Jellyfish

Venomous jellyfish have large numbers of stinging capsules (nematocysts) on their tentacles which inject venom when the tentacles contact skin. Pain and wheals are the usual effects but, rarely, systemic envenoming can be life-threatening. Many of the nematocysts will remain undischarged on tentacles that adhere to the victim. Therefore rubbing the area of the sting will cause further discharge and worsen envenoming.

- In box jellyfish stings, pouring vinegar over the sting will prevent discharge of nematocysts. For most other jellyfish, seawater should be poured over the stings and the adherent tentacles gently removed. Ice is useful for pain relief.
- Box jellyfish stings may occasionally be rapidly life-threatening. Antivenom is available and can be administered intramuscularly.

Further reading

The child who has been ill treated, abused or exploited

BOX 7.6.1 Minimum standards
- Knowledge of the in-country legal framework for child protection.
- Understanding of cross-cultural child-rearing practices.
- Links between health services, police child protection teams and/or social services in place.
- Access to X-rays and blood clotting measurements.
- Access to forensic advice.
- Access to photography services, with secure storage of images.
- Healthcare workers trained to recognise signs of physical and sexual abuse.

Children’s rights

Article 19 of the United Nations Convention on the Rights of the Child states that children (people less than 18 years of age) have a right to be protected from being hurt and maltreated physically and mentally. It goes on to state that governments should ensure that children are properly cared for and should protect them from violence, abuse and neglect by their parents or anyone who looks after them.

Child abuse results in actual or potential harm to the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power with the abuser.

Healthcare workers have a major responsibility in contributing to the prevention and recognition of childhood illness or abuse. This poses particular challenges for healthcare workers when they work with children and families from different belief systems and cultural backgrounds. They may find that they have to care for street children, child soldiers, and children separated from their parents by civil strife and unrest, and find themselves making difficult judgements about how a child can be best protected when they have few if any points of reference, and only limited contact with other agencies.

The basic principles of the investigation of child maltreatment are that:

- the welfare of the child is paramount
- multi-agency/multi-sectored collaboration is needed
- agencies must work together within the legal framework of the country (where this is in place).

Child maltreatment or abuse involves acts of omission and commission which result in harm to a child. It can occur in the family, in the community or in institutions (e.g. schools, hospitals, churches, mosques, temples, clubs, orphanages or other institutions). It encompasses:

- exploitation through trafficking for sexual or other forms of slavery
- exploitation through enforced prostitution
- physical abuse
- emotional abuse
- neglect
- sexual abuse
- fabricated induced illness (FII)
- conscription as child soldiers.

Features of presentation of a child to hospital which suggest possible ill treatment or abuse

- Delay in seeking medical help for an injury or serious clinical symptoms or signs (e.g. bleeding).
- A history that is vague or rehearsed, with inconsistencies and significant changes on re-telling or following questioning.
- No explanation of the cause of the injury.
- Repeated attendance at healthcare facilities (this may suggest fabricated or induced illness, FII; see below).
- Parents or carers being evasive or hostile.
- A history of injury that is inconsistent with the child’s age and/or developmental skills.
A ‘collusion of silence’, or one parent implicating the other.
Accusations that the child is a witch, or that witchcraft has been perpetrated by others.
The presence of other injuries, or a previous history of unusual injury.
Child appearing sad, withdrawn, anxious or frightened (‘frozen watchfulness’), or over-compliant.
Child may indicate the abuser.

Particular consideration needs to be given to children with disabilities who may be unable to communicate about their ill treatment, and where their presentation may be misattributed to their disability.

Children who suffer abuse are often threatened by being told that they will be to blame if the family is separated. Fear of what might happen to them may result in children between the ages of 4 and 10 years colluding with the abusive parent.

Physical abuse/ill treatment (non-accidental injury)

Physical abuse can be defined as any act resulting in a non-accidental physical injury, including not only intentional assault, but also the results of excessive or violent punishment. Physical abuse occurs when a person deliberately injures a child or young person.

Around 25–50% of all children report being physically abused, according to the World Health Organization (WHO).

Physical abuse usually coexists with emotional abuse, and sometimes accompanies sexual abuse. However, in some settings, physical chastisement (especially of older children) continues to be considered part of ‘good parenting’ and important for instilling discipline in a community’s children. In many countries, laws define which childhood punishments are considered excessive or abusive.

Some classifications define physical abuse as an injury that produces a mark. However, this does not take into consideration the emotional effects of physical abuse. The number and size of the bruises are helpful in distinguishing between mild and serious abuse. Any assault on a child is unacceptable and constitutes child abuse. A small bruise in a baby may predict future serious or fatal abuse.

Typical injuries include the following:
- Lash marks, especially on the trunk, legs and hands
- Bruises, especially on the face, scalp, and on or behind the ears and on the buttocks
- Certain patterns of bruises, such as fingertip marks or bruises in the shape of the implement used, or multiple bruises of different ages. However, current scientific evidence concludes that we cannot accurately date a bruise from clinical assessment or from a photograph.
- Burns, including branding and scalds, especially when these are bilateral and/or symmetrical (e.g., buttocks or face held against a hot object such as a radiator, or both hands or feet or buttocks scalded as a result of the child being immersed deliberately in hot water). A pattern suggesting a cigarette burn or burns is also important, but be careful about the possibility of impetigo, which may mimic such burns (impetigo heals quickly and without scarring with antibiotic treatment, topical if a small area and systemic if widespread, whereas burns heal more slowly and may scar).
- Injuries to the mouth (especially a torn frenulum)
- Bleeding from the mouth or nose in an infant (indicating the possibility of intentional suffocation)
- Adult bite marks
- Bony injuries, especially in non-ambulant children; skull fractures, spiral fractures of the humerus, rib fractures in young children and multiple fractures of different ages, epiphyseal separation at the end of long bones, periosteal separation and haematomas
- Inflicted head injury (especially in infants) involving tearing of the superficial veins over the brain and retina, causing subdural and retinal haemorrhages: this can be fatal, or may cause physical and mental impairment and visual loss.
- Failure to thrive due to neglect (category 2) or deliberate starvation (category 3)
- Induced illness, including suffocation or poisoning.

Figure 7.6.1 shows the common injury sites for both accidental and abusive injuries.

![Common sites for non-accidental injury and accidental injury](Image)

**FIGURE 7.6.1** Common sites for (a) non-accidental (abusive) injuries and (b) accidental injuries.

Particular care needs to be taken when interpreting skin marks in settings where traditional practitioners use cupping, coining, scarring or tattooing treatments.

Children are more likely to be killed or to experience violence in their own home than outside it. The triad of violence against a partner (usually the female partner), child abuse and substance misuse (drugs and/or alcohol) is a common association. There is a strong correlation between domestic violence and child abuse.

**Emotional and psychological abuse**

This can occur as isolated incidents, as well as within a pattern of failure over time on the part of a parent or caregiver to provide a developmentally appropriate and supportive environment. This has a high probability of damaging the
The consequences of emotional abuse vary with age and
with its duration, and may include the following:
- Emotional unavailability of the parent or carer (e.g. when
  they are preoccupied with their own needs because of
  mental health problems, substance abuse problems, or
  work commitments)
- Failure to allow the child to interact normally socially
  with others.

The consequences of emotional abuse vary with age and
with its duration, and may include the following:
- Impaired physical development: these children often fail
to reach their optimum potential in terms of growth; this
improves when the child is placed in a more nurturing
environment.
- Impaired cognitive development, including speech and
  language delay, poor concentration and academic
  underachievement.
- Behavioural abnormalities, such as anxious attach-
  ments, lack of social responsiveness, expressionless
  face, fear of speaking, eagerness to please, attention
  seeking, overactivity or ‘hyperactivity’, no wariness with
  strangers, hunger for human contact, inability to form
  relationships, self-injurious or self-stimulating behav-
  iours, hoarding and stealing of food, pica, enuresis and
  encopresis, and bizarre behavioural patterns (sometimes
  there is autistic-like behaviour).
- Impaired psychological development, especially with
  regard to speech and language: aggression, emotional
  unresponsiveness, emotional instability; impaired social
  development, low self-esteem, dependency and separa-
  tion anxiety; serious social difficulties, underachievement,
  negative self-evaluation, poor concentration, and poor
  academic performance or school attendance.
- Psychiatric disorders: emotional maltreatment and
  abuse have been described in association with three
  psychiatric disorders of childhood:
  - Depression
  - Reactive attachment disorder of infancy
  - Multiple personality disorder.
  In general, these children become sad, dejected and
  withdrawn.
- Medical problems include the following:
  - Failure to thrive
  - Recurrent and severe nappy rash
  - Generally unkempt appearance, with poor hygiene
  - Recurrent minor infections.

Neglect
Neglect includes both isolated incidents and a pattern
of failure over time on the part of a parent or other family
member to provide for the development and well-being of
the child (where the parent is in a position to do so) in one
or more of the following areas.

Neglect is persistent failure to meet a child’s essential
needs by inattention or omitting basic parenting tasks and
responsibilities in all aspects of their needs (health, hygiene,
clothing, education, and social, emotional, mental, spiritual
and moral needs). It also includes failure to provide appropri-
ate nutrition, shelter and safe living conditions.

Examples include lack of supervision, with failure to
protect the child from dangers (e.g. cold temperatures,
sunburn, drowning) due to poor supervision and attention
to safety in the home (e.g. not providing stair gates or locks
on windows), failure to thrive, and failure to meet the child’s
emotional needs for love, affection and stimulation.

Neglect is seen as the persistent failure of a parent or
carer to meet a child’s developmental, basic physical and/
or psychological needs by omission of basic parenting. It
results in serious impairment of the child’s physical health,
psychological well-being and development. It may coexist
with other forms of ill treatment.

The parents’ or carers’ own problems (e.g. learning
difficulties, mental and physical health problems, poverty,
inappropriate housing) can all contribute to this. In unstable
settings, such as armed conflict, there may be significant
security issues that contribute to their inability to provide a
safe environment for their children.

Child sexual abuse (CSA)
Introduction
This is the involvement of children in sexual activity to
which they cannot consent. Another definition could be
any activity in which an adult or older child uses a younger
child in a sexual way.

In addition to direct sexual contact between adult and
child (including intra-rural, oral, vaginal or anal sex and the
masturbation of an adult), it includes the use of penetrative
instrumentation, the production of pornographic imagery of
children, exposing a child to indecent acts or pornography,
and other voyeuristic practices. Very young children may
also be trafficked for use in the sex industry, and older
children may be groomed for prostitution.

Sexual abuse is a serious global problem that tran-
scends economic or social barriers. Poverty, emotional
deprivation and lack of education often mean that young
people are powerless to avoid being trapped both in sexu-
ally abusive situations and in domestic violence. However,
it is universally true that sexual abuse is most often suffered at
the hands of a neighbour, family friend or a trusted person,
including a parent. A significant power differential usually
exists between victim and abuser. This fact is important
when examining situations of sexual behaviour between
children themselves.

In legal terms there are two types:
1. When a stranger or someone the child knows abuses
   the child
2. Incest: when a relative by blood or by law abuses the
   child.

Some facts about CSA
- Child sexual abuse is a problem in all socio-economic
classes.
Children will feel less threatened if other aspects of their health are also examined at the same time. The normal child health enquiry about growth, diet, systems enquiry and school function is important. Clinical examination of the child should also be holistic, and incidental findings should be relayed back to the parent and child appropriately. A clinical assessment of the sexually abused child should ideally be conducted by trained and experienced professionals, and preferably a specialist forensically trained doctor or nurse. The environment of the clinical space should be child friendly and the examination unhurried. All examinations should consider the global health needs of the child first; the needs of law enforcement should not be paramount.

Careful history taking is the first step, and if prosecution is being sought, the history should be obtained without risk of contamination, either directly from the child before a recording witness or in the child's absence from the adult who knows first-hand what the child has said. The history should be elicited with free recall and by posing indirect questions (e.g. "Tell me why you are here" or "Is there something that has upset you? Can you talk about it?").

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Physical abuse and sexual abuse are seen together in about 15% of cases.

Physical signs of sexual abuse are uncommon even in long-standing, intrusive and painful abuse. Such subtle signs as may be present will be missed if the examiner does not encourage the child to be fully relaxed. The use of a high-quality lighting source is critical, as is the child's confidence and trust in the examiner.

Clinical examination and physical signs

Clinical assessment of the sexually abused child should ideally be conducted by trained and experienced professionals, and preferably a specialist forensically trained doctor or nurse. The environment of the clinical space should be child friendly and the examination unhurried. All examinations should consider the global health needs of the child first; the needs of law enforcement should not be paramount.

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posture. The gold standard is the use of photo-colposcopy, which provides magnification, light and a recording of the findings.

Small children are best examined in the frog-leg position, assisted by someone whom they trust. The knee–chest position may have to be used to define the hymenal free edge. Gentle anterior traction on the labia usually suffices to open or stretch the orifice. Older and pubertal girls may benefit from the use of stirrups and a damp swab to identify deep clefts. This should be done after appropriate specimens have been collected for forensic analysis.

Criminal prosecution from sexual abuse allegations and forensic evidence gathering is a demanding process that requires strong links between law enforcement agencies and forensic examiners. Doctors and nurses who expect to provide such a service require training from experts in the field.

Essential reading for forensic practitioners should include The Physical Signs of Child Sexual Abuse, produced by the Royal College of Paediatrics and Child Health in the UK in collaboration with the Royal College of Physicians of London and the Faculty of Forensic and Legal Medicine. This document presents a review of all the substantial research into individual physical signs. It also presents guidance on best practice relating to examinations and healthcare (see the Further reading list at the end of this section for details).

**Diagnosis of CSA**

This is usually achieved following multi-agency assessment, the history and medical examination being only a part of the process.

**Acute sexual assault findings** (within hours or a few days):
- Bruising and swelling, abrasions and lacerations to the external genitals without a history of accidental trauma.
- Grip marks and bruising around the limbs.
- Cigarette or lighter burns around the breasts and pubic area.
- Bite marks, including suction bites around the breasts, abdomen and thighs.
- Petechiae around the eyes, tears to the oral frenulum, petechiae over the posterior fauces.
- Visible petechiae over the hymen, hymenal tears, haematomas and bleeding.
- Petechiae or bites over the glans penis and scrotum.
- Bruising, oedema and lacerations around the anal area (oedema usually resolves within 48 hours).
- Semen may be found in the vagina or rectum.
- Pregnancy is a major and not uncommon result.

‘Chronic’ sexual abuse findings** (the most common presentation):
- Hymenal transsections, deep clefts and notches in the posterior hymen, and loss or absence of posterior hymenal tissue are signs seen almost exclusively in the abused child.
- Significant tears can heal rapidly, but may leave mounds or adhesions on the hymen.
- The size of the hymenal orifice is too variable to be a guide to penetration, but a gaping orifice created by loss of the posterior hymen is significant.
- A mounded scar over the fourchette is evidence of significant stretching trauma in the absence of a history of accidental straddle injury.

- Hymenal injuries are never acceptable from a history of a straddle or other fall unless there is convincing evidence of direct penetration by an object.
- Small superficial notches, bumps and labial adhesions are not uncommon in non-abused girls.
- Anal findings are uncommon. They include marked sustained laxity and gaping, deep and poorly healing fissures and venous congestion. Such signs may be seen in non-abused children, and must be considered in the context of the history given.

**Differential diagnoses**

Several common naturally occurring conditions not due to abuse may give rise to a suspicion of sexual abuse but must be excluded.

**Non-specific vulvo-vaginitis** is the commonest. A frequent presentation in the pre-pubescent child, symptoms are of intermittent mild dysuria, redness and a sticky discharge. Symptoms are likely to relate to withdrawal of the maternal oestrogen effect, which makes some children intolerant of the use of strong detergents and poor hygiene practices. The use of loose-fitting underwear, gentle cleansing and the regular application of simple emollients usually provide relief of a condition that tends to recur until early puberty.

The presence of **pinworms** can cause genital symptoms, as can localised eczema in the napkin area. These require appropriate measures.

**Lichen sclerosus et atrophicus** is an uncommon skin disorder which may be associated with other autoimmune disease, including morphia in adults, but it tends to be a stand-alone diagnosis in children. It presents with fragility, haemorrhaging and bruising of the skin of the labia, dysuria and occasional urinary retention. Diagnosis is made easy by the classical picture of de-pigmentation in a figure-of-eight configuration associated with obvious skin fragility, and easy bleeding on stretching. Vigorous treatment with emollients is often adequate in mild cases, but topical steroids may be required to control severe signs and symptoms.

**Retained foreign bodies** can be the cause of intermittent bloodstaining and purulent or offensive discharge in very young children. It should be recognised that repeated insertion of foreign bodies into the vagina by a young child may be the presenting sign of learned or disturbed behaviour.

**Constipation** can give rise to intermittent anal bleeding and discomfort.

**Inflammatory bowel disease** may present with anal fissures, bleeding and discharge.

It is important to communicate to parents and other professionals that sexual abuse may not result in any physical findings, and that there are few signs which are absolutely
diagnostic. Nevertheless, a medical examination following an allegation of sexual abuse may provide valuable forensic information as well as an opportunity for reassurance, treatment of infection, and access to wider therapeutic support.

Difficult judgements about how to proceed may have to be made in settings where female genital cutting is practised, and where legislation and/or community action against this practice is weak.

**Fabricated and induced illness (FII)**

This is the severe end of a spectrum of unusual or abnormal health-seeking behaviours in which significant harm is caused by a parent or carer (usually the mother), who deliberately fabricates signs or symptoms or induces illness in a child. Sometimes the abuse is the direct result of inappropriate and often invasive and unnecessary investigations or treatment by healthcare workers responding to the parent’s fabricated accounts of non-existent illness. It is probably more common in developed than developing countries. The child is frequently brought for multiple medical assessments and investigations, the perpetrator (often the child’s mother) denies knowledge of the causation of the illness, and the acute signs and symptoms cease when the child is separated from the perpetrator.

Healthcare workers in hospital are often the first professionals to suspect FII in a child on the basis of concerns about:

- being given erroneous or misleading information
- deliberate poisoning
- deliberate burns or damage to the skin
- the possibility of deliberate suffocation
- deliberate fabrication of fits
- removal of or tampering with medical monitoring equipment
- the introduction of foreign material into investigative tests.

**Immediate action when ill treatment or abuse is suspected**

- A detailed history and full medical examination are required (including inspection of the genitals). Where possible, obtain the consent of the parent or carer and the child to carry out the medical examination.
- If consent is withheld, work urgently within the legal framework of the country concerned to examine and protect the child in conjunction with police, social services or civil society organisations.
- Ensure that the child (if they are old enough and able to speak) is given the opportunity away from their parent or carer to say how they were hurt (disclosure), at the same time avoiding interference with any police investigation.

When responding to disclosure:

- Explain to the child that abuse is an unfair thing that happens to children, without condemning the offender.
- Determine the immediate need for safety.
- Don’t make promises that you cannot keep.
- Let the child know what you will do.
- Set in motion the process of getting help for the child.
- Take care of yourself.

**Do’s and don’ts of disclosure**

**Do use phrases like this:** ‘I believe you’; ‘You did the right thing by telling someone’; ‘I’m so sorry this has happened to you’; ‘It’s not your fault’; ‘I will try to help you so that it won’t happen again.’

**Don’t use phrases like this:** ‘Don’t say such things!’; ‘Are you sure it happened/is happening?’; ‘Are you telling the truth?’; ‘Why are you telling me?’; ‘Why didn’t you stop it?’; ‘What did you do to make this happen?’

- Consider whether other children in the family may need to be examined and protected.
- Record a full history as it is spoken, and include an evaluation of the child–parent interaction.
- Carry out a careful examination in a well-lit room.
- Record the details of the history and examination legibly and contemporaneously in the child’s medical notes. A form of the type available in the Appendix can be helpful.
- Include details of the child’s demeanour and presentation, and their height and weight plotted on a centile chart. Ensure that an examination of the child’s mouth, nose, ears and neck is undertaken, and complete a full systemic medical examination.
- Document any injuries on body diagrams (see Figure 7.6.1 and Appendix).
- Consider photo documentation (with the child’s consent, if possible) of injuries, and ensure that the images can be stored safely and confidentially.
- Check whether the family is known to the police and/or social services.
- Consider whether any additional medical investigations need to be carried out (e.g. X-rays for bony injuries, a skeletal survey in children under 3 years of age, clotting studies) (see Table 7.6.2).
- Admit the child to hospital if observation or treatment is indicated, or to a place of safety if the child is considered to be at risk. Staff can then have the opportunity to talk further with the child.
- If the parents refuse to allow the child to be examined or admitted, urgent action to protect the child will be required within the legal framework of the country. This may mean referral to the duty social worker (if a referral has not already been made) or the police.

**A thorough medical examination should include the following:**

- Observation of the child’s demeanour
- Height, weight and head circumference (in a preschool child) plotted on a centile chart
- Examination of the mouth, nose, ears, neck and genitals
- Inspection of skin surface for bruises, marks and cuts
- Examination of the eyes for retinal haemorrhages (pupil dilatation may be needed) (see Section 5.15).
- Systemic examination
- An assessment of the child’s developmental age.
Investigations to exclude medical causes should include the following:
- full blood count, platelets and clotting screen
- a detailed skeletal survey (especially in children under 3 years) to look for new and old fractures; a chest X-ray including the upper arms can be very valuable for identifying rib and humerus fractures
- investigations to exclude vitamin D deficiency, if there are fractures
- CT or MRI scan of the brain (if available), if non-accidental head injury is suspected;

**TABLE 7.6.2 Investigations in the differential diagnosis of child abuse**

<table>
<thead>
<tr>
<th>Injury</th>
<th>Differential diagnosis</th>
<th>Investigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bruising</td>
<td>Coagulation disorder, idiopathic thrombocytopenic purpura/Henoch–Schönlein disease, haemorrhagic disease of the newborn, septicemia, connective tissue disorders, birth marks, dyes, tattoos, drug reactions, self-inflicted injuries, traditional treatments</td>
<td>Full blood count, blood film, coagulation studies Chest X-ray Consider skeletal X-ray survey in children under 3 years of age Opinion of expert in skin diseases (if available)</td>
</tr>
<tr>
<td>Bites</td>
<td>Animal or human Adult or child</td>
<td>DNA skin swab (if available) Photography Forensic dental assessment (if available)</td>
</tr>
<tr>
<td>Fractures</td>
<td>Accidental injury, birth injury, infection, malignancy, osteogenesis imperfecta, osteopenia, nutritional deficiencies (including rickets)</td>
<td>Chest X-ray X-ray skeletal survey in children under 3 years of age Bone scan (if available) Radiology advice Blood calcium, phosphate, alkaline phosphatase and vitamin D levels (if available) CT scan for head injury (if available)</td>
</tr>
<tr>
<td>Scalds and burns</td>
<td>Other skin pathologies (e.g. staphylococcal and streptococcal infection), drug reactions, allergic reactions to plants (e.g. euphorbias)</td>
<td>Skin swabs Dermatology opinion (if available)</td>
</tr>
<tr>
<td>Head injury/unexplained fits or coma</td>
<td>Coagulation disorder, epilepsy or febrile convulsion, cerebral malaria, meningitis, poisoning</td>
<td>Retinal examination after pupil dilatation (see Section 5.15) CT scan (if available)</td>
</tr>
</tbody>
</table>

**TABLE 7.6.3 Differential diagnoses of genital and anal findings**

<table>
<thead>
<tr>
<th>Concerning sign</th>
<th>Differential diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal bleeding</td>
<td>Accidental injury, especially straddle injury, urethral prolapse, precocious puberty, lichen sclerosis atrophicus, foreign body in genital tract, severe vulvo-vaginitis</td>
</tr>
<tr>
<td>Rectal bleeding</td>
<td>Anal fissures caused by hard stool, inflammatory bowel disease, infective diarrhoea, rectal polyps, rectal prolapse</td>
</tr>
<tr>
<td>Vulvo-vaginitis</td>
<td>Poor hygiene, skin disease (e.g. eczema, lichen sclerosis), allergies to detergents/bath products</td>
</tr>
</tbody>
</table>

**Additional considerations when performing examination of the genital and anal areas**
- Ensure that a good light source is available, including the use of colposcopy, if this is available.
- Conduct interviews and examinations of children with another professional person present.
- Instrumental examination is not normally required in pre-pubertal girls. Assessment of the hymen in post-pubertal girls may require use of a cotton tip swab or other techniques.
- Knowledge of local practice with regard to female genital cutting and male circumcision is important when interpreting clinical findings.
- Interpretation of anal signs is difficult, and needs to be undertaken in conjunction with a careful history of the child’s bowel pattern.
- If forensic facilities are available, ensure that clothing items and relevant swabs are taken in line with local protocols, and that a chain of evidence is maintained to the forensic laboratory.
- Assess whether swabs for sexually transmitted infection (see Section 6.1.J) need to be taken immediately or at a follow-up review.
- Consider whether a pregnancy test needs to be carried out.
- Consider whether emergency contraception is needed.
- Consider the risks of HIV infection and whether post-exposure prophylaxis is needed in line with local protocols. This will vary depending on knowledge of the assailant, the nature of the injuries, and the country’s HIV prevalence rates.
- Consider whether hepatitis B immunisation (if available) is indicated.

**Special issues concerning the management of sexual abuse**

The child’s immediate needs are as follows:
To feel believed and acknowledged: All interaction with the child should convey this message. Intrusive questioning, especially questions that imply some measure of blame (e.g. "Why didn’t you tell earlier?") can cause a child to refuse to speak further and even retract previous statements. The protective parent or carer should be briefed about this risk.

To be safe from further harm: Protection usually involves the statutory services (if they exist). Police and social workers should be part of the multidisciplinary process that assesses the child's safe custody. The safety of siblings must also be considered at this stage, if not before.

To have all their health needs met: Their immediate needs are for reassurance that they are healthy, and that any changes in the genital area will heal. Care should be taken to use the right language to inform the parent and the child about these changes. The use of phrases such as "no longer a virgin" is highly inappropriate in this context, and indeed anatomically inaccurate in most cases.

Attention must be given to detection and treatment of all acquired sexually transmitted infection, including HIV, preferably within 2 weeks of an acute assault and possibly at the same time as the examination for long-standing abuse.

Pubescent girls should be offered emergency contraception where indicated.

All incidental findings (e.g. anaemia, rashes, heart murmurs) and reported health problems should be attended to and followed up where necessary.

**Forensic sampling in acute sexual assaults**

A decision to undertake forensic sampling depends upon the following:

- Has contact abuse been reported? There is always a possibility of transferred material if there has been direct contact. Even if a condom was used, relevant lubricant or saliva may be detected.
- How long is it since the assault? If it is less than 72–96 hours, there is a possibility of trace material being found, especially within skinfolds.
- Has there been bathing or washing? Material may still be available, but this is less likely if the child has been washed thoroughly.
- How active is the child or adolescent? Children who are immobile for reasons of illness or disability may retain trace material well beyond the standard time, as drainage from the vagina is erratic.

**What samples should be collected?**

The history should guide the practitioner in deciding where trace material is likely to be found. The history may direct one to unusual sites (e.g. swabs may identify traces of adhesive from a victim who has alleged being strapped down with masking tape; microscopic rope fibres may be recovered from around the ankles or wrists). It is sensible to collect duplicate swabs from each area sampled.

In general, swabs lightly moistened with sterile distilled water should be used to collect material that is visibly dried on or speculatively present. Dry swabs are used in moist areas such as the mouth, glans penis, anus and vagina.

If the child is very young or an infant, semen or saliva may be present over a wide area (e.g. in the hair, armpits, abdomen, thigh creases). Damp swabs may be collected over all these areas in a young baby, whereas an adolescent is more likely to carry evidence over the breasts and in and around the vaginal area.

The use of an ultraviolet (UV) light in a dark room may help to identify both deposits of semen and saliva, and areas of deep trauma within the skin. These latter areas fluoresce because of disturbance of melanin, haemoglobin and collagen tissue. The UV light should be used with caution, as there is a risk of material denaturing with extended use.

An example of systematic head-to-toe trace evidence gathering could be as follows:

- hair combings over a sheet of white paper, then folded and placed in a special plastic bag*
- cut areas of hair if dried material is visible
- specialised tooth brushings between the teeth and gums
- swabs if there has been oral ejaculation
- finger nail scrapings if there was violent resisted assault*
- damp swabs pressed firmly and rolled over any bites noted around the neck or breasts
- swabs from the axillae and from within the umbilicus in a small infant
- pubic hair combings*
- external vulval damp swabs
- dry high vaginal swabs
- swabs from the glans penis, behind the foreskin and over the shaft for saliva
- damp peri-anal swabs
- dry rectal swabs
- all clothing bagged individually as removed
- tampons and sanitary towels similarly bagged.

Every item collected should be fully labelled, bagged and sealed by the receiving witness, most commonly a police officer. It is sensible to allow a brief interval between samples to ensure that earlier samples have been correctly dealt with.

* Forensic material obtained in this way is only relevant if the alleged perpetrator denies all contact with the victim, or is unknown and therefore also a potential serial offender. Finding the perpetrator’s DNA in hair or other material on the victim is potent evidence in such cases.

**Sexually transmitted diseases (STDs)**

A sexually transmitted infection may be the presenting feature in sexual abuse. Children who have experienced contact sexual abuse should be screened for STDs. The screening programme should take local prevalence factors into account, as should the decision to offer prophylactic antibiotics or antiviral treatment (see also Section 6.1.3).

*Neisseria gonorrhoeae* (especially non-conjunctival gonococcus) is not an expected infection outside the neonatal period, and is strong evidence for sexual abuse.

*Chlamydia trachomatis* similarly usually implies sexual abuse. There is evidence for vertical transmission at birth, and limited research evidence for the persistence of asymptomatic colonisation beyond the first year of life.

The presence of either of these organisms, especially if symptomatic in mid-childhood and beyond, should raise the strongest suspicion of abuse, regardless of the presence of maternal infection.

*Trichomonas vaginalis* may cause an offensive discharge in adolescents, and is a strong marker for sexual activity, consensual or otherwise. It is not known to infect the...
In 1994, the United Nations General Assembly defined trafficking as the ‘illicit and clandestine movement of persons across national and international borders, largely from developing countries and some countries with economies in transition with the end goal of forcing women and girl children into sexually or economically oppressive and exploitative situations for the profit of recruiters, traffickers, crime syndicates, as well as other illegal activities related to trafficking, such as forced domestic labour, false marriages, clandestine employment and false adoption.’

It is estimated that in the last 30 years, trafficking in women and children in Asia for sexual exploitation alone has victimised over 30 million people.

Children are trafficked for a number of purposes, including:
- sexual exploitation
- adoption
- child labour
- child soldiers
- forced marriage
- body parts
- ritual sacrifice.

Parents are promised education or jobs for their children. Some children are simply captured, then traded for whatever commodity is in demand (domestic work, sex work, drug carrying or beggary).

Children who are displaced are highly vulnerable to sexual and physical abuse. They fear seeking help and often do not have the language to do so.

Different cultural situations produce different types of exploitation. In Asia, for example, girls as young as 13 years may be exported as mail-order brides, and in Thailand around 100,000 women and girls from border countries are imported into the sex trade. Large numbers of children are being trafficked in West and Central Africa, mainly for domestic work but also for sexual exploitation, to work in shops or on farms, or to be scavengers or street hawkers. Nearly 90% of these trafficked domestic workers are girls. Many of these girls are traded on into the Middle East and Europe.

The International Organisation for Migration (IOM) has produced an extensive document that comprehensively deals with all aspects of victim management (see Further reading section at the end of this section).

Advice, both for the country of origin and for the receiving country, is structured based on two principles:
- The child’s interests are paramount.
- Above all, do no harm.

The starting point is the assessment of risk both in the receiving country and in the country of origin if repatriated. Risk depends on numerous factors, including the following:
- the extent to which trafficking is controlled by organised criminal groups
- their known or estimated capacity to plan and implement reprisals against the victims and/or service delivery organisation staff
- the capacity of the local law enforcement agencies
- the extent of endemic corruption and how it adds to the level of risk.

It is critical that children have an appointed independent guardian who will act solely in their interest. Family members, including parents, may well be responsible or collusive in the trafficking, and drawing them in could greatly increase
the risk of serious harm, including death, or re-trafficking. In some cultures it may be socially acceptable for the family to shun or even kill a girl for having brought disgrace on her family.

Trafficked women may give birth to children within their repressive conditions. These children will be at very high risk of emotional abuse and neglect and early introduction into commercial sex. Babies are at risk of homicide.

Services provided for trafficked children should reflect the following needs (adapted from the IOM Report):

- **Approaches that demonstrate respect and promote participation** (e.g. children being allowed to express their views in the language they speak best).
- **An understanding of the complex ways in which their past experience has harmed them.** Children who are trafficked are subjected to a persistently threatening and dangerous environment. In the face of this type of chronic abuse and stress, children and adolescents develop a personality that is suited for survival, but that is ill adapted to cope in normal non-threatening situations. Healthcare practitioners are responsible for employing health-promoting strategies, programmes and activities that recognise the child’s level of development and help children and adolescents to reclaim and further develop their competencies for an active and meaningful life. This involves addressing a range of needs, including nutritional, physical and psychological development and education needs.
- **Tailoring services to meet the needs of each age group** and in ways appropriate to the age and characteristics of the child concerned, never merely following programmes designed for adults. They should be assessed and managed by professionals trained in child development. Medical assessments need to be child friendly and provided by people with expertise.
- **Implementing strategies aimed at mitigating the effects of past trauma and fostering healthier patterns of development.** One example of such strategies is stepwise early re-integration into education and into a peer group.

**Rape as a weapon of war**

The rape of adults and children of both sexes is a common phenomenon in conflict zones. As long ago as 1949, Article 29 of the Geneva Convention explicitly forbade degrading treatment, stating that ‘Women shall be protected against any attack on their honour – especially rape, enforced prostitution and indecent assault.’

Rape as a crime against humanity was first prosecuted in the International Criminal Court in 2001 when three Bosnian Serbs were convicted of systematic sexual violence against Muslim women.

However, prosecution of these crimes by the relevant states has been negligible.

In Rwanda, the mass rapes of the Tutsi women and girls permanently destroyed the capacity to child bear for some, and forced others to bear children outside their ethnic group. Vast numbers of women and girls were rejected by their communities and became outcasts. Thousands of children witnessed the violence on their mothers and sisters.

As rape as a weapon of war demoralises and destabilises entire communities, it weakens ethnic communities and ties, and affects populations with the exploitation of the reproductive rights and abilities of its victims. When rape is employed instead of a bullet, the weapon continues to wield its power beyond the primary victim. The battlefield may be the body, but the target is civil society. ‘Rape, as with all terror-warfare, is not exclusively an attack on the body – it is an attack on the “body-politic.” Its goal is not to maim or kill one person, but to control an entire socio-political process by crippling it. It is an attack directed equally against personal identity and cultural integrity.’

Thus in 1998, rape as an act of genocide was the decision of the International Criminal Tribunal for Rwanda. Despite these major precedents, prosecution of sexual crimes by the relevant states has been negligible. Rape has been a major feature of the war in South Sudan and in the Democratic Republic of Congo. Children as young as 5 years of age have been deliberately targeted. There is also strong anecdotal evidence that young soldiers barely in their teens have been ordered into gang rape to prove their “manhood”.

The provision of care for victims of mass sexual abuse at this level is a daunting task, and should involve major planning and resources. Emergency care for severe physical wounding in the course of the assaults is logistically difficult.

Pratt and Werchick recommend expanding access through ‘mobile teams of rape specialists’ that could not only provide treatment themselves, but also transport medical supplies and transfer knowledge to any staff already on the ground. Medications, including emergency contraception, hepatitis vaccine, STD prophylaxis and antiretroviral drugs, need to be available. Such teams will need to have access to surgical facilities, especially when very young children are involved.

Gang rape, the use of instruments and other violence increases the risk of HIV/AIDS transmission significantly; intercourse is accompanied by injuries and bleeding which increases the transmission of the virus compared with transmission during consensual sex. Internal vaginal and rectal injury can be very serious, and in the very young may be fatal.

According to Human Rights Watch, “children were reportedly forced to hold their mothers down while they were raped”. It is not difficult to see that a significant range of service provision is required at several levels to deal with such traumatic damage in childhood.

Therapeutic services in isolation without intensive educational programmes and a whole-community approach are probably doomed to fail. Rape as a weapon of war activates cultural beliefs that result in the marginalisation of its victims, especially women and children, thus preventing those victims from receiving psychosocial support, and depriving them of income. Women and girls are considered to be damaged and ‘contaminated’. Wives may be denounced by their husbands, blamed for the rape, and regarded as “married” to their rapists. Thus communities see their raped women and children as enemies and place them outside their sphere of moral obligation. Some communities may demand that their wives and children leave their villages.

Empowering young children and their mothers by providing education, and the teaching of new skills leading to longer-term economic stability, are also areas that need careful planning. Provision of safe housing and basic needs may be all that is possible in the immediate aftermath of sexual violence.
Additional considerations when investigating fabricated and induced illness (FII)

- The investigative process must involve early and continuing collaboration between all agencies, with detailed information sharing. Strategy planning meetings involving professionals from health, social services, police, education and legal departments can be very helpful.
- Draw up a health chronology using all accessible sources of information.
- Gather forensic or witness information.
- A decision must be made by the multi-agency team as to whether it is necessary to separate the child from the suspected perpetrator by voluntary or legal means.
- A decision must be made by the multi-agency team as to how and when to confront the parents.
- Ensure the child’s safety throughout the investigative process.
- Work within the country’s legal framework.

Medical aftercare following childhood maltreatment

It is important that these children are offered follow-up in order to:
- monitor the child’s overall progress
- ensure healing of injuries
- investigate and treat any acquired infection
- facilitate access to psychological therapeutic support.

Healthcare workers involved in the hospital care of children who have been abused may be asked to provide a police statement and to attend court as a witness.

Further reading

- Heise LL, Raikes A and Watts CH (1994) Violence against women: a neglected public health issue in less developed countries. Social Science and Medicine, 39, 1165–79.

Appendix

Examination under child protection procedures: suspected physical and/or sexual abuse

Patient details (circle correct information)

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of birth:</td>
<td>Time:</td>
</tr>
<tr>
<td>Age:</td>
<td>Place of examination:</td>
</tr>
<tr>
<td>MALE/FEMALE</td>
<td></td>
</tr>
<tr>
<td>Address (prior to examination):</td>
<td></td>
</tr>
</tbody>
</table>

Professionals involved in the assessment

<table>
<thead>
<tr>
<th>Doctor’s or nurse’s name:</th>
<th>Police officer’s name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social worker’s name:</td>
<td></td>
</tr>
<tr>
<td>School:</td>
<td></td>
</tr>
</tbody>
</table>

Why was this examination undertaken?
Family and Social History
(including names, dates of birth, ages, occupations/schools, relationships)

<table>
<thead>
<tr>
<th>History of any known medical problems</th>
</tr>
</thead>
</table>

Examination
Persons present during examination

1. 

2. 

3. 

4. 

Examination of child

<table>
<thead>
<tr>
<th>Age:</th>
<th>Years: Months:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Height/percentile</th>
<th>........cm/........</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Weight/percentile</th>
<th>........kg/........</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Head circumference/percentile</th>
<th>........cm/........</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

General appearance of child (any obvious neglect):

Significant comments made by the child or the parent/carer (record as accurately as possible):

Developmental assessment (circle correct answers):

Delayed development Yes/No

If Yes Severe /Moderate /Mild

Level of puberty: Pre-pubertal/Post-pubertal

General examination (use body maps for any injuries)
(include inspection of oral frenum and palate and scalp)
FIGURE 7.6.2 Diagram on which to mark signs of injury to the front of the body. Reproduced with permission from Southampton City Primary Care Trust.

FIGURE 7.6.3 Diagram on which to mark signs of injury to the back of the body. Reproduced with permission from Southampton City Primary Care Trust.

FIGURE 7.6.4 Diagram on which to mark signs of injury to the right side of the body. Reproduced with permission from Southampton City Primary Care Trust.

FIGURE 7.6.5 Diagram on which to mark signs of injury to the left side of the body. Reproduced with permission from Southampton City Primary Care Trust.
FIGURE 7.6.6 Diagram on which to draw the shape and position of any lesion on the female genitalia or anus. Reproduced with permission from Southampton City Primary Care Trust.

FIGURE 7.6.7 Diagram on which to draw the shape and position of any lesion on the male genitalia or anus. Reproduced with permission from Southampton City Primary Care Trust.

## Examination of female genitalia

<table>
<thead>
<tr>
<th>Issue/area examined</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>External genitalia</td>
<td></td>
</tr>
<tr>
<td>Pubertal signs?</td>
<td></td>
</tr>
<tr>
<td>Labial separation or traction used?</td>
<td></td>
</tr>
<tr>
<td>Labial fusion?</td>
<td></td>
</tr>
<tr>
<td>Urethral opening</td>
<td></td>
</tr>
<tr>
<td>Labia minora</td>
<td></td>
</tr>
<tr>
<td>Peri-hymenal tissues</td>
<td></td>
</tr>
<tr>
<td>Posterior fourchette</td>
<td></td>
</tr>
<tr>
<td>Perineum</td>
<td></td>
</tr>
<tr>
<td>Hymenal opening</td>
<td></td>
</tr>
<tr>
<td>Hymen</td>
<td></td>
</tr>
</tbody>
</table>

*Examination position*

## Examination of anus

<table>
<thead>
<tr>
<th>Issue/area examined</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anal laxity/anal grip</td>
<td></td>
</tr>
<tr>
<td>Anal folds</td>
<td></td>
</tr>
<tr>
<td>Anal margin</td>
<td></td>
</tr>
<tr>
<td>Surrounding tissues</td>
<td></td>
</tr>
</tbody>
</table>

*Examination position*
### Examination of male genitalia

<table>
<thead>
<tr>
<th>Issue/area examined</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frenulum</td>
<td></td>
</tr>
<tr>
<td>Urethral meatus/</td>
<td></td>
</tr>
<tr>
<td>Any discharge</td>
<td></td>
</tr>
<tr>
<td>Signs of genital injury?</td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td></td>
</tr>
<tr>
<td>Testicular swelling?</td>
<td></td>
</tr>
<tr>
<td>Warts or skin disorders?</td>
<td></td>
</tr>
<tr>
<td>Examination position</td>
<td></td>
</tr>
</tbody>
</table>

**Photographs taken of injuries**
- By whom: ..............................................
- Of what: ..............................................

**X-rays taken**
- Of what: ..............................................

**Forensic samples collected**
- By whom: .............................................. Handed to whom: ..............................................
- List samples collected: ..............................
  - ..............................................
  - ..............................................
  - ..............................................

**Screening for STDs**
- Date of tests: .............................................. Results and date:
- Tests taken: ..............................................
  - ..............................................
  - ..............................................
  - ..............................................

**Any other clinical investigation:**

**Summary and interpretation of significant abnormal findings:**

**Conclusions and doctor's or senior nurse's opinion:**

**Points discussed with social worker and parent/carer** (and their opinion if applicable):
Arrangements for health follow-up for child (including investigations):

Signature: ................................................. Date: ................................

Circulation list for report:

Social worker: ..................................................

Police: ..........................................................

Head-teacher at school: ...........................................

Others (please specify): ...........................................

<table>
<thead>
<tr>
<th>Name(s) of other children possibly at risk of abuse:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surname</td>
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<tr>
<td>---------</td>
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</table>

Checklist after examination:
1 Have you been able to give a clear opinion on the case?
2 Have you considered alternative explanations for the findings?
3 Does the social worker understand your findings and opinion?
4 If the injuries are serious or indicate serious risk, have you considered the need for police involvement?
5 Are you happy with plans for the immediate safety of the child?
6 Are you in agreement with the proposed long-term management?
7 Is it important for you to attend the case conference? If so, make sure that the social worker knows this.
8 Have you recorded your discussions?
9 Have you written a care plan?