

## Appendix 1

### Indicators of Abuse

Some indicators are highly suggestive of abuse, others less so. No list of indicators can be complete, and it is important in every case to consider the child's experience of living in his/her family and the other things that are happening in his/her life. If a child has suffered one kind of abuse, the likelihood of suffering another kind is increased. It is for the individual professional/worker to assess the situation and make a judgement about whether or not there is a need to refer a child to Children's Social Care or the Police, in accordance with Section 5 of these procedures.

#### 1 Indicators of Physical Abuse

'Physical abuse varies from fatal to severe or moderate. All abuse is serious, and soft tissue injuries such as bruising involve considerable force in their production. This in turn inflicts pain and is invariably associated with some degree of emotional abuse, including harsh words, threats and rejection. The degree of danger of an injury relates especially to the age of the child. A small bruise in a baby may be a predictor of later serious or fatal abuse whereas a beating in an older child may denote no threat to life'.<sup>22</sup>

**The degree of risk to the child relates to the situation in the family rather than to the severity of the injury. The following offers a guide to the more common injuries found in cases of child abuse.**

There are certain inconsistencies that are known by research and experience to suggest a cause for concern in relation to physical abuse. These include:

- unexplained delay in seeking treatment that is obviously needed, or treatment is sought at an inappropriate time
- unawareness or denial of any injury
- incompatible, vague or inadequate, discrepant explanations for the injury
- inappropriate to the child's development eg non-mobile child
- inappropriate care response eg unconcerned, aggressive
- inappropriate child response eg did not cry/felt no pain
- reluctance to give information or failure to mention previous injuries known to have occurred
- consent for further medical investigation is refused

Repeated presentation of minor injuries or illnesses, often to the GP or Accident and Emergency, which may represent a 'cry for help' and which, if not taken seriously, may lead to more serious injury.

---

<sup>22</sup> Hobbs CJ, Hanks HGI, Wynne JM, Child Abuse and Neglect, 1999, page 64

**NB:** Minor injuries in babies may be an indication that more serious injuries, like fractures, have already been sustained.

## 1.1 Bruises

Bruising occurs when blood is released from blood vessels into the surrounding tissues and is usually the result of trauma, accidental or non-accidental. Accidental bruising has a correlation to the developmental stage and mobility of a child under 5 years old. Non-mobile children should not have bruises without a clear, usually observed, incident consistent with the injury. In rare cases of severe bleeding disorder the force required to cause the injury may be minimal. If parents/main carers suspect that the child suffers from a bleeding disorder, and indicate that the child 'bruises very easily', this can be checked by the Paediatrician.

Recent reviews of research literature by the Department of Child Health, Cardiff University ([www.core-info.cardiff.ac.uk](http://www.core-info.cardiff.ac.uk)) have been used in these guidelines:

## 1.2 Accidental Bruising

- occurs from everyday play activities and accidents
- patterns do not differ by socio-economic group
- patterns do not differ between boys and girls
- increase in number in summer months and with increasing family size
- increase in number with age and mobility
- very uncommon in infants who are not yet crawling
- in walking children are commonest on shins and knees
- most occur over bony prominences and at the front of the body, including the forehead
- uncommon on back, buttocks, forearm, face, ears, abdomen, upper arm, posterior leg, foot or hands

**NB:** Bruising to the forehead, however, is commonly accidental.

## 1.3 Non-Accidental Bruises

- no gender difference
- on average more numerous than in accidental bruising
- on average significantly bigger than accidental bruising
- commonest sites are head, ear, face, neck, trunk, buttocks and arms
- common on soft parts of the body away from bony prominences
- multiple bruises in clusters
- may carry the impression of the implement used

- patterned bruising can be accompanied by petechiae (pinpoint bruising) eg slap marks or compression injuries

**NB:** Fatal non-accidental head injury and fractures can occur without bruising

#### 1.4 Patterns of Bruising

Some patterns of bruising suggest the cause of the injury, eg

- (i) **Bruising in or around the mouth, or torn frenulum in non-mobile children** (flap of tissue between gum and lip). In small babies this can indicate force-feeding. It may be associated with injuries to other parts of the mouth such as the teeth, tongue, palate and inner cheeks
- (ii) **Grasp marks** - on the arms, or chest of a child, caused often by forcibly holding the child
- (iii) **Finger-tip bruises** - these are small, round or oval and may occur on the face or the body. Often there will be a single mark (thumb) on one surface, with several reciprocal marks (fingers) on an opposite surface. If seen on cheeks, these marks are suggestive of gripping or squeezing the face
- (iv) **Linear bruising** - this may occur for example on the cheeks or ears (including behind the ears), caused by hand slaps; or on the bottom or back, caused by a hand, belt, or stick
- (v) **Bite marks** - these are always inflicted injuries. They are usually round or oval marks often with a gap at each side or two crescent-shaped bruises. They can be made by an adult or a child, and it is sometimes possible for a forensic dentist to identify the perpetrator if the mark is recent and clear. Animal bites result in a different type of injury, with puncturing of the skin, although these too may be considered abusive if the dog's owner encouraged the attack.

**We cannot age bruises accurately by colour.** There is inter-observer variation in the perception of the colour of a bruise. Different colours appear in the same bruise at the same time and not all colours occur in every bruise. Bruises which occur at different times may display different colours. Research has shown that yellow discolouration does not occur within 24 hours of a bruise being sustained.

**Bruising and black children.** It is sometimes more difficult to see bruising in black children. Tenderness or minor swelling over the area of injury is an important clinical finding.

**Eye injuries** - should always be seen by a Doctor, even when they are thought to be accidental, as all the damage may not be visible without a proper examination, and treatment may be needed.

**Some medical conditions can masquerade as bruising.** A medical opinion is usually required to make the diagnosis.

### **1.5 Fractures and Joint Injuries**

The following should be noted:

- it takes considerable force to fracture a bone in an infant or child. All fractures require a consistent history and should be consistent with the developmental age of the child
- any fracture that does not have a clearly accidental history should cause concern
- fractures should be suspected if there is pain, swelling or occasionally discoloration over a limb or a joint, or a young child stops using a limb
- it is very rare for a child under one year to sustain a fracture accidentally and toddlers rarely sustain more than a greenstick, spiral tibia, or supracondylar fracture accidentally. Fractures normally cause pain and it is difficult for a parent to be unaware that the child has been hurt apart from where the fracture is greenstick, torous, or scaphoid
- non-accidental fractures can be asymptomatic, particularly in infants where a skeletal survey may be required even in the absence of signs and symptoms. The need for a skeletal survey will be decided by the Paediatrician
- the medical assessment of fractures and other bony injury often requires the involvement of several medical specialities including Paediatrician, orthopaedic surgeon, and radiologist amongst others

### **1.6 Fractures that May Cause Concern**

Any fracture can be non-accidental and most can be caused accidentally. However, in the absence of underlying bone disease, certain fractures cause more concern than others. These include:

- any fracture in a young non-mobile child without consistent history
- spiral fracture, particularly of the humerus
- fractured femur in a child who is not yet walking
- multiple fractures
- multiple fractures in various stages of healing
- injuries to the growing ends of the long bones (metaphyseal fractures)
- rib fractures
- some skull fractures particularly complex ones or those which cross suture lines
- spinal fractures

A tender swollen limb with a normal X-ray may require a further X-ray **11-14 days** later to reveal a fracture or bleeding under the lining of the bone.

A skeletal survey may be recommended by the Paediatrician particularly in infants and toddlers who present with bruising or other injuries. It may need to be repeated, in total or partially, **2-3 weeks** after the first survey.

Some medical conditions masquerade as non-accidental bony injury. The Paediatrician will consider these when giving an opinion on the injury.

### **1.7 Brain and Eye Injuries**

Death and permanent damage amongst abused infants and children are most frequently caused by head trauma, particularly in infants less than 6 months of age. Shaking injuries account for a significant proportion of these. The infants can present to hospital with a variety of signs and symptoms, including:

- sub-conjunctival haemorrhages
- bruising or other injuries to the head
- skull fractures with overlying swelling
- enlarged head
- irritability
- vomiting, drowsiness
- failure to thrive
- collapse and unconsciousness
- fits

The infants are often found to have other injuries when examined, such as a torn frenulum, retinal haemorrhages, fractures on skeletal survey and subdural haematomas and hypoxic changes on brain scan. A skeletal survey is recommended on any infant in whom non-accidental head injury is suspected. Repeat brain scans are also required.

### **1.8 Internal Injuries**

Intra-abdominal injuries occur rarely either from accidental or non-accidental injury but do occasionally occur particularly in infants and young children. They have a high mortality rate. Diagnosis is difficult particularly in the absence of any history. If they do occur:

- they are most common in the small bowel, but any solid organ can be involved
- they can be present without any sign of external bruising or bruising may be delayed

- indicators can be unexplained collapse/severe abdominal pain/sepsis vomiting, restlessness, fever, pain, pallor and shock

Management needs to be undertaken by paediatric surgeons.

## 1.9 Burns and Scalds

Burns and scalds are common accidental injuries, resulting from varying degrees of parental inattention, so neglect may have to be considered at presentation. A number involve deliberate abuse. 1-29% have been reported as deliberately inflicted. Features causing concern about non-accidental injury include:

- the same features in the history and presentation as for non-accidental bruising
- burns or scalds with clear outlines of glove and stocking effect
- small round marks which look as if they have been 'punched out' and have a dark, thick base, may be deliberate cigarette burns: brushing accidentally against a cigarette causes a flame-shaped mark. However, impetigo looks very similar and a paediatric opinion should be sought
- contact burns with the outline of the hot object
- friction burns
- bilateral burns
- burns on backs of hands and on feet

**NB:** A full thickness scald can occur in one second from liquids at a temperature of 60°C.

## 1.10 Scars

Most children have some scars particularly on the areas most commonly injured accidentally such as knees and elbows, but an exceptionally large number should cause concern, particularly if of different ages and if accompanied by current bruising. Unusually shaped scars, (eg old cigarette burns) or large scars (eg burns that did not receive treatment) are also of concern.

## 1.11 Intentional Poisoning

A child's ingestion of tablets, medicines, laxatives, domestic products, alcohol, drugs, and dangerous amounts of salt, may not always be due to accidental carelessness. A carer may administer substances like sedatives to a child to keep them quiet at night, or may wish to harm the child.

Symptoms may be extremely variable but may include drowsiness, vomiting, or seizures. Multiple attendances of children in a family with 'accidental ingestions' at an Emergency Department may signify

intentional poisoning or at least lack of appropriate parental supervision when neglect may be a factor. 'Double' ingestions are of particular concern.

### **1.12 Suffocation**

It may be impossible to differentiate intentional airways obstruction from other causes of unexplained death in infancy. It may present in young infants as:

- sudden death
- a well baby with a history of recurrent episodes of apnoea (cessation or suspension of breathing), cyanotic (blue) episodes, recurrent seizures, unexplained or unusual collapse, bleeding from the mouth and nose
- may be associated with petechiae (pinpoint bruising) around upper body, other injuries such as fractured ribs on skeletal survey or intra-cranial injury.

All infants should be admitted and investigated.

### **1.13 Fabricated or Induced Illness**

This is the induction of an appearance of illness, or an actual state of physical ill health, most often by a parent/carer and may include some cases of suffocation, non-accidental poisoning and sudden infant death. The child is presented to health professionals for investigation/treatment. It may be done in three ways:

- fabrication of symptoms of illness or injury, (inventing a story about illness)
- alteration of laboratory specimens like urine or blood
- direct production by the perpetrator of the physical signs or the disease itself in the child eg causing scabbed lesions or poisoning

In the first two of these, the harm to the child is indirect and caused by medical investigation/treatment; in the third, the harm is caused directly by the perpetrator, and then possibly compounded by medical investigation/treatment.

The acute signs and symptoms of the illness cease when the child is separated from the perpetrator.

It is important not to confuse this form of abuse with the actions of an over-anxious parent/carer who frequently seeks advice from health professionals.

There are many and varied presentations of this condition but it should be considered if:

- the signs and symptoms are unexplained and/or inconsistent
- new symptoms appear on resolution of the previous ones
- bizarre symptoms
- child's activities inappropriately restricted
- incongruity between story and actions of parents/carers

The Doctor is usually the professional who first suspects Fabricated or Induced Illness. Its management requires involvement of other agencies, as outlined in the Protocol for Fabricated or Induced Illness (Appendix 11).

## **2 Indicators of Emotional Abuse**

It is necessary to have further information about the context in which some of the following factors are seen, as they may have a number of different causes, some not related to abuse.

- Physical, mental and emotional developmental delay or disturbance
- Punishment which appears excessive
- Domestic abuse between carers or others
- Over-reaction to mistakes
- Sudden speech disorders
- Fear of new situations
- Inappropriate emotional responses to stressful situations
- Self-mutilation
- Fear of parents being contacted
- Extremes of passivity or aggression
- Wetting/soiling
- Substance misuse
- Chronic running away
- Inability to play
- Compulsive stealing

Parents/main caregivers' responses to the child may give cause for concern:

- Scapegoating
- Ostracizing from normal family contact or activities
- Not allowing the child to receive gifts, play with toys, go on outings, when other family members are allowed to
- Indifference to the child's needs
- Hostility towards the child
- Ridicule, sarcasm, deliberate frightening, threatening
- Deliberately withholding, or forcing a child to 'earn', basic necessities like food, clothes, drink and warmth
- Cruelty, like being locked up in cold, dark surroundings

- Encouraging other members of the family to respond to the child in any of these ways

Where emotional abuse is suspected, it will be most helpful to request expert assessment by the relevant Child and Family Therapy team (Child and Adolescent Mental Health Services).

Sometimes children may exhibit signs of emotional abuse when the cause is outside the family. Experience of bullying or racism may be the cause.

### 3 Indicators of Sexual Abuse

**Sexual abuse often occurs in association with other types of abuse.** Its presentation can be varied and include:

- (i) **Disclosure:** this should be taken seriously and assessed by experienced professionals. Bear in mind that the child may at first disclose only a minor part of any abuse and professionals should have a low threshold for requesting a medical examination
- (ii) **Specific physical findings** eg genital signs of a sexual assault after an allegation of rape
- (iii) **Behavioural changes** eg sexualised behaviour inconsistent with the child's age and development, eg new onset of bowel or bladder disturbance in a child who was previously clean and dry, self harm in older children and young people
- (iv) **Physical findings presenting as a medical problem** eg rectal bleeding presenting as diarrhoea, vulvovaginitis
- (v) **Physical findings** such as love bites/bruising around breasts, thighs or genitalia
- (vi) **Specific signs or symptoms** eg pregnancy, sexually transmitted diseases

Medical examination is important in these children to look for medical and forensic evidence, to check on the physical and psychological wellbeing of the child, and to assess for further investigation and treatment and support.

### 4 Indicators of Neglect

Neglect occurs when the standard of care falls below acceptable standards. It is important to keep the same expected standard of care for all children and not lower it in areas of high deprivation. Disabled children are at particular risk. Neglect covers the whole of the child's life and includes:

- (i) neglect of the child's physical needs, eg nutrition/hygiene/clothing with presentation outside acceptable norms, failure to thrive, occasionally obesity
- (ii) neglect of the child's medical needs, including routine needs such as immunisation as well as more urgent medical care

- (iii) poor supervision and lack of awareness of safety, eg leading to increased 'accidental' injury and increased Accident and Emergency Department attendances
- (iv) failure to ensure adequate stimulation and education
- (v) neglect of social needs
- (vi) lack of appropriate affection

These children may present with:

- the physical signs of neglect: failure to thrive, poor hygiene and personal presentation
- behavioural problems such as scavenging for food, voracious appetite, chronic running away, low self esteem, poor social functioning, indiscriminately seeking affection or attention from adults
- developmental problems such as not reaching developmental milestones, poor language development, poor intellectual and social development

Failure to thrive may be recognised in primary health care using standard techniques of growth measurement in a programme of health surveillance. The reason for the failure to thrive can only be discovered through a more detailed assessment, including an appropriate medical assessment.

For further information see 'Child Protection: Messages from Research', 1995, HMSO, London, pages 11-22.