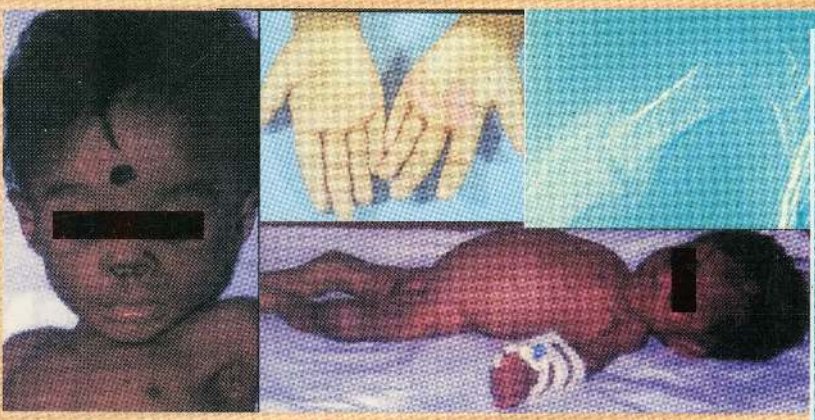

Child Abuse:

A Manual for Medical Officers in Sri Lanka

By Prof. D.G.Harendra de Silva

Professor & Head, Dept. Of Paediatrics, University of Kelaniya &
Chairman, National Child Protection Authority - Sri Lanka

With Contributions from:

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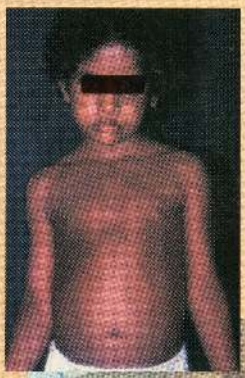

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Child Abuse: a Handbook for Medical Officers in Sri Lanka

Definition of Child Abuse:

What is child abuse? There are many definitions of child abuse. One of the most accepted definitions is as follows. *"Acts or omissions leading to actual or potential damage to health and development, and exposure to unnecessary suffering".*

A wider definition is:

"Anything which individuals, institutions, or processes do (acts) or fail (omissions) to do which directly or indirectly harms children or damages the prospects of safe and healthy development into adulthood"

The definitions of specific forms of child abuse (e.g. sexual or emotional abuse) would use this principle, but would be more specific in its description.

Introduction:

Is it a problem in a developing country like ours? Don't we often deny its existence? Is it a new phenomenon, or do we not recognise it? Even Western countries where it is considered a problem have gone through a 'phase of denial', while most developing countries are still 'denying' it's existence. On the other hand in the less developed countries, there are small groups (e.g. 'activists', some professionals) who may accept the problem. Child abuse is often considered to demonstrate an 'iceberg' phenomenon, where only a small proportion would be seen 'above the surface'; i.e. identified. When the public is made aware of the problem and children made aware of their rights, the reporting of cases would increase. At the same time when professionals like doctors, teachers, lawyers, judges, police, and child care/social workers become aware of it's existence and often given training, there would be more recognition as well as appropriate action taken. As a result of more reporting and increased recognition, the 'iceberg would surface' and an apparent increase in the incidence would be seen. In the West, physical abuse was recognised as a problem only in the 1960's, and the 'incidence' of child physical abuse has increased many fold since then. Similarly in sexual abuse; only after it being initially considered a problem in the West in the mid-eighties was the apparent 'epidemic' observed subsequently. Here again these apparent 'epidemics' were most likely seen not because of a true increase in incidence, but due to increased reporting and recognition.

All over the world including Sri Lankan society has justified corporal

Types of child abuse include

- Physical abuse
- Nutritional, medical neglect
- Sexual abuse
- Intentional drugging and poisoning
- Munchausen by proxy
- Emotional abuse
- Child labour and conscription by armies, which usually are not listed in textbooks.

punishment of children through phrases like "spare the rod and spoil the child", "The taste of the curry depends on how much it is stirred", and through verses; e.g. "Ganadevi hella". An18th century verse (translated from Sinhala).

"Canes, eckles, gripped in hand, used as whips
My eyes are always filled with tears while in class
Although I hear the soft and loving voices of my parents
My body is full of red lumps and bumps."

Although physical punishment is not acceptable by adults in present society, it persists as regard to children. Physical punishment remains as an important strategy parents (and teachers) use to have power and control over children. Psychologists consider corporal punishment to discipline children is ineffective, and it teaches children violence as well as resentment and a desire for revenge, and it may result in delinquency. It could induce fear in a child and learned imitative behaviour in the child and the child's self esteem may also be affected. Corporal punishment of children and physical abuse is closely connected. Many of the parents who end up abusing a kid have started out by 'disciplining' the child through physical punishment. It would be difficult to control the degree of the blow when you are angry and then things go out of hand. The degree of danger to a child is related to the age. A small bruise in a baby may predict future serious or fatal abuse, while the presence of a similar injury in an older child would not be a predictor of a threat to life. The parents who abuse children have often been abused or faced violence as children. Although most instances of abuse occur as a result of parents losing control of themselves at times of stress, some instances are premeditated and sadistic in nature.

"Peer Abuse"

Bullying is a wilful, conscious desire to hurt another and put him/her under stress, and is often seen as 'peer abuse' in schools. It may include physical assault and intimidation, social isolation, theft and extortion, verbal abuse including teasing, racial and sexual harassment or harassment on grounds of religion, race, sexuality or gender. 'Ragging' in schools is also a form of bullying. Adults, both parents and teachers sometimes may be responsible or they may be 'passive perpetrators' by turning a blind eye. Most school bully's are bullied or abused at home and they are very 'insecure'; and because they are so weak inside they have to appear strong on the outside.

Child abuse is prevalent in **a**ll-social, economic, ethnic and religious groups, but would be more common in poor socio-economic groups with increased number of crises including violence in life, with ***limited economic and social resources.***

The abuser is often a **related caregiver male or female.** When the father is **unemployed** and or an alcoholic abuse by the father is more common, and it may be associated with **spouse abuse, domestic violence and marital difficulties. The 'triad' of alcoholism, spouse abuse and child abuse,** physical, sexual and or emotional is a common observation; however, alcoholism should not be considered a primary cause, but is often an 'excuse'. In most of these instances the mother does not report abuse for the fear of social/economic/'survival' repercussions.

A **male sexual** partner of the mother or **'stepfather'** is also a common male perpetrator of both physical and sexual abuse of the children. Some men, who are paedophiles, often initially have sexual relationship with the mother (or even get legally married) as the first step of approaching the children. In this type of situation the mother often becomes aware of the abuse at some stage, but 'helpless' in reporting because of the possibility of divulging her involvement.

Another observation in Sri Lanka is: foreign paedophiles often get legally married to Sri Lankan widows or divorced Sri Lankan women, to be socially viewed as a 'respectable' person, and access to children becomes easier. These women are often paid a salary for the position of 'wife'. However, it must be emphasised that every foreigner married to a Sri Lankan should NOT be looked at in the same way.

'Paedophiles' are not necessarily 'white' or foreigners. A typical 'Sri Lankan paedophile' is described in the 'Kadugannawa Parcel Bomb Case' of 1945 heard in the Kandy Court, even long before the terms 'child abuse' or 'paedophilia' were described. Paedophiles (foreign or local) should not always be viewed as 'ugly' men with long unkempt hair, long teeth, blood-shot eyes and unshaved. They may be pleasant looking, and are often extremely 'helpful'. The paedophiles often may seek employment in jobs with access to children. Teachers, orphanage or children's hostel employees, school van or bus drivers, etc. Again it must be emphasised that a vast majority of people in these jobs are not paedophiles, but only a very small proportion of them would be involved in paedophilia.

Foreign paedophiles are also generally very 'helpful'. They often generate income to a large number of people in the area, as well as to professionals and officials; and as a result, they would be reluctant to inform authorities/take action, for loss of short-term gain. These paedophiles are also very helpful to the children, buying meals, clothes or other 'goodies' for these children, who otherwise would not have had access to. They often help out the parents with money or goods. They may build or renovate houses. Foreign trips for the children are arranged, and some are taken in the pretext of 'adoption. **However, there are many foreigners who are genuine philanthropists who help poor Sri Lankan families.** These foreign paedophiles are also involved in income generation 'projects' to support their own activity. They may be involved in paedophile 'rings' supplying children to casual paedophile visitors to Sri Lanka. They may also be involved in child and or adult pornography production. Pornography produced for a few rupees in Sri Lanka may be sold for hundreds or thousands of dollars in the paedophile rings. A lot of the pornographic material is probably smuggled out through the Internet, and most paedophiles are likely to be computer experts as shown by evidence from Western law enforcement agencies.

Physical abuse

Cardinal features:

- **Repetitive pattern** – Parents sometimes use different doctors/hospitals to avoid detection.
- Often there is a **delay is getting medical attention.**
- The explanation for the injury is often **implausible;** i.e. there is often an inconsistency between the **explanation, which usually is trivial, compared to the injury, which would often be a major injury.**

Inconsistency of their explanation considering the age and development of the child is another feature **(The injury is not in keeping with the development of the child).** Ref. Case history of NI described below.

- **A changing explanation** is another feature.
- **Unusual behaviour of parents.** Refusal to allow proper medical advise, or admission, unprovoked aggression towards staff.
- **Patterns of injury suggestive of abuse:**
  - Bruising in a young baby
  - Multiple injuries in a moderate fall
  - Severe head injury in babies or toddlers
  - Rib fractures
  - Subdural haematoma or retinal haemorrhage
  - Multiple cigarette or firebrand burns
  - Fractures in infants and toddlers
- **Physical abuse is often associated with other forms of abuse such as nutritional neglect and failure to thrive and other forms of neglect. It may also coexist with sexual abuse.**
- **The injuries are often multiple, at different stages of healing.**

(Examples would be illustrated by the case histories described below)

Types of injuries.

Bruises are present in 90% of physically abused children. The time taken for a bruise to appear depends on the depth of the injury – deeper ones taking a longer time to appear. Yellow bruises are usually more than 18 hours, and in superficial bruises it may occur at 3 days, while it may take 7-10 days in deeper bruises. Black, blue, purple bruises may be from 1 hour to the time of resolution.

- Bruises on the ***lower back, buttocks, and outer thighs*** are related often to ***punishment.***
- ***Bruises on the genitalia and inner thigh*** suggest sadistic sexual abuse,or punishment for problems of'toileting'. Pinching of penis or ligature marks may sometimes be seen.
- ***Injury to the head and neck is common.*** Slap marks on cheeks and neck extending on the scalp and linear marks of hands or fingers are seen. A slap would cause parallel linear bruises on the cheeks.
- Bruises to the ear are unusual in accidents since the triangle of the shoulder, skull and base of neck is protective to the ear.

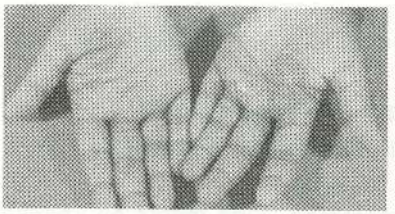
- Injury to the mastoid, and lower jaw, eyes and mouth is strongly associated with abuse, while a bruise around the neck would suggest attempted choking.
- Bruises on the trunk would suggest abuse, while lower abdominal bruises-suggest sexual abuse.
- Limbs, chest and face may have grab marks or fingertip bruises.
- Rings on the finger of an abuser may have telltale marks.
- A pair of small crescent shaped bruises facing each other would suggest a **pinch-mark.**
- **Belts, straps, loops of flex (cord)** would leave parallel marks, which tend to curve with the contours of the body (usually on the back, buttocks, or some times on the side of the chest).
- A **stick or cane** could cause linear abrasions with a 'tramline' appearance of darker bruising on either side, while the centre is paler.
- **Bite Marks:** are always Non accidental. Identification of the perpetrator is possible if the bite is recent and clear. The inter-canine distance usually more than 3.0 Cm. in the adult and the older child (> 8 years). Serial photographs at 24 hr. intervals with a millimetre rule may be compared with dental impressions of the suspected perpetrator. ABO blood grouping can be done from saliva washings of the skin around the bite.

In the case of bruises, a bleeding disorders has to be excluded.

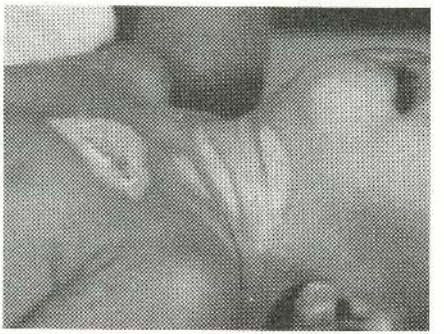
Lacerations may be linear, and lacerations of the frenulum, the upper lip are common.

Burns. It is difficult to imagine adults deliberately inflicting burns on young children. As a result doctors may not consider this possibility and the inflicted injury may be overlooked.

Burns may be the result of an 'impulsive' immediate response of an adult or it



Hot water poured on hand by uncle – for 'shouting aloud



Hot water thrown at mother and child by father.

may be a premeditated deliberate act. When burns are related to sexual abuse, it may be related to threatening the child into silence or due to sadism. There are no specific sites for burns. However, burns of hand especially the back of the hand, buttocks, feet (commonly the soles), and genitalia are common. Burns on the dorsum of the hands are less likely to be accidental. Contact burns are usually due to fires, grills, irons or other heated metal objects and cigarettes in the West. Firebrands are common in Sri Lanka. In Western countries an association of burns, especially of buttocks or genitalia (close to) and sexual abuse has been demonstrated. Cigarette burns may be single or multiple, are circular and the size is comparable to a cigarette, and it may appear as a shallow crater.

Scalds due to hot water "dunking" (immersion) burns of buttocks or limbs seen in Western countries. These injuries are less common in Sri Lanka probably because hot running water is not available in Sri Lanka. However, pouring or throwing of hot water on children has been observed.

Features of inflicted scalds.

- Glove & stocking distribution:
- Absence of splash marks – restraint of child:
- Soles may be spared if soles pressed against a cooler base of cotainer:
- Pour or thrown pattern in unusual sites –back of hand, face, genitals
- Clear 'tide mark':

Fractures may be single or multiple, recent or old, or a combination. Important patterns of fractures due to abuse include:

- Single fracture- e.g. humerus with excessive unexplained bruising.
- Multiple fractures in different bones, at different stages of healing.
- Metaphyseal - epiphyseal fractures at end of long bones.
- Rib fractures – single or multiple.
- Periosteal new bone formation.
- Skull fractures with intracranial injury.

Long bone fractures

Metaphyseal fractures.

The fracture is in a corner or 'bucket handle' in appearance, depending on the orientation of the X-ray. It is due to twisting or pulling forces and they are often multiple. Clinically it may be associated with soft tissue swelling. Periosteal new bone formation may be seen with healing in the more severe injuries. These fractures are highly related to physical abuse. (Refer case NI)

Epiphyseal plate injuries.

It involves the separation of the epiphysis due to disruption of the cartilage. It may involve cartilage and bone or cartilage alone. In the latter case radiological diagnosis will be difficult, until healing signs appear in 7-10 days.

Transverse, oblique and spiral fractures.

Sub-periosteal new bone formation, spiral or oblique fractures are usually due to gripping or twisting.

- Transverse fractures may be due to – angulation e.g. directs blow.
- Oblique transverse fractures are due to: angulation or bending ending with axial loading (compression)
- Spiral fractures are a result of axial twisting +/- axial loading.
- Oblique fractures are a result of angulation and axial twisting in the presence of axial loading.
- *Axial loading applies to bones e.g. Tibia, which are weight bearing at the time of injury.*

Periosteal new bone formation.

Sub-periosteal bleeding causes the periosteum to lift and separation of the osteogenic layer from the cortex. A thin layer of subperiosteal new bone is formed in 7-10 days. Grabbing, pulling or twisting of a limb may cause it.

A fracture of the femur is more often likely to due to abuse, and metaphyseal fractures are also seen on the distal end (as well as the proximal end of tibia). The humerus is another bone frequently seen in abuse and tends to be diaphyseal or distal metaphyseal, while accidental fractures are more likely supracondyler (although at times it could also be due to abuse). A range of fractures to the shaft at both ends of the bones resulting in spiral or oblique fractures could occur when an infant is violently grasped by the arms, pulled, jerked or swung. A direct blow could produce a transverse fracture.

Rib fractures are diagnosed usually by radiography, and are single or multiple and seen most often posteriorly near the costo-transverse process articulation. It is most often due to abuse, and occurs as result of a child being held with palms laterally, the thumbs anteriorly and the fingers posteriorly causing antero-posterior compression often with violent shaking. On X-ray there may not be any evidence during the acute stage especially when posterior. Callus formation enhances identification within 2 weeks, while in one month the only remaining change may be slight cortical thickening. Cardiopulmonary rescucitation of children is an unlikely cause of rib fracture. Antenatal rib fractures have been shown as a form of abuse in the unborn child in attempting to abort the child by blows or by purposeful falls. Although rib fractures have been described in traumatic deliveries especially breech it is very uncommon. Spinal injury is usually due to forced extension or flexion and may occur at different levels. Defects in the lucency of the anterior superior edge of the vertebral bodies, often in the lower thoracic/upper lumbar with narrowed disc spaces are typical.

Skull fractures

Skull fractures are all too common in severe child abuse. However, a skull fracture is usually detected after X-rays. Skull fractures are usually a result of an impact with a solid object. When a baby is shaken violently, there could be intra-cranial injury without Skull fractures, unless it is associated with in impact with solid surface. Skull fractures cannot be readily aged since it does not heal with callus formation.

Skull fractures can be classified as:

- Single- unbranched fracture linear, zig-zag, or curved – maximum width of 2mm.
- Multiple (Complex), more than one fracture, single fracture with a branching or stellate appearance.
- Depressed – Inward displacement of bone
- "Growing Fracture" – More than 3 Cm, may enlarge with time sometimes associated with a leptomenigeal cyst.

Skull fracture reports should include, Site, whether suture lines crossed, configuration (as above), Orientation, length, other features, presence of suture separation, presence of soft tissue swelling. Most skull fractures are on the parietal bone in both accidental and non-accidental injury, while fractures of the frontal bone are rare. Occipital fractures are more common in abuse, while a depressed occipital fracture is virtually diagnostic of abuse. Growing fractures are associated with severe injury, and abuse should be excluded.

A skeletal survey should be considered mandatory in suspected physical abuse when/in:

- Presenting with a fracture suggestive of abuse
- Physical abuse of a child less than 3 years
- Older child with marked soft tissue injury
- Localised pain, limp or reluctance to use a limb
- Past history of a fracture
- Unexplained neurological symptoms of signs
- A dying child under suspicious or unusual circumstances

Chest, long bones, hands, skull, spine and pelvis all antero-posterior views should be done.

Very often there would not be any clinical evidence of fractures, and the number of radiologically evident fractures may surprise the clinician. It would reveal **multiple fractures** at **different stages of healing** signifying repeated physical abuse.

Osteogenesis imperfecta, *is an inherited disease of connective tissue in which decreased calcification and fractures occur with minimal trauma. 'Wormian' bones of the skull are predominantly seen.* There are four different types:

Type I: Dominantly inherited, Blue sclera, Mild to moderate affliction.

Type II: Sporadic Dominant, Lethal, and intrauterine fractures present, Blue sclera present.

Type III: Very Rare Dominantly inherited, Moderate to severe, Blue early then grey sclera.

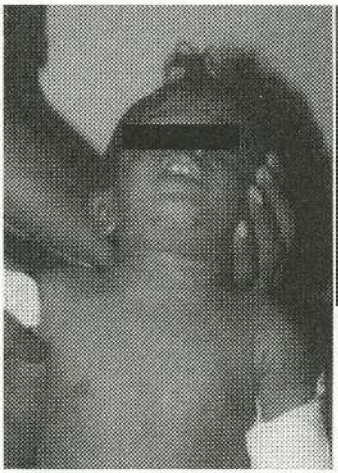
Type IV: Dominantly inherited - Mild to moderate affection, **Normal sclera,** Osteoporosis may be present, sometimes normal. IV A normal teeth (IV B abnormal teeth). Type IV may cause diagnostic difficulties especially since the sclera are normal, and because of an increased tendency to bruise. However, Fractures of ribs, skull, metaphysis and intracranial injury are not features.

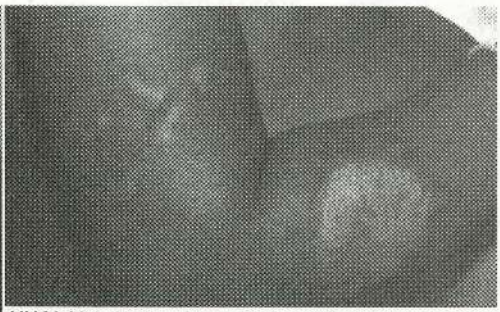
Intracranial injuries include subarachnoid haemorrhage, subdural haematoma, bleeding into ventricles and to cerebrum, cerebral contusion and oedema. Coma, fits & apnoea are associated features. Retinal haemorrhages are common if you look for it.

Subarachnoid haemorrhage may be due to a ruptured aneurysm or due to trauma and is often difficult to diagnose, since blood stained CSF may be dismissed as a 'traumatic' tap. However the presence of retinal haemorrhage should arouse suspicion.

Subdural haemorrhage should always be considered as traumatic; although a clotting problem could theoretically cause bleeding it is considered unlikely. Subdural haemorrhage may be a consequent of violent shaking or banging of the head on a hard surface in a child held by the shoulders. When there is violent shaking *(shaken baby syndrome)* or a sudden impact, the veins that bridge across the subdural space tear with the *'shearing'* forces of this movement. When the veins get avulsed, blood collects in the subdural space. Recent evidence indicate that shaking alone may not be the sole contributor, and shaking followed by impact caused an acceleration factor 50 times that of shaking only. These findings led to the proposal of ***'Shaken impact syndrome'***. Fundoscopy is important since retinal haemorrhages are associated with subdural bleeding. A CT scan would demonstrate the subdural collection. It is indicated in children with fractures of the skull, or children brought unconscious or semi- conscious without any other explanation or with retinal haemorrhages. (An MRI scan is sometimes more useful)

Blunt injuries to the abdomen could cause lacerations of the liver, stomach





NK.Multiple burns all over the body at different stages of healing. The explanation given by the mother was; that the elder child who had lit a piece of polythene had taken it across the room and the melting polythene had dripped on the baby. This explanation was not in keeping with the injuries we observed.

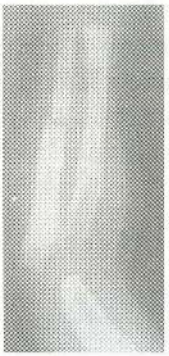
and mesentery. Children with such injuries may be collapsed or brought dead. In cases where children are brought dead and if there are suspicions of physical injury, post-mortem X-rays before the post-mortem examination is desirable. Some important aspects include:

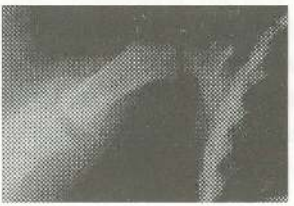
- There may not be any external injuries.
- Delay in presentation and/or denial of trauma.
- Other injuries to head, limbs and trunk may be present.

- Free gas in some patients on X-ray
- When the child is in shock and in poor condition, a high index of suspicion is needed.

A few case histories of physical abuse and neglect would establish the existence of child abuse in Sri Lanka, and would illustrate some of the difficulties in identifying it, as well as its typical features. Unless the doctor is sensitised to suspect physical abuse, identification would be difficult.

- ***NK,*** was from a Sinhala family. The mother was unmarried and she has had multiple partners, and has had several children from different partners, and the present partner had abused this child. He had a plaster for a fracture for which he was brought for. He had ***multiple*** burns at different stages of healing, all over the arm and forehand, which were most likely caused by firebrands. The explanation given by the mother was; that the elder child who had lit a piece of polythene had taken it across the room and the melting polythene had dripped on the baby. **This explanation was not in keeping with the injuries** we observed, since there were burns on the chin and also on the chest and back. The explanation was implausible, as the injuries were at **different sites not conforming to a pattern** (that would have been seen if the mother's explanation was acceptable), and **at different stages of healing** indicating **repeated burns** (abuse). These burns are unlikely to be due to accidental injury, and are therefore called **Non Accidental Injuries-(NAI).**

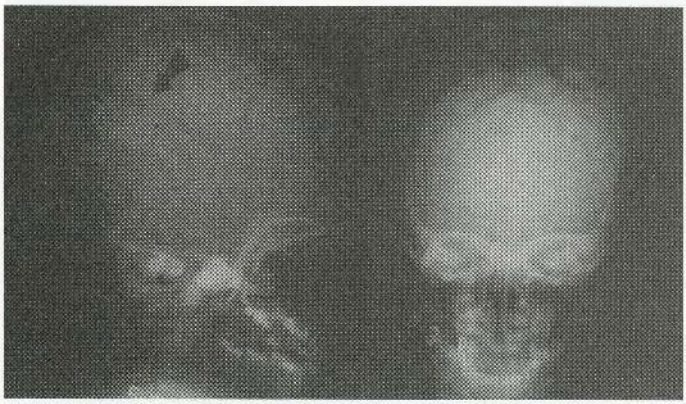




Multiple fractures at different stages of healing

Although he had been treated for a fracture of the humerus and an X-ray of the humerus had been taken a skeletal survey had not been done. It is **imperative** that a **skeletal survey** (of X-rays) is done in all cases where there is suspicion of physical abuse. X-rays of the forearm demonstrated multiple fractures of both ulnar/radius on both sides. ***These multiple fractures*** were at ***different stages of healing*** with varied periosteal reactions in the different fractures. A fracture of the right humerus was forming a callus. He also ***had multiple fractures of ribs*** at the ***angle of the rib*** where it typically occurs due to compression injuries to the chest.

• ***MA,*** was a child of a Tamil estate labourer. Both partners were divorced, & they had their families of their own. This is the youngest child of the father of the previous marriage. The stepmother was the most likely abuser. She was an ill looking girl, with multiple swellings of the thighs, arms and with scars. Multiple parallel linear abrasions on the skin of the side of the chest were observed. A stick most likely caused it. ***The explanations given were far-fetched.*** **Multiple *fractures of ribs*** were observed typically due to a compression force. A swelling of the left hip was observed, and the left lower limb and the hip were flexed. A fracture of the neck of the femur was confirmed by x-ray. Another 'old' fracture (at a different stage of healing) of the lower end of



Skull X-rays show wide fracture of Parietal bone. CT scan showed a subdural Hemorrhage

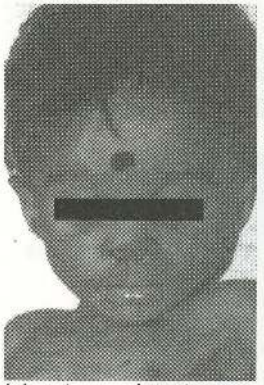
Clinically a Swollen elbow. Radiologically a supra-condyler fracture was confirmed

MA. Multiple fractures of lower limb. A recent fracture of the femur and an old fracture of fibula

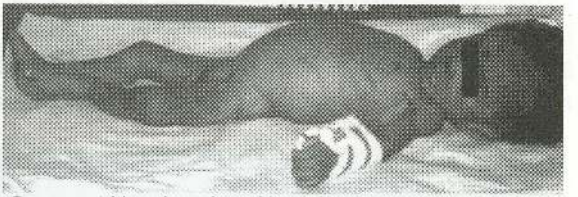
Clinical pictures and X-rays of MA

tibia on the left side was also seen. The child also had a swollen arm, and a fracture of the lower end of the humerus was seen on x-ray.
A skull X-ray showed a wide linear fracture. A CT done 2 months after admission (delay due to repairs to CT machine/waiting list) showed a resolving subdural effusion.

• The mother, who was living alone in a rural village from Hambantota, brought

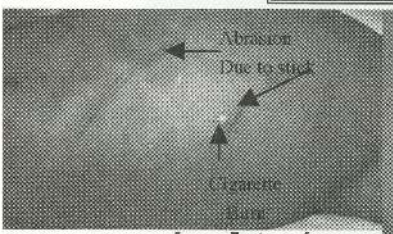


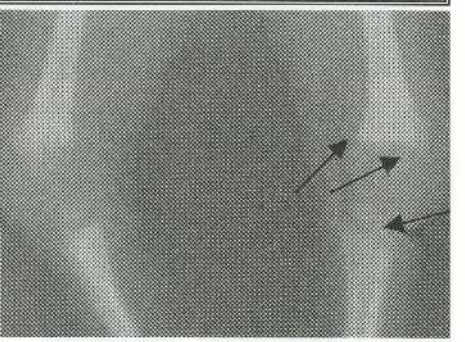
Injury to nasal septum.
Scar on L/S face



Gross nutritional neglect. Note. Bruising on chest

Multiple, parallel, linear abrasions with a 'tramline appearance' were seen on the side of the chest which are characteristic of a stick or a cane causing this. The explanation given was inconsistent with the injury; because the mother said "it was caused by the mat" ('pedura'-in Sinhala), which is a very unlikely explanation. Two small round burns were also seen on the side of the chest, which were most likely due to cigarette burns,

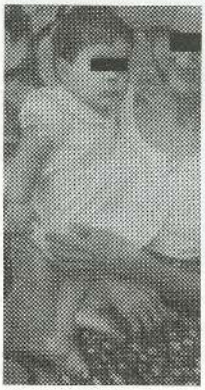




X-rays the knees and ankles showed multiple "bucket handle" fractures of the metaphysis also known as "chip" fractures. Pulling or twisting of the legs causing the bone to 'chip' at the attachment of tendons causes these fractures.

NI, a 7/12 old girl. The father was working away in Colombo, and a male friend of hers probably abused the child. The mother refused to speak (most likely because her love affair would have then be exposed). NI had been seen first at Badulla hospital, then at Hambantota and at Matara. From Matara, she was referred to the ENT surgeon for the repair of an injury to the nasal septum. The ENT surgeon referred the child for management of severe malnutrition. Moving from one hospital to another feature to arouse suspicion.

Multiple, parallel, linear abrasions with a 'tramline appearance' were seen on the side of the chest which are characteristic of a stick or a cane causing this. The ***explanation given was inconsistent with the injury;*** because the mother said "it was caused by the mat" ('pedura'-in Sinhala), which is a very unlikely explanation. Two small round burns were also seen on the side of the chest which were most likely due to cigarette burns, hence the reason to suspect a 'male friend' of the mother. ***The laceration on the nasal septum was supposed to have been caused by the child falling against an arm of a chair. This explanation is implausible, as a child of 7 months cannot walk (i.e. not in keeping with the development of the child), and the height of the child and the arm of a chair is not consistent.***



NI-after a few months with the Grandmother

A fracture of the skull was seen. X-rays the knees and ankles showed multiple ***"bucket handle"*** fractures of the metaphysis also known as "chip" fractures. Pulling or twisting of the legs causing the bone to 'chip' at the attachment of tendons causes these fractures. A chest X-ray revealed ***multiple fractures of ribs, suggestive of due to compression of the chest.***

The presence of severe malnutrition ('nutritional neglect' - another form of child abuse) demonstrated the association of physical abuse and nutritional neglect. A period in the ward and with the grandmother completely reversed the nutritional status.

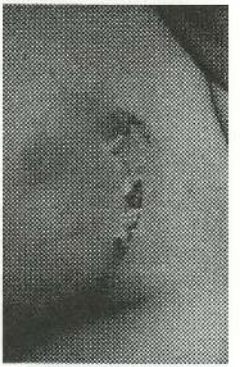
• **M** was from poor and a large Muslim family. The mother had to go out for work and the aunt used to look after the child, it was most likely that these injuries were caused by the aunt. The fracture of the right humerus was a typical ***spiral fracture*** (caused by twisting of a limb). A fracture was also seen on left side. These fractures were at different stages of healing. The amount of

periosteal reaction and callus formation was extensive and variable, indicating repeated abuse.

♦ **These case studies illustrate most of the features in terms of the history, and injuries, in physical abuse. It also illustrates that it occurs in all ethnic groups. A high degree of suspicion is needed to identify child abuse. It is also clear that unless clinical suspicion led to skeletal surveys, most injuries would not have been identified.**

Intentional Poisoning

♦ A one-year-old child was transferred from Matara to the ENT ward with stridor. A burn with a 'drip' mark aroused our suspicion, and it turned out to be a case of intentional poisoning with acid.



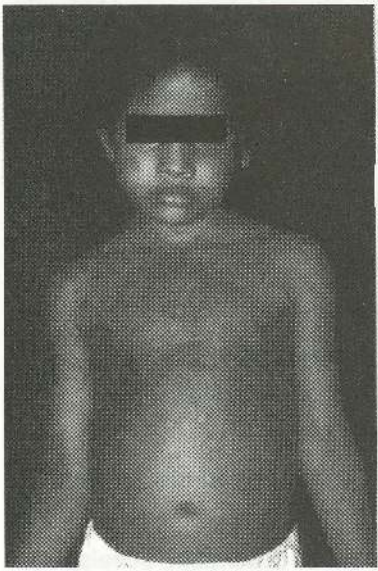
The drip mark with burning aroused suspicion of acid burn

♦ Two siblings were brought after intentional poisoning by the father. 4 years previously the boy had been treated for a fracture of the femur. During that admission the story of the boy 'father broke my leg' was denied by parents, and conveniently ignored by the doctor. This case illustrates the need to recognise the abuse. In this case the failure to recognise it 4 years previously nearly ended in murder. ***Children would very rarely lie.*** Take their word seriously. The father was an alcoholic and a wife beater, illustrating the association. The excuse of the father was; that the mother had a 'loose character' and that he believed that the children were illegitimate, which was 'accepted' by some officers and action against the father was not initiated. The question here is; whether the children were illegitimate or not, the father has no right to attempt to kill the children.

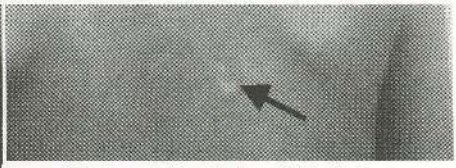
Child labour is usually not included in textbooks as a form of abuse, but in developing countries this is a common form of abuse. Every child has a right to live with his/her parents. Apart from the abuse of hard physical labour, most of these children are abused physically. They are also sexually abused. Emotional abuse, as well as nutritional and medical deprivation is also common. They invariably are deprived of an education.

• **R** was a child servant brought by police. The inconsistent history suggested that she had been kidnapped. The multiple linear abrasions tell the suffering she has undergone in the hands of the 'mistress'. An X-ray showed a calcified haematoma. Healed multiple scars of burns and lacerations/abrasions were seen all over the body.

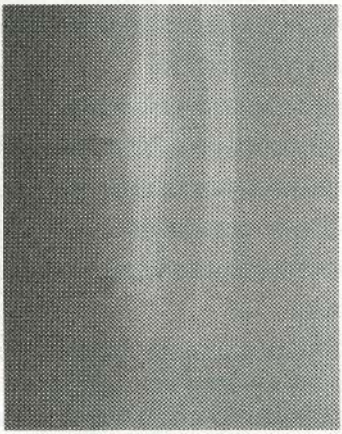
- PR, a 5 year old boy was brought by police with burns of the foot with maggots (worms), multiple fractures,.& multiple scars due to whipping with an electric chord. A schoolmaster allegedly employed him.



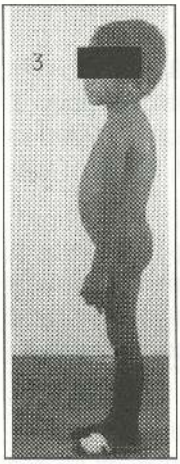
R-Multiple scars on body



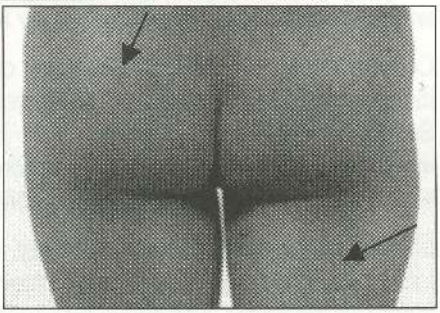
PR -Burnt with a firebrand. Healed scar



Multiple fractures of ulnar detected on skeletal survey. There was no external evidence, nor was the child able to remember an incident.



5 year old servant. Note stunting, and wound on foot.



Whip marks with an electric cord.

Munchausen by Proxy

This condition is always linked to the crucial factor that a parent or caregiver usually the mother, fabricates an illness in a child and misleads a physician into believing that the child has an illness which needs investigation. 'Doctor shopping' is a feature. Medical investigations that are undertaken include; invasive procedures, exploratory surgery, multiple x-rays, lab investigations and poisoning. Often it may lead to a life threatening situations and can be fatal. Tampering of lab samples is a feature.

- Intentional production of physical or psychological signs and symptoms in anoth er person (Proxy) who is under the individual's care.
- Repeated visits to doctor.
- Perpetrator denies the aetiology of the child's illness.
- Motivation for the perpetrator's behaviour is to assume the sick role by proxy.
- External incentives such as economic gains is absent (at least initially)
- The behaviour does not fit into any mental disorder.
- Symptoms and signs disappear when the child is separated from the carer.

Sexual Abuse

What is SEX ABUSE? It is: 'The involvement of dependent, developmentally immature children and adolescents in sexual activities they do not truly comprehend, to which they are unable to give informed consent; or which violate social taboos of family roles'.

Consequences of childhood sex abuse often manifest in adult life, and would include, Neurosis, Psychosis, Promiscuity, Prostitution, Homosexuality & Sexual Molestation of Children. It is known that adult rapists - give an increased incidence of maternal or female childhood SEX abuse. These effects can be very damaging to the individual and society.

It is a common form of abuse, but what is seen is only the tip of the iceberg. Incest is probably the most common form of sex abuse followed by abuse by friends of the family. Sex abuse by strangers is the least common. The types of sex abuse are molestation, sexual intercourse and rape. Exposure to pornography is also included under this form of abuse.

We administered an anonymous questionnaire to 899, A- level and undergraduate students. **85 (18%)** of boys admitted having been sexually abused during childhood. **19 (4.5%)** of the girls had been abused. We grouped the sample into 3 social classes depending on the occupation of parents. Because of the small numbers it is difficult to interpret the significance in the incidence of sex abuse in the social class I. however the overall incidence of 15% in the

poorer group contrasts significantly with the incidence of 10% in the middle class. This discrepancy is more obvious when we look at the sexes separately. 25% of the poorer males have been sexually abused during childhood compared to 15% of middle class boys, while in the case of girls the incidence goes up to 7% compared to 3.2% (more than double) in middle class girls. These differences were statistically significant. This study was followed by another study where the questionnaire was given after a lecture on child abuse. The rates were higher in this group with approximately 21% of boys and 11% of girls giving a history of sex abuse. Another study done in Anuradhapura has given an approximate figure of 16% for both sexes.

In the case of boys a majority had been abused either by a relative or neighbour. Others included, brother, teachers, and priests. A significant fact was that

28 (6%) of males admitted having abused (or still abusing) boys as well as girls. A significant finding was that 20 (71%) of them had been sexually abused during childhood. Although this is a known fact, it signifies the need to prevent sexual abuse of children, since today's ***abused become tomorrow's abusers.***

older women abused 19 boys. In the case of girls, a majority had not divulged the abuser, which suggests the abuser to be an immediate family member.

The modes of abuse of boys include Inter-crural, Rectal, Oral, intercourse, Pornography, & Fondling. The methods of abuse of girls included, Penetrative, Inter-crural, & oral intercourse as well as Fondling.

Physical Examination in Sexual Abuse of Children

Adapted from a booklet produced by NCPA for training in identification of sexual abuse, March 2000, Colombo, by C.J.Hobbs & D.G.Harendra de Silva.

Reference: Readers are advised to refer the following text for a full description

Child Abuse and Neglect : A Clinician's Handbook
By Christopher J. Hobbs, Helga G.I.Hanks & Jane M. Wynne.

General Points to be taken in the history, before examination.

- Document - **where, when, who.**
- Separate history from examination.
- Take the child's history separately from the adult's history.
- Define common and important symptoms e.g. vaginal bleeding, discharge, pain etc.
- General paediatric history.

- When a child alleges Sex assault (72 hours for children and 5 days for post pubertal) forensic tests may prove positive. Vaginal rectal, & skin swabs are ideally done within hours of the assault.
- **Bruising ('Love bites'), grip marks, scratches and lacerations, burns should be documented as soon as possible: within 24hours.**
- **Where there is vaginal or rectal bleeding IMMEDIATE referral is needed for possible surgery)**
- **If pregnancy or genital infection is possible, same day referral is needed.**
- IT IS NOW KNOWN THAT HEALING IS RAPID, AND CHILDREN UNDERSTATE RATHER THAN EXAGGERATE THEIR ABUSE.
- **THE COMBINATION OF THESE FACTORS MEANS THAT DELAYED EXAMINATION MAY BE NEGATIVE EVEN WHEN THERE HAS BEEN PENETRATION, DESCRIBED AS A 'BIT' OF TOUCHING.**

- Details of any disclosure including times of assault, nature of assault, anything said, symptoms of child post assault behaviour/activity
- Family and social history Any medical history (include constipation, skin disease, previous infections, injuries etc)

Examination:

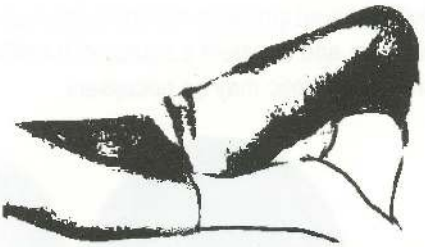
- Record: Emotional, demeanour, growth, general health, CVS, Resp, Abdo etc
- In instances where Non-genital/anal injury is present - draw on body plans measurements, sites etc.
- Record evidence of maltreatment, skin disorders, & signs of constipation.
- Stage of Sexual Development. It is advantageous to use Tanner's staging.
- Record Evidence of Physical Abuse –bruises, bite-marks, on breasts, thighs, buttocks, pubic areas, as well as other areas.
- Note position of examination, method of examination, photographs if taken and drawings
- Make notes on co-operation or lack of co-operation.

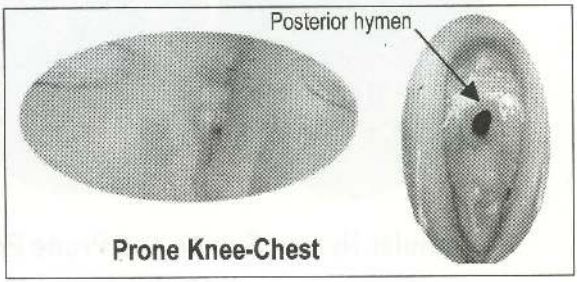
Position of Examination – Girls

Frog legged position

- Prone Knee-Chest Position (Gives a better view of the posterior margin of hymen)

  Note any injuries, skin disorders, warts. Etc.
- Is the hymeneal opening visible & gaping before the thighs are abducted (Associated with genital abuse)



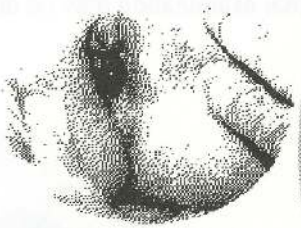


Prone Knee-Chest

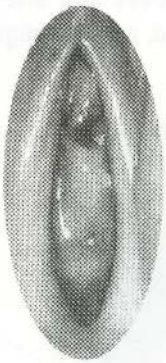
Methods of Examination

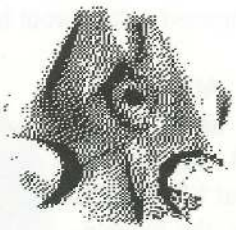
Labial Traction

Examination of Hymen



Labial Separation



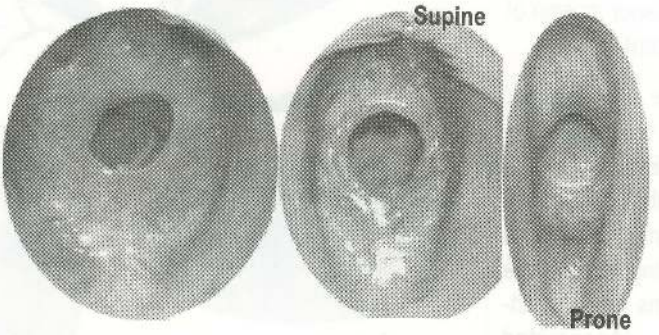


Labial Traction – Pre pubertal hymen

- In **newborns** and **infancy** it is **thick and redundant** due to maternal oestrogenic effects.
- **Pre-pubertal changes.** The hymen is thinner and flatter with a sharp edge. Clearly visible blood vessels are a feature.

- **Pubertal –** The hymen again becomes thicker, pale, and redundant withfolds (called 'petals') of hymeneal tissue meet in the midline.

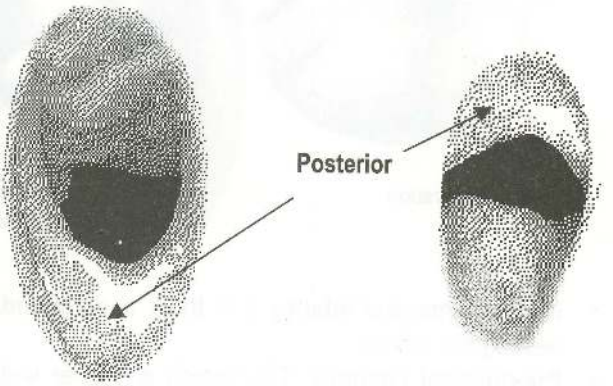
Examination of Post-pubertal girls. A speculum may be used, in abused post-pubertal girls with marked hymeneal damage, to swab the cervix for gonorrhoea, and to detect a source of bleeding in a badly traumatized girl. A general anaesthetic may be necessary.



Annular Hymen Supine and Prone Positions

Digital examination is NOT indicated pre-pubertally. In pubertal girls (with oestrogenised hymen), INSPECTION ALONE will not give adequate information on tears and dilatation. When examining pubertal girls, it is usual to examine with gloves and after looking at the hymen with a dampened cotton wool bud, a gentle digital examination may be done.

◆ **At puberty, the 'usual' hymeneal opening is about 1.0 Cm. And even the examiner's smallest finger will cause discomfort, and it may be inferred that penile penetration is unlikely and digital penetration infrequent, if at all.**



♦ **An index finger (1.5-Cm), inserted without discomfort would clearly be consistent with digital penetration. A 2-finger examination with ease (3.5-4.5 Cm) would be consistent with penile penetration.**

In about 50% of children referred for sexual abuse, no abnormality would be found. Delay allows healing which may be rapid & complete

A pubertal child (Note oestrogenization) penetrative hymenal injury may NOT be visualized by labial separation only. Demonstrated with a Foley catheter and cotton bud. Separation of the hymenal edge with a cotton bud is often essential to demonstrate hymenal tears in pubertal girls because of hymenal 'petals' that are present.

♦ There may be little correlation between the abuser's confession and reality. In a study of 160 children with diagnosed CSA (a majority with penetration) only 60% had abnormal physical findings.

Pre-pubertal Examination

Child Sexual Abuse is the usual cause of Pre-pubertal vaginal bleeding. Child Sexual Abuse is very likely in cases of foreign body in the vagina (Associated with Bleeding/Offensive discharge). [Insertion of a FB causes pain, and non-abused children are unaware of the vaginal orifice – Therefore it is unlikely for it to be due to non-abuse reasons]

A gaping hymeneal orifice on abduction of legs, before any labial manipulation, is suggestive of abuse.

If the posterior aspect of the hymen is not visible on labial traction and appears 'rolled' knee chest examination will allow better visualisation as the hymen 'unfolds'.

Labial Traction is more successful than Labial Separation. The knee-chest position is still better.

Measurements.

- Dimensions of the hymeneal orifice would depend on the method (e.g.Labial separation/traction, knee chest) used.
- A rigid tape placed adjacent to the genitalia could be used.
- The HORIZONTAL measurement and the method (e.g. Labial separation/traction, knee chest) noted.

- Glass rod measurements are considered inaccurate.

Age	*Labial Separation*	*Labial Traction*
2-4 Yrs.	*0.39+/- 0.14 Cm*	*0.52+/- 0.14 Cm*
5-7 Yrs.	*0.42+/- 0.17 Cm*	*0.56+/- 0.18 Cm*
8 Yrs –pre-adolasc	*0.57+/- 0.16 Cm*	*0.69+/- 0.2 Cm*
Pubertal	*Tampon user 1.5 Cm*	*Non- Tampon user 1.2 Cm*
Sexually active Pubertal	*2.5 Cm*	

The 'Normal' measurements are for reference. To be used with other indicators
**** Normal Diameters do not exclude sexual abuse.**

Trauma.

Acute trauma causing swelling, erythema, abrasions, and bruising settles over days, and even hymeneal lacerations may heal rapidly in prepubertal girls if the abuse stops. Healing involves regeneration and repair. Superficial abrasions and lacerations heal by regeneration only. **The process begins with thrombosis and inflammation followed by regeneration of the epithelium with new cell formation and then differentiation into a new surface epithelium. The wound heals by 48-72 hours and differentiation is complete in 5-7 days. The superficial injury has thus healed without residue in a week.**

However, if the laceration has been deeper and healing involved, repair with formation of granulation tissue would occur, and subsequently there would be scar tissue. The regeneration in this situation is followed by organisation, which is the replacement of coagulated blood by granulation tissue and wound contraction. The granulation tissue appears red initially but with time as the cellular and vascular components of the tissue decrease. It's colour changes to become paler. Most scars mature in about 60 days. However, as the scar contracts it may distort the surrounding tissue in an unexpected way. The final scar is much smaller than the initial injury.

Points to REMEMBER

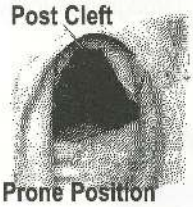
- Healing in Hymeneal Trauma is RAPID
- The Hymen when **stretched** may recover, EVEN in cases of penetration (Usually in Digital) and there may be normal findings.

- **Size of the Hymeneal opening depends on:**
  - Age
  - Stage of Pubertal development
  - Position (supine/knee-chest)
  - Degree of Labial Traction
  - Relaxation of Child
  - Obesity (Only the vertical diameter is increased)
- The usual SHAPE of the Hymen is Annular or Cresenteric (Absent 11-1 O'clock)
- Healing may lead to contracture.
- Healing may take place if the child is protected from further abuse.
- Attenuated hymen due to chronic abuse DOES NOT RECOVER
- A 'NORMAL' hymeneal orifice DOES NOT EXCLUDE CSA: On the other hand a minor abnormality (alone) does NOT PROVE CSA.

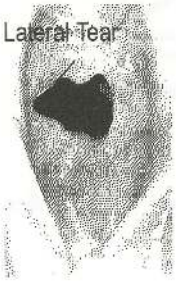
The Hymeneal opening is Usually **symmetrical** in Mid-Childhood.

The following should be considered as possible signs of previous trauma.

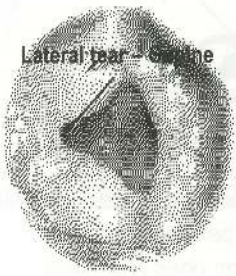
- Marked Asymmetry (e.g.: a small notch at 11 O'clock and a Marked notch at 1 O'clock)
- Sharp angles
- Square angles



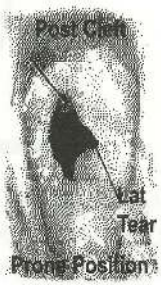
Lateral Tear - Prone



Lateral tear – Supine Position



Post & Lateral tear - Prone



- Distortion of Hymeneal Margins
  Minor bumps in the hymeneal margins are probably normal variants.

BUT, Bumps with—

- A distorted hymeneal margin,
- Vascular pattern,
- Especially if POSTERIOR or LATERALLY

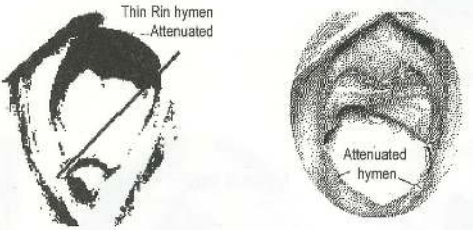
ARE SEEN IN ASSOCIATION WITH CSA

Hymeneal Tears, transections, lacerations

- Caused by penile penetration (Or attempted), are likely to cause greater damage than digital.
- Usually found at 5-7 O'clock
- May extend to the posterior Fourchette and or and occasionally to the posterior vaginal wall.
- Synechiae (Bridging scars) may be formed following these injuries.
- A notch in the posterior half of the hymen is suggestive of abuse.
- Lateral or anterior notches, if deep asymmetric (Anterior) or associated with distortion and scarring are consistent with CSA.
- A single, shallow, symmetrical notch at 12 O'clock is usually normal.

Attenuation of the hymen.

- Attenuation of the hymen is described as "a sign of damage due to hymeneal tissue being rubbed or worn away due to chronic abuse".
- May be symmetric, and often posterior or lateral



Attenuated Hymen

- Attenuation of the hymen, with resultant enlargement of the orifice is a-DIAGNOSTIC SIGN of penetrative injury.
- Attenuation of the hymen does NOT heal.
- The orifice will remain deficient and wide.

- Even after puberty, the hymen will remain deficient, unable to develop into characteristic 'petals' over the attenuated area.
- If there has been stretching of the hymen, without loss of tissue, healing will take place (If the abuse STOPS), and the orifice will become smaller again.
- Scars are very unusual, but may be seen at the posterior fourchette, after a splitting or shearing injury.
- Vulvar coitus may cause a split, which scars or results in labial (posterior) fusion.
- Hymeneal tears due to digital penetration may be seen circumferentially, but mainly seen between 9-3 O'clock, anteriorly.

Hymeneal tears heal in 1-3 days, but may be seen in the ACUTE stage with:

- Gaping hymen
- Oedematous hymen or peri-hymeneal tissue.
- Localized abrasions.

When tears heal they leave:

- V shaped 'notches' in the hymeneal margins
- 'Clefts' (Cleft at 12 o'clock associated with a cresenteric hymen may be normal)
- 'Bumps' where a tear has healed, and the opposed sides have not been accurately aligned, there is some thickening and disruption of the hymen [A vaginal ridge or a minor bump may be normal].
- An asymmetric, square or distorted shape of the hymeneal orifice.
- Concavities of the hymeneal ring: Posterior/Lateral location, angular or irregular features, hymeneal ring narrowing.
- The physical signs and the reported abuse, DO NOT ALWAYS Correlate as expected. If the disruption of the hymen is more forcible, causing multiple tears, only remnants or tags of hymen will remain.
- However, even if there is a history of penetration, up to 1/3rd of the girls have NO abnormality. (57% if digital, 3.5% if penile). With continued healing, fewer and fewer of the signs would be evident.

* **Definite scars in the hymen are rare, but thickened, irregular margins of a distorted hymen are seen. Changes are usually lateral or inferior (posterior).**
* **Previous teaching in gynaecological practice suggested hymeneal tears do not heal.**

* **In CSA however, there is healing if the child is protected from further CSA, EXCEPT when there is Attenuation of the hymen.**
* **Occasionally traumatised hymen will heal to obliterate the orifice. However, unlike congenital imperforate hymen, it will have a thickened, disorganised appearance.**

Labial Fusion. Adhesions in non-abused children usually under the age of 2 years, are commonly anterior, very superficial, semi-transparent, and easily ruptured by lateral traction. However, it may be indistinguishable from fusion due to abuse. Injury to the posterior fourchette by intra-crural or intra-labial coitus causing trauma to the tissues may lead to posterior labial adhesion.

Urethra. Pouting or dilated urethra as well as urethral prolapse may be associated with CSA – But not diagnostic.

Other factors:

Masturbation. Masturbation is universal, may start in infancy and may not be associated with abuse. However, obsessive rubbing against an adult's knee, a chair, or manually, CSA or emotional abuse should be considered. Children who have been sexually aroused by an adult by masturbating them (Boy or Girl), may become sexually excited even during a medical examination (Boys may get a sustained erection or Girls may rub their thighs together). Other children who have been hurt or frightened during CSA, may dissociate and are 'absent' during the examination and may even fall asleep.

There is NO Association between hymeneal damage and gymnastics, cycling/horse riding, or other sport. Tampon use has little effect with only a slight difference in diameter (1.2 Cm vs. 1.5 Cm in post-pubertal girls).

Vulvitis & Vulvovaginitis – Are non-specific signs associated with abuse. Caused by infection (non-specific or STD), or trauma (e.g. vigorous rubbing). But not diagnostic on it's own.

Anal Injuries. Perianal redness may be due to: Poor hygiene, nappy rash, candidiasis, threadworms, eczema, seborrhoeic dermatitis, lichen sclerosus, excessive washing (sometimes cleaning and inspection as a form of child abuse), Beta haemolytic streptococcal infection.

It may also be due to:

- Intra-crural intercourse where the erythema extends foward to involve the perineum, labia. Post fourchette maybe red and friable.
- Repeated friction of the perianal tissue leads to skin thickening, there may

be a loss of skin folds and the skin looks smooth and shiny.

- Hyperpigmentation of the inner thighs and perianally could occur in long term intracrural intercourse. It is a non-specific sign – more com mon in pigmented skin and obesity.
- The perianal skin should be free of scars, and the midline raphae should be differentiated from a scar. Superficial fissures heal without scarring; but deeper ones may scar.
- Infection continued constipation or abuse might delay healing.
- Scars may be fan-shaped, linear or with heaped-up skin or skin tags

Skin tags. Skin tags may form at the end of a healing fissure, or may be congenital.

Tags, thickening of skin folds and scars are found more frequently in sexually abused than non-abused children, and should be noted. However, it's significance requires critical assessment.

Swelling of perianal tissue. An oedematous ring around the anus resulting from acute trauma as in forcible penetration, seen 24-48 hours after abuse.

Bruising. In the perianal region is uncommon, but bruises on neck, breasts, lower abdomen, and grip marks on arms thighs and knees are common. Bruising, lacerations, burns , ligatures to genitals are less common but under recognised.

Fissures. Stretching of the anus causes fissures (by a large hard stool, implement, or penile penetration). The cause is not evident on examination. Constipation is a common cause of fissure, but most constipated children do not have fissures.

Fissures are caused by stretching and are not diagnostic of abuse, but particular note is taken:

- If there is no history of constipation and there is no evidence of such on examination.
- If there are multiple fissures. But a single fissure at 6 or 12 o'clock is highly significant esp. when associated with pain & bleeding.
- If it is deep and extends to the perianal skin.

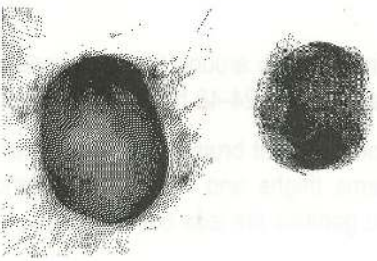
Anal laxity and reduced anal tone.

- Laxity and reduced tone may be due to repeated anal stretching (pen-etration).
- Gross faecal loading may result in a visibly relaxed sphincter.
- Gaping anus may be seen after acute sodomy. The anus is widely open 1-2Cm with other acute signs of trauma such as redness, swelling, fissures or occasionally bruising.

- It may last from a few hours to days.
- Anal verge haematoma are uncommon and are painful and associated with forcible anal penetration.

Reflex Anal Dilatation (RAD).

- The child lies in the left lateral position and the buttocks are gently separated. It is not necessary to use more pressure than needed to see the anus. In any case it is not possible to dilate the internalsphincter by increased tension.
- The internal sphincter is observed over a period of 30 seconds.
- The external and internal sphincters relax and the anal canal opens like a tube and the examiner may see into the rectum. In younger children the view may be obscured by the prolapsing mucosa.



Reflex Anal Dilatation (RAD). When buttocks are parted- both sphincters relax and central hole allows view to rectum 0.5-2.0 Cm AP and Vertically. May open and shut, faeces may be visible.

- The opening may close/open repeatedly and the extent of dilatation may vary up to 25 mm.
- Minor degrees of dilatation may represent healing.
- An unexplained aspect of RAD is: the inconsistency in demonstra tion,the sign may persist or vary from examination to examination even over a time span of a few hours.
- If the child wants to defecate, the examination should be delayed until the bowel is emptied and wait for a further 30 minutes.

- RAD is commoner in anally abused groups than others.
- RAD is an uncommon physical sign (which even many paediatricians have not seen), and when seen in an otherwise normal child is a cause for concern and justifies follow-up.
- When the anal abuse ceases, the sign disappears over weeks to months During healing lesser degrees of dilatation is seen.
- RAD is known to occur in inflammatory bowel disease and after anal manipulations.

- RAD of >1cm is supportive evidence abuse: is more likely than not to be associated with abuse.(RCP 1991)
- RAD of >1.5 Cm which is reproducible is a supportive sign of child sexual abuse (RCP 1997)
- RAD is a sign associated with buggery but the diagnosis of childabuse is made up of the entire clinical jigsaw of history, examination,and investigations put in a wider context of the social service's (probation officer), and the police's knowledge of the child and the family / environment.

Extract from the proposed Medico-Legal Examination Form (MLEF) for alleged victims of Child Abuse

INSTRUCTIONS SHEET

To all officers

Child abuse is a **criminal offence** and under the existing law it is ***mandatory to inform police*** and take necessary action. "Settlement" outside court is not possible. Ensure strict confidentiality at all times.It is an offence to divulge the identity of the victim. Information should be divulged, only to the relevant authority. The procedure to provide safety and best interests of the child should be **ensured** at a case conference. At the case conference a decision should be made either to give protection to the child in the paediatric ward (on a temporary basis), registered orphanage, or to send the child home (if safety can be ensured). The statement should be recorded in the own words of the complainant and not the interpretation of the interviewer. It is now possible under the new law to record the statement on videotape by trained interviewers at the NCPA/Children's' and Women's Bureau (205/1 Castle Street Colombo 8, Tel 672911-4, Fax 672915). The video evidence law is now in force, and therefore it is admissible in court.

The following professionals should participate at the case conference:- Judicial Medical Officer who examined the child, Paediatrician, Psychiatrist/Psychologist, Probation officer, Police officer in charge of investigation, Representative of Non Government organisations (especially those able to provide protection to the child / follow up case). The responsibility of organising the case conference and its venue lies with the **Judicial Medical Officer and the Paediatrician. The probation officer and the police should have their relevant reports ready.** It should be held within a 2-week period. If the victim first presents to the medical officer, s/he should examine the child and thereafter report to the JMO/Police. Reporting is mandatory since the offence/s, comes under the penal code.

To Judicial Medical Officers: - All suspected child abuse victims should be examined by a Paediatrician to ensure that an overall general assessment is made. A report from the probation officer is essential. All children should be referred to a Psychiatrist/ Psychologist for assessment and therapy. Examine as early as possible and collect, relevant forensic data/specimens. If in doubt, always refer to a consultant JMO for a second opinion.
Tear off slip A (in the new proposed MLEF form) to be posted to NCPA is Mandatory. Please return the completed police copy as soon as possible to the respective police station (Do not delay till the case conference is held).

To police officer in charge in the case: All offences coming within the definition of child abuse are listed in annexure A. Under the 1998 amendment to the Judicature Act, in case of statutory rape (victim is less than 16 years), non-summary procedure has been dispensed with. Cases to be referred to High Court. Police Officers should at all times be in 'mufti' during investigations. The Child victim should be safe guarded at all times and be given protective custody when necessary. The victim should not be "arrested", "remanded", handcuffed nor referred to as the "accused". All priorities should be given to cases of Child Abuse (code of Criminal procedure (Amendment) Act No 28 of 98).
Tear off slip B (in the new proposed MLEF form) to be posted to NCPA (Mandatory).

To Paediatricians: An overall assessment should be made. Examine the child with a view to ascertain evidence of all types of abuse including neglect.

Interviewing victims of child abuse

Children view the world from different 'angles' than adults and therefore should not be considered as 'mini-adults'. Adults who interview tend to ask complex questions, which the child may not be able to understand, leading to errors in the statements that would ultimately lead to questionable credibility of the child witness. Inconsistencies, misinterpretations and distortions in a child's statement are usually due to a lack of interviewer skills. It is a particular challenge to the personnel interviewing child victims due to the private nature and the stigma of the incident as well as the complex relationship sometimes with the alleged offender.

The interviewer should be able to build a 'bridge' of understanding and communication between the child's world and that of the adult to ensure the best chance of discovering the truth.

Four factors to be considered are:

1 Be **sensitive** to the child's level of development: The questions should be phrased to relate to the child's language maturation, memory, knowledge, reasoning and emotional maturity.
2. **Flexibility:** Do not stick to rigid protocols of questioning. It would be useful to follow the child's relation of the account.
3. Be **objective:** The interviewer should take an objective neutral stand. Tone of voice, facial expressions, suggestive or accusatory phrasing of questions may lead the witness to give a biased statement.
4. Be **Empathic:** The interviewer must take steps to overcome anxiety, and fear in children which is often inevitable. Understanding nature of comments would allay anxiety and fear in the child, so that s/he could focus more on remembering the actual event accurately.

How to talk to children.

The content of the language and the words used must be within the capabilities of understanding for that age, culture and other factors applicable to an individual child. Certain words used by professionals may not be understood by the child or may have other meanings. Words like 'witness' or 'perpetrator' or technical terms for anatomy of the body (especially in Sinhala or Tamil) would be difficult to understand. The term 'court' in English could mean a tennis court. The term used for 'penis' would vary from area to area in Sri Lanka, and according to age. A child of 5 or 6 may not have learnt measurements like inches or height. Therefore it would be futile to ask a child of that age about the length of an item or the height of a person. The same child may not have a concept of time, but may be able to relate to a holiday, a festival or the time of a radio/TV program.

It may be useful to explain to the child that some questions would be difficult to understand and being sensitive to this would be useful.

Simple language is easy to understand.

- Use short questions and sentences.
- Avoid long words – e.g. "identification"

Be objective and avoid suggestions.

Spontaneous information from children may be limited, and open-ended questions are useful in getting accurate information. Specific questions may help recall, but if misleading it could give rise to erroneous answers, especially with 3-4 year olds who are vulnerable to suggestion. ***However it does not mean that they have poor memories or are always suggestible.***

The environment should be 'non-judgemental'.
The tone of your voice and facial expressions could bring about a feeling of kindness. You would be judgmental when you label the accused as a "bad person" who did a "bad thing". **Avoid it.** Children who do not co-operate should not be **threatened, bribed, coerced** or **contradicted**. When there is an inconsistency in the history, explain that they may be confused, but do NOT challenge them.

By beginning an interview with a broad, open-ended question you give the child the opportunity to narrate an independent spontaneous disclosure. If the narration is brief, you may help by asking a focussed question – related to the initial spontaneous account.

Try to avoid "yes/no" type of questions. Leading questions should be avoided as much as possible. "What did he do with his hands is a better question than "did he hit you". If you are compelled to ask a "yes/no" question, follow it up by elaborating "tell me more", "I am not sure what you mean" –which would then facilitate a spontaneous follow-up response.

Children would be anxious and scared at the time of interview. If you say, "do not be scared" it may appear that you are not sensitive and do not understand the child's position. It is better to say, "I understand your feelings of fear". It is also important to let the child know that only some people who should know about the story would have to be told for his/her safety. This would prevent a feeling of betrayal of confidence later on.

Children who suffer from Post-traumatic stress disorder (PTSD) would not want to be reminded of the traumatic event. The interviewer may perceive these children as 'uncooperative, withdrawn, indifferent, indecisive etc.'. They may take a long time to answer questions.
Before you start asking specific questions you have to understand the child's development. Understanding basic concepts of "first", "last", "middle", "before", "after" by a small child could be assessed by keeping objects (e.g. toys) in line and questioning. Using colours of crayons could assess concepts of colours. Measurements, such as length, of an object, height of a person, dimensions of a room would depend on the age, educational level etc. Time (how long) may also be difficult for some children. Finding out locations from a child may be difficult, but they may remember landmarks or the name of a

person nearby. The interviewer should also be able to understand the child's perception of relatives in the statement. "Uncles/aunts" may not necessarily be related.

Most children who have been sexually abused would have been told by the offender not to disclose the incident through manipulation, bribes (e.g. chocolates), threats of bodily harm to the child or a loved one (e.g. Mother), or other threats of sending the child to jail for doing 'wrong' things. The child may have also been told not to trust authority like the police. It is often difficult for a child to talk about what would be considered as 'secret' or 'shameful' acts. At the same time a child may not have taken the decision to talk about the incident, but an adult like a professional would have disclosed it to the authorities. For all the reasons it would take a long time to interview a child (much longer than a clinical history). The interviewer has to be very patient and would have to have several sessions.

Forensic sampling in possible child sexual abuse

(From training course in Child Abuse by Dr. Chris Hobbs, March 2000 Colombo)

General principles:

These facilities and procedure may not be available in most developing countries. However, it is not difficult to set up most procedures mentioned here.

1. Forensic tests are based on Locard's principle that every contact leaves a trace
2. Evidential trace material may be stains of: blood, semen,vaginal fluid, faeces, saliva, lubricant or debris: pubichair, fibres
3. The timing of the forensic sampling is critical for some investigations see table
4. The method of sampling, labelling, storing and delivery of samples is important - samples are usually given to a police officer-Police forces will provide "rape kits" but clinics should have equipment ready for the unex pected referral (not yet available in Sari Lanka)
5. Plain swabs are used (non-albumen coated)
6. Moist material is collected with dry swabs and dry material with damp swabs - Use a minimal amount of tap water
7. Specimens are labelled immediately in a standard format: HS 1, HS 2 represents the first two specimenstaken Dr. H. Silva - and the site is recorded
8. Control unused dry and damp swabs are taken

9. Other samples may be taken from furniture, carpets or clothing
10. Adolescents and rape allegations - all the investigations listed are indicated and usually a screen for STD. Consider HIV testing. Requires follow-up medically.
11. Is emergency contraception needed?

Sample	Timing	Notes
Seminal fluid (SF) Spermatozoa (S)	Vagina 1- 12-18 hours SF 6 days S Anus - 3 hours SF 3 days S Mouth - 12-14 hours S Clothing/bedding - until washed S &SF	External swab taken before Internal SF may be found on abdomen, thighs, ano-genital area Salivary DNA - bites, love Bites, ano-genital area Semen - on saliva specimen or swab
Saliva Urine Blood	Mouth - 6-12 hours As soon as possible	Drug/alcohol assay DNA Drug/alcohol/solvent

- Bathing, urination, defecation all eliminate or dilute material
- note1 drainage varies with age and mobility
- Collect alien hairs
- Pulled hairs are needed for DNA and not done routinely
- Lubricant should be revealed on routine testing

PENAL CODE (AMENDMENT) ACT NO. 22 OF 1995

The Penal Code (Amendment) Act No. 22 of 1995 contains provision to strengthen the law relating to the following offences. They deal primarily with sexual offences and offences against children.

Use of children in obscene publications, exhibition, etc.

Cruelty to children.

Grievous hurt

Sexual harassment

Procuration

Sexual exploitation of children

Trafficking in persons

Rape
Incest
Unnatural offences
Grave sexual abuse
Publication of matter relating to sexual offences.
Grievous hurt
Given below is a summary of the relevant amendments,

Ss. 285 – 287. USING CHILDREN FOR OBSCENE PUBLICATIONS, EXHIBITION, ETC. Previous sentence of Imprisonment extending to 3 months or fine or both, changed to minimum penalty of 2 years imprisonment (not exceeding 10 years and fine at discretion of court. There was no provision dealing with the use of children in such publication, exhibition, etc.

CRUELTY TO CHILDREN was an offence (S. 308A) under the Children and Young Persons Ordinance with a penalty of imprisonment extending to 3 years or fine upto Rs. 1,000/- or both. Amendment: minimum sentence of 2 years imprisonment (not exceeding 10 Years) with fine and compensation if court so determines.

S.311: GRIEVOUS HURT: Recognition of new categories of grievous hurt.

S.345. SEXUAL HARASSMENT TO A WOMAN (including in a place of work) Imprisonment extending to 5 years or fine or both compensation if court so determines.

S.360 A PROCURATION of girl or woman: Minimum sentence of 2 years (not exceeding 10 years) and fine at the discretion of court.

S 360B. New change: **SEXUAL EXPLOITATION OF CHILDREN:** Minimum sentence of 5 years (not exceeding 20 years) with fine at discretion of court. Previously, causing children to be involved in prostitution was an offence under the Children & Young Persons Ordinance, but the definition of the offence was not sufficient to deal with the perpetrators effectively. It did not deal with other forms of sexual abuse.

S. 360C. **TRAFFICKING** in persons Minimum penalty of 02 years imprisonment. (Not exceeding 20 years) ; minimum penalty of 5 years (not exceeding 20 years) in the case of children ; fine at discretion of court. Previously, SLAVERY was the offence recognised. The amendments repealed reference to slavery and created offence of Trafficking in Persons.

S. 363 Recognition of marital rape where spouses are judicially separated. (Marital rape was not offence). The age of statutory rape is increased to 16 years. (Unless the woman is his wife who is over 12 years of age) Age of statutory rape was 12 years.

There is specific provision that evidence of physical injury is not essential prove lack of consent. Minimum sentence of 7 years imprisonment.

For the following -a minimum sentence of 10 years and not exceeding 20 years is provided :

a) Custodial rape
b) Rape of a pregnant woman.
c) Rape of a woman under 18 years.
d) Rape of a woman who is mentally or physically disabled.
e) Gang rape.

The court is vested with discretion to impose a term of imprisonment the case of an offender under 18 years and where the victim is under 16 years and has consented to the act of intercourse.

S. 364A, DEFILEMENT OF GIRLS BETWEEN 12 AND 14.
Replaced under GRAVE SEXUAL ABUSE. (s. 365B)

New section 364A. Relates to the offence of INCEST. At present incest is an offence under the Marriage Laws. Minimum sentence of 7 years (and not exceeding 20 years) and fine.

Where victim is under 16 years, minimum sentence of 15 years imprisonment (not exceeding 20 years) and fine. There is provision that prosecution for incest shall be commenced only with the written sanction of the Attorney General.

S.365. UNNATURAL OFFENCE. Minimum sentence of 10 years imprisonment (not exceeding 20 years) and fine. Imprisonment which extend to 10 years and fine.

S 365B GRAVE SEXUAL ABUSE. Previously, there was no offence of GRAVE SEXUAL ABUSE. Minimum sentence of 7 years (not exceeding 20 years) and fine and compensation. Where victim is under 18 years the minimum sentence is 10 years.

S. 365C. PUBLICATION OF MATTER RELATING TO SEXUAL OFFENCES:

There was no offence of PUBLICATION OF MATTER RELATING TO SEXUAL OFFENCES. The offences are sexual harassment, incest, rape,

grave sexual abuse, sexual exploitation of procuration, unnatural offence or gross indecency between males where such publication may identify the person against whom such offence is committed. Imprisonment which may extend to 2 years or fine or both.

RECENT AMENDMENTS TO THE LAWS RELATING TO PREVENTION OF CHILD ABUSE – RECOMMENDED BY THE PRESIDENTIAL TASK FORCE ON CHILD PROTECTION

Amendments were introduced to the following enactments in 1998.

Judicature Act, No. 2 of 1978

Code of Criminal Procedure Act, No. 15 of 1979

Penal Code of 1889

A summary of the amendments as contained in the amending legislation is given below:

Judicature (Amendment) Act, No. 27 of 1998

This amendment is to dispense with the requirement of a non-summary inquiry in the case of the offence of statutory rape. In the case of the offences of murder, culpable homicide not amounting to murder, attempted murder, rape and certain offences under the Offensive Weapons Act, there was the requirement of a non-summary inquiry being conducted by the Magistrate's Court preceding the filing of an indictment in the High Court. This often becomes a protracted inquiry and is not conducive to the expeditious conclusion of the trial itself. It was therefore provided that the requirement of conducting a non-summary inquiry be dispensed with in the case of statutory rape (ie. where the victim is under 16 years of age and consent to sexual intercourse is immaterial). While speedy trial would be in the interest of the welfare of such victims, such an amendment would also prevent a child from being exposed twice over to a traumatic court procedure which a child of tender years will find difficult to withstand and also help to avoid the adverse long term effects it could have on her mental status.

Code of Criminal procedure (Amendment) Act, No. 28 of 1998

Persons arrested without a warrant, cannot in terms of section 37 of the Code of Criminal Procedure Act be detained in police custody for more than 24 hours. As regards persons arrested without a warrant in respect of child abuse, the above amending Act empowers a Magistrate to order the detention of such persons in police custody for a period not exceeding 03 days for purposes of investigation. Such an order may be made upon a certificate being filed by a police officer (not below the rank of a Superintendent of Police) to

the effect that such detention is necessary for purposes of investigation. Such special provision was enacted to facilitate the investigation process and assist its speedy conclusion in the interest of child victims who are very often placed in vulnerable situations.
This amendment also contains provision to require the giving of priority to cases of child abuse as a measure of enhancing their protective rights.

It also prescribes a form for referral of victims of child abuse to institutes of care and protection pending trial. Prior to the amendment there was no prescribed form for this purpose and there were instances where even remand warrants were used. This situation was unsatisfactory since a victim of child abuse then tends to be treated as an offender rather than a victim.

Penal Code (Amendment) Act No. 29 of 1998

This amendment prohibits the use of persons less than 18 years for the following purposes:
Begging
Procuring persons for sexual intercourse
Trafficking in restricted articles

The amendment also imposes a legal obligation on developers of films and photographs to inform the police of indecent or obscene material in relation to children received by such persons for developing.

AMENDMENTS TO THE EVIDENCE ORDINANCE: To permit reception in or video taped evidence of the preliminary interview of a child witness. To enable a court to dispenses with the requirement of taking of oath in respect of child witness.

To enable age indication in a doctor 's certificate to be considered prima facie proof of age where age is relevant in a case and there is no better evidence.

Amendment to the Employment of Women, Children and Young persons ordinance. Minimum age for domestic employment of children 14 years.

National Child Protection Authority.

Chairman/committee appointed by Her Excellency the President consisting of appointed / Ex Officio members: a multidisciplinary group of members.

Summary of functions of the National Child Protection Authority.

- Advise the government in the Formulation of National policy, and on measures to be taken on the prevention of child abuse, and the protection/treatment of victims.

- To create an awareness of the rights of the child, as carry out other media campaigns against the child abuse.
- Consult relevant Ministries as well as other National / Private / Provincial & Local bodies and recommend measures to prevent child abuse and protect victims.
- Recommend legal, administrative and other reforms necessary for imple mentation of National policy for the Prevention of Child Abuse.
- To monitor implementation of laws relating child abuse / protection and to monitor the progress of investigation and criminal procedures related of child abuse.
- To recommend measures to protect children affected by armed conflict and to help those affected physically and mentally to re-integrate intostable society.
- Secure safety and protection of children involved in criminal investigation / proceedings (Juvenile Justice).
- The CPA would assist, & co-ordinate NGOO and provincial / Local administrative bodies in the campaigns.
- To prepare and maintain a National database on Child Abuse.
- Monitor National, Religious & NGO organisations providing childcare / Protection services.
- To conduct & co-ordinate, research in relation to child abuse and child protection.
- To engage in dialogue with sections connected with tourism to prevent opportunities of child abuse.
- To liase and exchange information with foreign governments and inter national organisations with respect to detection and prevention of child-abuse.

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