Analysis of Perpetrator Admissions to Inflicted Traumatic Brain Injury in Children

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Background: Scientific and courtroom debate exists regarding the timing of onset of symptoms and the mechanism of injury in infants and children with inflicted traumatic brain injury (ITBI).

Objectives: To determine the time interval between ITBI and the onset of symptoms and to explore the mechanism of ITBI.

Design, Setting, and Patients: Retrospective review of all cases of pediatric ITBI admitted between January 1, 1981, and July 31, 2001, to a large academic medical center and cases admitted to 2 additional academic institutions between January 1, 1996, and August 31, 2000, and January 1, 2001, and July 31, 2001, comparing 81 cases of ITBI in which perpetrators admitted to abuse with 90 cases in which no abuse admission was made. The patients with perpetrator admissions to ITBI consisted of 53 boys (65%) and 28 girls (35%). Their ages ranged from 2 weeks to 52 months.

Main Outcome Measures: Characteristics associated with perpetrator admissions to ITBI in children.

Results: Shaking was the most common mechanism of injury among all cases with perpetrator admissions: 55 (68%) of the 81 perpetrators admitted to shaking the children. Impact was not described in 44 (54%) of the 81 cases. In cases in which only impact was described, 60% (12/20) of the children showed skull or scalp injury, compared with 12% (4/32) with skull or scalp injury in the shake only group. In 52 (91%) of 57 cases in which the time to the onset of symptoms was described, symptoms appeared immediately after the abuse. In 5 cases (9%), the timing of symptoms was less clear, but they occurred within 24 hours. None of the children were described as behaving normally after the event.

Conclusions: The symptoms of inflicted head injury in children are immediate. Most perpetrators admitted to shaking without impact. These data, combined with the relative lack of skull and scalp injury, suggest that shaking alone can produce the symptoms seen in children with ITBI.


Inflicted traumatic brain injury (ITBI) is a leading cause of death and disability in young children. While many descriptive studies of ITBI have been published, questions remain regarding the timing and mechanism of injury. Although studies have identified the perpetrators of abusive head trauma, none have focused primarily on information provided by admitted perpetrators.

The determination of the timing of an abusive event is critical for investigators attempting to determine the identity of a perpetrator. Because initial histories often are falsified or minimized, the historical timing of injury is obscured. In a study of 95 cases of accidental head injury, Willman et al found that 94 children experienced immediate symptoms after sustaining their injuries. Their conclusion was that the symptoms of severe head injury are immediate. In a study by Starling et al, 36 of 37 confessed perpetrators were with the child when the symptoms began, supporting the conclusion that the symptoms of ITBI are immediate.

Debate continues regarding the exact mechanism of ITBI in children. Whether shaking alone can cause the severe intracranial injury associated with the condition known as shaken baby syndrome is a topic of considerable debate. Duhaime and colleagues concluded that blunt impact was necessary to cause the intracranial injuries seen in shaken baby syndrome. However, Alexander et al reported that the intracranial injuries seen in patients with no evidence of external trauma were of equal severity to those found in patients in whom direct head trauma was observed, concluding that shaking alone could cause these injuries.
The analysis of perpetrators’ admissions of ITBI can be used to evaluate the timing and mechanisms of injury. In this study, cases in which perpetrators admitted to ITBI were examined to elucidate the length of the time interval between injury and the onset of symptoms and to better understand the mechanisms of ITBI. In many cases, the perpetrators admitted to injuring the children, but did not give detailed confessions of abuse.

METHODS

The medical records of hospitalized head-injured children at 3 academic medical centers were reviewed: The Children’s Hospital, University of Colorado Health Sciences Center, between January 1, 1981, and July 31, 2001; Vanderbilt University Medical Center, Nashville, Tenn, between January 1, 1996, and August 31, 2000; and the Children’s Hospital of The King’s Daughters, between January 1, 2001 and July 31, 2001. Institutional review board–approval was obtained at each center before the project onset. Cases of ITBI were identified by each hospital’s child abuse evaluation team using the following criteria: child younger than 3 years with radiological evidence of intracranial bleeding and no history of trauma explaining the findings and either retinal hemorrhages or associated noncranial injuries considered highly concerning for abuse, such as fractures or bruising. Perpetrators’ admissions to inflicted head trauma also were used as evidence that the injuries were abuse related. Cases in which there were perpetrator admissions to some or all of the injuries were included in the study. Data extracted included information regarding the nature, timing, and mechanism of injury; relevant medical and social histories; and case outcomes.Perpetrators of ITBI who did not admit to abuse were used as a comparison group. Perpetrators in the nonadmitting comparison group were identified by various methods, including whether they were the primary suspect in a criminal investigation.

Categorical variables were described using frequencies. Differences between the admission and control groups were compared using χ² analysis. Continuous variables were tested for normality using the Shapiro-Wilk test, and were described using the median and range when the data were nonparametric and the mean and standard error when the data were normally distributed. Nonparametric continuous variables were compared between groups using the Wilcoxon rank sum test, and normally distributed variables were compared using the t test. Simple and multiple logistic regression analyses were used to identify crude and independent predictors of admission. The Cramer V was used to measure the strength of the association between nominal variables and admission group. The Cramer V takes a value of 0 when there is no correlation and 1 when the variables are perfectly correlated. P < .05 indicated significance. The McNemar test was conducted to determine any difference in agreement between perpetrator-reported symptoms and those noted on admission. The data were analyzed using SAS statistical software, version 8.0 (SAS Institute Inc, Cary, NC).

RESULTS

A total of 628 head-injured patients were screened, with 453 cases of ITBI identified using the criteria described. Of these cases, suspected or admitted perpetrators could be identified in 171 (38%). Perpetrators admitted to abuse in 81 cases; and in 90 cases, no admission was made. All cases with a perpetrator admission had evidence of intracranial bleeding, including 80 (99%) of the 81 children with an acute and/or chronic subdural hematoma and 1 child with an isolated subarachnoid hemorrhage. Of the 81 children, 67 (83%) had both intracranial bleeding and retinal hemorrhages. Twelve children (15%) had intracranial bleeding with other abuse-related injuries, but no retinal hemorrhages, on presentation. Two children (3%) had intracranial bleeding with perpetrator admission, but no retinal hemorrhages or other injuries. Thirty-two (40%) of the children had intracranial bleeding, abuse-related injuries, and retinal hemorrhages. The demographic information of the 81 children (mean age, 3.5 months; age range, 0.5-52.0 months) who experienced ITBI by admitted perpetrators is summarized as follows:

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No. (%) of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>28 (35)</td>
</tr>
<tr>
<td>Male</td>
<td>53 (65)</td>
</tr>
<tr>
<td>Condition at discharge*</td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>8 (10)</td>
</tr>
<tr>
<td>Impaired</td>
<td>57 (71)</td>
</tr>
<tr>
<td>Died</td>
<td>15 (19)</td>
</tr>
<tr>
<td>Acute subdural hematoma</td>
<td>73 (90)</td>
</tr>
<tr>
<td>Retinal hemorrhages</td>
<td>67 (83)</td>
</tr>
</tbody>
</table>

*One child had an unknown discharge condition.

Of the perpetrators admitting to inflicted injury, the most common perpetrator was the father, followed by the mother’s boyfriend, and then by the mother (Table 1). Few baby-sitters admitted to injuring the children, with a frequency 14 times less that of the parents. Most of the perpetrators lived with the child (mother, 11 [92%] of 12; father, 38 [84%] of 45; or mother’s boyfriend, 11 [85%] of 13). Although most (59% or 48 of 81) of the children lived with both parents, perpetrators were alone with the child at the time of injury in 67 (91%) of 74 cases. In the remaining 7 cases (9%), whether the perpetrator was alone with the child could not be determined.

The most common initial symptoms reported by the admitted perpetrators were loss of muscle tone (“became limp”) (n = 29), seizures (n = 25), vomiting (n = 24), lethargy (n = 23), and apnea (n = 21). Some perpetrators reported more than 1 symptom occurring simultaneously. Seizures and lethargy were the 2 most common symptoms noted by medical staff at the time of the hospital admission.

No significant differences were seen between symptoms as reported by the perpetrators and those noted on
hospital admission, including seizures, lethargy, fussiness or crying, and respiratory or cardiac arrest. Of the 81 cases examined, 58 (72%) had agreement between the hospital and perpetrator on the presence of symptoms consistent with seizures; in 8 children (10%), seizures were noted by the perpetrator but not on hospital admission; and in 15 children (19%), seizures were noted on hospital admission but not by the perpetrator (P = .14). Of the 81 cases, there was agreement that the patient was lethargic for 46 (57%); for 16 children (20%), lethargy was noted only by the perpetrator but not on hospital admission; and for 19 children (24%), lethargy was noted only on hospital admission but not by the perpetrator (percentages do not total 100 because of rounding) (P = .61). For 64 (79%) of the cases, there was agreement that the patient was fussy or crying; for 8 children (10%), fussiness was noted by the perpetrator but not on hospital admission; and for 9 children (11%), crying was noted on hospital admission but not by the perpetrator (P = .81). For 68 (84%) of the cases, there was perpetrator and hospital agreement that the patient was in respiratory or cardiac arrest; for 7 children (9%), respiratory arrest was noted by the perpetrator but not on hospital admission; and for 6 children (7%), respiratory arrest was noted on hospital admission but not by the perpetrator (P = .78).

In 69 of the 81 cases with perpetrator admissions to ITBI, enough information was provided to define the historical mechanism of ITBI. Twenty perpetrators admitted only to impact without shaking. In 17 of these children, acute subdural hematomas were present; and in 14, retinal hemorrhages were noted. Eight of these children had skull fractures and an additional 4 had scalp swelling. Admissions of impact for these 20 patients included being struck by an object or slapped (n = 8), being thrown onto a hard surface such as the floor (n = 6), being thrown to a soft surface (n = 3), being dropped (n = 2), and being hit against an object (n = 1). In contrast, 32 perpetrators admitted to only shaking. Among these children, skull fractures were noted in only 2, and scalp swelling in 2 others. In children with only admitted shaking, subdural hematomas were noted in 29 and retinal hemorrhages were present in 27. Seventeen perpetrators admitted to a combination of shaking and impact (Table 2).

No relationship was found between the mechanism of injury to which the perpetrator admitted (impact only, shaking only, or impact and shaking) and the condition of the child at hospital discharge (P = .58) (Table 3). Also, no correlation was noted between the mechanism of injury and initial symptoms noted by the perpetrator, such as seizures (Cramer V = 0.14), apnea (Cramer V = 0.16), respiratory arrest (Cramer V = 0.04), or respiratory distress (Cramer V = 0.02). Similarly, there was no correlation between the mechanism of injury and the symptoms noted on hospital admission.

The period between injury and the onset of symptoms was documented, and could be ascertained in 57 of the 81 cases with perpetrator admissions to ITBI. In 52 (91%) of these cases, perpetrators indicated that symptoms appeared immediately after the abuse (Figure). In the remaining 5 cases (9%), the perpetrators’ statements tangentially addressed timing issues regarding the abusive event, but the exact time was not specified. In 3 of these cases, the children were not observed for up to 6 hours after injury, but when next observed were severely symptomatic. In the remaining 2 cases, the parents’ history changed substantially over time and/or did not include specific information regarding the timing of onset of symptoms. In both of these cases, however, the perpetrator provided sufficient information to conclude that the injured child became ill no later than 24 hours after the injury.

### Table 2
Comparison of Injuries by History Among the 69 Children Whose Perpetrators Admitted to Inflicting Traumatic Brain Injury

<table>
<thead>
<tr>
<th>Type of Injury</th>
<th>Impact Only (n = 20)</th>
<th>Shaking Only (n = 32)</th>
<th>Impact and Shaking (n = 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subdural hematoma</td>
<td>17 (85)</td>
<td>29 (91)</td>
<td>17 (100)</td>
</tr>
<tr>
<td>Retinal hemorrhage</td>
<td>14 (70)</td>
<td>27 (84)</td>
<td>16 (94)</td>
</tr>
<tr>
<td>Skull fracture</td>
<td>8 (40)</td>
<td>2 (6)</td>
<td>3 (18)</td>
</tr>
<tr>
<td>Scalp swelling</td>
<td>4 (20)</td>
<td>2 (6)</td>
<td>2 (12)</td>
</tr>
</tbody>
</table>

*Data are given as number (percentage) of each group.

### Table 3
Comparison of Patient Outcome With Mechanism of Injury Among the 68 Children Whose Perpetrators Admitted to Inflicting Traumatic Brain Injury

<table>
<thead>
<tr>
<th>Patient Outcome</th>
<th>Impact Only (n = 20)</th>
<th>Shaking Only† (n = 32)</th>
<th>Impact and Shaking (n = 17)</th>
<th>Total‡</th>
</tr>
</thead>
<tbody>
<tr>
<td>Died</td>
<td>4 (20)</td>
<td>5 (16)</td>
<td>4 (24)</td>
<td>13 (19)</td>
</tr>
<tr>
<td>Impaired</td>
<td>12 (60)</td>
<td>24 (77)</td>
<td>11 (65)</td>
<td>48 (69)</td>
</tr>
<tr>
<td>Healthy</td>
<td>4 (20)</td>
<td>2 (6)</td>
<td>2 (12)</td>
<td>8 (12)</td>
</tr>
<tr>
<td>Total‡</td>
<td>20 (100)</td>
<td>31 (46)</td>
<td>17 (29)</td>
<td>68 (100)</td>
</tr>
</tbody>
</table>

*Data are given as number (percentage) of the total of each column unless otherwise indicated.
†One child in this group had an unknown outcome and is not included in this analysis.
‡Data are given as number (percentage) of 68 children.

The determination of the timing of injury is critical to the investigation of ITBI, and physicians are frequently asked to comment on these issues. Although argument will be made that perpetrator admissions are not reliable scientific evidence, such statements constitute the only witnessed accounts available for analysis. When the reported symptoms noted by the perpetrators were compared with those seen at hospital admission, no significant differences were noted.

Most perpetrators in this study reported that symptoms appeared immediately after the injury was in-
It has been debated for many years regarding the mechanism of injury in ITBI and whether impact is necessary to produce the clinical findings. Another debated issue involving ITBI is the determination of the timing of injury, which can be critical for physicians treating the child and investigators attempting to determine the identity of a perpetrator. An analysis of perpetrator admissions to inflicted injury in children provides a unique insight into the mechanism and timing of injury.

This study supports research showing that the onset of symptoms in children with ITBI is immediate. It also supports the position that shaking alone produces the symptoms seen in ITBI. Physicians treating these children will have a more accurate understanding of the timing and mechanism of injury to provide appropriate medical care for the children and more accurate information to investigators.
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REFERENCES