Back to basics: recognising the signs of physical abuse

School based staff are often said to be 'ideally placed' to recognise indicators of physical abuse, but this is often more difficult than people think. Jenni Whitehead offers practical advice and understanding of physical abuse and how it might present in school.

Definition of physical abuse:

Physical abuse is the actual or likely physical injury to a child, or failure to prevent physical injury (or suffering). It is a form of significant harm that might include: hitting, shaking, throwing, poisoning, suffocating, burning, scalding or otherwise causing physical harm to a child. Physical harm may also be caused when a parent fabricates the symptoms of, or deliberately induces illness in a child.

All children experience injury from time to time. The vast majority of injuries to children are accidental, even those that are unexplained. Injuries that appear to be non-accidental must always be taken seriously, and careful consideration should be given to both the injury itself – does it need immediate attention/treatment, and how has it happened – and also to what the injury implies about the adult-child relationship.

The school's role

It is essential that school-based staff are prepared to and know how to ask non-leading questions about any injuries that they are concerned about.

School-based staff are not investigators, but have a statutory duty to pass on concerns to agencies that can investigate – children's social services and the police. Schools have a duty to 'assist' those agencies that are investigating, and the most obvious way we assist is by passing concerns on and sharing information about the child and their family that would support an investigation.

Children may present in school with a whole range of injuries – bruises, scratches, cuts, swellings and sores – and it is essential that school-based staff are prepared to and know how to ask non-leading questions about any injuries that they are concerned about. If after trying to ascertain how an injury has occurred the member of staff still has concerns, they have a statutory duty to report to their designated teacher for child protection.

Questions

Stick to simple questions! 'That's a nasty bruise you have there. How did that happen?', or, 'You have a bruise – tell me what happened.' Avoid leading questions or leading statements such as, 'Have you fallen off your bike again?', or, 'I wish you would stop fighting with your brother.' Allow the child to give their own explanation in their own words, and then think through what they have said. Does it make sense? Does the explanation work? Does it sound like a script? Does the child seem uncomfortable with what they are saying? Does the story change throughout the day?
If any of these apply, the member of staff needs to speak to the DT without delay.

**Spotting injuries**

*Bruises*

All children bruise, but what would make one bruise more significant than another?

There may be discrepancies between the injuries and the explanation given, and the explanation may even be impossible – for example a one-month-old baby with facial bruising could not have been injured while falling over. A child with several bruises of different ages has not sustained them all in a single incident. (This is not to say that education staff should be trying to age bruises, but you can tell a fresh bruise from a fading bruise.)

There may be a series of bruises and other marks suggesting the possibility of repeated injury. (Please note that this is not to say that we should wait for a second or third bruise before we act, but hindsight might cause us to think, 'This child had the same marks last week'. It is never too late to act.)

The site of the bruise is particularly significant. Accidental bruising commonly occurs over the bony parts of the body. For example, a child who comes over the top of their bike is likely to sustain bruising to the forehead, nose and chin. Children who play football are likely to present with bruises to the shins, and other sports can result in bruises and marks associated with that sport. (e.g., rugby players may experience red marks around their neck if someone rags them around their neck – I know they shouldn't do that, but they do!).

With regard to children who have a physical disability, bruising to the bony parts of the body may also be significant, depending on the child's mobility. A bruised shin on a child who uses a wheelchair may well be non-accidental.

Bruising to soft tissue should always cause concern and raise questions. On the face, soft tissue is around the eyes and on the cheek, ears and neck. Children can get bruising to both eyes as a result of a bang to the forehead or the bridge of their nose, but we still need to try to find out how it has happened as it could be as a result of someone knocking them into something, resulting in a blow to the forehead or nose.

The pattern of bruising may suggest a particular cause:

Slap marks and fingertip bruises, often to the left side of the face as the right-handed adult slaps or grabs that side. Also, the imprint of implements may be seen, such as trainers or hairbrushes.

Bruising to the outer ear may be the result of a blow. Small nip marks to the ear may suggest that the ear has been pulled. It is important to understand that such marks, while they may be small in size, can be particularly significant in understanding the child's experience.

Bruising to the neck is significant as it is rare for such bruising to occur accidentally. That is not to say that it is impossible to accidentally bruise your neck, but if you fall forward it is more common to
injure the chin; if you fall sideways the shoulder, arms and jawbone are more likely to bear the brunt of the impact.

Bruising to the chest wall, upper back and ribs should raise concerns as, again, these are unusual sites of accidental injury.

Fingertip bruising to the upper arms and/or underarm region or ribcage may suggest that the child has been held tightly and possibly shaken. These are serious injuries and may cause the fragile blood vessels in the eyes and on the surface of the brain to be torn. Further examination by a paediatrician may reveal retinal haemorrhages, rib fractures and subdural haematomas.

Bruising to the mouth and tears to the frenulum (the tag of flesh you can feel by running your tongue under the centre of your top lip, joining your upper lip to your gum) should always raise concerns. Such injuries can be caused by a direct blow to the mouth or by a feeding bottle being forced into the mouth.

**Burns and scalds**

Child abuse literature always talks about cigarette burns as being a possible feature of physical abuse, but in reality the deliberate burning of children with cigarettes is relatively rare. However, cigarette burns are considered to be at the extreme end of abuse and signify sadistic cruelty. A person deliberately and repeatedly burning a child with a cigarette cannot be compared to a person who loses their temper and smacks a child too hard. Most parents, if they are honest, will admit that either they have lost their temper and smacked their child or that they have smacked their child too hard; however, most parents also have a mechanism that kicks in and stops them from continuing – the moment of realisation when they think, ‘Oh my God, what have I done?’

The person who deliberately burns a child again and again does not have that mechanism. The second time they burn the child they will have to hold them still and be able to ignore the child’s distress; this is why cigarette burns are considered to be an extremely sadistic form of behaviour, with the adult getting gratification from the child’s pain and distress.

It has been known for older children to burn themselves or others as a ‘dare’, but even in these cases an explanation should be sought – it is not ok to simply presume that such an injury has been as a result of a ‘dare’.

Cigarette burns form a circular lesion with a crater. It is important to note that some skin infections cause almost identical sores, so trying to get a history for such sores is extremely important.

Scalds are caused by hot liquids. Most scalds are accidental, but could indicate a lack of supervision. Scalds are characterised by drip and splash burns, whereas children who have had their hands or feet dipped or held in scalding water show a glove or sock pattern.

Contact burns from hot, dry surfaces tend to be more uniform and may follow the shape of the implement used (e.g., small, triangular burns from the tip of an iron). Occasionally, school staff pick up on a child having difficulty holding their pencil because of burnt fingertips. When asked, the story unfolds to reveal that someone has ‘taught’ the child that the fire is hot by putting their fingers on the bars around the gas fire.
Fractures

Fractures in very young children should cause concern, and explanations should be sought. Non-accidental fractures can be difficult to detect, and school-based staff are pretty much reliant on the explanation in making judgements about whether to refer on to children's social care. However, delays in seeking treatment should cause further concern, as should changing explanations. Most children will come into school ready to show off their broken arm and tell the tale of how it happened, so it should raise concerns when a child is reluctant to talk about the injury or becomes upset at the mention of it.

In physical abuse cases, it is not unusual for full skeletal surveys to reveal fractures of different ages. Bones can heal untreated but often do not heal well, and this will show up on x-rays.

Reluctance to seek treatment or failure to attend

In some cases of neglect where the parent does not seek or delays seeking treatment, the effect on the child can be physical. For example, the repeated failure to attend appointments for treatment to the eyes can result in impaired vision, and failure to attend dental appointments can result in chronic toothache.

Misuse of drugs and medicines

There are a number of reported cases of parents administering methadone to children, and cases where the child has swallowed methadone because it has not been kept securely. Another reported misuse of medicine is the increase of dosage of Ritalin by the parent in order to subdue/control the child.

Fabricated and or induced illness

Fabricated or induced illness is a very complex form of abuse and demands a multi-agency response and diagnosis. This form of abuse can develop when a very needy parent discovers that having an ill child allows some of their own needs to be fulfilled; an ill child brings attention, support, sympathy and often comfort from others, and this can cause a parent to either fabricate an illness or actually induce an illness through the use of drugs or poisons.

In most cases it will be health professionals who pick up on this form of abuse, but schools can also have reason to raise concerns. For example, a parent may insist that their child has seizures and fits, but school staff never see such seizures. Or, a parent may claim that their child's illness means that they cannot take part in particular activities, which could be contrary to the behaviours displayed by the child within school.

The parent who is fabricating or inducing illness can be very manipulative, playing one member of staff off against another or even one agency against another in an attempt to gain allies. Early referral of concern about this may well reveal that a health professional has also raised concerns.
Disability and physical abuse
Disabled children may be particularly vulnerable to physical abuse, including:

- rough handling during the provision of basic care needs
- inappropriate restraint used to control behaviours
- over-sedation
- neglect of physiotherapy exercise, resulting in weakened limbs
- forced feeding
- neglect of medical needs
- forced participation in activity that the child cannot physically manage
- neglect of intimate care, resulting in severe nappy rash and bed sores
- inappropriate use of isolation (e.g., locking in rooms), causing the child to self harm
- lack of supervision, resulting in injury through falling

Sexual abuse
The sexual abuse of children and young people can also constitute physical abuse. Some forms of sexual abuse involve the penetration of objects into the vagina, anus or mouth, which can cause extensive physical damage and extreme physical pain. Sexual abuse involving the penetration of a very small child is always also physical abuse, as adults’ bodies and children’s bodies are not designed to fit together and the penetration will be experienced as physically painful.

Obesity and diet
Whether or not obesity is a form of child abuse is controversial; however, clinically obese children risk medical complications, including heart problems. Obesity is also seen by many professionals as a form of neglect. A few years ago the government declared that obesity was a health issue and not a child protection issue, but more recently children’s social care have made severely obese children the subject of a child protection plan. Such cases have usually started with a health professional trying to work with the family to change parental perceptions and behaviours, encouraging changes to diet and exercise. Obesity becomes a child protection issue when parents refuse to change behaviours and the child is viewed as being at risk of significant harm as a result.

Tips on managing concerns
While teachers act ‘in loco parentis’, giving them a duty of care towards their pupils, they are not the parent and do not have the same powers and permissions as parents. A teacher is not at liberty to undress a child to look for signs of physical abuse, and to do so without the parent’s permission runs the risk of litigation, with the parent claiming that their child has been assaulted.

Teachers can ask children, ‘Do you want to show me?’ in response to a child reporting an injury that is hidden by clothing; if the child says no, the teacher must not attempt to lift the child’s clothing. The rule is that if you are seeing injury during a normal, expected work activity or if the child shows you an injury voluntarily, you cannot be accused of assault. First aiders are in a slightly different position here in that treating injury is integral to their role. They may have to actively encourage the child to let them see the injury in order to offer appropriate treatment.
If a child is telling you about an abusive injury but refuses to show you, you have no right to look but you must still refer the disclosure.

Never go home carrying a concern that a child may be being abused – it is always ok to seek advice

If a member of staff who is not the DT reports a suspicious injury and concerns about the explanation of the injury, the DT must think very carefully about whether they also need to see the injury before making a referral. It may be necessary to have the person who has seen the injury present when making the referral so that they can describe what they have seen directly to children’s social services.

In most cases of suspected physical abuse, it is expected that the DT will contact the parent before making a referral. The parent may have an acceptable explanation for the injury that clears the issue up. However, there is an exception where it is believed that informing the parent before seeking advice from children’s social services may put the child at risk of further abuse. Obviously, someone has to tell the parent that a referral has been made, and where you feel to do so would pose more risk to the child, this would be part of the discussion and decision-making during the referral process. Remember, the ACPC guidance in NI states ‘a parent/carer is told by the school that a referral is to be made unless the parent/carer is the subject of the allegation’.

If in doubt, act! Never go home carrying a concern that a child may be being abused – it is always ok to seek advice.

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