CHILD ABUSE – A LEGAL PRACTITIONERS' GUIDE

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This article has been prepared specifically for the benefit of legal practitioners interested in child care law, for whom it is important to be familiar with the history and nature of child abuse, and the work of practitioners in other disciplines, such as social work, psychology, and paediatrics. The article begins with a brief history of child abuse and a description of the most common forms of abuse a practitioner may encounter, including signs and symptoms. There will then be consideration of the powers and procedures of social services departments which are vested with wide powers in relation to the investigation of child abuse and the protection of children.

A BRIEF HISTORY OF CHILD ABUSE

Child abuse has no specific boundaries. What may be regarded as abuse in a particular society at a particular time may not be so in another. This article will be based generally upon the approach of western societies to child abuse, particularly over the last 150 years. Auguste Ambrose Tardieu, a Professor of Forensic Medicine and Dean of the Medical School at the University of Paris, published a paper in 1860 entitled '*Etude medico legale sur les services et mauvais traitments exercis des enfants*', bringing public attention for the first time to the cruelty of children. In the 1860s baby farming (people who adopted children in return for payment and then killed them or let them die of neglect) led to prosecutions and changes in the law on the registration of birth and the duty to support illegitimate children. The story of Mary Ellen in 1878 marked the point at which child abuse became recognised. She was found by a New York city social worker chained and starved by her adoptive parents. There were no laws at that time addressing the abuse of children by their carers. The New York police department refused to take action. Henry Berg, founder of the Society for the Prevention of Cruelty to Animals, intervened, and the case was brought to trial. Mary Ellen was placed in an orphanage and her adoptive mother was jailed for one year.

News of the case spread, including detailed newspaper accounts of Mary Ellen's rescue and the trial that ensued. This led to the founding of the Society for the Prevention of Cruelty to Children in 1875. Many other child protection agencies were formed during the late nineteenth century, including the founding of hospitals and charity homes for abandoned and abused children. The first such society in the UK was formed in Liverpool in 1882. The English societies eventually merged to form the National Society for the Prevention of Cruelty to Children (NSPCC). In due course, the Prevention of Cruelty to Children Act 1889 was passed, and from that time there has been a succession of statutory legislation, including the Children and Young Persons Act 1933 which clarified and increased a local authority's powers to remove children from their families. Legislation culminated in the Children Act 1989. In the 1970s and 1980s there has been a succession of child abuse inquiries, including the Maria Colwell inquiry in 1974, the Jasmine Beckford inquiry in 1985 (*The Jasmine Beckford Report* (London Borough of Brent, 1985)), and the Cleveland inquiry in 1988 (*The Report of the Inquiry into Child Abuse in Cleveland* (HMSO, 1987)). Despite the legislation and inquiries, from time to time child deaths through abuse still occur.

The American paediatrician, Henry Kempe, in 1978 identified five stages a society goes through in recognising and dealing with child abuse:

(1) realising that child abuse can take place;
(2) acceptance that children are abused (injuries can be seen);
(3) recognition that physical and emotional abuse can occur and damage a child's development;
(4) recognition that sexual abuse exists;
(5) recognition that society needs to adopt a preventative approach and to become more proactive.

The main categories of abuse are:

(1) physical abuse;
(2) emotional abuse;
(3) neglect; and
(4) sexual abuse.

Increasingly, there are further recognised categories of abuse, such as Munchausen Syndrome by Proxy. It is important to remember that a child may suffer a range of abuse, including, for example physical and emotional abuse, and an abused child will not fit necessarily into a particular category. However, for the benefit of study it is useful to consider each of the main forms of abuse separately.

PHYSICAL ABUSE

Physical abuse may include punching, kicking, biting,

a child being shaken or thrown, an injury inflicted by a weapon, for example a stick, a cigarette or a knife, burn or scald injuries, or injury inflicted through the administration of a noxious substance, for example salt poisoning. Workers such as nursery nurses, teachers, social workers, and health visitors should receive training concerning the identification of common signs and symptoms of abuse in order to consider whether a referral to social services or the police is necessary. To the trained eye, non-accidental injury is much easier to identify than accidental injury, for example fingertip-shaped bruising under a child's jaw or cheeks, or bruising in an unusual place such as behind a child's ear, on the back of his neck or the base of his spine. A torn fraenulum (skin under the tongue) in a young child can occur through force-feeding. Haemorrhaging at the back of a child's eye caused by severe shaking is evidenced by pinpricked dots in the whites of the eyes. Sometimes the pattern of an injury on a child's skin may suggest a non-accidental injury, for example finger-marks from a slap (which are often seen on the side of a child's face) where the imprint of an adult's hand can be made out, or teeth marks in a semi-circular pattern. Care should be taken to ensure, through an odontologist's report, that any teeth marks are the result of an adult's bite. A paediatrician, who will usually carry out an examination of a child with a suspected non-accidental injury, will be familiar with the common explanations given by parents for a child's bruise or injury, for example falling off a bed, falling down stairs, falling from a bicycle, or similar explanations.

Children often experience forms of bruising and injury at certain stages of development when they are involved in physical activity. However, where the explanation does not fit the medical findings, alarm bells should ring. For example if a very young baby of 4 to 6 weeks is alleged to have fallen off a bed, this should be treated with scepticism in the absence of any other explanation because children up to the age of approximately 4 months cannot roll over.

If a child has not reached crawling stage (which usually occurs at 7 to 10 months) an explanation of his injury being caused as a result of falling down stairs should, again, be treated with scepticism. Children who have accidents in the playground or by falling off bicycles will usually suffer injuries on areas of the body such as the forehead, shins, elbows, ankles, shoulders, hips and knees, but are less likely to receive injuries on, for example, the inside of the thigh, behind the ear or at the base of the neck. The colour of the bruising can help a paediatrician relate the explanation to the injury because the bruise will change colour from red to purple, to yellow, to brown over a period of approximately one week. The nature and severity of burns will assist in determining whether an injury is accidental. A child who is alleged to have suffered burns because of an excessively hot bath will usually have irregular marks or splashes on the legs because he jumped from one foot to the other. If the burn has a clear demarcation line, which may take the appearance of a sock, it is possible that the child may have been placed or held in a boiling hot bath deliberately. If a toddler pulls over a saucepan or a teacup the burn area will often be to his head, shoulders or arms.

If a child has suffered a fracture, types of fractures which arouse suspicion of abuse include rib fractures in infants, multiple or wide skull fractures, spiral fractures of the upper arm or thigh, acute fractures of long bones, and multiple fractures of different ages. As with bruises, the healing faces of fractures (except skull fractures) follow a regular course and can be dated by a radiologist or orthopaedic surgeon to see if they correspond with the date of the injury. How much force is required to cause an injury is not known, but is a question courts often ask of paediatricians, and rightly so. From studies, paediatricians know that it is unusual for an infant to fall out of a bed or cot and sustain a fracture or any permanent brain damage. A fall of at least one metre or more is required before an infant's bone is fractured. Head injuries account for the commonest cause of death in children who are abused. In addition, 95% of serious brain/head injuries during the first years of a child's life are the result of physical abuse. If a child has a head injury and there is also fingertip-shaped bruising around the trunk of his body, this should add to the suspicion of non-accidental injury. If a baby is unwell or irritable the fontanelle (the membranous space in an infant's skull at the angles of the parietal bones) may bulge and there may be haemorrhaging into the whites of the eye. Shaking can cause haemorrhaging between the brain and the bony skull from ruptured blood vessels.

When acting for a parent it is important to note that there are sometimes organic causes for the appearance of non-accidental injury – for example impetigo may be mistaken for a cigarette burn, Mongolian blue spot, often found in children of Asian descent, may be mistaken for a bruise, and various blood disorders can result in a misdiagnosis of abuse, for example haemophilia.

EMOTIONAL ABUSE

Emotional abuse is much more difficult to detect and prove before a court than physical abuse. Emotional abuse may be defined as 'the severe adverse effect on the behavioural and emotional development of a child caused by persistent or severe emotional ill-treatment'. A child may be rejected and isolated by the carers, verbally assaulted, bullied, ignored, corrupted or encouraged to participate in antisocial and deviant behaviour. A child may receive harsh punishment for

trivial reasons, and may receive no positive affirmation at all. Children who have experienced emotional abuse may fail to thrive physically, or may be withdrawn. Some children may show difficult behaviour or learning disorders.

In any case which involves allegations of emotional abuse, consideration should be given to obtaining a report from a consultant child psychiatrist, who will consider, amongst other matters, issues such as bonding – a complicated process by which parents grow to love their child, and attachment – the other half of bonding by which the significant carer is singled out by the baby/child with gaze, voice, and later on, with movement.

Two factors impair an adult's ability to reciprocate the attachment shown by the child – the parent's own childhood experience, and the quality of relationships that the parent has with others. Parents who received very poor parenting or who have no close relationships with other adults may be very insensitive to the meaning of the cues given by their children, and this can lead to an insecure attachment pattern. Parents with psychiatric disorders which impair their sensitivity may also have major difficulties. For a more detailed analysis of attachment and bonding, see Bowlby *Attachment and Loss* (Hogarth Press, 1969), Bowlby *Attachment and Loss, Separation Anxiety and Anger* (Hogarth Press, 1978), and Rutter (ed) 'Attachment and the Development of Social Relationships', in Rutter (ed) *Scientific Foundations of Developmental Psychiatry* (Heinemann Medical), at pp 267–9).

Signs of emotional abuse in children may be:

- delayed physical, mental and emotional development;
- admission of punishment that may seem excessive;
- overreaction to mistakes;
- continual self-deprecation;
- sudden speech disorders;
- fear of new situations;
- inappropriate emotional responses to painful situations;
- neurotic behaviour;
- self-mutilation;
- fear of parents being contacted;
- drugs and solvent abuse;
- running away from home;
- compulsive stealing and scavenging.

NEGLECT

Neglect may be defined as the persistent or severe neglect of a child which results in serious impairment of the child's health or development including non-organic failure to thrive. There is a clear overlap between neglect and emotional abuse. However, neglect is more an act of omission than commission. It may include failure to provide adequate nutrition, a lack of stimulation of the child, failure to seek medical attention during serious illness, failure to prevent the child from putting himself in danger, or the 'home alone' case where the child is left alone with an inappropriate carer or no carer at all. In addition, the child may be socially isolated from school, suffer from low self-esteem, and have destructive tendencies.

SEXUAL ABUSE

The definition of sexual abuse adopted by the Department of Health is 'the involvement of dependent, immature children and adolescents in sexual activity which they do not really comprehend, to which they are unable to give informed consent, which violate the social taboos of family life and are knowingly not prevented by the carer'. Child sexual abuse has been present in our society for centuries, but the first report was published in France in 1886 by Paul Bernard. In the UK the present laws on incest came into force in 1890. In 1987 the media in the UK focused great attention on the Cleveland inquiry and the issues of child sexual abuse. Unlike non-accidental injury, physical signs are sometimes absent in child sexual abuse, making a definite diagnosis more difficult. Therefore, close co-operation and exchange of information between services, agencies and different types of professionals are vital, not only to make a diagnosis, but also for the well-being of the abused child. Accurate diagnosis of child sexual abuse depends on careful history-taking and relevant clinical examinations. Whilst compiling a history it is very important for the practitioner to take seriously what the child says and to spend some time listening to the child – sometimes the child makes a clear and spontaneous allegation. However, no single sign should be taken to diagnose child sexual abuse. The Cleveland report is essential reading for anybody involved in the diagnosis, investigation or representation of parties involved in a child sexual abuse matter. A practitioner acting for a parent accused of abuse must carry out a careful balancing exercise between representing the accused thoroughly and appropriately, and being sensitive to the child who is the subject of the investigation.

Consideration should be given to obtaining the leave of the court for papers to be disclosed to a psychologist or psychiatrist with special expertise in the investigation and treatment of alleged sex offenders. Where there is disputed medical evidence a second opinion should be sought from a suitably qualified paediatrician. Recent case-law has indicated that where a serious allegation of sexual abuse has been made the level of proof is over and above the simple balance of probability test.

The Department of Health publishes guidance entitled *Diagnosis of Child Sexual Abuse – Guidance for Doctors* (HMSO, 1988), which is essential reading for any legal practitioner who may wish to question the accuracy of the medical evidence and the procedure that was followed in obtaining it.

MUNCHAUSEN SYNDROME BY PROXY

The term 'Munchausen Syndrome by Proxy' was first used in 1977 to describe children whose mothers invent stories of illness about their children, and substantiate their stories by fabricating false physical signs, with the result that needless investigation and treatment of the child is undertaken. The syndrome may take the form of perceived illness, 'doctor-shopping', enforced invalidism, or fabricated illness. A mother who is inexperienced and/or under stress, lonely or herself ill, is all the more likely to perceive an illness in her child which others do not perceive. Most doctors, however, would not class this as child abuse unless the mother's persistence and refusal to accept normal results is excessive and has an effect upon the child's quality of life. Doctor-shopping occurs where parents claim that their healthy child is ill and, as each doctor in turn refuses further investigation, the parents consult yet another doctor. The result for the child is a series of repetitive investigations and unpleasant treatment which, in its severe form, amounts to child abuse. Enforced invalidism relates to cases in which parents who have an ill or disabled child seek to keep the child ill and increase the level of disability to be sure that the child is regarded as incapacitated. For example, the parents of a child who has normal intelligence and who has difficulty with spelling may argue that the child has a learning difficulty and persuade the education authorities to accept the child into a special school.

When dealing with perceived illness, doctor-shopping and enforced invalidism, the doctor should bear in mind that these types of behaviour are an extension of the usual way in which many parents behave when their children are ill. As with all forms of child abuse, it is the degree of abuse that is important. The traditional idea of Munchausen Syndrome by Proxy concerns parents who fabricate illness in their children. A child may show signs of fitting, apnoea and drowsiness caused by suffocation or pressure on the neck, vomiting induced by salt poisoning, failure to thrive by the withholding of food, diarrhoea caused by the admission of laxatives and rashes caused by the application of caustic substances or dyes which lead to scratching and blisters to the child's skin. In any case in which there is a hint of Munchausen Syndrome by Proxy the involvement of relevant experts is essential – in cases where children have died in suspicious circumstances an appropriate expert should examine slides taken from the child's organs following a post-mortem so as to reconsider the opinion of the original coroner. Warning signals that will alert a paediatrician to Munchausen Syndrome by Proxy are as follows:

- a child whose illness is unexplained, prolonged, and extraordinary;
- a child whose symptoms and signs are inappropriate or incongruous, or are manifest only when the parent is present;
- treatments which are ineffective or poorly tolerated by the child;
- a child who is alleged to be allergic to a great variety of food and drugs;
- a parent who is not as worried by the child's illness as the doctor;
- a parent who is constantly with the ill child in hospital and who is happy to be on the children's ward and has unusually close relationships with the staff;
- a family in which sudden, unexplained infant death has occurred and/or in which members are alleged to have many different serious medical disorders.

The second article in this series will consider the risk factors prevalent in typical cases of child abuse, the role of the social services departments dealing with child protection, and the procedures which they follow in the investigation and treatment.