Recognition of child maltreatment: lessons from history

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ABSTRACT

The *Archives of Disease in Childhood*'s centenary provides an opportunity to reflect on how our attitudes to child abuse have changed. Many are still reluctant to think the unthinkable and ask the awkward questions, but several high-profile cases have shown that recognition is still wanting, despite mandatory safeguarding training for all professionals working with children.

A timeline of significant cases which have changed practice in the UK is given in the table and some of the most important will be discussed in this review.

INTRODUCTION

Maltreatment would probably not have been in the differential diagnosis for children presenting to paediatricians 100 years ago. It is counter-intuitive for health professionals, whose job it is to relieve pain and suffering, to think that a parent or carer could harm their child, but numerous serious case reviews have shown that failure to recognise abuse can be fatal.

The *Archives of Disease in Childhood*'s centenary provides an opportunity to reflect on how our attitudes have changed. Many are still reluctant to think the unthinkable and ask the awkward questions, but several high-profile cases have shown that recognition is still wanting, despite mandatory safeguarding training for all professionals working with children.

Significant cases which have changed practice and law in the UK are given in the timeline (see online supplemental figure) and some of the most important will be discussed in this review.

BACKGROUND

Children have been abused since antiquity. Infanticide, filicide and sexual abuse of children may not be as prevalent today as in ancient Greek or Roman times, but there is no doubt that they still exist. Over the centuries, there have been significant changes in the attitude to cruelty and punishment of children. In Victorian England, children were considered to be the property of their parents who could use and abuse them at will. In 1884 the National Society for the Protection of Cruelty to Children (NSPCC) was founded in the UK and soon after, in 1889, the first child protection law gave the NSPCC a statutory right to intervene in child protection cases.

A shift towards a less punitive attitude to child rearing began with the League of Nations Declaration of rights of the child in 1924 followed by the legally binding and more comprehensive United Nations Convention on the Rights of the Child (1989), which has influenced national legislation worldwide.

Corporal punishment was abolished in state schools in Norway in 1936 but not until 1987 in the UK where discipline in schools and institutions continued to be a problem. In 1990 the 'Pindown' enquiry reviewed the practice of locking up 'difficult' children in children's homes in Staffordshire, sometimes for weeks or months, to 'pin down' the problem.[1]

Sweden was the first country in the world to explicitly prohibit disciplinary violence against children in a family setting. Physical chastisement of children by their parents was abolished in Scotland in 2020 and in Wales in 2022 but parents in England can still legally smack their children.

PHYSICAL ABUSE

In the 1940s and 1950s Caffey and Silverman, radiologists in the USA, suggested that multiple fractures associated with subdural haematomas could be the result of inflicted trauma rather than an unrecognised disease.[2 3] These papers were largely ignored until 1962 when Henry Kempe described 'The battered child syndrome' and the term non-accidental injury of children was used. Kempe recognised a 'reluctance on the part of many physicians to accept the radiologic signs as indications of repetitive trauma and possible abuse. This reluctance stems from the emotional unwillingness of the physician to consider abuse as the cause of the child's difficulty'.[3 4] This attitude and the fact that doctors did not know how to deal with these cases persisted well into the 1970s and even today, despite mandatory training, many still find it difficult to recognise and accept child abuse.

Caffey, Silverman and Kempe described what can now be recognised as non-accidental head injury akin to the 'shaken baby syndrome', a term which has caused considerable controversy. The triad of retinal haemorrhage, encephalopathy and subdural haematoma may be non-specific markers of intracranial pathology and may not be sufficient to infer shaking or abuse, but it is now widely accepted that physical abuse by violent shaking can cause these three signs.[5]

VIOLENT DEATHS

The first formal enquiry into the death of a child in England took place in 1945 following the death of 12-year-old Dennis O'Neill who was killed by his foster father. It was not until after the death of Maria Colwell in 1973 that the lack

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of co-ordination of services was recognised as a significant risk and Area Child Protection Committees were set up in England and Wales to co-ordinate services. Dennis O'Neill (1945), Maria Colwell (1973), Jasmine Beckford (1984), Kimberly Carlisle (1986), Victoria Climbié (2000) and Peter Connelly (2008) were all killed by foster or step parents.

Victoria Climbié was 'privately' fostered by an aunt who brought her to the UK from French-speaking Ivory Coast when she was 8 years old. She was tortured and murdered by her aunt and her aunt's boyfriend. During her life in Britain, Victoria was known to four local authorities, two child protection police teams, two hospitals, an NSPCC centre and a few local churches. On her first hospital admission, junior doctors thought her injuries were non-accidental, but the consultant thought they were self-inflicted scratch marks from scabies, so the social services referral was withdrawn. On the second hospital admission with scalds to her head and signs of emotional and physical abuse, the consultant wrote 'able to discharge' in the notes assuming police and social care would follow-up the case.[6]

The Laming enquiry into Victoria's death was largely responsible for some much-needed changes in child protection in England, but there are some very important lessons for health professionals. An opportunity was missed on the first admission because the consultant diagnosed scabies. All junior doctors should remember that everyone has the responsibility for referrals and alert the authorities even if their senior disagrees. Another opportunity was missed at the second hospital because of assumptions that someone else would follow-up the safeguarding concerns. Most important was the extremely poor communication both with other agencies and with Victoria herself, who spoke French.

Five years after the Laming report, 17-month-old Peter Connelly died at the hands of his parent and carers, while on the UK's '"At Risk' register. In the 16 months before his death, 282 children died of neglect, abuse or in the care system in the UK. Of that total, 72 died in accidents, stabbings or shootings while in foster or residential care, while the remaining 210 died of abuse or neglect at the hands of their families.[7]

Kyra Ishaq was starved to death when she was 7 years old. She had been home schooled, so both she and Victoria Climbié, who had never attended school in the UK, were invisible to education services. In many serious case reviews, there are instances where social care and health professionals had visited the home but not actually seen the child in question.

Professional communication both interagency and between colleagues in the same agency has been a significant factor in many cases. Failures of information sharing contributed to the deaths of Holly Wells and Jessica Chapman, 10-year-old girls killed by their school caretaker, whose employer was unaware that he had been previously investigated by police for indecent assault and rape. This led to enhanced checks and revised registration for those working with children.[8]

UNNATURAL, UNEXPECTED, INFANT AND CHILD DEATHS

In 1985 Christoffel and Zieserl reviewed unexpected deaths in a paediatric teaching hospital in Chicago and identified deaths thought to be due to child abuse and neglect. Some injuries were only discovered at autopsy.[9]

In the 1980s, Emery drew attention to the fact that some deaths attributed to Sudden Infant Death Syndrome (SIDS) or registered as 'unascertained' might have been the result of maltreatment, what he termed 'gentle battering' as there are no specific signs of smothering at autopsy.[10] In the past, signs of maltreatment might have been wrongly attributed to another cause, for example, intracranial haemorrhage to accidental trauma or broken ribs to resuscitation. Investigations into unexpected death in infancy and early childhood have not been routinely undertaken until relatively recently.[11]

A retrospective survey of child deaths from 1996 to 2002 in Wolverhampton found 7/34 preventable deaths were caused by homicide. Six of the seven children had been identified in life as vulnerable, were known to social services and were the subject of serious case reviews. These six children died from intracranial haemorrhage, probably from violent shaking. The seventh died from salt poisoning, which the mother admitted.[12]

The importance of a detailed history, including 'who found the infant lifeless?" was important in this case:

> "Ryan" was born in 1991, the second child of young unemployed parents. His sister "Rosie" had died aged 10 months from SIDS 2 years previously. Ryan was found lifeless in his cot by his father. A skeletal survey was performed and old rib fractures were found but these were not the cause of his death which was registered as "unascertained". Father had another child "Leila" with a new partner. A pre-birth conference and the Care of the Next Infant (CONI) programme was offered. At 6 weeks father found "Leila" dead in her cot. Father later confessed that he had smothered all three infants.

As specific risk factors and causes for SIDS were recognised, the term Sudden Unexpected Death in Infancy (SUDI) became preferred[13] with SIDS reserved for those where no cause was found. It was not until 2004 that a multi-agency protocol for the care and investigation of SUDIs was launched following an intercollegiate working party chaired by Baroness Helena Kennedy QC who said "It is every family's right to have their baby's death properly investigated".[14] In England, a multi-agency protocol for the care and investigation of SUDI has now been developed, and a National Child Mortality Database set up to collect data following detailed child death review procedures for all child deaths.[11 15] Without this protocol which involves a joint visit to the scene of death by police and health, this case might have had a very different outcome:

> A 5-month old girl was found unresponsive by her mother in the corner of a double bed. The mother was living in a women's refuge where she had fled to escape domestic violence fuelled by drug and alcohol misuse. Resuscitation was carried out at the scene, but she was dead on arrival in hospital. On examination, there was frothy blood stained secretion around her mouth and nose.
>
> A home visit was carried out by the paediatrician and police officer the next morning. The bedroom was untidy with several small plastic "nappy sacs" (for disposing of used nappies) scattered around the room and on the bed within easy reach of the infant. On the floor in the corridor outside the bedroom a crumpled nappy sac covered in pink froth was found. On further questioning, the mother said that she had picked up her baby, put her over her shoulder and run down the corridor screaming. At the place where the crumpled nappy sac was found she had passed the baby to a staff member who attempted resuscitation. It was thought likely that the baby had screwed up the nappy sac, put it in her mouth and asphyxiated. When her mother gave her to the staff member, the nappy sac must have become dislodged from her airway and fallen onto the floor. All the SUDI investigations, including the skeletal survey were normal. At the multi-agency meeting, serious child welfare concerns were expressed but the most likely explanation was thought to be accidental asphyxia. If the nappy sac had not been found a very different conclusion might have been reached. The coroner recorded a verdict of accidental death by choking caused by a plastic bag in the mouth.

Repeat SUDI is rare but recognition that some of these deaths were the result of homicide was difficult when deaths

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were not adequately investigated.[16] Several high-profile cases resulting in wrongful conviction might have been avoided if the current guidelines for management, including detailed history, death scene visit and investigations, including blood tests and skin biopsy to exclude inherited metabolic diseases, had been performed.[17 18]

FABRICATED OR INDUCED ILLNESS: MUNCHAUSEN SYNDROME BY PROXY

Munchausen syndrome has been used to describe fictitious illness in adults.[19] Baron Von Munchausen was an 18th-century mercenary who described his adventures in a way which bore little resemblance to reality. The term Munchausen syndrome by proxy was first used by Roy Meadow in 1977 in a 6-year-old girl with apparent haematuria.[20] The deliberate poisoning, suffocation or the fabrication of illness by a parent or carer is now termed fabricated or induced illness (FII). When investigations have excluded other causes, the possibility of maltreatment should be considered when a child presents with recurrent apnoeic spells or repeat Acute Life Threatening Episodes, also known as Brief Resolved Unexplained Events.[21]

The concept of covert homicide in infancy and unnatural child death has been the subject of several papers and correspondence in this and other journals. Covert video surveillance has exposed cases of smothering, poisoning, a deliberate fracture and other forms of abuse, but the ethics of conducting such studies has been controversial.[22–25]

A 2-year prospective study to determine the epidemiology of Munchausen syndrome by proxy in the UK and Ireland found an annual incidence of at least 2.8/100 000 children aged under 1 year and at least 0.5/100 000 for those under 16 years, highlighting the seriousness of potential outcomes.[26]

Although the usual perpetrator of FII is the child's mother, cases involving children's nurses may cause serious harm to more children. In 1991 Beverley Allitt was found guilty of murdering four and attempting the murder of three children on the children's ward at Grantham and Kestevan Hospital in Lincolnshire.[27] In 2023, Lucy Letby was convicted of killing seven neonates and attempting to kill seven others on the neonatal unit at the Countess of Chester Hospital. Covert fatal abuse is extremely difficult to detect and there are still concerns about the reliability of Lucy Letby's conviction.[28]

CHILD SEXUAL ABUSE

Sexual abuse of children was described as a hidden paediatric problem in 1977 by Henry Kempe.[29] Nearly 50 years later, child sexual abuse (CSA) still remains difficult to recognise as it can present in many different ways and may not demonstrate any signs or symptoms. Much goes unreported or only disclosed later in adulthood.

In 1987, there was a sudden increase in the numbers of children referred with suspected sexual abuse by two paediatricians in Cleveland based on the finding of reflex anal dilatation. As a result, 121 children were removed from their parents, sometimes in the middle of the night, overwhelming the capacity of the local social services who were only able to find a safe place for some in the children's ward of the local hospital. There was a public outcry and huge media interest both in the national press and in medical journals, culminating in a judicial enquiry. Although many thought that the diagnosis of CSA was made on a single sign, the enquiry found that in no case was this the sole ground for diagnosis and most of the children taken into care had in fact been abused.[30]

Professional disagreements over the reliability of reflex anal dilatation as a sign of sexual abuse, when it was also seen in other conditions, continued until evidence-based guidelines from the Royal College of Paediatrics and Child Health (RCPCH) were able to state that: *Dynamic anal dilatation is suggestive of anal abuse when standard examination technique is used*.[31 32] Physical signs should always be assessed in the context of the history with inter-agency co-operation to build up the picture.

Recognition of CSA remains challenging as it may present as physical abuse, medically unexplained symptoms, genitourinary symptoms, emotional and behavioural changes or challenging behaviours. Many cases are not diagnosed until adulthood when victims may present with a wide range of physical and mental health issues. In the UK, the recent Independent Inquiry into Child Sexual Abuse, the Ofsted (Office for Standards in Education) review of sexual abuse in schools and colleges in England and the Child Safeguarding Practice Review Panel's review into CSA within the family environment have highlighted many of the difficulties encountered.[33–35] Children may not be able to disclose abuse for fear that the consequences may be worse than the abuse suffered. Micheal Seed describes this graphically in his autobiography 'Nobody's Child'.[36]

CONCLUSIONS

The elimination of violence against children is called for in several targets of the 2030 United Nations Agenda for Sustainable Development: 'end abuse, exploitation, trafficking and all forms of violence against and torture of children'.

Unfortunately, independent enquiries continue to make many of the same recommendations: improve interagency communication, develop professional curiosity and listen to the child.

We must keep our focus on the child, not the parents, carers or other adults, putting the child's best interests first and foremost. So many disasters could have been prevented by asking the right questions, communicating with other agencies and, most importantly, talking to and listening to the child.

Children are our future. Learning the lessons from history is vital to keep our children and young people safe from harm.

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