

RECOGNITION OF CHILD ABUSE (5TH EDITION)

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INTRODUCTION

The purpose of this literature review is to describe the state of the art in relation to the recognition of child abuse and neglect. Inevitably, I make considerable reference to the medical literature which is inaccessible to many readers so I have included public domain documents where possible. Despite the medical slant, this section is intended for every type of professional. I have kept medical technical terms to a minimum and have included a glossary at the end of the document.

My changes to this fifth edition bring in useful concepts from the literature of the last two years. The definitions of abuse are taken from the current version of Working Together.¹ I am extremely grateful to Geraldine Newbold (Assistant Chief Legal Officer - People) for her corrections to and comments on the text.

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The named nurse and doctor networks in Hertfordshire are now firmly established. These professionals have considerable expertise and can give you valuable advice whoever you are. Don't hesitate to discuss your concerns about a child with your named nurse or doctor.

FREQUENCY OF CHILD ABUSE

Out of approximately 11 million children in England, 3 million are vulnerable on the grounds of poverty and 3-400,000 are "in need" (i.e. of services under the 1989 Children Act) on the grounds of disability, looked after, mental illness or adverse parental circumstances.² Some 350,000 children grow up in a "low warmth, high criticism" environment and are in need, although their need may not be ascertained. Additionally mental and physical ill health, poverty and major accidents commonly afflict these families. Frequently, these families are known to child protection services. It is the most vulnerable in society who are subject to the child protection process. Nevertheless, not all families who abuse children have identifiable adverse criteria; abuse exists at all levels of society and in all cultures.

Parental alcohol addiction, substance misuse and domestic violence affect a high proportion of child protection registrations.³ In England in the last 5-years, there has been an approximately 60% rise in child protection enquiries with a 30% rise in Protection Plans. In the year 2013-2014, there were about 140,000 child protection inquiries, 60,000 initial conferences and 48,000 children subject to a Plan. In Hertfordshire during this same year, 1414 children became subject to a Plan, the category of registration being: neglect 60%, emotional abuse 32%, physical injury 4% and sexual abuse or multiple 4%.⁴

PHYSICAL ABUSE

A form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

Throughout this section, I will make several references to a key review by Maguire, this is free, download it now.⁵ In our recent audit of forensic medical examinations, we were struck by the high proportion of children (about half) examined for physical abuse (usually bruising) who had already made an allegation.

SMACKING

Physical abuse often arises from a wish to chastise. English law allows smacking by parents in that parents can use the defence of “reasonable chastisement” but only in respect of a charge of common assault.

The introduction of the Children Act 2004 changed the law, to remove the reasonable chastisement defence for actual bodily harm. Actual bodily harm includes minor visible injuries such as a graze, a scratch, an abrasion or bruising around the eye. Common assault implies a transient trifling injury such as reddening of the skin or no injury at all. The use of an implement to hit a child though not specifically prohibited is more likely to leave a mark. Thus the law allows a parent to smack a child where doing so leaves no mark upon the skin, so only light smacks are permitted. “Over chastisement” which implies at least actual bodily harm would be against the law and the reasonable chastisement defence would not apply. This means, for example, that a parent can no longer justify beating a child on the grounds that child is difficult to raise.⁶

The defence applies only to parents and adults acting in loco parentis with the parent’s permission. Physical chastisement, i.e. corporal punishment, of any form has been prohibited in state schools since 1986, private since 1998 and by child minders since 2003. Although the reasonable chastisement defence only applies to the criminal law the concept influences decisions taken in the family court.

It is important that all professionals treat injuries caused to children by their parents as an assault and do not condone or excuse this because their intention was to discipline the child. Professionals should be cautious about referring to such assaults as “over-chastisement” as this can have the effect of minimising the impact on the child of the injuries or implying the child’s behaviour was a contributory cause.

There is evidence that even smacking allowed within the law is harmful to children. For example, minor forms of regular smacking of pre-school children is associated with an increased risk of antisocial behaviour after 2-3 years even when allowing for other parenting risk factors and the presence of such behaviour at study entry.^{7, 8} Maternal depression and violence between adult partners are associated with a greater risk of smacking children than either factor present alone regardless of child behaviour.⁹ Parents who experience physical punishment in their childhood are more likely to smack their own children.¹⁰

BURNS (SEE APPENDIX)

A recent large UK series of children aged 0-15 years reported 8% of burns were suspected maltreatment.¹¹ This may be a higher proportion than we diagnose in our current routine practice. The diagnosis of abuse burn is highly dependent upon systematic multiagency investigation, including the forensic home visit. Inability to explain the source of the burn, delay in presentation, denial or trivialisation of the injury and a tendency to blame the child are all suspicious of abuse.¹² We should be concerned when the history does not match the burn or when the child’s development does not match the explanation; e.g. when a small child is said to have climbed into the bath or up into the washbasin. Both accident and abuse burns result from contact with a wide range of household appliances. A deep contact burn is more likely to result from abuse because a child would rapidly withdraw from a hot object. Abuse dip scald or forced immersion injuries have a characteristic pattern, affecting the hands, feet, buttocks with clear demarcation between scalded and spared skin and sometimes a spared

central area over the buttocks where the child has been forced against the bath wall, as illustrated in the Maguire⁵ and BMJ reviews¹³. Deliberate cigarette burns are rounded, full thickness, deep, cratered and heal to a scar.

There is a questionnaire at the end of this document which enables professionals to recognise when to be concerned about a burn.

BRUISES

Bruises are unusual in babies under 6-months-old who are unable to sit or crawl. Once infants develop mobility, the frequency of accidental bruises steadily rises from approximately 10% of those who can sit to 40% of those who can walk. These bruises are usually <1 cm in diameter, over the forehead, bony part of the cheek or jaw, or shins. An active baby in the first 18 months might have two or perhaps three of these. In older children, most accidental bruises are over bony prominences and sometimes associated with a graze. Between 18-months and 3-years, forehead and facial bruises (over bone) are common (17% of children) but unusual in older children. Accidental bruising of the hands and feet and lower legs (particularly the shins and often multiple) are frequent. 14% of children 6-11 years have bruises over the lower back but bruises at this site are unusual under the age of three years. An active boisterous child may have up to 12 accidental bruises at these sites.

Non-accidental bruises are more likely to be around the mouth and adjacent cheek, neck, eye-socket, ear, chest, abdomen, upper arms, buttocks and upper legs. All these areas are relatively protected. Some bruises have a particular configuration, such as a slap, fingertip bruises, pinch marks or marks from an implement. Non-accidental bruises are usually multiple and cannot easily be explained on the basis of simple falls.^{14, 15} Maguire clearly illustrates accident versus abuse bruising patterns.⁵

When the nature of the bruise does not differentiate non-accidental from accidental injury, the key issue is the discrepant history where there is either no explanation or an inadequate explanation. Full assessment usually requires a strategy meeting.

Serious cases highlight the child who presents with severe or repeated bruising where the parent forestalls an investigation by suggesting bullying, a fall, self-injury or injury from siblings. Bruising from bullying (including bigger teenage siblings) requires investigation, accidents are liable to produce bruises on exposed bony surfaces along with grazes, self-injury is rare and pre-teen siblings are not usually strong enough to produce significant bruising.

PRECURSOR INJURY

These are minor injuries in babies and young children which result from mounting parental tension, where the benign explanation from the parent is accepted by professionals, only for the infant or child to present again with more serious inflicted injury. These precursor injuries include facial bruises, bleeding from the nose or the mouth (sometimes with a torn labial frenulum), and subconjunctival haemorrhage. Dale et al found a history of precursor injury, often in association with constant crying, in 13 of 21 seriously injured young children.¹⁶ This author reported an identical type-of finding in 19/42 serious case or management reviews conducted in Hertfordshire. The most common injuries were a bruise on the face of a baby or multiple bruises on the face of a toddler. Poor documentation and poor reporting was the most consistent medical failure in both series.

The Hertfordshire series also included more serious injuries such as subdural haemorrhage, inflicted-type fractures and multiple bruises which had not been subject to an adequate multi-agency investigation. This echoes the Welsh experience where one-third of physically abused infants were reinjured after discharge home, often seriously.¹⁷

It is important to remember, however, these types of minor injury in young children represent a diagnostic challenge for a variety of reasons. A strategy meeting, following multi-agency investigation is often essential.

MOUTH AND DENTAL INJURIES AND DENTAL NEGLECT

“Abusive injuries to the mouth are not always obvious and, unless a child discloses abuse, will come to light only if you notice that permanent teeth are inexplicably missing. All areas of the mouth can be injured in physical abuse: teeth may be displaced or broken and there may be cuts, abrasions or bruises to the inside of the lips, the roof of the mouth, the tongue or the lingual frenulum.”¹⁸ A dental opinion is essential. Dental neglect commonly co-exists with oral injuries and would be suggested by obvious dental disease, likely to have had a significant impact (e.g. pain) on the child for which the parent has not sought treatment.¹⁹

BLEEDING FROM THE MOUTH AND NOSE (ONH) IN INFANTS

Spontaneous nosebleeds common in school age children are rare in infants and most infants with this type of bleeding should be admitted for investigation.²⁰ Causes include suffocation, trauma and serious illness. Haemorrhage from suffocation probably arises from the lungs although is often recorded as a nose bleed. This should be much less common now with “back-to-sleep” measures to limit sudden death (see below). Serious illness includes coagulation defects which in a minority are a manifestation of malignancy. A retrospective review of 88 infants with ONH found 52 due to trauma, 15 probably or definitely inflicted and 13 possibly so. Of the remaining “accidental” cases, a high proportion should have had a more rigorous investigation of the social background.²¹

TORN LABIAL FRENULUM (FRENUM, FRAENUM)

A torn labial frenulum in an infant is likely to be an abuse injury and might be produced for example by attempted force feeding or a direct blow. This injury *without adequate explanation* in a child under 2-years-old should prompt a skeletal survey and under 1-year consideration of additional ophthalmoscopy and neuroimaging.⁵ An inflicted torn frenulum is often associated with other injuries, often internal. A similar injury in an older child is likely to be accidental.

BITES

Abusive bites are the only physical injury which offers the potential of identification of the perpetrator. This would require the service of a forensic odontologist identified via BAFO or the NPIA.²² A bite leaves an oval or circular mark, consisting of two symmetrical, opposing, u-shaped arches separated at their base by an open space. The arcs may include puncture wounds, indentations or bruising from the marks of individual teeth. Download investigation instructions from the NSPCC.¹⁸

DIFFERENTIAL DIAGNOSIS OF EXTERNAL PHYSICAL ABUSE

Mongolian blue spots, birthmarks (e.g. café-au-lait naevi) and stains from the dye of clothing or ink can be mistaken for bruises. Coagulation disorders (e.g. haemophilia) can present as bruising. Cystic fibrosis can present with emaciation and bruising due to prolongation of the prothrombin time. Chicken pox, impetigo and other skin lesions can be mistaken for cigarette burns. In young rapidly growing adolescents, linear reddish striae (stretch marks) running across the back can be mistaken for marks of beating. In sickle cell anaemia the "hand and foot syndrome" is characterised by painful swelling. "Moharram scars" on the chest and back are self-inflicted by adolescent Shia Muslim males in religious ritual.²³ Phytophotodermatitis (solar keratosis) from plants can simulate a burn, and is especially common in children playing naked outdoors in the summer holidays.²⁴ A rare vasculitis called Degos disease may present as lesions suggestive of cigarette burns and a blood stained subdural fluid collection.²⁵ A bite may be confused with other skin disorders – e.g., ringworm, drug reaction, pityriasis rosea.

HEAD INJURY

Head trauma is the most frequent cause of morbidity and death in abused children. At least 300 children a year develop cerebral palsy as a result of shaking injury. In a 1998 opinion poll, 2% of parents would smack a child on the head and 3% would shake a child as a form of discipline.²⁶ The NSPCC leaflet is very helpful.²⁷

It is difficult to be dogmatic about the amount of force required to inflict various types of head injury in an infant. A fall between 1-2 metres (e.g. from an adult's shoulder) may inflict a skull fracture and some transient symptoms of brain injury (vomiting, irritability) but rarely serious direct brain injury.^{28, 29} Serious brain injury requires "significant forces", as immediately reported by the carer, such as being struck by a car and thrown several feet or falling out of a window onto concrete.³⁰

In 1972 the American John Caffey popularised the term the "whiplash shaken baby syndrome",³¹ now probably better called abusive head trauma. It is characterised by serious or lethal head injury but often without external injury. Clinical presentation may vary from non-specific signs such as poor feeding, vomiting and lethargy to acute presentation with unexplained coma and seizures. There may be bruises, rib fractures, long-bone fractures and abdominal injuries (see below); 75% to 90% have retinal haemorrhage, which may be missed without a full ophthalmic examination. Subdural haemorrhage (bleeding over the surface of the brain) is frequent although may be missed on imaging and only be detected at post mortem. Subdural haemorrhage may occur subacutely (develop over weeks), leading to the infant presenting with progressive head enlargement.^{32, 33, 34}

The mechanism behind the triad of acute encephalopathy (seizures and coma), subdural haemorrhage and retinal haemorrhage has long been thought to be shaking injury. The similar timing of this type of presentation to the age when babies are known to cry a lot suggests there could be a role for primary prevention.³⁵ A survey of parents of 3345 infants showed 5-6% reported having smothered, slapped or shaken their 6-month-old infant at least once because of its crying.³⁶ Court decisions in the USA, Canada and the UK have thrown doubt on the shaking hypothesis. Geddes proposed an alternative "unified theory" but this was dismissed in a Court of Appeal judgement in 2005. Nevertheless the court held that the presence of the triad did not automatically lead to a diagnosis of abusive head trauma.^{37, 38} A recent report, however, supports the shaking hypothesis as it describes perpetrator

confessions in well documented cases consistent with abusive head trauma. All of the 29 perpetrators in the series described violent shaking sometimes on many occasions “because it stopped the infant’s crying”^{39, 40}.

When comparing the infant’s initial presentation at hospital with abusive versus accidental head trauma; abusive is more likely to present with initial symptoms of not breathing or difficulty breathing, followed by fits or found-lifeless, without a history of trauma in half or external injury in a third; while accidental is associated with a very specific history of trauma and half attend before symptoms develop. For this reason many infants with abusive head trauma are initially thought to have an infection based encephalitic-type illness.⁴¹

Kemp has usefully calculated the odds ratios and predictive probabilities of abusive head trauma given different combinations of features, apnoea, bruise, long bone fracture, retinal haemorrhage, rib fracture and seizure.⁴²

It is important doctors exclude alternative medical causes for this triad. These include at least two rare syndromes, Menke’s disease and Glutaric aciduria. These syndromes are usually associated with marked loss of brain substance on imaging at the time of the original presentation.^{43, 44} Clotting disorders must also be excluded, a rare but striking example of which is an inborn error of bile salt transport.⁴⁵

FRACTURES

NSPCC inform provides an authoritative summary leaflet.⁴⁶ About one-third to one-half of fractures in children under 12-months-old is inflicted (abuse). This proportion is higher the younger and less mobile the infant. Long bone fractures may present with general irritability without a clear history of injury, with local tenderness and/or swelling manifest as reluctance to move a limb or to weight bear.

On X-ray, fractures in infants can be both missed and over diagnosed. We have seen hair-line fractures missed and nutrient artery tracks mistaken for the same. The same applies to metaphyseal flake fractures. Skilled interpretation of X-rays is essential.

Fractures that are more likely due to abuse include:

- Where caretakers report either a change in the infant's behaviour, but no accidental event, or a minor fall, but the injury is more severe than expected;
- Fractures of the radius/ulna, tibia/fibula, or femur in the **non-ambulatory** infant, generally less than 10 or 12-months of age.
- Midshaft or metaphyseal fracture of the humerus in an infant.
- Rib fracture in a child with normal bones who has not suffered a major accident.
- The presence of other injuries which are difficult to explain.

Interpretation of an injury depends on circumstances. Thus a spiral fracture of the femur in a toddler who walks and runs is likely to be *accidental* while the same injury in a 6-months-old infant is probably *abuse*. Well recognized *accidental* fractures in active ambulant toddlers also include spiral of the tibia and mid-shaft clavicle; and in both the absence of a clear history and a delay in presentation are common and not usually of concern.

Ambulant toddlers can suffer *abuse* fractures. The incidence of abuse fracture is 14% between 1 and 2-years-old, 8% between 2 and 3 and unusual over 5-years-old. We would be

concerned about any unusual or avulsion fracture in an ambulant toddler where the parent is vague about the event responsible or blames another young child.^{47, 48, 49, 50}

There is no simple rule to differentiating abuse from accidental injury and one has to consider all aspects. Interpretation of any fracture is dependent on taking a good history which should include (a) the time and place of the injury, (b) who saw the fall, (c) the dynamics and distance of the fall and (e) the child's end position.

A full skeletal survey is indicated in any physically injured child under the age of 2-years in whom abuse is suspected. The yield in the second year is as high as in the first.⁵¹ The decision to survey older children is more individual. The survey will detect occult injuries and exclude a generalised bone disorder, which might pre-dispose to fracture. The decision for skeletal survey should be taken jointly by a consultant paediatrician, a consultant radiologist and if necessary the named doctor.⁵²

Mobile children who present with isolated skull fracture do not generally need a skeletal survey so long as there is a good explanation and no other concerns, immobile children (generally babies) should have a survey, where additional fractures are found in about 12%.⁵³

Pathological fracture occurs spontaneously without trauma due to fragile or brittle bones. Probably the most common cause of this type of fracture is chronic physical incapacity; where the child is in a wheel-chair and the bones are slender (gracile) and ghost-like on X-ray. In the non-disabled, hereditary brittle bone disease (osteogenesis imperfecta – OI) is often suggested of which there are several genetic types. The severe types are obvious clinically and radiologically but the rare milder types more difficult. First order evidence in favour of OI would be: recurrent unexplained fractures in foster care, blue sclerae in both the child and a parent, a history of recurrent fractures in one parent, multiple Wormian bones on skull X-ray or dentinogenesis imperfecta (translucent, fragile & discoloured teeth which should be differentiated from dental injury by expert dental examination). Second order evidence would be: joint hypermobility and discoloured sclerae in a child under 6 months. Without these features, the likelihood of OI is as low as 1/3,000,000 births and this is probably an overestimate.⁵⁴ A multidisciplinary perspective is essential to avoid over-diagnosis of OI which could expose a child to further serious inflicted injury.^{55, 56, 57} In an otherwise healthy young child, we can forget about temporary brittle bone disease, which is not considered a real entity by mainstream medical opinion.⁵⁸

Another type of brittle bone disease, copper deficiency, would usually result from extreme prematurity or malnutrition. Small pre-term infants may have fragile bones from complex hormonal and nutritional causes.

Recently congenital rickets has been a suggested cause of multiple fractures and internal injuries in infants.⁵⁹ Vitamin D deficiency, manifest as a low 25-hydroxyvitamin D (25OHD) level in the blood is widespread in women of child bearing age, especially in certain ethnic groups. Where X-rays do not show rickets and blood calcium, phosphate, alkaline phosphatase and parathyroid hormone levels are normal, a low blood 25OHD level is not implicated in unexplained fracture (or internal injury).^{60, 61}

VISCERAL INJURY

Injury to the viscera (organs of chest and abdomen) is the second commonest cause of fatality after head injury. There is a peak between 2-4 years but fatalities up to 11-years have

been described. This type of injury is important because considerable force is usually required and diagnosis is difficult because of the unusual nature and lack of history. Presentation includes bleeding from the mouth, coughing up blood, abdominal distension with bruises and rib fractures or sudden collapse at home in association with several bruises on examination. These children often have multiple injuries: head, bone, burns. Detection is problematic: maintain clinical vigilance, do liver and pancreatic enzymes although they may not be reliable, do not rely on ultrasound imaging, rather regard contrast enhanced CT scanning as the investigation of choice.⁶²

Penetrating needle trauma may manifest as multiple pinprick scars in an otherwise well infant or there may be no external signs of injury. The needles are found on X-ray but there is the danger of the needles mistakenly thought an artefact and external to the child.⁶³

FACTITIOUS/INDUCED ILLNESS SYNDROME (FII)

(Munchausen syndrome by proxy)

Example: *“A girl with asthma spent years undergoing unnecessary, harmful and potentially lethal treatment because doctors trusted her parents too much, a High Court judge in London has found.”*⁶⁴

Physical harm may be caused when a parent or carer feigns the symptoms of, or deliberately causes ill health to a child whom they are looking after. The term FII is now preferred to Munchausen Syndrome which implies a psychiatric diagnosis in the parent which often cannot be confirmed. Meadow describes this disorder to have four principle presentations, perceived illness, doctor shopping, enforced invalidism and fabricated illness. Classically the mother presents the child with symptoms and is unreasonably not reassured by the doctor, even after extensive investigation of the child. It is reasonable for patients to seek second and even third opinions but not usually multiple (8-9) opinions.

Behaviours exhibited by carers might include: (1) deliberately inducing symptoms in children by administering medication or other substances, or by means of suffocation; (2) interfering with treatments by over dosing, not administering them or interfering with medical equipment such as infusion lines; (3) obtaining specialist treatments or equipment for children who do not require them; (4) exaggerating symptoms, causing professionals to undertake investigations and treatments which may be invasive, are unnecessary and therefore are harmful and possibly dangerous; (5) claiming the child has symptoms which are unverifiable unless observed directly, such as pain, frequency of passing urine, vomiting, or fits; (6) alleging psychological illness in a child.

Symptoms most frequently reported in FII include: apnoea, anorexia or feeding problems, diarrhoea, seizures, cyanosis, behaviour, asthma, allergy, fevers and pain. Many children present with unusual or puzzling symptoms.⁶⁵

Then there is the situation where the child is chronically not at school, ostensibly for medical reasons. The parent may describe symptoms which are vague in nature, difficult to diagnose and which teachers have not themselves noticed e.g. headaches, tummy aches and dizzy spells. There may be frequent contact with a variety of health professionals or referrals for second opinions. The child may attend several hospitals with the same complaint. The child may be under medical investigation which drags on without conclusion because of failed appointments and the child is just kept at home. The child may express a profound fear about

having a condition. To teachers the parent may use impressive medical terminology to describe their own, the child's (or sibling's) illness. This illness is excluded on subsequent multiagency enquiry.

In the classic syndrome the mother is a chronic confabulator, has presented with fabricated illness herself (somatising disorder) and may have indulged in substance misuse and self-harm.⁶⁶ At the milder end of the spectrum, however, the mother may be over-anxious and unconsciously exaggerates the child's symptoms. This can engage a naive doctor in over-investigation, which stokes the furnace of concern. Public domain caretaker blogs may be revealing.⁶⁷

FII itself can be a very difficult condition to diagnose and may require considerable multi-agency detective work. If front-line staff (e.g. school) ever suspect a child is attending multiple medical appointments for exaggerated symptoms they should convey their concerns to the named nurse (e.g. via the school nurse).

Sometimes the evidence may extend over several years, over multiple children and exist in several counties. All other forms of abuse may co-exist with this syndrome. Indeed, the parents present as over-conscientious about health issues and neglect the child's basic care. The DOH and the RCPCH have published guidance.^{68, 69, 70} As explained by Bass and Glazer, in a comprehensive review, management depends on the parent's capacity to acknowledge the abusive behaviour and collaborate with helping agencies.⁷¹

MOTHERING TO DEATH

Meadow has also described this syndrome where the healthy child had been put to bed and treated as if ill, dependent and incapable. His series was of 3 only-children who had been confined to bed sometime between infancy and 16-years-old and had died as disabled adults. In each case the three mothers evaded medical, educational and social services.⁷²

SUDDEN UNEXPECTED DEATH.

Sudden unexpected death in infancy (SUDI/SIDS) and childhood; and apparent acute life threatening events (ALTE).

Working Together to Safeguard Children 2013 defines an unexpected death as one that was not anticipated as a significant possibility 24-hours beforehand, or where there was an unexpected collapse leading directly up to the death which might occur later. Approximately 20 children up to 18-years die suddenly and unexpectedly in Hertfordshire every year, 60% are under 1-year-old. Child-protection or general welfare concerns are a factor in about one-third of the infants and rather less of the children.

"We already know enough (to prevent cot death): the challenge is how to change behaviour".⁷³ The "back to sleep" campaign of the early 1990s has been instrumental in reducing sudden **infant** deaths around the world, exhorting parents to use the supine rather the prone sleep position, avoid excessive swaddling and avoid smoking. Co-sleeping or bed sharing is currently the most frequently identified preventable contributory factor in the **infant** deaths. Co-sleeping is contraindicated when the mother drinks, smokes, takes sedatives or drugs. Co-sleeping on the sofa is much more dangerous for the infant than sleeping in the parental bed. Because of a fear that exhausted mothers will accidentally sofa-sleep in order to avoid co-bed sleeping we do not advocate a blanket ban on co-sleeping, only a strict

adherence to the contra-indications and of course observance of “Back-to-Sleep” advice as well.⁷⁴ Vulnerable families are particularly likely to disregard this type of advice. Any assessment of parenting must include the ability to accept advice designed to limit the risk of sudden unexpected infant death (where relevant). Reliable parent friendly information is available from the Lullaby Trust.

Where the family is vulnerable, your most potentially life-saving question to the parent is probably, “Please let me see where the baby sleeps”.

As regards the child deaths there are a variety of causes and no simple prevention message. Two slightly more frequent causes are infection and hanging, the latter usually classed as accidental. One sub-group of concern is teenagers who commit suicide. These often have had difficult lives and considerable input from various agencies but at the time of the suicide seem to be very much on their own.⁷⁵

Also known as near miss cot deaths, ALTE may be related. In this disorder, the child is found moribund by the parent and is successfully resuscitated. There is more likely to be an acute medical cause but one would be suspicious if these events recurred repeatedly and only in the presence of the same person.⁷⁶ Retinal haemorrhage is an unusual finding in ALTE and would raise suspicion of abuse.⁷⁷

EMOTIONAL ABUSE

The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or ‘making fun’ of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child’s developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Emotional abuse has an important impact on a developing child’s mental health, behaviour and self-esteem. It can be especially damaging in infancy. Underlying emotional abuse may be as important, if not more so, than other more visible forms of abuse in terms of its impact on the child. Emotional abuse is a common accompaniment of the following circumstances: family violence, mental illness in a parent, alcoholism and substance misuse.

The effect on the pre-school child is to show a limited attention span, aggressive behaviour and in severe cases elective mutism. Persistently abused children do not develop sufficient maturity to play co-operatively. Severely abused toddlers may show indiscriminately friendly behaviour and crave physical contact “touch hunger” even in the presence of their primary caregiver. The school age child shows behaviour problems, learning difficulties and low self-esteem with a feeling of worthlessness. More able children may show pseudomaturity with their main social interaction with adults rather than fellow-pupils. Some may show aggressive and threatening behaviour, which is habitual, because at home it is the only way of attracting attention.⁷⁸

DOMESTIC VIOLENCE

(See also *infant and child homicide* below.)

Domestic violence has an impact in a number of ways. It can pose a threat to an unborn child, because assaults on pregnant women frequently involve punches or kicks directed at the abdomen, risking injury to both mother and foetus. Children may also suffer blows and even fatality during episodes of violence, which is primarily directed against the mother. Children may be greatly distressed by witnessing the physical and emotional suffering of a parent. Both the physical assaults and psychological abuse suffered by adult victims who experience domestic violence can have a negative impact on their ability to look after their children. The negative impact of domestic violence is exacerbated when the violence is combined with drink or drug misuse; children witness the violence; children are drawn into the violence or are pressurised into concealing the assaults.

Childhood exposure to violence involving the primary care giver during the early years of life has an enduring detrimental effect on cognitive functioning, exposure between birth and two years is particularly potent. This effect is independent of other potential confounding factors such as parent IQ and stimulation at home.⁷⁹

A longitudinal survey of 44 children on the child protection register revealed domestic violence to be strongly associated with failure of the protection process.⁸⁰ A survey of 341 adult domestic violence victims attending A&E showed limited documentation of the event, frequent failure to identify the assailant and concluded there must have been a significant number of similarly injured attendees who were not differentiated from street violence.⁸¹

Logged calls to the police reveal 35% of all households call again within 5 weeks, 45% of those call a third time within a further 5 weeks, and most call a third time within a year. Class and ethnicity is of little importance. A survey of men revealed two-thirds would consider using violence in a domestic dispute and one-fifth had actually done so.⁸²

In Hertfordshire the police attend approximately 14,000 domestic violence callouts a year. About 4,000 of these are medium or high risk and in 40% a child is in the house or a witness. About 7,800 such incidents are notified to TAS, many involving more than one child.

In the USA screening in primary care settings showed 30% of 154 women attending routine child surveillance visits revealed abuse (16% recent & 6% during pregnancy),⁸³ as did 52% of 157 women attending an A&E department with a young child.⁸⁴ A variety of studies in London also have suggested a 30% incidence, with the violence often severe, repeated and steadily worsening. Domestic violence is rarely a one-off event. Though advocated by some organisations,⁸⁵ and despite the above findings, routine screening for domestic violence in healthcare settings remains of unproven value,⁸⁶ complex problems require complex solutions.⁸⁷ Nevertheless, at least locally, there is a belief that certain front-line health services (A&E, mental health and substance use) could identify and refer more victims.⁸⁸

General Practitioners and other professionals should be aware of recent comprehensive guidance.⁸⁹

MENTAL ILLNESS⁵

While it would be wrong to imply that all adults with mental health problems are bad parents it is important to be aware mental illness and child abuse are closely interwoven in a complex

cause and effect relationship. Chronic self-harm is a recurring theme in serious case reviews conducted in this county and in reports of fatal child abuse (see below).

A small and possibly predictable subgroup can display sudden violence. Adults with serious mental illness - those with schizophrenia, major depression and bipolar disorder - are two or three times more likely than people without mental illness to demonstrate assaultive behaviour. The lifetime prevalence of violence among people with serious mental illness is 16% (the background risk in the general population being 7%). The risk rises dramatically with substance (or alcohol) misuse to 35% and is highest when substance misuse and serious mental illness are combined at 44%. Surveys of this risk are likely to be underestimates as the focus is generally on street violence and violence to health professionals, ignoring the greater danger to close relatives. Past violence tends to predict future violence. Effective treatment of the mental illness is likely to substantially lower the risk of violence.^{90 91}

Childbirth poses a risk to mental health and a chronically mentally ill woman can destabilise in the puerperium. One quarter of new female psychiatric referrals have a young child. Clinicians need therefore to "think family". The greatest danger exists with those who do not comply with treatment programmes. Very small children cannot anticipate parental harm nor behave in a way to prevent it happening. Acute mental illness constitutes a risk to the child if the child is the subject of the mother's delusions (e.g. "I killed her before the Mafia got to her"). Indeed, it is important to take seriously any threat made by a parent that they may harm their child, especially on a background of mental disturbance (e.g. "You'll take her over my dead body, I'll kill her first and then myself.").

Personality disorder constitutes a greater risk for the child than mental illness, is characterised by deeply ingrained and enduring behaviour patterns leading to difficulties in social functioning and performance and often presents with psychiatric problems such as depression, anxiety and substance misuse. The commonest psychiatric diagnosis in women who abuse their children is a mixture of mild depression associated with personality dysfunction. Abusive mothers are more likely to have assertive, demanding and suspicious personality traits and to be excessively critical, with high expectations, of their children.⁹² Abusive and at risk mothers are over-critical of everyday transgressions (e.g. watching TV past bedtime, wearing wrinkled clothes) and are more likely to use verbal threats and spanking instead of reasoning with the child.⁹³ Men who kill or injure their children are not usually mentally ill but may have a history of criminality and diagnosis of sociopathic personality disorder.⁹⁴ Parents who present their child repeatedly with psychosomatic symptoms may fear harming their child or are inflicting harm. Even when psychiatric assessment has not lead to a formal diagnosis or recognised a treatable psychiatric condition, the parent's bizarre behaviour may still constitute a risk to the children.⁹⁵

ALCOHOLISM

Parental alcoholism causes great emotional distress for the child. The child fears abandonment, fears the parent may die (often having seen the parent lifeless in a coma), fears the parent does not love them and fears being branded as a "loser". Children are aware of their parents drinking from about the age of 4-5 years and by 9-10 years believe they should be able to get their parent to stop the abuse. Older children no longer believe this. Some children gain refuge from their social network, the non-abusing parent, older siblings or in school.⁹⁶

Two-and-a-half-million children in the UK live with parents who drink hazardously and 700,000 with dependent drinkers. Alcohol is feature of most domestic violence offences.⁹⁷ Alcohol is the most harmful drug when considering the impact to users and others.⁹⁸ Most adults who abuse alcohol deny their addiction and seriously underestimate the impact the habit has on their child. Alcoholic adults exhibit certain patterns of drinking, drinking regularly during the day and amnesic binge drinking. Often family members have given warnings about excess drinking. The alcoholic parent may be the victim or the perpetrator of domestic violence.

The alcoholic parent will often claim to be able to abstain on his/her own initiative but is rarely able to do so without professional outside help. If a parent is arrested for drunkenness in charge of a child there should be an accompanying child protection investigation.

Alcoholism is a hidden problem and we need to get better at asking about it. The self-administered questionnaire recommended by the DoH is useful in this respect.⁹⁹

FETAL ALCOHOL SYNDROME (FAS)

Both amnesic binge drinking and continuous heavy drinking are harmful to the fetus. The FAS is a series of permanent birth defects including growth failure, minor facial changes and developmental problems.¹⁰⁰ Fetal alcohol spectrum disorder (FASD) consists of the neurobehavioural aspects of the syndrome including: hyperactivity, attention deficits and poor motor coordination. The incidence of FAS is about 1-3/1000 children and FASD 9/1000.

Screening for use of alcohol and illicit drugs during pregnancy may help prevent FASD. Pregnant women with high levels of drinking decrease after brief interventions. There are several screening tools available.¹⁰¹

The diagnosis of FAS has implications for the management of that family. Suspicion of this diagnosis should be confirmed by systematic investigation, which includes an expert assessment of the mother's drinking and the opinion of a paediatrician with expertise in this area of diagnosis.

ILLEGAL SUBSTANCE MISUSE

There are some 300,000 children of problem drug users in the UK, approximately one per dependent adult.¹⁰²

Illicit drug use is a chronic relapsing condition and adults presenting themselves for treatment will generally have been misusing drugs on a dependent basis for years. Pregnant women often conceal their drug taking, and sometimes also the pregnancy. The tendency to stereotype misusers as devious and self-neglecting can set up a vicious cycle of failure. Substance misusing parents encounters with health and social services are generally negative and lead to fears that the children will be removed. This is perhaps an important reason for poor compliance and failure.¹⁰³ For example, a Glasgow study revealed the majority of infants born to mothers prescribed methadone during pregnancy were exposed to polysubstance misuse, and almost one half were additionally exposed to excess alcohol.¹⁰⁴

Factors associated with a poor outcome for the child include: mother is addicted, a long period of drug use, continuing substance misuse, use of other drugs besides methadone, adverse effect on lifestyle, poverty, domestic violence, lack of social support (the relative assumed to provide support is poorly assessed or rejected by the parent), low parental

education, mother aged under 18-years or over 30-years, infant with withdrawal syndrome, previous child abuse, previous child in care, mother was in care as child, poor parenting skills evident.¹⁰⁵

Teenage drug abusers rarely present themselves spontaneously for help. They mainly seek help to relieve a crisis and to get out of trouble. A common referral route is via the youth justice system. Treatment involves a careful assessment and a comprehensive approach involving several agencies.¹⁰⁶

DRUG MISUSE IN PREGNANCY

Cocaine can cause abnormalities of the fetal renal and genital tracts and also vascular occlusion of the brain leading to stroke. The benzodiazepine group of sedatives can have an effect similar to alcohol. Any drug abused by the mother (and particularly solvent inhalation) may lead to lack of oxygen to mother and fetus. Injected drugs (such as opiates) lead to a risk of bacterial sepsis, HIV and hepatitis, which can be passed on to the baby. Most drugs are associated with poor fetal growth and in particular poor head growth. There is an increased risk of placental separation and premature labour. The observed increasing incidence of gastroschisis (a major congenital defect of the anterior abdominal wall) seems to be associated consistently with lower maternal age. This may be due to periconceptional tobacco smoking and use of recreational drugs such as alcohol, marijuana, and cocaine.¹⁰⁷

The pregnancy is often unexpected and unwanted. Most drugs are associated with immediate or delayed withdrawal symptoms in the baby, often accompanied by seizures. Breast-feeding is usually contraindicated. SUDI occurs more frequently. Drug misuse in pregnancy needs careful coordinated management.¹⁰⁸

Neonatal drug withdrawal includes signs such as irritability, seizures, tremors, sensitivity to loud noise, diarrhoea and vomiting,, excess hunger and respiratory arrest. The onset is usually in the first 72 hours but may be delayed up to 4-weeks.¹⁰⁹

NO PRENATAL CARE: UNBOOKED PREGNANCY

Denial of pregnancy, concealment of pregnancy, substance misuse disorders, multiparity, and financial barriers to care are associated with a lack of seeking prenatal care. Unbooked pregnancy conveys a high risk as one third of infants require intensive care for a variety of serious medical complications. It is associated with neonaticide (see fatal child abuse below). Denial implies the mother is intellectually aware of the pregnancy but keeps it from her consciousness while concealment implies the mother consciously hides the pregnancy from others. These mothers are unlikely to be prepared for motherhood. The multiparous mother is likely to have experienced her older children taken into care. Substance misusing mothers are motivated to conceal pregnancy for fear of legal complications and custody loss. A recent review showed mothers who failed to book were often sent home with their babies without adequate psychiatric assessment although some had child protection supervision. About half the infants eventually entered care and most of those of the substance misusing mothers.¹¹⁰

Pregnancy denial may not last throughout the whole pregnancy and can be a reaction to external stresses and internal conflicts in women who have been otherwise well adjusted. Paternity, exposure to violence and other stresses are also factors. Although pre-discharge psychiatric assessment is indicated,¹¹¹ absence of psychosis does not exclude subsequent risk to the baby.

NEGLECT

The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- Provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- Protect a child from physical and emotional harm or danger;
- Ensure adequate supervision (including the use of inadequate care-givers); or
- Ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Safeguarding Children Across Services; Messages from Research examines the evidence base around emotional abuse and neglect.¹¹² In particular, this publication examines the poor outcomes for neglected children when child protection teams fail to effectively engage with the problems.

Neglect is the most frequent reason for child protection registration but is the least well-handled of all the various forms of child abuse.¹¹³ These other forms present dramatically with an injury or allegation, while neglect presents as a steady trickle of less pressing concerns. A systematic approach is essential. Neglect is the end result of a failure of parenting which may relate to a serious underlying problem. For example, an audit in this county of 48 neglect related child protection conferences revealed the problem affecting the main carer was exposure to domestic violence 50%, a significant mental health problem 40%, alcoholism 30%, substance misuse 25% and learning disability 6%, with some inevitable doubling-up. About 40% of families were non-compliant with assessments by specialist agencies (e.g. adult mental health).

Neglect may be more evident in risky parental lifestyle and condition of the home, than in actual harm to the child. It may be wrong to wait for the child to "prove" the neglect before intervention.

Judgments about the degree and seriousness of neglect are often seen as value laden and set against differing class, culture or social norms and it is not unusual for there to be disagreement about the threshold for intervention. Practitioners often see parents as inadequate and ill prepared for parenting rather than deliberately subjecting their children to sustained abuse but neglectful care is often deeply ingrained within the family, coupled with a sense of helplessness and hopelessness that becomes pervasive and workers often become enveloped within the family dynamics in their efforts to raise the living standards to a good enough level.

Babies are dependent, if not fed regularly, kept dry, warm and clean, they will suffer recurrent infections, nappy rash which may scar and failure to thrive. Neglect has a profound effect on the child's mental development and behaviour. Lack of opportunity leads to delay in developing the normal motor milestones. Babies are sociable and seek interaction. The neglected infant may show withdrawal, "looking away" behaviour and emotional flattening. Severely neglected infants may show self-stimulating behaviour such as persistent head-banging and rocking. The neglected child may be anxiously attached at 12-18 months and at

two years be angry, frustrated and non-compliant. In unfamiliar surroundings the neglected and abused child may creep quietly into a corner and observe warily (frozen watchfulness) or be ill at ease whining and unhappy, clinging to the caregiver (who responds with irritation) or explore aimlessly, interacting more to other adults in the room than to the caregiver.⁷⁸

In some neglected children you can see *deprivation hands and feet*, which are chronically red and swollen, and do not improve on warming. Neglected children often have dry, thin sparse hair, thickened yellow nails, a dirty smelly body, head lice and carious teeth. The effect at school and nursery is to be shunned by peers. Another manifestation is *psychosocial short stature*, which can be associated with hyperphagia. This distinctive syndrome is characterised by stealing food, hoarding food, drinking and eating excessively and eating discarded food. This may be witnessed at home, at school or in foster care. The child shows catch-up growth when removed from the source of stress.¹¹⁴

FAILURE TO THRIVE

The child who is "failing to thrive" is growing slowly and in practice this means, "falling through the centile lines" of the weight chart. The most important cause of the failure is undernutrition and can be explained by common problems such as delayed progression to solid foods, poor appetite and a desire to eat only a narrow range of foods. About 5-10% of children with failure to thrive are abused or neglected. Failure to thrive is more common in abusing or neglecting families but such families account only for a small proportion of all cases of failure to thrive. Management requires active collaboration from the health visitor, dietician and paediatrician. One would consider child protection procedures if the family were non-compliant with management or if there was other worrying information about the family.¹¹⁵

The term "non-organic failure to thrive" means medical causes are excluded and it is time to consider social causes including neglect by ignorance and deliberate underfeeding (a form of FII) where the mother knowingly lies about how much she is giving the baby. Doctors must set down their findings and interpretation clearly in writing.

PARENTS WITH LEARNING DISABILITY

Learning disability (LD) is common, affecting 1–2.5% of the general population in the Western world, and encompasses many different conditions. It usually leads to major functional impairment and lifelong need for support and interventions. Learning disability and mental retardation are labels applied to individuals who consistently test below a certain IQ level (usually 70) and who show functional impairment as a consequence of low IQ. The modern approach to the problem of the learning disabled parent is the parental skills model of in-depth assessment.¹¹⁶ People with learning disability have the right to have children but also have a responsibility to provide adequate care.¹¹⁷

There can be a continuous cycle of parental learning difficulty leading to child abuse and especially neglect passing down the generations. Within the low normal IQ and moderate LD population is a group of individuals whose impaired learning and functionality relate as much to nurture as to nature. In modern society, individuals with IQs in the range 70–84 are at high risk of developing academic and behavioural problems. Individuals with learning disability are likely to have other problems, in particular epilepsy (14-44%), and psychiatric difficulties including depression, anxiety and eating disorders.

The learning disabled may not be able to: travel independently, tell the time, look after the house, and provide consistent discipline. IQ does not relate in any systematic way to parenting competence until it falls below 55-60. Below this level parenting is less competent, generalisation of learnt skills is poor and relapses are likely. Commitment to the child's wellbeing and good social skills are important. Learning disabled parents are less likely to seek help with parenting difficulties. The learning disabled parent's quality of care may deteriorate as the family enlarges. Where the learning disabled parent has abused or neglected the child, a high level of remedial intervention is unlikely to bring success^{118, 119}

The partner may have mental health problems and the relationship is more likely to be abusive. Where one parent has learning difficulty it is usually the mother and it may be the father who constitutes the risk to the child. Booth and Booth¹²⁰ interviewed 30 adults ("informants") who had been brought up by a LD parent or parents. Over half of the informants (16), including 10 women (six with learning difficulties), disclosed that they had been the victims of physical or sexual abuse. In only one instance was the abuser reported to be the parent with learning difficulties. Five informants accused their father without learning difficulties. Otherwise the perpetrator was named as a stepfather or stepmother, a brother or sister, or someone outside the family.

Woodhouse and Davies¹²¹ reported prior knowledge of parental disability may not prevent child abuse and in about half their families, the learning disability came to light as a result of the abuse. They reported 32 children of 22 LD parents in 19 families who were referred to their learning disability service over a 3-year period. The mother was learning disabled in all. All but one family involved child protection at the point of referral even though 12 were previously known to the learning disability service.

CHILD SEXUAL ABUSE

Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

INCIDENCE

Abusers are usually but not exclusively men. Many commence their habit of abuse as children or teenagers (see below). Most live in the same household as the victim and about half are biologically related. A high proportion of adult abusers have committed previous sexual offences. An abuser may "groom" a child over a period of time. Most use some form of threats or coercion at the time of abuse.¹²² Abuse by females has been described as "the ultimate taboo" and the abuser is often the mother.¹²³

We may be aware of only one in 800 children who are sexually abused. There may be a million girls and about half as many boys in England who have been sexually abused. Although society is now more willing to recognise the existence of child sexual abuse and professionals are better at dealing with families, outcomes for this group of children are not

much improved.¹²⁴ In several Western countries there has been a dramatic fall in the investigation and substantiation of sexual abuse over the last 2-3 decades. During the same period, recognition of domestic violence has rocketed. The fall is likely to be a failure of ascertainment. As explained below, diagnosis of sexual abuse is heavily dependent upon victim allegation, so is mainly confined to that minority of self-selected children who are prepared to be forthcoming and to those identified via perpetrator recorded video or photograph.

FEMALE GENITAL MUTILATION (FGM)

FMG ranges from a symbolic prick to the clitoris to extensive removal and narrowing of the vaginal opening, performed using scissors, razor blades and sharp knives.¹²⁵ Immediate risks are haemorrhage, infection and death. Long term risks are menstrual problems, infertility, psychosexual and psychological difficulties. Sexual intercourse is said to be more painful than childbirth. The UK's lack of success in prevention of FGM has been described as "shameful".¹²⁶ In October 2012 the Government commenced the 1-year pilot of a "passport", based on the Dutch model, which warns of the consequences of performing the procedure abroad. FGM is widespread across Africa, in at least 28 countries but not confined to that continent. Worldwide 100-140 million girls and women are thought to have suffered FGM. For example, in Guinea and Somalia 97% of all women have undergone mutilation, often of the most severe form. A sign the child is at risk is where the family belongs to a relevant community, the child is planning absence from school and talks about a special procedure or ceremony that will take place; with a high risk period in the summer holidays. More girls are refusing the procedure, so the trend is for it to be performed on infants; 20,000 girls are at risk in the UK.

CHILD SEXUAL EXPLOITATION

The term sexual exploitation (SE) is used where the abuser stands to gain social standing or gain financially from the involvement of other abusers. The victim (often between 10 and 16 years old) is often vulnerable, for example on the grounds of being looked after. Organised exploitation first came to light where "groups of men were able to groom, pimp and traffic girls across the country with virtual impunity where offenders were identified to police but not prosecuted".¹²⁷ The use of the term "prostitution" has had the effect of portraying these girls as participating criminals rather than as victims. The grooming period is very short and a high proportion of victims are raped on the first night. A victim will be raped by several men, even though many believe they are in a loving relationship.

The Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups reported 48% of children who suffered SE had injuries requiring attendance at accident and emergency, 41% had drug and alcohol problems, 32% self-harmed, 27% had other additional mental health problems and 39% had sexually transmitted infections. This clearly identifies the health agencies to which these children might present. They may present with chronic fatigue, pregnancy requesting termination and exhibit what is interpreted to be sexually risky behaviour.¹²⁸

SEXUAL ABUSE BY YOUNG PEOPLE

Pre-pubertal children exhibit a variety of sexual behaviours, the most frequent are self-stimulation, exhibitionism and related to personal boundaries. Thus for a 5-year-old boy to touch his genitals occasionally, his mother's breasts or to look at people when undressing

would be commonplace. Putting mouth on sex parts, trying to have intercourse and other intrusive behaviours, would be of concern.¹²⁹

Between 25-40% of all alleged sexual abuse involves young perpetrators, most are adolescent males but some are young children and females. There is no particular ethnic bias but learning disability is over represented in perpetrators and victims. In comparison to sexual experimentation, abusive behaviour is not consensual, involves coercion and sometimes significant force. Victimisation from sexual abuse or exposure to domestic violence are considered the great risk factors. Hawkes has proposed a chain reaction, where perpetrators have suffered neglect and abuse in their early lives, which has led them to externalise their response to sexual abuse. In Hawkes' series the young people suffered similar sexual harm to that meted out to their victims. A review of 700 British child and adolescent sexual abusers reported victims were usually known to the abuser but not related, the abuse was often in school or residence, half had penetrated or tried to and an important minority had multiple victims.^{130 131 132 133}

PRESENTATION OF SEXUAL ABUSE

Presentation may occur in a number of ways, a veiled or clear statement, behavioural change or psychosomatic or physical symptoms.¹³⁴

A statement by the child is the single most important factor in making the diagnosis. This narrows down the opportunities.

DISCLOSURE

The nature of the disclosure is dependent on the child's age and mental development. The child may make the disclosure to a family member, a family friend or a professional such as a teacher. Occasionally disclosure may be in the form of a diary or drawings. Disclosure by the pre-school child is more likely to be accidental, without the child realising the implications and be triggered by a chance event or conversation. Disclosure by the school-aged child is generally more deliberate but many (particularly boys) do not disclose.

Frequently the child makes a delayed, unconvincing disclosure, followed by retraction. Children are more likely to delay disclosure if the abuse is intra-familial (incest), they are older, they fear serious consequences for other family members (e.g. the mother) and if they believe themselves responsible in some way for the abuse. The severity of the abuse is not a factor. Children are very sensitive to the possible reactions of adults and will not speak unless they get the opportunity, which does not arise in many families.^{135, 136, 137, 138, 139}

A particular subgroup concerns disputes over where a child should live or how much time they should spend with a non-resident parent for a number of reasons. An analysis of 136 such cases found allegations prompted the divorce (or separation) (11%), the child did not feel safe enough to tell until after the break-up (19%), the abuser took the opportunity of unsupervised contact to commence abuse and to get back at the spouse (41%), or the allegation was inconclusive (9%) or false; either mistaken from heightened emotions with over-interpretation of a young child's utterances (11%) or deliberately false (3%).¹⁴⁰ Practitioners must try to investigate these types of allegation systematically,¹⁴¹ and there are dangers from jumping to conclusions.¹⁴²

SPEAKING TO THE CHILD

It is important to listen to the child and good practice to record verbatim what the child says. Do not stop a witness who is freely recalling significant events.. Take care to avoid asking leading questions. Where it is necessary to ask questions, they should, as far as possible in the circumstances, be open-ended or specific-closed rather than forced-choice, leading or multiple. Any early discussions with the child should ask no more questions than are necessary in the circumstances to take immediate action. Make a comprehensive note of the discussion, taking care to record the timing, setting and people present as well as what was said by the witness and anybody else present (particularly the actual questions asked of the witness) and make a note of the demeanour of the witness and anything else that might be relevant to any subsequent formal interview or the wider investigation. Fully record any comments made by the witness or events that might be relevant to the legal process up to the time of the interview. An Achieving Best Evidence (ABE) interview will be required as part of any S47 Children Act 1989 and/or criminal investigation.¹⁴³

The English criminal justice system relies heavily on spoken testimony and the 1999 Youth Justice and Criminal Evidence Act effectively removed legal constraints on calling younger witnesses. Although the majority of child witnesses are over 10-years, a number of four and 5-year-olds have been cross-examined at trial. The Appeal Court in 2010 upheld a conviction for rape based on the evidence of a child aged three at interview who was describing events when she was aged two. In the case of children the Court of Appeal judgment in R v B [2011] Crim.L.R. 233 makes it clear that "...although the chronological age of the child will inevitably help to inform the judicial decision about competency, in the end the decision is a decision about the individual child and his or her competence to give evidence in the particular trial."

Young children are especially vulnerable to inept adult questioning.¹⁴⁴ A study of 27 sexually abused children (23 photographically recorded by the perpetrator) showed although they were generally highly avoidant and often denied the abuse there was no difference in the reporting of abuse in the different age groups.¹⁴⁵ Children who have already disclosed abuse are more likely to disclose during the forensic interview (range in different studies is from 72% to 93%) than children who have not disclosed (range 7% to 60%).¹⁴⁶

PHYSICAL AND PSYCHOSOMATIC ILLNESS

Often cited as helpful in the diagnosis, somatic symptoms (e.g. headaches, aches and pains) are extremely common in children, as are genitourinary and bowel symptoms (e.g. pain passing urine and irritation), and often have an alternative explanation. Nevertheless, these symptoms always require a medical evaluation (see below).

ABNORMAL BEHAVIOUR

Behavioural symptoms include aggressive behaviour, excessive masturbation, age-inappropriate sex play, attempted insertion of objects vaginally, marked withdrawal and running away.

OBTAINING A MEDICAL EXAMINATION

Medical examination usually involves two senior doctors and should be properly planned by means of a strategy discussion. This is not a job for the family GP. The examination involves inspection and *not* internal examination (with the possible exception of a recent rape

allegation in a teenager). The examination will be performed in the presence of a trusted and caring adult, usually the child's mother. Examination of the genitalia is done as part of a general examination and usually at the end. Examination is never forced upon a child. In general the relevant paediatric team should examine victims under 13-years-old (depending on local arrangements) and the adult forensic team those who are older.

A person with parental responsibility should give consent to examination for any child under 16-years-old. An exception to this rule is children between the ages of 14 to 16 (occasionally younger) who may be "Fraser competent" and give their own consent.

In general the medical examination should follow the ABE interview of the child.

MEDICAL EXAMINATION

A sympathetic gentle examination can either detect abnormal signs or reassure the child and family that no damage has occurred. It is mandatory to offer an examination if the child has genital symptoms such as irritation, discharge or bleeding. Otherwise the decision to do an examination should be taken jointly by a suitable adult with parental responsibility, child and professionals.

Physical signs of sexual abuse are subtle and rarely diagnostic, healing occurs rapidly and scarring is rare. A substantial proportion of children alleging sexual abuse have no abnormal signs. A diagnosis of sexual abuse is rarely made on physical findings alone. Absence of abnormal signs does not imply absence of abuse.

A retrospective analysis of 236 sexually abused children with perpetrator conviction found only 14% had abnormal findings and only 1% anal findings (despite several allegations of anal penetration). Bleeding at the time of penetration and examination within 72 hours was more likely to be associated with abnormal findings. A much larger 5-year prospective study of 2384 children referred for possible sexual abuse reported a normal medical examination in 96%. Of those who disclosed abuse, 69% alleged anal or vaginal penetration (957 girls and 177 boys), which led to a slightly higher rate of abnormality (6% versus 2%).

Why such a low proportion of children who allege penetrative sexual abuse have normal medical findings remains a conundrum. Young children do not always understand the meaning of the terms they use. A statement "he put his thing in my private" may or may not mean full penetration has occurred. The child lacks a sophisticated understanding of what has happened and misinterprets simulated intercourse as either penile vaginal or penile-anal penetration.

Research indicates that medical, social, and legal professionals have relied too heavily on the medical examination in diagnosing child sexual abuse. History from the child remains the single most important diagnostic feature in coming to the conclusion that a child has been sexually abused.^{147, 148}

Pregnancy in a child under 16-years indicates either abuse or unlawful though possibly consensual sexual intercourse (indulged in by 25% of young people under 16-years-old). In England the age of consent for any form of sexual activity is 16 for both heterosexual and homosexual sex. The Sexual Offences Act 2003 introduced a series of laws to protect children under 16 from sexual abuse. The law is not intended to prosecute mutually agreed teenage sexual activity between two young people of a similar age unless it involves abuse or

exploitation. It is illegal to have sex with a child under 13. Where someone is in a position of trust they cannot legally have sex with a young person under 18 in their care.

A suspected sexually transmitted infection needs joint genitourinary and paediatric evaluation. Infection with gonorrhoea, chlamydia, syphilis and trichomonas in prepubertal children is usually symptomatic, disclosure is rare and few have diagnostic signs of sexual abuse. Nevertheless, outside the perinatal period the presence of any of these infections in a prepubertal child “almost always” means sexual contact, even when testing of close contacts had failed to reveal a source.¹⁴⁹

Post Exposure Prophylaxis Following Sexual Exposure (PEPSE) is available within a tight time frame. HIV antiretroviral therapy has to be given within 72 hours after sexual contact.¹⁵⁰ The same applies to Hepatitis B immunoglobulin while an accelerated course of Hepatitis B vaccination can be started within 6-weeks.

CHILD SEXUAL ABUSE – MEDICAL RESPONSIBILITIES.

There has been considerable discussion in the medical literature on the dilemma facing doctors and other professionals who are the receipt of a disclosure of child sexual abuse where referral to social services may result in widespread repercussions for the family.¹⁵¹ It is worth remembering child sexual abuse often has serious long-term consequences for the victim’s mental health and vulnerability including sexual exploitation.^{152, 153, 154, 155} The professional has a responsibility to be an advocate and a voice for the abused child who is more vulnerable than the adults and must make the appropriate referral to social services if they become aware of any form of child abuse .

WORKING WITH THE CHILDREN ACT 1989

It is important to be aware of certain interpretations of the Act that can lead to a failure to protect children. The Act considers that children are best raised within their own families except in limited circumstances such as when they are at risk of or suffering significant harm. Children may remain in their parents care during care proceedings whilst assessments are undertaken. Care plans for rehabilitation can lead to re-abuse. It is not correct to leave abused and neglected children within their families under the impression that the alternative of care can be worse.¹⁵⁶ The situation has not improved in the last 10-years, as highlighted by Davies and Ward.¹¹²

Decisions to separate children from their families are only taken when there is no realistic option for the children to be cared for by a parent or family member. .

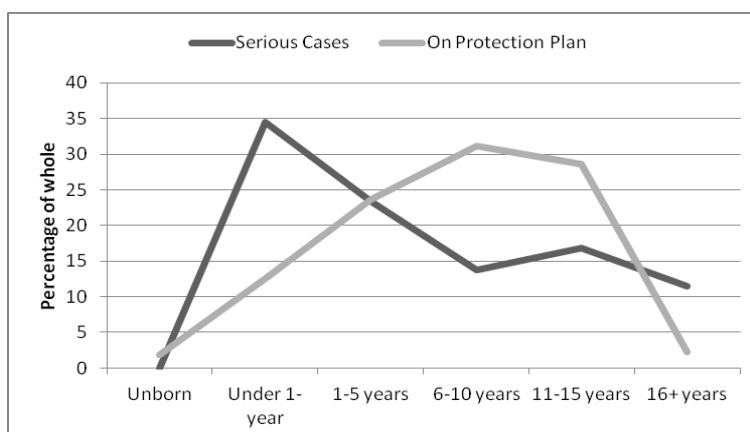


Figure 1. Comparison of ages of children subject to serious case review with the ages of children subject to a protection plan.

Ofsted¹⁵⁷ has been concerned about the large number of babies less than one year old in serious case reviews. Ofsted believes there are shortcomings in the timeliness and quality of pre-birth assessments, poor assessment of parenting capacity and a low appreciation of the vulnerability of babies. Very often the only professionals involved with such families are from health. The dichotomy between the age of vulnerability and the age at which risk is ascertained is illustrated by Figure 1. This compares the peak age of children subject to a serious case review with the older peak age in numbers of children subject to a protection plan.

One does not always need to demonstrate "significant harm" before acting. An example would be in a young baby whose parent indulges in serious alcohol or substance misuse where the baby is not likely to demonstrate actual harm on medical examination but there is clearly a risk of significant harm. The Children Act 1989 envisages partnership working both between agencies and with families but this requires a two way process. "In serious abuse partnership as avoiding confrontation, or mere togetherness, is always dangerous. However, partnership is still possible, provided it is made explicit that the focus of all work is the child's welfare. *A joint acknowledgment of maltreatment is mandatory, not merely desirable.* Family reunification is not automatic. Indeed, partnership can exist around relinquishment of parental care, this being just as legitimate a therapeutic goal as reunification. Professional style should be mutually respectful and as inclusive of parents as possible while still maintaining the child's safety."¹⁵⁸

CRIMINAL PROSECUTION

Criminal proceedings are independent of child protection proceedings under the Children Act. Evidence gathered during the separate processes should normally be shared between the agencies when in the best interest of the child subject to compliance with the correct legal processes for information sharing/disclosure. Neither the decision of the police and CPS to drop criminal proceedings, nor the failure of a criminal prosecution in the courts, implies absence of abuse.

The criminal standard of proof is beyond reasonable doubt. In family proceedings the standard of proof is the balance of probabilities.

FATAL CHILD ABUSE

Fatal child abuse is rare (about 50-300 cases / year) in comparison to the total number of child protection investigations and children made subject to a child protection plan. This makes fatal abuse difficult to predict. Furthermore, only about half the fatal abuse cases are previously known to child protection agencies. Some workers have described checklists to predict fatal abuse but these seem to lack specificity. Reder, Duncan and co-workers argue that it may be more useful to examine the parent's behaviour.^{159, 160, 161} Physical abuse is the commonest cause of death, followed by neglect. It has been estimated that at least 10-times as many children survive abuse as die but end up permanently and severely disabled.

Most children are killed in the first year of life. This means that obstetric, neonatal and infant health services need to be particularly alert to adverse circumstances.

In a family with a history of abuse, a phenomenon known as "closure" may herald heightened risk to the child. Closure is where the family shut themselves off from contact with the outside world and members of the professional network. Closure can occur intermittently leading up

to a child's death. Variants on this theme are flight and "disguised compliance". In the latter, the family cooperates on a temporary basis, effectively pre-empting decisive action by the child protection agency.

It is sometimes as if the parent has an urge to be restrained from maiming or killing. The parent may deliver a covert warning by consulting a professional, either a mental health problem or a minor probably inflicted injury. The parent may request the social worker to take the child into care. A consistent observation has been that the anxiety of the parent and the pressure of demand seems out of keeping with the nature of the problem being presented.

NEONATICIDE

This is generally committed by a shy, timid adolescent living with her parents who is concealing her pregnancy, or in a state of denial and in the absence of any psychiatric symptoms; 95% of women who commit neonaticide deliver at home and only 15% receive any antenatal care. Methods of killing include stifling the newborn's first cry, or drowning the newborn in the toilet. The body is often ineffectively concealed and may be merely placed in a wardrobe.¹⁶² Maternal passivity is characteristic; a more active mother might seek an abortion. It has been speculated neonaticide is common but only about 10 cases are officially recognised a year. Few neonaticides are caused by men.

INFANT AND CHILD HOMICIDE

This has a closer relationship with maternal mental illness; the mother is usually older and often living with a partner. Most female perpetrators are the sole or main carer while male perpetrators tend to do little care work but are left alone with the child for a short time while the mother goes out. Men (responsible for over half the deaths) have little experience of child care and no idea how to bring up a baby, being "shocked" at its arrival. There is little social support, a low level of education and commonly among the men a criminal background, often of violent offences. There is a strong association with domestic violence and chronic parental alcohol and substance misuse.^{163, 164, 165} A third to a half the perpetrators have made previous suicide attempts. They may kill "all available children" using a variety of methods and then attempt suicide at the time or shortly afterwards.¹⁶⁶

Always take seriously any threat to kill by the carer. Interviews of children who survived attempted filicide revealed they had been subject to many similar near fatal attempts, often with threats to kill and some had been saved by their siblings.¹⁶⁷ Where filicide occurred on a background of domestic violence, many community agencies had been involved with the family (average 9) but few had ever attempted a risk assessment, threats to kill were again a striking feature.¹⁶⁸

HONOUR CRIMES:

This is about male dominance and the concept "women are like silk, drop in the mud and tainted forever, while many are like gold you can wipe the mud off", The most minor behaviour such as kissing a boy, receiving flowers or texting can lead to a girl's murder. The risk is independent of class and is common to the culture of many countries. Organised crime is involved for kudos and not for money.¹⁶⁹ (See Forced Marriage below.)

THE MEANING OF THE CHILD.

Reder and co-workers believe that consideration of the “meaning of the child” can help predict serious child abuse. For example, a parent can ascribe a negative meaning to a child who is linked with adverse factors associated with conception, pregnancy, birth or early life or with the break-up of a relationship (as in the baby Peter case). Sometimes the child fails to live up to the parent’s expectations. There may be a particular risk for the previously rejected child returned from fostering. See Reder P, Duncan S: reference 160; pp 39-55.

FORCED MARRIAGE

Pressure or abuse is used to obtain marriage without consent. This may involve the young person being taken abroad without realising this is the intended outcome. Professionals may be concerned when a pupil becomes anxious or emotionally withdrawn, has failed to do her homework, has been missing school without good reason or siblings have left education early or returned married from a holiday abroad. Court wardship and or special orders may be appropriate measures.

Child marriage is a widespread problem around the world despite laws to prevent the practice in many countries. It is the epitome of gender inequality. Girls who marry as children are at increased risk of violence, suffer early and frequent pregnancies, stillbirths and newborn deaths.¹⁷⁰

MISSING CHILDREN

Each year in Britain it is estimated that approximately 100,000 young people under the age of 16 run-away overnight, a quarter of these being aged under 11-years-old with no improvement in the statistics from 1999 to 2011. Fifty-five percent run away more than once. Females are significantly more likely to run away than males. Reasons for running away from home include family conflict, actual maltreatment, being forced to leave (one quarter) and general unhappiness; 10% run away for more than 4-weeks. Approximately one quarter who run away overnight either: sleep rough or with someone they just met, or beg or steal to survive (or a combination of all three risky behaviours); this would equate to 18,000 a year. About 70% of runaways are not reported missing. Only around 5% seek help from agencies when they run away. As of 2011, there were only 5 registered refuge bed spaces for young people in the whole of the UK. Chronic running away drifts into homelessness and sexual exploitation. The running away can become entrenched if the child is placed in care, particularly if there are frequent placements.^{171, 172, 173}

DISABLED CHILDREN

The term disability embraces both physical and mental impairment. Thus it includes cerebral palsy and muscular dystrophies, chronic illness such as diabetes and cystic fibrosis and autism, learning disability, ADHD and emotional and behavioural difficulty. Children with disabilities are substantially at greater risk of suffering physical violence than their peers. Those with psychological problems and cerebral palsy are at particular risk, multiplied by 10 (odds ratio) in some studies.¹⁷⁴

Many disabled children have difficulty with communication. Current communication systems (e.g. Makaton and Bliss) do not include a vocabulary for private parts, bullying and abuse.¹⁷⁵

Disabled children are not all the same, and have a wide range of abilities and needs. Interviewers need to be aware of the extensive differences between potential witnesses in their social, emotional and cognitive development, and in their communication skills, the degree of their understanding and in their particular needs. It will nearly always be necessary to seek specialist advice on what special procedures are appropriate and to consider if the services of an intermediary or an interpreter are required.

S 16 (1) of the Youth Justice and Criminal Evidence Act 1999 allows for an approved intermediary (a communications specialist) to help a vulnerable adult or child witness to communicate with the police, legal representatives and the court. Achieving Best Evidence in Criminal Proceedings (section k offers specific guidance on interviewing children with disabilities).¹⁴³

Sometimes supporting the parent(s) will not achieve better care of the child. When a reasonably supported parent continues to neglect a child consider the following: (a) are all children in the household neglected or just the disabled child, (b) what is the “meaning” of this child to the parent and (c) are there general concerns about parental risky behaviour (violence, chaos, drugs, alcohol etc)? There is a danger of over empathizing with the parent which encourages the worker to see the child as the problem. Professionals may respond differently to injuries, even broken bones, depending on the disability of the child victim.¹⁷⁶

GLOSSARY OF MEDICAL TERMS

Term	Explanation
Acute.	<i>Acute</i> : short (and usually severe), coming to a crisis. <i>Chronic</i> : long drawn out, lingering, lasting but without indicating severity. <i>Subacute</i> : not acute but progressing more rapidly than chronic.
Amylase	An enzyme secreted into the bowel from the pancreas, and present in small amounts in the blood, which converts starches into sugars.
Anterior	Situated at the front. In front of.
Benzodiazepines	A group of minor tranquillisers including Valium (diazepam), Librium and many others, pharmaceutical names usually ending in <i>-epam</i> .
Bone	<i>Diaphysis</i> : the shaft of the long (=limb) bone. <i>Metaphysis</i> : the junction of bone and cartilage, which is the growing point. <i>Epiphysis</i> : a portion of bone with its own centre of bone formation. An epiphysis caps the growing point at each end of the long bone.
Brain	The brain is separated from the skull by three membranes or mater (=mother): <i>dura mater</i> , a thick fibrous membrane, which is close to the bone, <i>arachnoid</i> a more delicate structure and <i>pia</i> which adheres to the surface of the brain. The brain floats in <i>cerebrospinal fluid</i> (CSF), which occupies the space between the arachnoid and pia mater. Spaces between the other membranes are virtual but acute bleeding can occur following a skull fracture between the bone and dura (=extra-dural) and (usually) more chronic bleeding between the dura and the arachnoid (=subdural).
Broken versus fractured bone	A <i>fracture</i> is a breach in the continuity of the bone resulting from injury. In other words the bone is <i>broken</i> . <i>Depressed</i> : where the broken bone presses on an underlying structure such as the brain. <i>Impacted</i> : where one end of the broken bone is driven into the other. <i>Greenstick</i> : incomplete fracture in children where the bone is only cracked or fissured. <i>Compound</i> : where there is a wound allowing communication to the open air. <i>Pathological</i> : where the bone is abnormal and fragile.
Callus	New material by which fractured bones are consolidated
Delirium tremens	Delirious disorder of the brain produced by over-absorption of alcohol, often marked by convulsive or trembling symptoms and hallucination.
Dentogenesis	Occurs in association with osteogenesis imperfecta (congenital fragile

imperfecta	bone disease). Teeth are translucent, yellowish or blue-grey, irregular, prone to caries and late erupting
Ecchymosis	Extravasation of blood under the skin producing a bruise.
Infanticide	When a mother causes death of her child under the age of 12 months by wilful act or omission but at the time the balance of her mind was disturbed (see reference 163 for full definition).
Filicide	The killing of one's son or daughter.
Frenulum also frenum or fraenum	A fold of mucous membrane which connects two parts and in this text refers to the labial frenulum on the inside of the upper and lower lips or the lingual frenulum on the underside of the tongue.
Fourchette	A membranous fold connecting the posterior ends of the labia minora.
Hymen	A membranous structure partially closing the vaginal entrance. It normally has an opening of a few millimetres.
Labium (<i>pl. -ia</i>)	Lip or lip like organ. Labia majora are two large lip like folds encircling the vagina. Labia minora are two smaller folds lying within the labia majora.
Multiparous	A woman who has borne more than one child.
Neonaticide	Killing of a newborn child, usually during the first day of life.
Oesophageal varices	Abnormally dilated, lengthened, and tortuous veins lining the gullet, which cause vomiting of fresh blood. A complication of cirrhosis (=a wasting of the proper tissue of the liver, accompanied by fibrosis).
Pancreas	Tongue shaped glandular organ, which lies behind the stomach.
Petechia (<i>pl. -ae</i>)	A small haemorrhagic spot in the skin, lining of the mouth or eye.
Posterior	Situated at the back. Behind.
Rachitic	Suffering from rickets
Sclera	The outermost membrane of the eyeball, the sclerotic. The "white of the eye".
Seizures versus fits	The <i>epilepsies</i> are a group of conditions resulting from disordered electrical activity of the brain. Many different types of disorder can produce "fits" or "convulsions", including acute brain injury.

	<p><i>Convulsion</i>: refers to the involuntary contraction of muscles, which occurs during these episodes. Some common convulsions in children are not epileptic at all: e.g. breath-holding episodes. <i>Fit</i>: an attack of illness, especially epilepsy</p>
SIDS or SUDI	<p>Sudden unexpected death in infancy is defined in the text of which sudden infant death syndrome (SIDS) is the major cause. SIDS or cot death is the death of an infant under one year of age which remains unexplained after the performance of a complete postmortem investigation, including an autopsy, an examination of the scene of death and review of the case history. "Near miss cot death", or better-called apparent life threatening event (ALTE), may have a variety of acute medical causes including epilepsy, cardiac and infectious or may occur non-accidentally (during shaking for example).</p>
Skull	<p><i>Parietal</i>: either of the two bones (parietal bones) which form part of the sides and top of the skull, between the frontal and the occipital.</p>
Wormian	<p>Associated with the name of the Danish anatomist Olaus Worm (1588-1654), applied especially to the supernumerary bones developed in the sutures of the skull.</p>

BURNS AND SCALDS IN SMALL CHILDREN. WHEN TO WORRY

<i>Question. In your opinion:</i>	Yes	Possible	No
Was there unreasonable delay in presentation of a severe & painful injury?			
Has a carer brought the child when it should have been the parent?			
Is there no clear history of the injury, e.g. the parent "found" the child with the burn or in scalding water?			
Is the parent blaming another small child for the injury?			
Has the parent offered more than one possible explanation for the injury? (Check with colleagues)			
Is the history incompatible with the child's ability to climb, explore and turn on taps?			
Is there a recent history of previous accidents requiring hospital attendance?			
Does the parent seem unconcerned about a significant burn injury?			
Is the child under 8-months-old?			
Is there evidence of neglect (e.g. non-organic failure to thrive, dirty etc)?			
Is the child on the Child Protection Register?			
Do you think the history fails to explain the injury?			
Are there other injuries (e.g. bruises) besides the burn?			
Does the burn look older than the history suggests?			
Is the scald symmetrical and involving both feet or both hands in a glove or stocking distribution and with a clear tidemark?			
Does the scald affect the buttocks, perineum and feet?			
Does the scald have a central spared area (hole in doughnut sign) over the buttocks or lower back?			
If a full thickness contact-burn, is there a clear outline of the hot object?			
Is there a cigarette burn? (Punched out, round, full thickness?)			
Is there a contact burn on the back of the hand?			
Do you have other concerns about this child's welfare?			

This questionnaire reminds you about internationally recognised features of child abuse related burn (or scald). There is no exact score or threshold of concern but if you find yourself answering "yes" to one or "possibly" to several of these questions you should contact the relevant child protection team. Document any bruises by drawing them out on a body chart and taking photographs.

You will need to consult with colleagues on your unit to determine all the facts relevant to the above questions. If you are concerned about child abuse or child welfare contact your line manager, relevant social services department and local (community) paediatrician.

You should usually inform the parents you are making a referral to social services but not accuse the parent directly of ill treatment. It is Health's duty to report injuries under certain circumstances. Investigation of possible inflicted injury requires multi-agency investigation before a definite conclusion.

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