

SIGNS AND SYMPTOMS OF CHILD ABUSE A GUIDE FOR STAFF

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INTRODUCTION

The aim of this document is to help staff identify signs and symptoms which may indicate child abuse. The identification and confirmation of child abuse is rarely simple and hence this booklet should be viewed as a guide and not a blueprint as to whether abuse has taken place.

The Bradford Safeguarding Children Board adopted the 'Working Together' categories of abuse which colleagues have elaborated on.

A Definition of "Child Abuse"

An abused child is a boy or girl under the age of 18 years who has suffered physical injury, neglect, emotional or sexual abuse which the person or persons who had custody, charge or care of the child either caused or knowingly failed to prevent.

A child is considered to be abused or at risk of abuse when the basic needs of that child are not being met through avoidable acts of either commission or omission by parents or carers.

The concept of Significant Harm

The concept of "significant harm" was introduced by the Children Act 1989 as the threshold for intervention in family life for the protection of children. There are no absolute criteria but consideration is given to the severity of ill-treatment; the degree and extent of physical harm and the duration and frequency of abuse and neglect.

Confidentiality

In all matters relating to Child Protection the highest degree of confidentiality must be maintained. However, this has to be balanced against the need to protect children from significant harm. Children who disclose significant harm need to know that the information will be passed on to the appropriate statutory agency, either the Social Services or the Police so that it can be properly investigated and the necessary help obtained. Information must not be passed on to any other individual or organisation.

If there is a conflict of interest between the needs of a child, who is suspected of suffering significant harm, and the needs of an adult, the welfare of the child is paramount.



PHYSICAL INJURY

Physical injury is the actual or likely physical injury to a child under the age of 18 years, or failure to prevent physical injury (or suffering) to a child including deliberate poisoning, suffocation and illness fabricated or induced by carers.

Bruises

All children, especially toddlers, are injured from time to time, and the vast majority of those injuries are accidental, even those which are unexplained. Some features should alert one to the possibility of non-accidental injury:

- There may be a delay in seeking medical help or such help may not have been sought at all.
- The account of the accident may be vague or may vary from one telling to another. Parents reliving a genuine accident will usually tell a detailed vivid story.
- The parents may be more concerned about their own problems than about the child's injuries, and they may be hostile and leave before the discussion is finished.
- The interaction between child and parents may be abnormal and the child may be sad, afraid or even withdrawn. Classic "frozen watchfulness" is a late stage resulting from repeated physical and emotional abuse. It should be noted, however, that some physically abused children may relate to their parents remarkably well.
- If children think they are going home with their parents, they may be unwilling to say what has happened while the adults are present. Given a safe environment the child may well give an accurate account of the incidents of abuse.

There may be discrepancies between the injuries and the story given, or the explanation may even be impossible, for example a four-week-old baby with facial bruising could not have been injured whilst falling over because they are unable to sit up in the first place, or alternatively, a child with bruises of different ages could not have sustained them all in a single incident. (Workers should be aware, however, that the ageing of bruises is not an exact science; as they age, bruises change colour from red to blue and through brown to yellow, but the timing of these changes varies from one individual to another and from one site to another.)



- There may be a series of different marks or bruises suggesting repeated injuries. The greater the number of incidents, the less likely it is that they have been accidental.
- The pattern of bruises may suggest a particular cause: slap marks, fingertip bruises and the imprint of weapons are commonly seen. Large areas of petechial haemorrhages, often with parallel dense lines within them, occur after hard slaps, particularly on the buttocks and cheeks. The left cheek is most commonly affected since the right-handed adult, facing the child, slaps the left cheek. Fingertip bruises on the upper arms or chest wall may suggest that the child has been held tightly and then shaken. In this situation, the fragile blood vessels in the eyes and on the surface of the brain may be torn. Examination by a paediatrician may then reveal retinal haemorrhages, rib fractures and subdural haematomas. This constitutes a medical emergency.
- The site of bruising may give cause for concern. Accidental bruises commonly occur over bony prominences; bruising on other sites is more suspicious. Certain injuries are inherently suspicious. Bruising to the outer ear may happen when the ear is "boxed" or compressed against the side of the skull by a blow or when the margin of the ear is pinched. Fresh or healed tears of the frenulum of the upper lip are caused by a blow to the mouth or by a feeding bottle being forced into the mouth. Such injuries seldom occur accidentally.

Burns and scalds

These are particularly difficult to handle because of the emotional connotations. Neglected children are more prone to accidental burns whereas abused children may be deliberately burned. The principles applied to bruises are relevant - the injuries seen should be compared with the story given.

Scalds are burns caused by hot liquids. Blistering often occurs and the skin may be pale and soggy and peel off in sheets. The injuries tend to be variable in depth but demonstrate characteristic drip, pour and splash patterns. Children whose hands or feet have been dipped in scalding water show a "glove or stocking" pattern.

Contact burns from a hot dry surface are often uniform in density and may follow the shape of the branding object.

Cigarette burns are part of the mythology of child abuse. However, they are in fact relatively uncommon. Typically, deliberately inflicted cigarette burns form a circular lesion with a crater. Skin infections can leave almost identical marks.

Parents of accidentally burned children are often defensive and guilty but show appropriate concern for the child.



Fractures

In young children these should give cause for concern in that it has been suggested that as many as half of all fractures under the age of two years are non-accidental. Spiral fractures of long bones in babies are especially suspicious as are rib fractures. Spiral fracture suggest a pulling and twisting force which would be an unusual mechanism in an accident to a non-mobile infant. Older children, however, may suffer spiral fractures accidentally. Rib fractures are unusual in accidentally injured babies and toddlers but multiple bilateral rib fractures occur when a young child's chest wall is violently squeezed. Such fractures are often difficult to detect in the early stages, both clinically and radiologically, and may be found only when healing occurs and callus is seen on X-ray.

Metaphyseal fractures, chips of bone pulled from the ends of long bones, are highly suggestive of abuse. Subperiosteal haemorrhage occurs when the lining membrane is stripped from the developing long bone during incidents in which the arms or legs are grabbed and twisted or pulled. Again, such injuries may only become evident after 10 to 14 days when healing and calcification are seen on X-ray.

Single linear skull fractures may occur after apparently minor head injuries and may present after one or two days with a localised swelling. Most such injuries do not result in serious injury, however. In one study, babies falling from a height of less than one metre, even onto a hard floor, had only a one per cent chance of suffering a skull fracture, and 80 per cent suffered no injury whatever. Even in falls from a greater height, any fractures were single and linear, and serious intracranial injury was uncommon. Extensive or branched fractures are less likely to be accidental and serious intracranial damage suggests the more severe force associated with nonaccidental injury.

Fractures of the humerus or clavicle may occur in birth injury, particularly after breech delivery, and may not be clinically evident. By the age of two weeks, however, X-rays will show evidence of healing.

A skeletal survey, usually performed in young children where serious abuse is suspected, may show fractures of different ages and in suspicious sites.

Differential diagnosis

There are various diseases, both acute and chronic, which cause easy bruising, and which may lead to the suspicion of non-accidental injury. These include such conditions as Idiopathic Thrombocytopenic Purpura (ITP), and Haemophilia, which should be considered if a child has extensive unexplained bruising.



Differential diagnosis (continued)

Osteogenesis imperfecta (brittle bone disease) is a condition, inherited as an autosomal dominant, in which bones break with even minor trauma. Usually sufferers will have blue sclerae (the whites of the eyes), and there will often be a family history of the disorder.

The diagnosis of non-accidental injury, which is often not easy, should take account of the whole picture of the injuries seen and the story given. In view of the possible pitfalls, the diagnosis of child abuse requires the help of an experienced paediatrician.

**Fabricated or Induced Illness by carers
(previously known as Munchausen's Syndrome by Proxy)**

This describes a situation where parents or carers fabricate or cause illness in their child. There are three main types of fabricated illness: verbal fabrication; tampering with charts and specimens and producing physical signs to suggest illness. Boys and girls are equally affected. By the time of diagnosis the child's apparent ill health may have been a problem for months or years.

The features are those of persistent or recurrent illness with a discrepancy between the child's apparently good health and a story of serious symptoms. Some of the more typical symptoms are seizures, spontaneous bleeding, stopping breathing, diarrhoea and fever. Mothers are the carers most likely to perpetrate the deception and they typically are very attentive to the needs their child. Untreated the problem leads to serious effects on the emotional health of the child in addition to physical effects if fabrication involves the production of physical symptoms.

Often these children will be taken to different hospitals and doctors and bringing together the complete story is one of the steps in achieving a diagnosis. Communication between professionals who have contact with the child is therefore very important.



SEXUAL ABUSE

Sexual abuse is the actual or likely sexual exploitation of a child or adolescent. The child may be dependent and/or developmentally immature.

Presentation of sexual abuse

1. Statement of the Child

The abuse is rarely disclosed at the time. Children only talk about the trauma of sexual abuse after much thought. They also choose the person to talk to very carefully. This might be a teacher or leader of a children's group whom they feel that they can trust. It is important know how to respond to this situation. Important points are:

- Do not agree to keep secrets
- Listen without interruption
- Make "noises" which will encourage the child to continue or ask an open question such as "what happened next". Do not ask leading questions e.g. "was it your dad?"
- Provide appropriate reassurance
- Let the child know that you will pass the information on to someone responsible
- Consider the urgency of the situation
- Immediately afterwards record the facts, date and sign.
- Contact Social Services or the Police

2. Symptoms due to local trauma or infection: perineal soreness, vaginal discharge, urinary tract infection, anal pain or bleeding are non-specific symptoms which may be indicative of sexual abuse. Bruising, lacerations, burns, bites or scratches on the inner thighs, breast, genital or anal region should be thoroughly investigated and deserve a full explanation.

3. Symptoms attributable to emotional effects: loss of concentration, enuresis, encopresis and anorexia may be related to various emotional factors but sexual abuse should be considered.

4. Self harm: many victims of sexual abuse will in some way act out their distress. Common amongst adolescent behaviour is drug abuse, alcohol abuse and prostitution. Attempts at suicide are often of self-loathing and the inability to betray the abuser who may be quite close. Self-mutilation can be a symptom of sexual abuse. Victims may burn or scar themselves or make themselves ill.



5. Sexualised conduct or inappropriate sexual knowledge of young children: such conduct or knowledge may be acquired by observing others or pornographic videos/literature. Children who have been sexually abused may describe pain or other features, such as the quality of semen, which cannot be acquired by observation only.

6. Sexually transmitted disease: a small proportion of sexually abused children may have sexually transmitted disease (STD). STD after infancy in children and adolescents who are not sexually active is strongly suggestive but not proof of sexual abuse. Gonorrhoea, syphilis, venereal warts, genital herpes, chlamydia, trachomatous and HIV infection are all primarily sexually transmitted conditions and so are matters for clinical diagnosis followed by multidisciplinary consideration.

7. Pregnancy: a girl who seems lost to explain her pregnancy, or who refuses to identify the father, may have been abused by a member of the family.

Medical examination in suspected sexual abuse

The child should be examined with the knowledge and agreement of a parent. The child's wishes and feelings about the pace and process of the examination should be taken into account. The examination should be conducted as soon as possible after the event and should take place in privacy, in an environment where the child can be comfortable, usually a hospital or medical setting. The examination should not be conducted later than the child's usual bedtime unless there is reason to suspect serious injury requiring medical attention.

Medical assessment of sexual abuse will usually require a joint examination by a paediatrician and a forensic physician (Police Surgeon). Genital and anal examination should be in the context of a general clinical examination and include a search for other forms of abuse and an appraisal of growth, development and general health.

Signs of sexual abuse

A substantial proportion of sexually abused children show no abnormal physical findings. In girls the hymenal orifice dimension is not a reliable indicator of sexual abuse, although a hymenal diameter exceeding 1cm in a pre-pubertal girl occurs more commonly in abused girls.

In penetrating sexual abuse lacerations or scars in the hymen or attenuation of the hymen with loss of hymenal tissue may be noted. Supportive findings of sexual abuse which are not diagnostic are notches in the hymenal edge associated with scarring or bumps on the hymen with some disruption. Recent abuse may cause bruising, redness, splitting and bleeding to the genital area.



Signs of sexual abuse (continued)

Signs of anal abuse are likely to be most prominent in young children, but in many cases there are no abnormal signs.

Fissures, scars and skin tags around the anal verge may be indicative of sexual abuse in the absence of an alternative explanation. Perianal bruising or bleeding without reasonable explanation raises substantial suspicion. Other findings such as anal laxity may be supportive of sexual abuse but are not diagnostic and it is always important to consider clinical findings in the context of the medical history, as the presence of constipation or other medical conditions may affect clinical findings.

In boys the genitalia should be examined; bruising or trauma to the penis or scrotum may occur in sexual abuse.

Medical examinations are an integral part of the investigation of sexual abuse. However, child protection decisions should not rely solely on medical evidence or opinion. Whilst these form a vital part of the decision-making process, the totality of background information should be considered.

A substantial proportion of sexually abused children show no abnormal physical findings.

EMOTIONAL ABUSE

Emotional abuse is the actual or likely severe adverse effect on the emotional and behavioural development of a child caused by persistent or severe emotional ill-treatment or rejection. All abuse involves some emotional ill-treatment.

Components of emotional abuse

1. Rejecting the child - The adult refuses to acknowledge the child's worth and the legitimacy of their needs.

2. Isolating the child - The adult cuts the child off from normal social experiences and contacts and prevents them from making friendships, thus making them believe they are alone in the world.

3. Terrorising the child - The adult verbally abuses the child, creating a climate of fear. The child is bullied and frightened and is made to believe that the world is capricious and hostile.



Components of emotional abuse (continued)

4. Ignoring the child - The adult deprives the child of essential stimulation and responsiveness, stifling emotional growth and intellectual development.

5. Corrupting the child - The adult mis-socialises the child, for example stimulating them to engage in anti-social behaviour, reinforcing that deviance and making them unfit for normal social experiences.

There is a tremendous variation in the delivery of care and parenting. The most important aspects of emotional abuse are the effects on children and the consequences for them. Those effects and consequences are diverse and vary significantly with age.

Infants

Lack of encouragement shown towards infants can result in the impairment of social and psychomotor skills; infants can appear withdrawn with developmental delay.

Infants may indulge in acts of self-stimulation (banging of the head or rocking movements); there may be a noted lack of social responsiveness.

Pre-school children

At the age where language development is at its most sensitive, emotional abuse can result in significant delay in language acquisition and, in severe cases, the child may be effectively mute. Behavioural problems are also common, and may be manifested as a reduced attention span, which often goes along with hyperactivity. Emotionally abused children may show significant growth retardation. Children may be aggressive, especially towards their peers, and may at other times be significantly withdrawn. A lack of selective attachment is quite frequently seen, and inappropriate physical contacts to strangers, even in the presence of the main carer, is common.

School-age children

Learning difficulties are a manifestation of emotional abuse in this age group, with poor concentration and significant over-activity. Such children may be disruptive in schools, and may also show behavioural abnormalities such as aggression, or inappropriate or unusual patterns of defecation or urination. These children often have low self-esteem, which in its mildest form shows very poor social interaction and may result in other behaviour patterns, such as repetitive rocking, self mutilation or masturbation. As with neglect, if the abuse is substituted by sensitive care and displays of appropriate emotions (usually in an alternative environment), there is a rapid and dramatic improvement in growth, developmental attainment, behaviour and social and emotional adjustment.



NEGLECT

Neglect is the persistent failure to meet a child's basic physical and psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also involve neglect of a child's basic emotional needs.

Neglect is difficult to diagnose because by definition it has to be present for a period of time.

All age groups can be affected by neglect but the pre-school child is the most vulnerable. The diagnosis is made by collecting vital pieces of the jigsaw. A child is neglected if its basic needs are unmet. Manifestations of this are when the child is:

1. Malnourished, ill-clad, dirty, without proper shelter or sleeping arrangements
2. Without supervision, unattended.
3. Ill and lacking essential medical care
4. Denied normal experiences that produce feelings of being loved, wanted, secure and worthy (emotional neglect)
5. Failing to attend school regularly.

The issue of standards of parental care and behaviour is a major problem in proving neglect. The lack of clear definitions makes it problematic to prove, particularly in a court of law. General neglect may be difficult to prove but 'failure to thrive' a specific type of neglect, is easier to define.

Failure to thrive

'Failure to thrive' is a term applied to babies and toddlers whose growth rate, particularly in weight but also in length, is exceptionally poor. It is important to realise that there are many medical reasons for failure to thrive, such as chronic infection, failure to absorb food because of cystic fibrosis or coeliac disease, major congenital heart disease and many others. Nevertheless, about three-quarters of all infants seen by hospital paediatricians with failure to thrive are growing poorly for non-organic reasons. Whether through ignorance or neglect they lack the necessary elements of care, food, attention and love, which promote normal growth.



Failure to thrive (continued)

At the extreme, failure to thrive is easily detected. The infant is obviously undernourished, thin with wasted buttocks and prominent folds of skin. It is important to remember that the pads of fat in the cheeks, which are essential if an infant is to suck effectively, are preserved even when the rest of the baby's fat stores have disappeared. Thus the clothed infant may appear to be well nourished when in fact gaining weight poorly.

Serious growth failure in the first two years of life has irreversible long-term effects on body size and health and one would like therefore to diagnose failure to thrive before it is obvious on examination. This is achieved by weighing all babies regularly and plotting the weights on a standard growth chart, often called a centile chart. These charts have been produced by analysing growth data from thousands of normal children and then drawing centile lines on a graph.

Growth charts now have 9 centile lines although some are still in use with 7 centile lines. The lines on the 9 centile charts correspond to the 99.6th, 98th, 91st, 75th, 50th, 25th, 9th, 2nd and 0.4th growth lines. Basically, 50% of normal individuals fall below the 50th centile for the particular characteristic such as weight, length or head circumference.

Only 2% of the population will fall below the 2nd centile but this will include children who are genetically small and whose growth is appropriate. Only one child in 250 will fall below the 0.4th line and children whose growth is below this line need assessment.

Two further features of the centile charts increase their usefulness. Firstly, the slope of the printed line at a particular point on the chart is an indication of the rate of growth at the particular age; the steeper the slope, the faster the growth rate. The growth rate of a particular child can be compared with normal by plotting serial measurements on the printed chart and seeing whether the child's growth is "parallel to the centile lines". The weight curve of a child who is failing to thrive for non-organic reasons may accelerate upwards across the centile lines when brought into a more nurturing environment. The child is then said to be showing "catch-up growth".

Secondly, the weight centile of a normal child of average build will be the same as the height centile. A baby whose height and weight are both on the third centile is probably adequately nourished but genetically small whereas one whose weight is on the third centile and whose height is on the fiftieth centile is probably failing to thrive. The diagnosis of non-organic failure to thrive needs careful interpretation of growth charts and investigation to rule out medical conditions. It is confirmed by the finding of catch-up growth when the child is moved to a more nurturing environment.

