an investigation to be initiated into the cause of the child's injuries and the identity of the perpetrator, if any. All state, county and local social welfare and law enforcement agencies shall have a duty to give full cooperation to the juvenile or family court to investigate reports and to protect and enhance the welfare of children and siblings of children who are the subject of any report made pursuant to this act.

Section 7. IMMUNITY FROM LIABILITY.—Any physician or institution participating in the making of a report pursuant to this act shall have unqualified immunity from any liability, civil or criminal, that might otherwise be incurred or imposed. Any school teacher, nurse or social worker making a report in his official capacity pursuant to this act shall have immunity if such report was made in good faith, from any liability, civil or criminal, that might otherwise be incurred or imposed, and such reporters shall be presumed to have acted in good faith. All other persons who report, although not required to do so by the provisions of this act, shall be immune from all liability, civil or criminal, that might otherwise be incurred or imposed if acting in good faith and on reasonable cause. All reporters shall have the same immunity with respect to participation in any judicial proceeding resulting from such report as is granted for making the report.

Section 8. EVIDENCE NOT PRIVILEGED.—Neither the physician-patient privilege nor the husband-wife privilege shall be a ground for

excluding evidence regarding a child's injuries or the cause thereof, in any judicial proceeding resulting from a report pursuant to this act.

Section 9. PENALTY.—*Anyone knowingly and willfully violating the provisions of this act shall be guilty of a misdemeanor.*

Section 10. *The provisions of this act shall be liberally construed in order to effectively carry out the purposes of this act in the interest of protecting and enhancing the welfare of children.*