Battered child syndrome: Is India in dire straits?

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Abstract Battered child syndrome, battered baby syndrome, shaken baby syndrome, non-accidental injuries of childhood, etc. are all variants of forms of child abuse that has many names but a single outcome – the child is injured at the hands of a caretaker, more often than not a close relative. Although there are clear guidelines in most developed countries as to what the clinicians should do if they suspect a case of battered child syndrome, no such specific streamlined guidelines exist in most of the developing countries including India. In India, the National Commission for Protection of Child’s Rights and the Indian Academy of Pediatricians have recently taken the initiative to educate pediatricians about child abuse and formulate policies on reporting. Although the pediatricians have woken up to the reality of child abuse, rest of the medical fraternity is yet to wake up to the fact that a big proportion of children in India are being battered and most go unnoticed and unreported. In India, there is a need for the medical and nursing educators, practitioners, policy makers, political and legislative wings of the society to get together and raise awareness, formulate specific guidelines regarding the management of a case of suspected battered child; who should investigate and how the investigation has to be done, how to ensure safe settings for at-risk children and facilitate permanent placement for children who cannot return home.

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1. Introduction

Battered child syndrome, battered baby syndrome, shaken baby syndrome, non-accidental injuries of childhood, etc. are all variants of forms of child abuse that has many names but a single outcome – the child is injured at the hands of a caretaker, more often than not a close relative.1,2 It was not recognized as a separate entity until early 1960s when Henry Kempe and his colleagues coined the term “Battered Child Syndrome”.3 A child that undergoes abuse at the hands of elders at home is often brought to the hospital with injuries that are inconsistent with the history given by the parents or caregivers. They can present with multiple fractures of different ages to intracranial infection like picture and many a times may be
treated as such in the initial stages. Since the victimized children are often too young to complain about the abuse on their own, it becomes essential that other people who are more likely to identify the abuse should be made aware of the signs of child abuse and should have precise guidelines as to how and where to report it whenever suspected. These people, in most circumstances, include doctors and nurses who work in the hospitals, in the emergency or outpatient departments. To this effect, there are clear guidelines in most developed countries as to what they should do if they suspect a battered child syndrome. Unfortunately, no such specific streamlined guidelines exist in most of the developing countries including India.

2. Burden of problem

The World Health Organization (WHO) estimates that 40 million children are subjected to abuse and neglect around the world. Most of the industrialized countries have their own reporting and surveillance system and have data on child battery but in developing countries including India, there is lack of data regarding the extent of child battering that takes place within the households or institutions. In India, there is no way to know how many cases of battered child syndrome occur every year as they are hardly reported and there is no system in place for surveillance of the same. Literature search reveals only few case reports. Over a period of 10 years there were just a handful of cases reported in various journals from all over India. This is only the tip of the iceberg as the country does not have specific streamlined guidelines on when and how to report on suspicion of a battered child syndrome. When such children are discharged to go back to the same household where they suffered abuse, many times they end up dead. In 2007, India published a report on one of the largest surveys done on child abuse and found that two out of every three children were physically abused and 88.6% of them suffered at the hands of their own parents. Unfortunately the methodology restricted the study to only older children who could give history of abuse. Therefore the magnitude of the problem given in the report only highlights among children above the age of 5 years. The one who ends up in the hospitals or graves from birth to few months to few years who cannot give history of abuse still has no voice.

3. Culture and medicine

In India, the culture of corporal punishment is still viewed as normal and when does that cross the line and becomes child battery, is not watched closely by any agency. What happens within the walls of someone’s home, be it child abuse, is not considered as a neighbour’s problem and thus most child battery cases go unnoticed and unreported. With poverty and lack of health care threatening survival, child battery does not receive much attention. Over the years child labor has come to the forefront and efforts are on to deal with it in India, spearheaded by the National Commission for Protection of Child’s Rights (NCPCR) but battered child syndrome is yet to receive such widespread attention.

In medical education, the specialties that should specifically deal with battered child syndrome are Pediatrics and Forensic Medicine. Searches of various Indian textbooks that are commonly used by students in various regions of the country show that most of them do not vividly cover the topic. The textbooks that do mention it, do not have specific instructions as to what the doctor’s or nurse’s action should be, should they suspect battered child syndrome. Under such circumstances, the chance of child battery being reported to any authority is very slim. It is rare that doctors take the trouble of reporting and insisting on the child’s welfare in terms of changing custody and involving police and child welfare organizations as was done by Dr. Holla and Dr. Gupta from the Army Hospital, Delhi.

Among the cases published from India, only one mentioned details as to how the doctors reported to the police and involved the non-governmental organization for protecting the child from further abuse. Most of the other articles do not detail about what was done further in terms of the cause, the perpetrator and protection of children. In one of the cases, the parents gave the explanation that the 5-month-old female baby had suffered shaken baby syndrome because she was shaken by a 5-year-old elder brother while playing with her. While this may be possible, the likelihood of it being false is more as it is hard to imagine a 5-year-old being able to shake the child so badly as to cause such severe injuries. In another case, a child presented with seizures, vomiting, irritability and lethargy. Though shaken baby syndrome was suspected on account of clinical presentation, it was not thought to be intentional as it was an apparently loving and harmonious family. There was history of the child being left alone with the maid while the parents were at work. The parent confessed to playing with the child by throwing the child in the air and catching. Accidental injuries can happen with babies due to their fragile states but all the same, doctors and nurses need to be vigilant when such cases come to the hospital emergency rooms or outpatient departments.

4. Medicolegal aspects and recent developments

Battered baby syndrome may result in a very poor outcome and major long-standing sequelae are frequent. Cognitive or behavioral sequelae can become apparent only after a long sign-free interval in cases of shaken baby syndrome, due to increasing demands placed on the child during development. A key step in the management of such a problem and to prevent further recurrence is to diagnose shaken baby syndrome at the outset. This diagnosis comprises four basic steps. Identifying existence of intracranial lesions, which must be given due consideration even in the absence of symptoms that are not specific for neurological damage, such as paraparesis or vomiting; a verdict of shaking; analysis of the circumstances of shaking; and correct identification of the perpetrator. While the physician is solely responsible for the first two steps, the role of child protection services comes into prime existence for the last two steps. In order to protect the child, the diagnosis must be reported irrespective of the context of such battery. The confidentiality of the physician–patient relationship no longer holds in cases of abuse and cruelty to child. In such an event, the Indian Penal Code obliges the physician to notify the legal authorities. Some of the questions that run in physicians mind that keep them from reporting such cases include fear of worsening the relationship with the family or those within the family, fear of an overly severe response from the police or judicial system, fear that the adult might be impris-
onded, and personal interest of the physician, which at many times overrides the legal aspects, to not get involved in legal issues. Nevertheless, none of these fears justify not reporting such an incident. Victim compensation is yet another medico-legal issue entertained in many nations but the Indian subcontinent. Whatever the context of the crime may be (voluntary or involuntary), battered baby constitutes an offense and the victim should become eligible for compensation. Since the cognitive and behavioral sequelae of battered baby can well hamper a child’s ability to grow up as a normal adult and sustain economically independent life, compensation would be a major factor in reducing handicap.

The NCPCR and the Indian Academy of Pediatricians (IAP) have recently taken the initiative to educate pediatricians about child abuse and formulate policies on reporting. The guidelines mandate that pediatricians coming across cases of child abuse should report to police, non-governmental organizations (NGOs) or help-lines. If they fail to do so, they can be punished for up to two years imprisonment. Pediatricians have woken up to the reality of child abuse and are working towards remedial measures but rest of the medical fraternity is yet to wake up to the fact that a big proportion of children in India are being battered and most go unnoticed and unreported.

5. Need of the hour

Child battery offends the basic values of our humanity. Rightly said, ‘there can be no keener revelation of a society’s soul than the way in which it treats its children’. While we are already in dire straits, listlessness towards the situation and not trying on the off chance to bring the situation back to normality will undoubtedly put child welfare over a barrel, a foregone conclusion which the society will regret sooner or later. The medical and nursing fraternity must improve their level of awareness towards the problem of child battering, be better equipped to identify them and be more knowledgeable to deal with the circumstance so that the child does not go back to the same environment or suffer further battering. This will come under the purview of not only the medical and nursing educators, practitioners, policy makers, but also the political and legislative wings of the society. They all need to come together and raise awareness, formulate specific guidelines regarding the management of a case of suspected battered child or non-accidental injuries of childhood; who should investigate and how the investigation has to be done, how to ensure safe settings for at-risk children and facilitate permanent placement for children who cannot return home.

References

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