
Annual Report



DUTCH EXPERTISE CENTRE ON CHILD ABUSE

1.1.2018 to 12.31.2018

May 2018, commissioned by the DECCA board
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This annual report was compiled by:

L. de Bock (project worker), F. Kamberg (central coordinator), M.Kamphuis (medical director).

1. INTRODUCTION

The Dutch Expertise Centre on Child Abuse (DECCA) was founded on October 31st, 2014 by the Academic Medical Centre Amsterdam, the Erasmus Medical Centre Rotterdam, the University Medical Centre Utrecht and the Dutch Forensic Institute (NFI).

DECCA uses a combination of expertise in paediatrics and forensic-medical expertise in determining whether injuries justify a suspicion of child abuse. DECCA aims to contribute to the protection of children by accelerating and improving the detection of child abuse, as well as child abuse policy.

DECCA offers a solution for medical professionals nationwide who are in need of advice on child abuse without having to disclose patient data. These include paediatricians, child safety doctors, forensic doctors, and other medical professionals. Additionally, children can be referred to one of the DECCA hospitals for consultation. DECCA can be reached 24 hours a day, 7 days a week.

This fourth annual report aims to map DECCA's achievements in 2018. Beside DECCA's core activity, the interpretation of injury in children, this report contains information on our other endeavours: knowledge dissemination and education at congresses and workshops, as well as publications by our medical professionals. DECCA's future perspectives as envisioned by the board will be expounded in the final section.

The highlights of 2018 were:

- The number of advisory cases increased by 15,1%;
- DECCA held a national congress that was very well received;
- DECCA-doctors gave more than 40 presentations on their activities for DECCA
- DECCA-doctors published a total of 25 peer-reviewed articles on child abuse;
- DECCA was included in the national code for reporting child abuse (November 2018);
- A communication plan was devised, to be implemented in 2019;
- All parties comprising DECCA initiated the development of a formal cooperation agreement;
- Further professionalization with regard to privacy rules, quality control, data management, etc. DECCA appointed a medical director in October 2018, which strongly contributed to these improvements.

More information on DECCA (about the organisation and its position, as well as its goals, values and method) can be found in the General Protocol and the document Quality Standards, available on www.DECCA.nu/documentatie.

May 20th, 2019

E. van de Putte, chairman DECCA, on behalf of the board

2. GENERAL INFORMATION

GENERAL DATA

Name:	Dutch Expertise Centre on Child Abuse (DECCA)
Legal form:	Foundation
Chamber of Commerce:	61809551
Office address:	Lundlaan 6 Utrecht
Mail address:	KE04.133.1, Postbus 85090, 3508 AB Utrecht
Website:	www.DECCA.nu
Email address:	info@DECCA.nu
Telephone:	0900-4445444 (Note: only for requests for advice and consultation by medical professionals; general questions can be submitted by email only)
IBAN:	NL83 TRIO 0197 9961 08 NL06 TRIO 0379 2049 40
BIC:	TRIONL2U
RSIN:	8544.97.730
ANBI-status:	Granted from 10.31.2014 as a Public Benefit Organisation

3. MANAGEMENT AND MANAGEMENT MEETINGS

BOARD

From 1.1.2017 to 12.31.2017, the board of DECCA consisted of the following members:

- Chairman: Ms. Prof. E.M. van de Putte, MD, PhD
- Secretary: Mr. W.A. Karst, MSc
- Treasurer: Mr. J.K. Poot, MSc
- Director: Mr. Prof. R.R. van Rijn, MD, PhD
- Director: Ms. M.J. Affourtit, MSc

THE BOARD IS SUPPORTED BY:

- Medical director: ms. M. Kamphuis, MD (from October 1st, 2018)
- Central coordinator: ms. F. Kamberg
- Secretary: ms. D. Riem-van de Meent

ADVISORY COMMISSION

- Ms. A. Laeven-De Boer, of Berenschot Consultancy, MD
- Mr. Prof. H.S.A. Heymans, professor emeritus paediatrics AMC, MD, PhD
- Ms. S. Petra-de Jong, MD, capacity manager Board of Directors UMCU

LOCAL COORDINATORS

Each DECCA location has its own coordinator:

- AUMC: Ms. A.H. Teeuw, MD
- UMCU: Ms. I.M.B. Russel, MSc
- EUR: Ms. M.J. Affourtit, MSc
- NFI: Mr. W.A. Karst, MSc

ADVISORS TO THE BOARD

- Ms. N. Coebergh, Child Safety Doctor with Child Protection Services Rotterdam Rijnmond, MD
- Mr. B. Kruyver, forensic doctor with the Public Health Institute in the region Hollands Noorden, MD
- Local coordinators Ms. A.H. Teeuw (MD) and Ms. I.M.B. Russel (MSc) are additional advisors to the board.

BOARD MEETINGS

From the 1st of January to the 31st of December 2018, there have been 8 meetings of the board. A majority of board members was present at each of these meetings. At three of the meetings, the advisors and local coordinators were present. Two meetings were held with the advisory commission.

4. GENERAL OVERVIEW OF CASE STUDIES

In the past year, DECCA has again shown that it plays an important role in injury interpretation in case of suspected child abuse. DECCA distinguishes itself from all other paediatric-forensic expertise in the country by combining medical-forensic expertise and multidisciplinary care. Additionally, our services can be reached at every hour of the day.

Since DECCA was founded, the number of cases it provided advice on has annually increased by between ten and fifteen per cent. 2018 showed a similar increase (Table 1). The number of face-to-face consultancies fluctuated. The most numerous among advisees continue to be paediatricians and Child Safety Doctors (*vertrouwensarts*) (Tables 5 and 7). Again, requests for advice were mainly issued from the provinces Utrecht, Noord-Holland, Zuid-Holland and Noord-Brabant (Tables 6 and 18). Hardly any requests were issued from Limburg, Friesland and Drenthe.

2018 continued an upward curve in the amount of cases in which DECCA's advice was additionally supported by medical literature: from 14% in 2016 and 25% in 2017 to 41,9% in 2018. The amount of available medical literature is growing and DECCA paediatricians are specifically trained in using medical literature to support their advice. This is an essential quality standard for DECCA. Its paediatricians are trained in Bayesian Formulation¹, which is also used by the Dutch Forensic Institute (NFI). Apart from paediatricians and forensic doctors, 7 other specialisations were involved in both the advice provided by DECCA and face-to-face consultations carried out by DECCA. This underlines the fact that often in the determination of injury in children, forensic medicine alone does not suffice and that several other medical disciplines may well be necessary in arriving at a satisfactory conclusion.

DECCA fulfils an important role in Step 1 of the Code of Report, in which there is still no certainty if the reported case does in fact concern child abuse. This is apparent from the fact that in 46,7% of advisory cases, no contact was yet established with Child Protection Services (*Veilig Thuis*), an obligatory part of Step 2 of the Code of Report (Table 13). In 10% of advisory cases, Child Protection Services were consulted prior to contacting DECCA, which is to say that the advisee requested advice from DECCA during Step 2 of the Code of Report. Additionally, DECCA is involved in Step 5 of the Code of Report, which mainly concerns consultations and advice requested by Child Protection Services: 17,9% of advisory cases (Table 13) and 43,6% of consultations (Table 25). However, Step 5 also includes requests for advice or consultations DECCA received after the case was reported, yet in which the advisee is not Child Protection Services itself. This was the case for 24% of advisory cases (Table 13) and 43,6% of consultations (Table 25). During Step 5, it is of equally crucial importance to justify a suspicion of abuse. The added value of DECCA is apparent from the fact that in 34% of advisory cases, injury interpretation showed that inflicted injury was (almost certainly) not the case (Table 16). The Code of Report may now be terminated as there is no longer can be any reasonable suspicion of abuse. In these cases, the injury is most often concluded to be accidental or associated with disease. Knowledge of disease is typically found (much) less in forensic-medical

¹ DECCA uses a standardised sequence of terms in order to formulate its conclusions in terms of probability. This sequence is based on insights that follow from the so-called 'Bayesian Model' for evidence interpretation. Source: *NFI Vakbijlage Waarschijnlijkheidstermen, 18-10-2017*

experts than in professionals of other medical disciplines. In 26,2% of cases DECCA concluded child abuse to be highly likely to certain. These most often concerned physical abuse.

For a systematic overview of these statistics, see attachment 1.

5. KNOWLEDGE DISSEMINATION, EDUCATION, PRESENTATIONS

DECCA also has an educational function. Below is an oversight of DECCA's activities with regard to education and knowledge dissemination in 2018.

KNOWLEDGE DISSEMINATION

DECCA congress

On the 8th of February 2018, the annual DECCA congress took place. This year's title was 'Blind spots and eye-catchers: the differential diagnosis of child abuse, animal abuse and sexual abuse.' The congress was attended by 196 professionals: various paediatricians, Child Safety Doctors, forensic doctors, youth doctors, general practitioners, psychologists/social workers, nurses, veterinarians, emergency doctors, Child Abuse Detection Workers, police/ district attorneys, child abuse & domestic violence coordinators, as well as representatives of the Centre against Sexual Violence (CSG). The day was collectively graded 8,3/10. A detailed report of the congress can be found on <http://leck.nu/congres/>.

DECCA schooling days

In 2018, DECCA organised three schooling days for its paediatricians and forensic doctors. An integral part of these schooling days was the case studies meeting in which all advisory cases and consultations by DECCA in the week before (made anonymous) were discussed. Also, attention was given to DECCA's methodology, including the principles of Bayesian statistics, the importance of the DEXA scan for children with fractures that necessitate interpretation, legal aspects in evaluating patient files, fractures in young children, as well as the Code of Report and the new framework of evaluation.

For the schooling day in October, Child Safety Doctors (*vertrouwensarts*) were also invited, 18 of whom attended the event.

The dates and location of these schooling days were:

- March 20th 2018, location Dutch Forensic Institute (NFI), The Hague
- June 21st 2018, location EMC, Rotterdam
- October 4th 2018, location UMCU, Utrecht

PRESENTATIONS AND EDUCATION

Several DECCA doctors held a total of more than 40 presentations and provided education concerning child abuse and DECCA's activities. For an overview of these endeavours, see attachment 2.

6. EXPERT NETWORK, LITERATURE, PUBLICATIONS

HELPER SOCIETY

Several members of DECCA are part of the Helper Society, and are thereby granted access to an international network of medical experts who exchange, among other things, anonymous case studies on the topic of injury interpretation. Whenever DECCA is unable to reach a conclusion during its weekly case studies meetings, the Helper Society is consulted so that the opinion of (anonymous) international experts is taken into account in the final advice given by DECCA.

LITERATURE

Updates

Every 2-3 weeks, DECCA doctors receive an overview on publications relevant to injury interpretation in children and child safety. These overviews are compiled by DECCA doctors working for the Dutch Forensic Institute.

Child Abuse Atlas

In 2017 DECCA was part of the Child Abuse Atlas, see also <https://www.evidentiapublishing.com> and <https://www.childabuseatlas.com>. This provides its members access to The Quarterly Update, which contains scientific articles on child abuse.

PUBLICATIONS

In 2018, members of DECCA were involved in 25 publications on child abuse. 2 of these were published in Dutch scientific journals or other scientific publications. For a list of the publications, see attachment 3.

7. DECCA'S FINANCES

FINANCING ONGOING BOOK YEAR

In 2018, DECCA was financed in its entirety by the Ministry of Health, Welfare and Sport. Its funds mainly went into financing medical and supporting staff for DECCA locations, namely:

- Paediatricians at the Academic Medical Centre Amsterdam, the University Medical Centre Utrecht and the Erasmus Medical Centre in Rotterdam (guaranteeing a 24-hour service)
- Forensic doctors at the Dutch Forensic Institute
- A radiologist at UMC Amsterdam
- A coordinator and a secretary at UMC Utrecht

Additionally, part of the funds were spent on allowances for members of the board, the members of the advisory committee and the other regular advisors, connectivity costs (the central phone number), the further improvement of DECCA's website and the use of a well-secured database (Castor).

Finally, funds were spent on hiring external experts for the development of a communication plan, the formulation of a formal cooperation agreement between all parties comprising DECCA, scientific research on DEXA scans for bone fracture diagnostics, and other (organisational) costs.

ANBI-STATUS

Foundation DECCA has the Dutch tax status Public Benefit Organisation (ANBI) allotted to it by the Dutch Tax Agency.

FUTURE FINANCING

The Ministry of Health, Welfare and Sport is responsible for the continuity and availability of forensic medical expertise for children. DECCA is currently dependent on a yearly allotment of state funding. To safeguard the quality of DECCA's services in the future, however, it is necessary to achieve long-term certainty on financing. To this end, a dialogue is being held with the Ministry of Health, Welfare and Sport.

8. DECCA'S VISION FOR THE FUTURE

2018 showed a continuation of the upward trend in the amount of cases on which DECCA provided advice: 15% more than in 2017. The DECCA doctors (paediatricians and forensic doctors) of the four medical centres involved (UMC Amsterdam location AMC, the Erasmus Medical Centre Rotterdam, the Academic Medical Centre Utrecht (UMC) and the Dutch Forensic Institute NFI)) have closely worked together to make this possible.

DECCA distinguishes itself from other providers of forensic-medical expertise by evaluating injury or complaints from both paediatric and forensic-medical perspectives. Especially in case of doubt as to the nature of injury or complaints, the best triage is of crucial importance in order to avoid superfluous diagnostics and enable swift action if necessary. This is especially valuable for the first two steps of the Code of Report on Child Abuse, during which the nature of the injuries and/or complaints is yet to be determined. The crucial question is the likelihood of a non-accidental or external cause of injury, and whether this might justify a suspicion of abuse. However, DECCA also provides advice or face-to-face consultation after Steps 1 and 2.

2018 saw the introduction of the renewed Code of Report for child abuse and domestic violence. DECCA is mentioned in Step 2. This will most likely enable more medical professionals to find their way to DECCA's services when they need them. Much like in previous years, in 2018 most inquiries came from paediatricians (over 50% of requests for advice and 28% of requests for face-to-face consultation) and Child Safety Doctors (over 25% of requests for advice and almost 50% of requests for face-to-face consultation). Almost 50% of requests for advice were received before Child Protection Services had been involved (during Step 1 of the Code of Report).

Now that DECCA's position within this chain approach seems to have been consolidated, further professionalization is necessary. In October of 2018, the new medical director commenced his work on the visibility and professionalism of DECCA. DECCA closely works together at the FMEK project initiated by GGDGHOR².

In 2019, DECCA will continue its endeavours to professionalise. A formal cooperation agreement between the four DECCA centres has already been made. There will be another survey among advisees about DECCA's advice, so that we can find out about our mistakes and successes. The biannual visitations of DECCA centres are carried out at present. Another goal for DECCA in 2019 is to enhance its visibility among potential advisees, especially general practitioners and emergency doctors. The sooner a suspicion of child abuse can be falsified or supported, the sooner the child in question can be brought to safety. DECCA always informs the advisee if the case must be reported to Child Protection Services or not. DECCA works together closely with Child Safety Doctors (*vertrouwensarts*), by means of common schooling programmes as well as common case meetings.

DECCA is engaged in an active dialogue with the Ministry of Health, Welfare and Sport concerning a financing plan that moves beyond yearly allotments. Expectations are that such a long-term financing plan may be released in the course of 2019.

² ² FMEK: Forensic-medical expertise for children. <https://www.ggdghorkennisnet.nl/?file=47177&m=1557410632&action=file.download>

ATTACHMENT 1: OVERVIEW OF CASE STUDIES

GENERAL OVERVIEW OF CASE STUDIES

NUMBER OF CASES

From the January the 1st, 2018 to December the 31st, 2018, 268 cases were evaluated by DECCA. These cases form the basis for the analyses in this report. The cases consisted of 229 cases in which DECCA provided advice (85,4%, called 'advisory cases' in this report) and 39 cases in which the patient attended a face-to-face consultation by a DECCA doctor (14,6%, called 'face-to-face consultations' or simply 'consultations' in this report).

Table 1: Advisory cases and face-to-face consultations

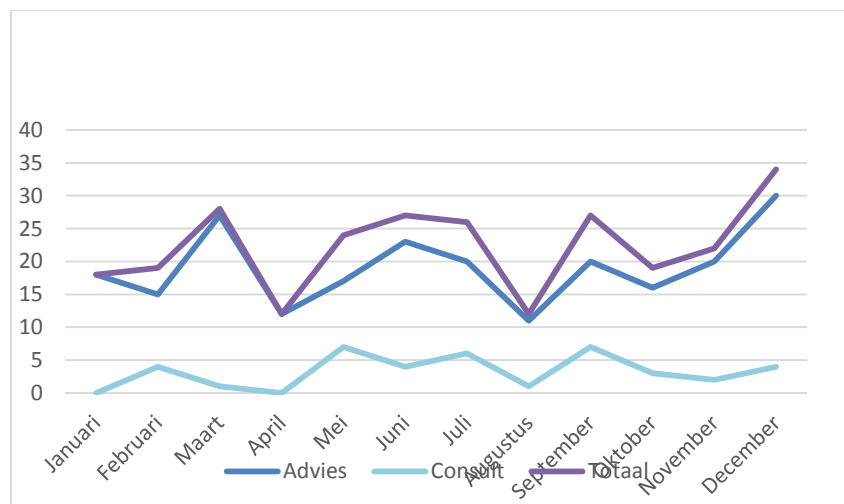
Year	2018	2017	2016	2015
Advisory cases	229	199	189	132
Face-to-face consultations	39	49	34*	103*
Total	268	248	223	235

*In 2015 and 2016, consultations were included for which there had been no explicit request to involve DECCA, but which had been discussed during the weekly DECCA meetings. However, since 2017, only those consultations are included for which the involvement of DECCA was specifically requested.

MONTH, DAY AND TIME OF INCOMING REQUESTS

Image 1 shows how the requests for advice and consultations are distributed across the year. The number of inquiries fluctuates. In April and August less cases came in than in other months, whereas December showed a sharp increase in the amount of cases. There is no discernible pattern in the distribution of cases when compared to previous years.

Image 1: number of advisory cases and face-to-face consultations per month in 2018 (n=268)



The majority of requests came in on weekdays (252 cases, 94,0%). Only 16 requests were reported during the weekend (Table 2). Most requests for advice came in on Tuesdays, whereas most requests for face-to-face consultations came in on Fridays. In 2017, most requests for advice came in on Wednesdays and most requests for consultations came in on Thursdays. In that year, 8% came in during the weekends.

Day of the week	Advice (%)	Consultations (%)	Total (%)
Mondays	42 (18,3%)	9 (23,1%)	51 (19,0%)
Tuesdays	47 (20,5%)	4 (10,3%)	51 (19,0%)
Wednesdays	34 (14,8%)	7 (17,9%)	41 (15,3%)
Thursdays	44 (19,2%)	5 (12,8%)	49 (18,3%)
Fridays	46 (20,1%)	14 (35,9%)	60 (22,4%)
Saturdays	11 (4,8%)	0 (0%)	11 (4,1%)
Sundays	5 (2,2%)	0 (0%)	5 (1,9%)
Total	229 (100%)	39 (100%)	268 (100%)

Most requests came in during office hours (77,2%)(Table 3). An analysis of cases reported outside of office hours is included further on in this report.

Time of day	Advice (%)	Consultations (%)	Total (%)
Office hours (n = 200)			
Weekdays from 8 to 17	167 (75,9%)	33 (84,6%)	200 (77,2%)
Out of hours (n = 59)			
Weekend from 8 to 17	4 (1,8%)	0 (0,0%)	4 (1,5%)
Weekend/weekday evenings from 17 to 23	43 (19,5%)	3 (7,7%)	46 (17,8%)
Weekend/weekday nights from 23 to 8	6 (2,7%)	3 (7,7%)	9 (3,5%)
Total	220 (100%)	39 (100%)	259 (100%)
* For 9 advisory cases, no time was documented			

WEEKLY MEETINGS

All advisory cases and face-to-face consultations are discussed during the weekly case studies, held alternately on Mondays and Tuesdays. These meetings are one-hour teleconferences in which all DECCA doctors take part, including the forensic paediatric radiologist.

24-HOUR CONNECTIVITY

In 2018, a total of 555 incoming phone calls were registered for 0900-4445444, see Table 4. This is significantly more than in 2017, when DECCA received 453 phone calls.

Most calls between DECCA doctors and advisees about patient cases took place after the first contact has been established, and so another phone line is used. 11 % of phone calls took place out of office hours. Statistics about DECCA's email traffic are not included in this report. At any rate, the amount of emails would be much larger than the amount of phone calls.

Table 4: phone calls to 0900-4445444 (n = 555)			
Properties	Number	Percentage	Duration (min)
Landline/mobile			
Mobile	186	33,5%	-
Landline	369	66,5%	-
Peak hours/ off-peak hours*			
Peak hours	493	88,8%	3076
Off-peak hours	62	11,2%	531
Distribution of calls per LECK-centre			
AUMC	172	31,0%	-
EMC	221	39,8%	-
UMCU	119	21,4%	-
no contact was established	43	7,7%	-
Average duration	-	-	6:29
* Peak hours are defined as: Monday to Friday, 8.00 to 19.00. 'Off-peak' is everything outside of these hours.			

ANALYSIS OF ADVICE BY DECCA

In 2018, there were 229 cases in which DECCA advised medical professionals ('advisory cases').

ABOUT THE ADVISEES

Much like in previous years, most requests for advice were submitted by paediatricians (52,4%), followed by Child Safety Doctors (*vertrouwensarts*) (25,8%), as is shown in Table 5. Requests for advice were mainly issued from provinces of The Netherlands that house a DECCA hospital (Utrecht, Noord-Holland and Zuid-Holland, Table 6).

Table 5: function of advisees (n = 229)

Function	Number (%)
Paediatrician†	120 (52,4%)
Child Safety Doctor	59 (25,8%)
Surgeon†	12 (5,2%)
General practitioner	10 (4,4%)
Emergency doctor†	8 (3,5%)
Child Protection (<i>jeugdzorg</i>) worker	4 (1,7%)
Youth doctor	3 (1,3%)
Forensic nurse	3 (1,3%)
Dermatologist†	3 (1,3%)
Other	7 (3,1%)
Total	229 (100%)

† Among these specialisms, requests were included that came from StR, SHO(resident) of the specialism, resident(SHO) general practise in residence at the specialism in question, NP, or medical intern.
Other (all 1x): child abuse/domestic violence detection worker, StR (unspecified), anaesthesiologist, paediatric neurologist, radiologist, rehabilitation specialist

Table 6: geographic location of advisees (n = 229)

Province	Frequency (%)
Zuid-Holland	69 (30,1%)
Utrecht	38 (16,6%)
Noord-Holland	34 (14,8%)
Noord-Brabant	26 (11,4%)
Gelderland	20 (8,7%)
Zeeland	14 (6,1%)
Groningen	11 (4,8%)
Overijssel	6 (2,6%)
Flevoland	6 (2,6%)
Limburg	2 (0,9%)
Friesland	2 (0,9%)
Drenthe	1 (0,4%)

Unknown	0 (0,0%)
Total	229 (100%)

ABOUT THE CHILDREN

In 2018, the amount of advisory cases concerning boys was almost equal to the amount of cases concerning girls (Table 7). In 7 cases, the child's gender was unknown. This gender distribution is similar to previous years. The average age of the children was 3 years and 3 weeks old. The youngest child was 6 days old, the oldest child 17. Note: the exact age in months was not always known. In case it was unknown, an average of 6 months was added to the child's age in years.

Table 7: gender of children subject of inquiry (n = 229)	
Gender	Frequency (%)
Boy	112 (48,9%)
Girl	110 (48,0%)
Unknown	7 (3,1%)
Total	229 (100%)

THE INQUIRIES

In Table 8, the cases on which DECCA gave advice are distributed across categories according to the subject of inquiry.

Table 8: categorisation of advice requests (n = 229)*	
Category	Frequency (%)
Advice with regard to injury/ skin deviations/ physical deviations	152 (66,4%)
Advice with regard to radiological deviations without re-evaluation by DECCA	53 (23,1%)
Advice with regard to radiological deviations re-evaluated by DECCA	44 (19,2%)
Advice with regard to behavioural signals/ symptoms/ risk factors	14 (6,1%)
Advice with regard to deviating results of supplementary investigations	5 (2,2%)
*A case may fit several categories.	

The most common question was if the observed injury could be explained. This could mean that the advisee wanted to know the nature of the injury or deviation, or the differential diagnosis of injury or deviation, or if the injury or deviation fit the described trauma mechanism, or if the injury or deviation justified a suspicion of child abuse.

There were also many questions on what supplementary investigation was necessary, especially in terms of the work-up in the case of suspicion of child abuse.

WHY WAS CHILD ABUSE SUSPECTED BY THE ADVISEES?

Table 9 shows the reasons why the professionals considered the possibility that their patients were victims of child abuse. The most common reason (88,6%) was the presence of injury and/or skin deviations. In almost 20% of cases, the explanation for the injury that was provided did not fit the injury.

In previous years, deviations were often found during supplementary examination. However, upon closer inspection these turned out to be found during medical digital imaging. These are almost always injuries. This year, any injury or deviations found during medical digital imaging are counted as part of the category 'injury and/or skin deviations'.

Reason	Frequency (%)
Injury and/or skin deviations (see Table 10)	203 (88,6%)
Injury did not fit the given explanation	40 (17,5%)
Physical symptoms	21 (9,2%)
Inconsistent narrative	18 (7,9%)
Injury does not fit the child's age	17 (7,4%)
Delay in presentation	16 (7,0%)
Presence of risk factors	11 (4,8%)
Precedent of (unexplained) injury in patient history	11 (4,8%)
Child claims he/she/ another child was abused	8 (3,5%)
Behavioural signals by child	6 (2,6%)
Deviations found in supplementary examination other than medical digital imaging † (see Table 11)	5 (2,2%)
Guardian/parent claims abuse has taken place	3 (1,3%)
Other child of the family claims abuse has taken place	3 (1,3%)
Injury in other child(ren) of the family	2 (0,9%)
Other‡	5 (2,2%)

* Several reasons may apply per case
† Deviations found during medical imaging are included under 'injury and/or skin deviations'
‡ Other (all 1x): So-called 'medical shopping' behaviour for which family has been placed under supervision, unobserved narrative according to which 3,5-year-old child is responsible, language barrier, inadequate interaction between child and guardian, signs of neglect on child.

In the 203 cases in which injury and/or skin deviations were found, these mostly concerned haematomas, fractures and brain injury and erythema. In 2018, no bald spots, stabbing wounds, internal thoracic injury, internal stomach injury or internal pelvic injury were reported to DECCA. Table 10 shows all kinds of injury that were evaluated by DECCA.

Table 11 shows the deviations that were found during supplementary examination other than medical imaging, which prompted suspicions of abuse.

Table 10: Injury and skin deviations in advisory cases (n = 203)*

Injury or skin deviations	Frequency (%)
Haematoma	77 (37,9%)
Fractures other than skull fractures	69 (34,0%)
Skull fractures	29 (14,3%)
Brain damage†	21 (10,3%)
Erythema	21 (10,3%)
Erosion	18 (8,9%)
Burn marks	14 (6,9%)
Retina bleedings	7 (3,4%)
Swelling	6 (3,0%)
Excoriation	5 (2,5%)
Genital injury/genital skin deviations	5 (2,5%)
Laceration	3 (1,5%)
Anal injury/skin deviations	3 (1,5%)
Scars	3 (1,5%)
Subgaleal bleedings	3 (1,5%)
Biting wounds	2 (1,0%)
Petechiae	2 (1,0%)
Necrosis	2 (1,0%)
Cutting wound	1 (0,5%)
Haematoma quadriceps	1 (0,5%)
Dent in skull	1 (0,5%)
Depigmentation	1 (0,5%)

* Several injuries and/or skin deviations may apply per case. Percentages are proportionate to the 203 observed cases of injury/skin deviations.
† Intracranial bleedings or other intracranial injury
Note: when haematoma was observed in the anal or genital regions, these cases were filed under the category 'genital injury/genital skin deviations'. In other words, the category 'haematoma' only contains haematoma outside of the anal/genital region. The same applies to erythema, scars, erosions, etc.

Table 11: deviations found during supplementary examination for advisory cases (n=5)*

Injury	Frequency (%)
Positive STD-diagnosis	2 (40,0%)
Intoxication	1 (20,0%)
Decrease in haemoglobin level	1 (20,0%)
Increase in liver enzymes	1 (20,0%)

* Several deviations may apply per case. Percentages are proportionate to the 5 cases in which deviations were found during supplementary examinations other than medical imaging

THE TYPES OF CHILD ABUSE SUSPECTED BY THE ADVISEE

Table 12 shows the types of child abuse that were suspected by the medical professionals who contacted DECCA for advice. In most cases, they considered the possibility physical assault or sexual abuse. These data largely correspond to those of previous years.

Type	Frequency (%)
Physical abuse/assault	200 (87,3)
Sexual abuse	32 (14,0)
Physical neglect	3 (1,3%)
Paediatric condition falsification	3 (1,3%)
Emotional abuse	1 (0,4%)
Emotional neglect	1 (0,4%)
Domestic violence	0 (0,0%)

* Several types may apply per case

INVOLVEMENT CHILD PROTECTION SERVICES PRIOR TO ADVICE

In 46,7% of advisory cases, DECCA was contacted during Step 1 of the Code of Report Child Abuse and Domestic Violence, before Child Protection Services were involved (Table 13). In 10,0% of cases, DECCA was consulted during Step 1 t/m 4 of the Code of Report (during which Child Protection Service is asked for advice). In 24% of cases, the case had already been reported with Child Protection Services (Step 5 of the Code of Report). In 17,9% of cases, the advisee was an employee of Child Protection Services him- or herself. These cases are very likely among those in which a report had already been filed (Step 5).

Contact	Number (%)
No	107 (46,7%)
Yes, advice requested	23 (10,0%)
Yes, report filed	55 (24,0%)
The advisee works for Child Protection Services him/herself	41 (17,9%)
Unknown	3 (1,3%)
Total	229 (100%)

EXPERTISE USED IN ADVICE

All requests for advice were taken up and treated by a DECCA paediatrician. In 96,5% of cases, the case was directly discussed with one of DECCA's forensic doctors. In the 3,5% in which this was not the case, at least the DECCA forensic doctors were consulted during the weekly case studies meetings. Paediatric radiology was

involved more often than in 2017: in 43,7% of cases (compared to 36,2% in 2017). At times, other specialists from 7 other disciplines were consulted (Table 14).

Table 14: expertise used in DECCA's advice (n = 229)*	
Discipline	Frequency (%)
Paediatrics	229 (100%)
Forensic Medicine	221 (96,5%)
Paediatric Radiology	100 (43,7%)
Paediatric Dermatology	6 (2,6%)
Paediatric Ophthalmology	2 (0,9%)
Paediatric Neurology	2 (0,9%)
Other	4 (1,7%)

* Several disciplines may apply per case
Other (all 1x): child surgery, paediatric haematology, paediatrician specialised in bone disease, paediatric neurosurgery

REEVALUATION RADIOLOGY FOR ADVISORY CASES

In 48 (21,0%) of cases, DECCA recommended a re-evaluation of radiological images by its paediatric radiologists.

TELEDIAGNOSTICS FOR ADVISORY CASES

For 168 advisory cases (73,4%) DECCA evaluated photographic footage of the injury or deviations provided by the advisee.

SUBJECT OF ADVICE BY DECCA

Table 15 shows the subject of the advice given by DECCA. When it is stated that advice was given with regard to a radiological skeletal survey, this means that advice was given either for or against the procedure. For some categories, a strikingly low amount of cases was documented (for instance, the category 'documentation' or 'follow-up'. It is suspected that advice on these topics was provided more often than is reflected in these numbers due to incomplete documentation.

For 96 (41,9%) of cases, DECCA's advice was supported with reference to medical-scientific literature, compared to 49 cases (24,6%) in 2017 and 26 cases (13,8%) in 2016.

Table 15: subject of advice (n = 229)*	
Advice concerned:	Frequency (%)
Radiological skeletal survey	89 (38,9%)
Physical examination	50 (21,8%)
Re-evaluation of radiology by DECCA radiologist	48 (21,0%)
Camera photos	45 (19,7%)
Obtaining forensic-medical expertise	45 (19,7%)
Supplementary anamnesis	43 (18,8%)
Medical care	43 (18,8%)
Radiological examination other than radiological skeletal survey	39 (17,0%)
Laboratory research	38 (16,6%)
Notifying Child Protection Services (<i>Veilig Thuis</i>)	32 (14,0%)
Consulting Child Protection Services (<i>Veilig Thuis</i>)	29 (12,7%)

Formulating an injury description	24 (10,5%)
Documentation	20 (8,7%)
No supplementary advice apart from injury interpretation	20 (8,7%)
Ophthalmoscopy	18 (7,9%)
Necessity of follow-up	12 (5,2%)
Obtaining (sub-)specialist expertise	11 (4,8%)
Obtaining information from the (medical) professionals involved	10 (4,4%)
Inspection of objects related to injury	9 (3,9%)
Referral to DECCA for face-to-face consultation	7 (3,1%)
Forensic-medical research	6 (2,6%)
Microbiological research	5 (2,2%)
Psychological examination	5 (2,2%)
Legal issues / reporting to the police	3 (1,3%)
Options for aid other than Child Protection Services in case of abusive family situation	3 (1,3%)
Other	5 (2,2%)
* In each case, advice may be given on several of the abovementioned subjects. Other (all 1x): injury in other child of the family, genetic diagnostics on <i>osteogenesis imperfecta</i> and DEXA-scan, home visit, reconstruction of growth curve, no further advice given because of involvement NFI	

SUSPICION OF CHILD ABUSE AFTER EVALUATION BY DECCA

Table 15 shows how likely DECCA estimated child abuse to be, based on the provided information. Over the years, the assessed probability of abuse tends to fluctuate. In 2017, it was concluded that in 16,3% of cases child abuse was certain or highly probable. In 2018, this percentage was 26,2%. DECCA reached the conclusion 'improbable/ almost certainly no abuse' in 34% of cases in 2018, compared to 47,3% in 2017.

Probability of abuse	Frequency (%)	
Almost certain†	20 (8,7%)	} 26,2%
Likely ‡	40 (17,5%)	
Possible¥	64 (27,9%)	
Unlikely§	53 (23,1%)	} 34,0%
Almost certainly not	25 (10,9%)	
Unclear, further inquiry necessary	27 (11,8%)	
Total	229 (100%)	
† For instance: in case a parent has admitted to committing child abuse		
‡ For example: in case of brain injury with subdural haematoma, retina haemorrhage, or rib fractures		
¥ For example: in case of linear parietal skull fracture without brain damage and without plausible explanation		
§ For example: in case of fractures associated with accidental injury with adequate explanation		
ψ The injury or deviation is explained by an underlying disease/affliction, birth trauma or normal variation		

In 7 cases, DECCA concluded that the injury fits a disease or other affliction that excludes child abuse. These were: lateral transfer Herpes Simplex, viral skin disease, *impetigo bullosa* 2x, infected skin tag, secondary infected haematoma i.e. coagulation disorder, striae. In one advisory case, the re-evaluation of radiological images showed that it concerned physiological natural variation (step-off).

ANALYSIS OF CONSULTATIONS BY DECCA

In 2018, DECCA carried out 39 face-to-face consultations.

TYPE OF CONSULTATION

In one case, the consultations took place both in a polyclinic and in the hospital (clinical). 31 Consultations were only polyclinical and 7 consultations were only clinical.

ABOUT THOSE WHO REQUESTED THE CONSULTATION

Whereas most advisory cases were requested by paediatricians, most of the 39 face-to-face consultations were requested by Child Safety Doctors (48,7%). Paediatricians were the second largest group to request consultations (28,2%). Table 17 provides an overview of all professions who requested consultations.

Function	Number (%)
Child Safety Doctor	19 (48,7%)
Paediatrician/resident paediatrician	11 (28,2%)
General practitioner	4 (10,3%)
Youth Services Worker	3 (7,7%)
Paediatric intensivist	1 (2,6%)
Unknown	1 (2,6%)
Total	39 (100%)

The medical professions who requested consultations were mostly active in DECCA hospitals (Table 18). From 6 provinces, there were no requests for consultations, much like last year.

Province	Number (%)
Utrecht	14 (35,9%)
Noord-Holland	9 (23,1%)
Zuid-Holland	9 (23,1%)
Noord-Brabant	3 (7,7%)
Zeeland	2 (5,1%)
Flevoland	1 (2,6%)
Friesland	0 (0,0%)
Groningen	0 (0,0%)
Drenthe	0 (0,0%)
Overijssel	0 (0,0%)

Gelderland	0 (0,0%)
Limburg	0 (0,0%)
Unknown	1 (2,6%)
Total	39 (100%)

ABOUT THE CHILDREN

In 2018, more girls than boys attended consultation at DECCA (66,7%, see Table 19). The average age of the children who attended consultation was 6 years and 3 months, considerably older than the average age in advisory cases. The youngest child was one month old; the oldest child was 19 years and 2 months old. Note: the exact age of the children in months was not known for each patient. If it was not, an average of 6 months were added to the amount of years.

Table 19: gender of children who attended consultation (n = 39)

Gender	Number (%)
Boy	13 (33,3%)
Girl	26 (66,7%)
Total	39 (100%)

For 17,9% of families, safety measures had already been taken. In most cases, this concerned out-of-home-placement (custodial placement) (Table 20).

Table 20: prior measures taken in families of children who attended consultation by DECCA (n = 39)*

Measures taken	Number (%)
Yes	7 (17,9%)
Safety plan	2 (5,1%)
Temporary surveillance	2 (5,1%)
Indefinite surveillance	1 (2,6%)
Custodial (out-of-home) placement	5 (12,8%)
No	24 (61,5%)
Unknown	8 (20,5%)
Total	39 (100%)
* In case of prior measures, several may apply per case	

REASONS FOR CONSULTATION

Table 21 shows the reasons given for requesting consultation, distributed across several categories. Much like the advisory cases, most consultations (84,6%) were held to ascertain the nature of injury, skin deviations or other physical deviations.

Table 21: distribution of reasons for consultation across categories (n = 39)*

Category	Frequency (%)
Injury/ skin deviations/ physical deviations	33 (84,6%)
Behavioural signs/ symptoms/ risk factors	7 (17,9%)
Radiological deviations	2 (5,1%)
Results of supplementary examination	0 (0%)
*Several categories may apply per case	

By far the most common request was the interpretation of injury and/or deviations, as well as the question if the injury fit the described trauma mechanism. There were several requests for genital examination in case of suspected sexual abuse. There were also general requests for a tip-to-toe examination to look for possible signs of physical abuse.

WHY DID THOSE WHO REQUESTED CONSULTATIONS SUSPECT CHILD ABUSE?

Table 22 shows the reasons why the medical professionals who requested consultations considered the possibility of child abuse. The child claimed that abuse had taken place in 33,3% of cases, compared to 28,6% in 2017. The presence of risk factors and behavioural symptoms, on the other hand, played a much less prominent role in 2018 (only 2,6% and 5,1% respectively, compared to 28,6% and 26,5% in 2017).

Table 22: suspicion of child abuse by those who requested face-to-face consultation (n = 39)*

Reason	Frequency (%)
Presence of injury and/or skin deviations	28 (71,8%)
Child claims he or she is victim of abuse	13 (33,3%)
Physical symptoms	4 (10,3%)
Other child from family claims abuse	4 (10,3%)
Parent/guardian claims abuse	3 (7,7%)
Behavioural signs in child	2 (5,1%)
Injury does not fit the child's age	2 (5,1%)
Extant suspicion that other child in the same family is victim of abuse	2 (5,1%)
Presence of risk factors	1 (2,6%)
Injury does not fit explanation given	1 (2,6%)
Delay in presentation	1 (2,6%)
Inconsistent narrative	1 (2,6%)
Prior (unexplained) injury in patient history	1 (2,6%)
* Several reasons may apply per case	
† Deviations found during medical imaging are generally injuries	

The observed injuries were most often haematomas (78,6%, see Table 23). This percentage is significantly higher than in 2017, when haematomas were found in 38,8% of consultations. Unlike in 2017, in 2018 no stab- or cutting wounds, burns, skull fractures, internal stomach injury or pelvic injury, anal injury or bald spots were found during face-to-face consultations.

Table 23: injury and skin deviations in consultations (n = 28)*	
Injury and skin deviations	Frequency (%)
Haematoma	22 (78,6%)
Erythema	4 (14,3%)
Erosion	4 (14,3%)
Excoriation	3 (10,7%)
Hyper- or hypopigmentation	3 (10,7%)
Fractures other than skull fractures	2 (7,1%)
Scars	2 (7,1%)
Brain damage†	1 (3,6%)
Retina bleedings	1 (3,6%)
Internal thoracic injury	1 (3,6%)
Genital injury	1 (3,6%)
Laceration	1 (3,6%)
Biting wound	1 (3,6%)

* Several injuries and/or skin deviations may apply per case, percentages are proportionate to the 28 cases of injury and skin deviations found during face-to-face consultations
 † Intracranial bleeding or other intracranial injury
 Note: when haematoma was observed in the anal or genital regions, these cases were filed under the category 'genital injury/genital skin deviations'. In other words, the category 'haematoma' only contains haematoma outside of the anal/genital region. The same applies to erythema, scars, erosions, etc.

TYPE OF ABUSE SUSPECTED BY THE MEDICAL WORKERS WHO REQUESTED CONSULTATIONS

Table 24 shows the type of child abuse suspected by the medical workers who requested consultations. In most cases, they suspected physical or sexual abuse. However, sexual abuse was suspected in 40,8% of cases in 2017, considerably more than in 2018.

Table 24: type of child abuse suspected by those who requested consultation by DECCA (n = 39)*	
Type	Frequency (%)
Physical abuse	35 (89,7%)
Sexual abuse	8 (20,5%)
Emotional abuse	4 (10,3%)
Domestic violence	4 (10,3%)
Physical neglect	0 (0,0%)
Emotional neglect	0 (0,0%)
Paediatric Condition Falsification	0 (0,0%)

* Several types may apply per case

INVOLVEMENT CHILD PROTECTION SERVICE (*VEILIG THUIS*) PRIOR TO CONSULTATION

In 43,6% of consultations, the case in question was already reported to Child Protection Services. This corresponds to Step 5 of the Code of Report Child Abuse and Domestic Violence. It can also be safely assumed that Child Protection Services had been notified in those 30,8% cases in which the request came from someone who works for Child Protection Services. Almost a quarter of requests for consultations came in during Step 1, that is to say, before Child Protection Services were notified.

Table 25: contact Child Protection Services prior to consultation by DECCA (n = 39)

Contact	Frequency
No	9 (23,1%)
Yes, advice requested	1 (2,6%)
Yes, report filed	17 (43,6%)
The person who requested consultation works for Child Protection Services his/herself	12 (30,8%)
Total	39 (100%)

OTHER MEASURES TAKEN PRIOR TO CONSULTATION

Table 26 shows whether medical professionals who requested face-to-face consultation from DECCA had already taken action at that point in time.

Table 26: other actions taken by the medical workers that requested consultation (n = 39)*

Actions taken	Frequency (%)
Medical assistance provided	18 (46,2%)
Reported to the police	8 (20,5%)
Discussion held with (medical) professionals involved in the case	3 (7,7%)
Obtaining (sub)specialist expertise	2 (5,1%)
Advice obtained from DECCA	2 (5,1%)
Forensic-medical expertise obtained from elsewhere	1 (2,6%)
Other	3 (7,7%)
None of the above	13 (33,3%)
* Several actions may apply per case Other: involving neighbourhood watch team, going to the police his/herself, out-of-house placement and temporary custodian care	

EXPERTISE USED IN CONSULTATIONS

Table 27 shows which expertise was used by DECCA in the face-to-face consultations. Nearly all consultations were handled by a paediatrician and a forensic doctor who are members of DECCA. In 12,8% of consultations, the DECCA paediatric radiologist was consulted. 7 Other disciplines were involved in the consultations carried out by DECCA in 2018.

Discipline	Frequency (%)
Paediatrics	39 (100%)
Forensic medicine	39 (100%)
Paediatric radiology	5 (12,8%)
Paediatric dermatology	5 (12,8%)
Microbiology	2 (5,1%)
Paediatric ophthalmology	1 (2,6%)
Paediatric neurology	1 (2,6%)
Child gynaecology	1 (2,6%)
Child and youth psychiatry	1 (2,6%)
Psychotrauma centre	1 (2,6%)

* Several types of expertise may apply per case

EVALUATION OF RADIOLOGY

In 5 consultations (12,8%) radiological images were made and/or re-evaluated by DECCA.

EXAMINATIONS BY DECCA IN CONSULTATIONS

Table 28 shows which examinations DECCA carried out during consultations. In almost all cases, these included physical examination. Other common examinations were: medical imaging, laboratory research and forensic-medical examination. According to our data, in 2 cases a medical photographer took pictures. However, it seems very likely that this is an underestimation due to incomplete documentation.

Examination	Frequency (%)
Physical examination	38 (97,4%)
Medical imaging	8 (20,5%)
Laboratory research	6 (15,4%)
Forensic-medical examination	4 (10,3%)
Microbiological examination	3 (7,7%)
Psychological examination	2 (5,1%)
Photography	2 (5,1%)
Discussion with other (medical) professionals involved in the case	1 (2,6%)
Evaluation external files	1 (2,6%)

* Several examinations may apply per case

SIGNALLING OTHER SIGNS OF CHILD ABUSE DURING CONSULTATIONS

In 14 of 39 cases (35,9%) DECCA registered possible signs of child abuse that had not been found until then. These were injuries, other physical deviations, deviations found during supplementary examination and physical symptoms.

SUSPICION OF ABUSE AFTER EVALUATION OF CONSULTATIONS BY DECCA

Table 29 shows DECCA's conclusions on the probability of child abuse based on the consultations. Compared to 2017, far fewer cases led DECCA to conclude that abuse was either unlikely or almost certainly not the case (23,1% in 2018 vs. 51,0% in 2017). On the other hand, the conclusion that abuse was likely to near certain was reached in 33,3% of cases in 2018, compared to only 24,4% in 2017.

Table 29: probability of abuse in consultations (n = 39)		
Probability of abuse	Frequency (%)	
Almost certain†	10	(25,6%)
Likely ‡	3	(7,7%)
Possible¥	14	(35,9%)
Unlikely§	4	(10,3%)
Almost certainly not	5	(12,8%)
Unclear, further inquiry necessary	3	(7,7%)
Total	39	(100%)
† For instance: in case a parent has admitted to committing child abuse ‡ For example: in case of brain injury with subdural haematoma, retina haemorrhage, or rib fractures ¥ For example: in case of linear parietal skull fracture without brain damage and without plausible explanation § For example: in case of fractures associated with accidental injury with adequate explanation ψ The injury or deviation is explained by an underlying disease/affliction, birth trauma or normal variation		

In 9 consultations, DECCA concluded that the symptoms were caused by disease or normal variation. These were: symptoms of irritation (3x), slate grey nevus/Mongolian spot (2x), café au lait macules/post-inflammatory hyperpigmentation, signs of automutilation, red coloration during compression and crying/possible artery anomaly, infections. In these cases, DECCA excluded the possibility of abuse.

SAFETY MEASURES TAKEN AFTER CONCLUSIONS BY DECCA

Table 30 shows which safety measures were taken after the evaluation of consultations by DECCA. In 51,3% measures were taken, most often by way of a so-called safety plan. In 11 cases of consultation, it was unknown if safety measures were taken. In 25,6% of cases, no safety measures were taken.

Table 30: safety measures after evaluation of consultations (n = 39)*	
Safety measure	Frequency (%)
Safety plan	14 (35,9%)
Out-of-home placement	3 (7,7%)
Temporary surveillance	3 (7,7%)
Surveillance	0 (0)
None	10 (25,6%)
Unknown	11 (28,2%)

* Several safety measures may apply per case

ANALYSIS OF OUT-OF-HOURS CASES

DECCA can be reached and mobilised 24/7. This is relatively expensive, but necessary to be able to satisfy the demand for care. The cases reported out of office hours are summarised below.

Of 268 cases, 59 (22,0%) were reported out of normal office hours (08:00-17:00). This is more than in 2017(17,3%). The out-of-hours cases in 2018 were 34 advisory cases and 9 consultations. The Tables below present an overview of these cases.

Table 31: day of incoming requests (n = 59)			
Day	Advice (%)	Consultations (%)	Total (%)
Monday	6 (11,3%)	0 (0)	6 (10,2%)
Tuesday	5 (9,4%)	1 (16,7)	6 (10,2%)
Wednesday	3 (5,7%)	3 (50,0%)	6 (10,2%)
Thursday	14 (26,4%)	1 (16,7%)	15 (25,4%)
Friday	9 (17,0%)	1 (16,7%)	10 (16,9%)
Saturday	11 (20,8%)	0 (0,0%)	11 (18,6%)
Sunday	5 (9,4%)	0 (0,0%)	5 (8,5%)
Total	53 (100%)	6 (100%)	59 (100%)
% of all cases in 2018*	24,1% of 220	15,4% of 39	22,8% of 259
* In 9 of advisory cases no time of incoming request was documented; however, these all concerned cases that came in during office hours			

ABOUT THOSE WHO REQUESTED ADVICE OR CONSULTATIONS

Most out-of-hours requests were made by paediatricians (62,7%, including StR, SHO, resident etc), followed by Child Safety Doctors (*vertrouwensarts*) (16,9%), and emergency doctors (6,8%, including SHOs general practice on an internship at ERs). The requests mainly came from provinces that house DECCA-hospitals (Zuid-Holland 33,9%, Noord-Holland 16,9% and Utrecht 15,3%).

Table 32 shows which expertise DECCA used in the out-of-hours requests. All advisory cases were handled by a paediatrician and 96,6% were immediately discussed with a DECCA forensic doctor. If this was not the case (3,4%), the cases were at least evaluated by a forensic doctor at the weekly DECCA case studies meeting. In 32,2% of cases, the DECCA paediatric radiologist was consulted. In a small amount of cases, a paediatric dermatologist was consulted.

Table 32: expertise used for out-of-hours advice/consultations (n = 59)*	
Discipline	Frequency (%)
Paediatrics	59 (100%)
Forensic medicine	57 (96,6%)
Paediatric radiology	19 (32,2%)
Paediatric dermatology	3 (5,1%)
* Several disciplines may apply per case	

SUSPICIONS OF ABUSE AFTER EVALUATION BY DECCA

It was relevant to know whether the cases that came in out of office hours were more or less severe with regard to the odds of child abuse. In 2018, DECCA concluded that the probability of child abuse for out-of-hours cases was slightly smaller (23,7%) than the probability of abuse across all cases in 2018 (27,2%).

In 27,1% of out-of-hours cases, child abuse was concluded to be unlikely to almost certainly not the case. Across all cases in 2018, this percentage was 32,5%. In these cases, it is very important to be able to quickly rule out or declare as unlikely the possibility of abuse, based on the available information.

Table 33: probability of abuse in consultations (n = 59)		
Probability of abuse	Frequency (%)	
Almost certain†	5 (8,5%)	
Likely ‡	9 (15,3%)	23,7%
Possible¥	22 (37,3%)	
Unlikely§	11 (18,6%)	
Almost certainly not	5 (8,5%)	27,1%
Unclear, further inquiry necessary	7 (11,9%)	
Total	59 (100%)	
† For instance: in case a parent has admitted to committing child abuse ‡ For example: in case of brain injury with subdural haematoma, retina bleedings, or rib fractures ¥ For example: in case of linear parietal skull fracture without brain damage and without plausible explanation § For example: in case of fractures associated with accidental injury with adequate explanation ψ The injury or deviation is explained by an underlying disease/affliction, birth trauma or normal variation		

ATTACHMENT 2: OVERVIEW PRESENTATIONS AND EDUCATION

Apart from the presentations listed below, DECCA doctors teach many different subjects to Bachelor and Master students at the academic centres in which they work. These educational activities are not elaborated on in this report.

Affourtit, Marjo

- 12-01-2018, WOKK (paediatricians)
- 29-3-2018 "What can DECCA do support professionals?"; valedictory symposium Noor Landsmeer
- 20-4-2018 "Child abuse and skin"; with Prof S. Pasmans, Dermatology Days
- 1-6-2018 "Child Abuse and the ER"; Dutch North Sea Emergency Conference
- 31-10-2018, WOKJA (youth doctors)
- 09-11-2018, WOKK (paediatricians)
- Internal schooling events for emergency doctors, emergency nurses, oral surgeons, ophthalmologists, anaesthetologists

Berkestijn, Frederique

- 15-3-2018 en 14-12-2018, Dutch Neurology Association: "Biemond course: common ground with neurology." "Per accident? Paediatric-radiological aspects of child abuse". Veldhoven

Nijs, Huub

- 12-01-2018, WOKK (paediatricians)
- 26-01-2018, WOKSEH (emergency doctors)
- 26-01-2018, CSG opening event Breda
- 08-02-2018, DECCA congress. Presentation: LED
- 07-09-2018, Forensic detectives Police Academy Apeldoorn
- 12-09-2018, so-called "Taakaccenthouders youth" Police Academy Apeldoorn
- 15-06-2018, SSR. Speaker on schooling DEA/Judges
- 05-07-2018, Child safety doctors at NFI
- 31-10-2018, WOKJA (youth doctors)
- 09-11-2018, WOKK (paediatricians)
- 15-11-2018, NSPOH forensic doctors. Presentation: FMEK
- 19-11-2018, youth doctors. Presentation: "TNO/Social medicine"
- 17-12-2018, Forensic coordinators police

Puiman, Patrycja

- 15-11- 2018, Surgery Department, Red Cross hospital, Beverwijk

Putte, Elise van de

- 08-02-2018, DECCA congres, Cinemec Utrecht Leidsche Rijn. Presentation: "3 years of DECCA"
- 08-02-2018, DECCA congres, Cinemec Utrecht Leidsche Rijn. Presentation: "Paediatric Condition Falsification (PCF) or Complaints with Insufficient Physical Explanation" (*Dutch: SOLK*)
- 07-03-2018, SSPK congress, Exhibition Centre Utrecht. Presentation: "When does SOLK become PCF?"
- 06-04-2018, PAOG Paediatrics Utrecht. Presentation: "Up-to-date: validity of screening instruments"
- 13-06-2018, NVK congress, Papendal Arnhem. Presentation: "How valid should a screening instrument for child abuse be?"
- 25-07-2018, IACAPAP, Prague, An Academic Perspective on Child Abuse in the Netherlands.
- 04-10-2018, DECCA Training Day Utrecht: "When to report a case with Child Protection Services?"
- 22-11-2018: congress Domestic Violence: "The sense and nonsense of child abuse screening in emergency healthcare"
- 19-12-2018, Presentation Wilhelmina Children's Hospital, Utrecht: "New Code of Report Child Abuse."

Rijn, Rick van

- 04-03-2018, Abusive head trauma: the role of CT and MRI. European Congress of Radiology, Vienna
- 22-01-2018, Recognizing and timing abusive head injuries. European Course of Paediatric Neuroradiology. European Society of Neuroradiology & European Society of Paediatric Radiology, Athens
- Juni 2018, Loos MH, de Jong VM, Goslings JC, van Rijn RR, Bakx R Incidence of child abuse in children attending the shockroom. European Paediatric Surgical Association, Paris. (also abstract)

Russel, Ingrid

- 25-01 t/m 26-01-2018, WOKSEH (emergency doctor)
- 24-09 t/m 25-09, WOKK (paediatricians)
- 31-10 t/m 01-11 WOKJA (youth doctors)
- 08-02-2018, LECK congress. Presentation: "DECCA case studies"
- 14-06-2018, NVK congress. Presentation: "Careful, fragile"
- 04-10-2018, DECCA schooling day with Child Safety Doctors. Presentation: "Fractures"
- 22-11-2018, NSPOH, Forensic Doctors The Netherlands. Presentation: "Forensic-medical expertise"

Smeijers, Anika

- 15-05-2018, presentation about DECCA, paediatrics department at Guest House Spaarne

Teeuw, Rian

- 23-02-2018, Team Based Learning Child Abuse for Bachelor Students 2nd year medicine AMC
- 07-6-2018, PCF lecture for paediatricians and doctor assistants VUMC
- 13-6-2018, NVK symposium. Workshop: "The sense and nonsense of screening for child abuse."
- 20-06-2018, Networking Event Municipality of Zwijndrecht. Presentation: "Effects of child abuse on the brain."
- 20-11-2018, Kempenhaeghe, Heeze. Speaker symposium child abuse
- 05-12-2018, EADV (European Academy of Dermatology and Venereology) Advanced Course, Amsterdam. Presentation: "Children and Sexual Abuse"

ATTACHMENT 3: OVERVIEW PUBLICATIONS

1. Alisic E, Groot A, Snetselaar H, Stroeken T, Hehenkamp L, **van de Putte E**. Children's perspectives on life and well-being after parental intimate partner homicide. *Eur J Psychotraumatol*. 2018 May 22;8(Suppl 6):1463796. doi: 10.1080/20008198.2018.1463796. eCollection 2017.
2. Atkinson N, **van Rijn RR**, Starling SP. Childhood Falls With Occipital Impacts. *Pediatr Emerg Care*. 2018 Dec;34(12):837-841. doi: 10.1097/PEC.0000000000001186.
3. Baos S, Brigden A, Anderson E, Hollingworth W, Price S, Mills N, Beasant L, Gaunt D, Garfield K, Metcalfe C, Parslow R, Downing H, Kessler D, Macleod J, Stallard P, Knoop H, **Van de Putte E**, **Nijhof S**, Bleijenberg G, Crawley E. Investigating the effectiveness and cost-effectiveness of FITNET-NHS (Fatigue In Teenagers on the interNET in the NHS) compared to Activity Management to treat paediatric chronic fatigue syndrome (CFS)/myalgic encephalomyelitis (ME): protocol for a randomised controlled trial. *Trials*. 2018 Feb 22;19(1):136. doi: 10.1186/s13063-018-2500-3.
4. **Bilo RAC**, Vester MEM, Nijs HGT, Duijst W. Een vermoeden van toegebracht hersenletsel. Expertise en Recht (*A suspicion of inflicted injury. Expertise and the law*) 2018;5: 193-204.
5. **Bilo RAC**. The Swedish Agency for health technology-report about traumatic shaking: much ado about nothing? *Forensic Sci Med Pathol*. 2018 Dec;14(4):541-544. doi: 10.1007/s12024-018-0006-7. Epub 2018 Aug 1
6. Farah R. W. Kools, Sara Mirali, Stephanie Holst-Bernal, Sanne L. **Nijhof**, Giulio Cavalli and Michael A. Grandner. Publications Are Not the Finish Line: Focusing on Societal Rather Than Publication Impact. *Front. Med.*, 12 November 2018 | <https://doi.org/10.3389/fmed.2018.00314>
7. Fieten KB, Bruins FM, Zijlstra WT, Schappin R, Figuee L, de Bruijn M, **Russel IMB**, van Os-Medendorp H, Pasmans SGMA. Parental treatment management skills in paediatric atopic dermatitis. *Clin Exp Dermatol*. 2018 Jun;43(4):461-463. doi: 10.1111/ced.13336. Epub 2017 Dec 20. No abstract available.
8. Groenewegen WA, **van de Putte EM**. General Data Protection Regulation and medical research: friend or foe? *Ned Tijdschr Geneeskd*. 2018 Oct 12;162. pii: D3308. Dutch
9. KMJ Heitink-Pollé, CSPM Uiterwaal, L Porcelijn, RYJ Tamminga, FJ Smiers, **NL van Woerden**, J Wesseling, AG Laarhoven, M de Haas, MCA Bruin. Intravenous Immunoglobulin versus Observation in Childhood Immune Thrombocytopenia: a Randomized Controlled Trial. *Blood*, 2018; 132: 883-891.
10. Hoytema van Konijnenburg EMM, Gigengack M, **Teeuw AH**, Sieswerda-Hoogendoorn T, Brilleslijper-Kater SN, Flapper BC, Lindauer RJL, van Goudoever JB, van der Lee JH; aftERcare group. Follow-up protocol was useful for children whose parents attended emergency departments after partner violence, substance abuse or a suicide attempt. *Acta Paediatr*. 2018 Jan;107(1):110-120. doi: 10.1111/apa.14082. Epub 2017 Oct 11.
11. Hymel KP, Laskey AL, Crowell KR, Wang M, Armijo-Garcia V, Frazier TN, Tieves KS, Foster R, Weeks K; Pediatric Brain Injury Research Network (PediBIRN) Investigators. Racial and Ethnic Disparities and Bias in the Evaluation and Reporting of Abusive Head Trauma. *J Pediatr*. 2018 Jul;198:137-143.e1. doi: 10.1016/j.jpeds.2018.01.048. Epub 2018 Mar 29.
12. Hymel KP, Wang M, Chinchilli VM, **Karst WA**, Willson DF, Dias MS, Herman BE, Carroll CL, Haney SB, Isaac R; Pediatric Brain Injury Research Network (PediBIRN) Investigators. Estimating the probability of abusive head trauma after abuse evaluation. *Child Abuse Negl*. 2019 Feb;88:266-274. doi: 10.1016/j.chiabu.2018.11.015. Epub 2018 Dec 11.
13. **Karst WA**, **Van Rijn RR**. Non-accidental injury in children. In: Kelly AM, Cronin P, Puig S (eds.) *Evidence-Based Emergency Imaging* 2018;34:545-53.
14. Louman S, Fredriks AM, **van Bellegem ACM**, **Teeuw AH**. Self-harm among children and adolescents. *Ned Tijdschr Geneeskd*. 2018 Oct 15;162. pii: D2609. Dutch.

15. **Nijs HGT**, De Groot R, Van Velthoven MFAM, Stoel RD. Is the visibility of standardized inflicted bruises improved by using an alternate ('forensic') light source? *Forensic Sci Int.* 2019 Jan;294:34-38. doi: 10.1016/j.forsciint.2018.10.029. Epub 2018 Nov 5.
16. Schouten MCM, **Russel IMB**, **van de Putte EM**. *Kindermishandeling*. Hoofdstuk in *Leerboek kinderverpleegkunde*. 5e herziene druk. Ulijn-ter Wal R, den Ridder K. Houten: Bohn Stafleu van Loghum; 2018, ISMB 9789036819121
17. Shelmerdine SC, Hutchinson JC, Al-Sarraj S, Cary N, Dawson T, Du Plessis D, Ince PG, McLaughlin S, Palm L, Smith C, Stoodley N, **van Rijn R**, Arthurs OJ, Jacques TS; British Neuropathological Society and International Society of Forensic Radiology and Imaging expert consensus statement for post mortem neurological imaging. *Neuropathol Appl Neurobiol.* 2018 Dec;44(7):663-672. doi: 10.1111/nan.12482. Epub 2018 Apr 16.
18. Sonnemans LJP, Vester MEM, Kolsteren EEM, Erwich JJHM, Nikkels PGJ, Kint PAM, **van Rijn RR**, Klein WM; Dutch post-mortem imaging guideline group. Dutch guideline for clinical foetal-neonatal and paediatric post-mortem radiology, including a review of literature. *Eur J Pediatr.* 2018 Jun;177(6):791-803. doi: 10.1007/s00431-018-3135-9. Epub 2018 Apr 19. Review.
19. **Teeuw AH**, Kraan RBJ, **van Rijn RR**, Bossuyt PMM, **Heymans HSA**. Screening for child abuse using a checklist and physical examinations in the emergency department led to the detection of more cases. *Acta Paediatr.* 2019 Feb;108(2):300-313. doi: 10.1111/apa.14495. Epub 2018 Aug 14.
20. Vester MEM, **Bilo RAC**, **Nijs HGT**, **van Rijn RR**. Pediatric constrictive asphyxia, a rare form of child abuse: A report of two cases. *Forensic Sci Int.* 2018 Apr;285:e17-e20. doi: 10.1016/j.forsciint.2018.01.003. Epub 2018 Jan 10.
21. Vos A, van der Wal AC, **Teeuw AH**, Bras J, Vink A, Nikkels PGJ; Dutch NODO group. Cardiovascular causes of sudden unexpected death in children and adolescents (0-17 years) : A nationwide autopsy study in the Netherlands. *Neth Heart J.* 2018 Oct;26(10):500-505. doi: 10.1007/s12471-018-1152-y. Erratum in: *Neth Heart J.* 2019 Feb;27(2):114.
22. Vrolijk-Bosschaart TF, Brilleslijper-Kater SN, Verlinden E, Widdershoven GAM, **Teeuw AH**, Voskes Y, van Duin EM, Verhoeff AP, de Leeuw M, Roskam MJ, Benninga MA, Lindauer RJL. A Descriptive Mixed-Methods Analysis of Sexual Behavior and Knowledge in Very Young Children Assessed for Sexual Abuse: The ASAC Study. *Front Psychol.* 2019 Jan 9;9:2716. doi: 10.3389/fpsyg.2018.02716. eCollection 2018.
23. Vrolijk-Bosschaart TF, Brilleslijper-Kater SN, Benninga MA, Lindauer RJL, **Teeuw AH**. Clinical practice: recognizing child sexual abuse-what makes it so difficult? *Eur J Pediatr.* 2018 Sep;177(9):1343-1350. doi: 10.1007/s00431-018-3193-z. Epub 2018 Jun 25.
24. Vrolijk-Bosschaart TF, Nagtegaal M, Brilleslijper-Kater SN, Benninga MA, Lindauer RJL, **Teeuw AHR**. How do you recognise sexual abuse in children? *Ned Tijdschr Geneeskd.* 2018 May 18;162. pii: D2632. Dutch.
25. Vrolijk-Bosschaart TF, Verlinden E, Langendam MW, De Smet V, **Teeuw AH**, Brilleslijper-Kater SN, Benninga MA, Lindauer RJL. The Diagnostic Utility of the Child Sexual Behavior Inventory for Sexual Abuse: A Systematic Review. *J Child Sex Abus.* 2018 Oct;27(7):729-751. doi: 10.1080/10538712.2018.1477215. Epub 2018 Jun 11. Review.

ATTACHMENT: LIST OF DECCA DOCTORS AS OF 31/12/2018

Naam	Functie	Centrum
M.J. Affourtit	Paediatrician	EMC
A.C.M. van Bellegem	Paediatrician	Amsterdam UMC
R.A.C. Bilo	Forensic doctor	NFI
M.G. Bouwman	Paediatrician	Amsterdam UMC
M. Kruijssen	Forensic doctor	NFI
W.A. Karst	Forensic doctor	NFI
S.L. Nijhof	Paediatrician	UMCU
H.G.T. Nijs	Forensic doctor	NFI
P.J. Puiman	Paediatrician	EMC
E.M. van de Putte	Paediatrician	UMCU
R.R. van Rijn	Paediatric radiologist	Amsterdam UMC
J.M. Ruskamp	Paediatrician	UMCU
I.M.B. Russel	Paediatrician	UMCU
A.S. Smeijers	Paediatrician	Amsterdam UMC
A.H. Teeuw	Paediatrician	Amsterdam UMC
H.C. Terlingen	Forensic doctor	NFI
S. de Vries	Forensic doctor	NFI
N.L. van Woerden	Forensic doctor	NFI
S.A.A. Wolt	Paediatrician	UMCU

Replacing radiologists

R.A.J. Nievelstein	Paediatric radiologist	UMCU
S.G.F. Robben	Paediatric radiologist	MUMC

The following specialists are frequently consulted

F. van Berkestijn	Paediatrician, paediatric neurologist	UMCU
S. Pasmans	Paediatric dermatologist	EMC
R. Bakx	Child Surgeon	Amsterdam UMC
A. van Dijk	Paediatrician, specialist bone disease	UMCU
F.J. Smiers	Paediatric haematologist	LUMC

EMC: Erasmus Medical Centre, Sophia Children's Hospital

AMC: Academic Medical Centre, Emma Children's Hospital

MUMC Maastricht University Medical Centre

UMCU: University Medical Centre Utrecht, Wilhelmina's Children's Hospital

NFI: Dutch Forensic Institute