J Forensic Sci, Jan. 1976, Vol. 21, No. 1

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The Battered Child Syndrome

Strange as it may seem, in this era of escalating intellectual enlightement, laws must be passed to protect innocent, harmless children from their parents and others who beat them into senselessness and even death. On 1 July 1965 such a law went into effect in Illinois, and Illinois became the 11th state to enact a child abuse statute [*1*]. Our law requires mandatory reporting of all definite or suspicious instances of child abuse to the Illinois Department of Children and Family Services. This legislation was drafted and its passage urged by a special committee appointed by the Illinois Commission on Children, of which I was a member. It was also endorsed by the Coroner of Cook County, whose office had examined many of the victims, and by many other interested persons who in their professional activities encountered battered children. All felt that the actual reporting and the concomitant publicity and education would serve as deterrents to this deplorable condition. Today, ten years later, the battered child has not been legislated out of existence, although all states now have similar reporting laws [*2*]. Both the incidence and the severity of these heinous acts continue to be alarming in our country as well as in many foreign countries [*3–9*]. Daily a large segment of our citizenry, the battered child, is being deprived of its right to life, liberty, and the pursuit of happiness. Physicians, attorneys, and other professionals must be in the forefront to diagnose the condition, treat the victims, take remedial action against the offenders, and attempt to formulate preventive measures.

Statistics concerning child abuse are hard to come by, but reported estimates indicate that in excess of 500 000 children [*10*] are severely injured each year in the United States. An increasing number of cases are reported each year in Illinois. In 1974 there were 1867 cases [*11*]. At cook County Hospital, which serves an economically depressed segment of the population, we have hospitalized an average of 60 cases per year of severe child abuse. Many others have been treated as outpatients. We have doubtless failed to diagnose abuse, as such, in many children presented to us with their first fracture, minor burns, or ecchymoses which they could have sustained in the manner related to us in the erroneous history.

In our series of 531 hospitalized, abused children, whose ages ranged from 2 weeks to 14 years, 21% were infants less than one year of age and 67.7% were 3 years of age or less. This demonstrates that these children are too young to elude the aggressor or relate to others the trauma to which they have been subjected. Boys constituted 55.7%. In 8.5% of our series, more than one child in a family was mistreated, with four being the maximum number. Also in this series 5.2% of the children were admitted on more than one occasion, with a maximum of four admissions for any one child.

Presented at the 27th Annual Meeting of the American Academy of Forensic Sciences, Chicago, Ill., 18–21 Feb. 1975. Received for publication 21 Feb. 1975; revised manuscript received 27 May 1975; accepted for publication 1 June 1975.

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The death rate of those children who had been admitted has been approximately 10% [*12*]. Such deaths have usually been due to skull fractures, cerebral concussion, subdural hematomas, severe burns, injuries to internal organs or combinations of such injuries. Many victims have been left physically or mentally handicapped, or both, and others have been left with convulsive disorders. Personality changes and psychological problems can be anticipated in the future for most of the victims.

Our hospitalized children have been the victims of every conceivable type of trauma. They have suffered from single or multiple injuries, and many have endured a series of repetitive injuries, often of increasing severity and occasionally leading to death.

We have diagnosed and treated bruises, lacerations, head injuries, and broken bones from beatings; burns from electric irons, cigarettes, stoves, hot water, and other hot liquids; ruptured internal organs such as liver, spleen, kidney, and bowel from direct trauma to the abdomen, such as a kick; human bites, multiple scars, missing teeth, and stab and gunshot wounds. Enucleated eyes and evisceration have been encountered. Children have been confined and at times chained in rooms, basements, and sheds; some have been buried alive. People who abuse their children may also neglect them to the extent that malnutrition and failure to thrive are common. In many instances, emotional abuse in additon to or in lieu of physical abuse may be inflicted with subsequent emotional scarring and damage.

Mothers have been among our worst offenders. Others who abuse our children include father, stepfather, paramour, sibling or some other close or distant relative, babysitter, foster parent, or guest. Children as young as 6 or 8 years have been reported to have battered their infant siblings to death. Offenders come from all strata of society and as a rule have been apparently "normal" persons. Only a few of our offenders have been overtly psychotic, mentally retarded, or have acted under the influence of alcohol or other drugs. Many were persons whose own lives were filled with stresses or frustrations. Often they themselves had been mistreated when young. Their lives have possibly been complicated by inadequate housing, inadequate finances, insufficient assistance, absence of a husband or father figure in the home, illicit sex relations, and too many young or unwanted children.

The varied and sundry explanations as to the cause of injuries sustained by a child when he is presented to the hospital or physician usually seem reasonable at first. Some will state that it was an accident, such as falling from a bed, basinette, bath table, or even slipping through the holder's arms. Often the custodian will complain about a hurt to his own body when he fell or bumped into a door while carrying the child. The physician or history taker usually accepts these stories as fact so he can quickly get to the treatment. Thought is not readily given to the force needed to cause such injury or the length of elapsed time between the "accident" and the presentment.

The usual parent or custodian will rush his child for immediate aid; however, the abusers, often fearful of the consequences to themselves, wait until they become truly frightened and until they have concocted their explanations.

The diagnosis of child abuse should be considered in these instances [*13*]:

(1) any young infant with any injury,
(2) any child with a history of multiple injuries,
(3) any child with multiple scars, or
(4) any child whose injuries are out of proportion to those which would be anticipated from the history given (for example, a 3-month-old infant would not sustain 19 fractures in a fall from a sofa).

Because many injuries may cause changes in X-rays, such studies are of great importance in establishing the causal diagnosis [*14–16*]. X-ray findings of multiple fractures in various stages of healing, or multiple areas of subperiosteal hemorrhages with calcifications, and

epiphysiolysis, are also confirmatory. X-rays may show free air in the chest or abdomen following trauma to internal organs and may confirm the presence of duodenal hematoma, which may appear as symptoms of intestinal obstruction. Special dye studies can demonstrate the presence of subdural hematomas, and scans with radioactive materials may indicate the presence of large hematomas in brain, liver, and other organs. The physician must always be certain to rule out any medical condition or illness which could result in similar X-rays, such as scurvy, syphilis, Vitamin A intoxication, or osteogenesis imperfecta. All X-ray films should be interpreted and diagnosed by a qualified roentgenologist.

It is obvious that the treatment should be commensurate with the nature and extent of the damage. Proper diet and general supportive therapy may be all that is required. Surgical procedures are commonly indicated; they may be repetitive and may extend over a long period, for example, subdural aspirations, skin grafts, plastic surgery, and so on. Burr holes, craniotomies, and other neurosurgical procedures including shunting have been performed on children with head injuries. Many of the burns require grafting; severed tendons and ruptured viscera require careful surgical repair. Other therapeutic measures have included amputations of gangrenous digits, tracheotomies, reduction of fractures, and insertions of chest tubes in children with pneumothorax.

Children who die as a result of their injuries become medical-legal cases and must be referred to the coroner or medical examiner as the case may be. Autopsies are extremely important because they tend to establish the definite cause of death and because information obtained during such examinations may be extremely useful in subsequent court proceedings should charges of murder or manslaughter be instituted. In our Cook County Hospital series of battered children, subdural hematomas with or without concomitant skull fracture were responsible for 50% of the fatalities [*17*]. Twenty-five percent of the deaths were due to ruptured internal organs; others were caused by burns, malnutrition, gas inhalation, evisceration, and burial in the back yard.

With the children who live, once the diagnosis has been established and treatment of the child's injuries has been instituted, attention should be given to the family situation, utilizing all possible investigative techniques. Decisions may then be made whether or not it is safe for the child to be returned to his home, and whether a remedial program should be established for the family. If the child is young and has been wantonly abused, and his life is in jeopardy, relief must be sought in the courts, seeking at least temporary removal of the child from an obviously dangerous environment.

Legal as well as medical problems surround the battered child when the courts must be used to protect his life. Most cases are settled through conferences with the social worker in attendance [*18*]. In such conferences, the social worker is able to discuss the stressful problems which activate the abuser and offer assistance to eradicate such devastating problems through staff counseling. In counseling, the mother may admit that she is pressured and requires assistance and she may even ask that her children be placed in a foster home temporarily for their own safety. In some instances the family may be hostile and rebel at any attempts to assist or counsel them. Where there is serious injury to the child and a great likelihood of lack of parental cooperation, the only recourse available may be to bring the case before the Juvenile Court. The purpose of the court hearing will be to determine whether or not the child is in such a dangerous situation that he must be temporarily removed for his own safety. Such a custody hearing is usually bitterly contested.

A prime problem in successfully litigating child abuse cases is the absence of adequate legal counsel to represent the rights of the child [*18,* p. 68]. The responsibility of the legal profession is to insure that everyone's rights are protected. There are at the present time very few specific rights of children spelled out in our laws, and few procedures are available to minors to utilize such existing rights for their own protection from wrongs

done to them before they attain their majority. When the solution to their problem is sought in the courtroom, very few abused children have been represented by their own attorneys. It has usually been considered inappropriate, and unnecessary, for private counsel to appear on behalf of the child in Juvenile Court proceedings [*19*].

Any attorney preparing a case of child abuse for trial will be confronted with a paucity of case law in the area of child abuse. This is because almost all cases of child abuse are "settled" at or before the original court hearing. In that hearing, if the child does not have a dedicated guardian ad litem, or private counsel to contest an unfavorable decision, it is unlikely that an appeal to a higher court will be taken [*18*, p. 69]. Consequently, an appellate court review of the trial court proceedings is rare, and thus little is added to the available legal literature on the subject of child abuse. Such review could contribute immensely to filling the void of legal remedies available to the abused child. It would also yield educational advantages to those who wish to do legal research in this field.

Criticism of a judge has often occurred when he has not ordered removal of a child from an unhealthy home, when in his opinion adequate proof of abuse was not presented in court. Occasionally, in spite of strenuous entreaties in court by our pediatrician and social workers, a judge has denied our pleas for temporary removal of a child from dangerous exposure, as a life-saving measure. Often, this same child will be killed by the next episode of inflicted trauma and brought to our hospital dying or dead [*20*].

The prosecuting lawyer is handicapped in meeting the required proof because of the secretive nature of child abuse. Abusive acts are usually inflicted within the privacy of the home, where they are either unobserved or witnessed only by a spouse who has a legal right to refuse to testify against the abusing mate.

The child's lawyer is forced to rely on circumstantial evidence and because of this he needs the full cooperation of the medical profession. Through the hospital's collection of medical records, X-rays, photographs, and slides, the lawyer may establish the circumstances that indicate or imply a battered child syndrome situation [*18*, p. 71]. The successful preparation of such evidence in child abuse cases must begin at the time the child is brought to the hospital. If the physician suspects child abuse, he should attempt to confirm his diagnosis and take necessary steps to document it. X-ray studies may be demonstrative evidence; photographs will preserve the nature and extent of the visible injuries; and careful questioning of the parents and the child, if he is of sufficient age, may result in admissions of guilt. Such statements should be meticulously entered in the medical record.

By their unwillingness to testify, physicians may augment other existing legal problems of the battered child. Even more damaging is their reluctance to become involved in any manner in a child abuse case. The calloused or unconcerned doctor may refuse to recognize the signs of child abuse, fail to diagnose the condition, and fail to report it. When a mandatory reporting statute exists and a physician violates the term of the statute by neglecting or refusing to report, he may become liable in a civil suit [*21*]. A court in California recently made an award of $600 000 to a battered child [*22*] whose father had brought suit against the physician and hospital who had failed to report the abuse promptly, thus allowing subsequent and more severe episodes of abuse to occur. Awards of this magnitude should prompt physicians to comply with the terms of the mandatory reporting laws of their state.

In spite of the numerous problems which are encountered, attempts are being made to solve the problems of the battered child and to save his life [*13*, p. 31].

1. All types of news and communications media and numerous professional societies, such as American Academy of Forensic Sciences, are making bold attempts to alert and inform the lay public and professionals of the existence of child abuse and what their

duties are concerning it. Concurrent with education is research on the problem itself and on the ways to solve it, including new legislation, if necessary. Various psychological tests are being formulated to determine potential abusers, and attempts will then be made to give them professional counseling before they injure their children. This is extremely important, because many children die as a result of the first episode of abuse. To identify the abuser after the fact obviously cannot help the dead victim, but it can focus attention on his siblings who may also be objects of abuse.

2. Child abuse teams are being formed in many hospitals. Such teams consist of representatives of the various disciplines that may be involved with every battered child, such as emergency room physician, pediatrician, social service worker, psychologist, psychiatrist, clergy, and attorney. Some workers in the field are urging that child abuse be established as a separate medical subspecialty.

3. Child abuse centers are being established in many cities where abuse is common or increasing in incidence. In such centers, all the necessary protective services are made available to the child and the family. These important units should be vigorously backed and supported by the community.

4. "Parents Anonymous" groups have formed in many cities. Their members, who were themselves abusing parents, attempt to assist in the counseling and rehabilitation of potential or actual abusers who seek help. They may staff a hot-line telephone number and be readily available. Having faced their own problems, these people are sympathetic and supporting to a frantic parent who is afraid he will lose control and lash out at his child.

5. Some young attorneys are now appearing in court on behalf of abused children on a pro bono publico basis. They fill the void of counsel representing the rights of the child.

6. Many agencies involved with child abuse (such as The Children's Rights Council of Chicago, recently incorporated), are attempting to consolidate, coordinate their efforts, and share their ideas, with the view that a combined force could be more efficient and economical in producing the desired results.

7. Day care centers and special day nurseries should be encouraged in order that distressed, harrassed guardians can be provided with a safe place to leave their children for a few hours each day, thus relieving themselves, for a while, of their problems and stresses.

8. Proponents of a "Bill of Rights for Children" are proposing incorporation of such a bill into our statutes. Such a law would enumerate specific rights and responsibilities of children as well as the resources available to them in time of trouble.

9. In my own opinion, vast improvements in social conditions will be necessary before we can curb this serious problem and it behooves every concerned person to give of himself to this end.

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