REPORTING CHILD ABUSE IN BELGIUM

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ABSTRACT

Belgian society has become increasingly aware of the problem of abuse and neglect of children. Recent changes to both Belgian Penal Law and the Code of Medicine now allows dentists to report suspected cases of abuse to provincial trust centres or official authorities, bypassing issues of professional confidentiality. Data on different kinds of child abuse and neglect are presented for the Dutch and French-speaking parts of Belgium for 2001-2002. An increase in notified cases for both regions is noted, along with apparent differences in the type of abuse reported.

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INTRODUCTION

Over the last decade Belgian society has become increasingly aware of the problem of abuse and neglect of children. Several court cases, and the ensuing media coverage, has brought the discussion to the public forum. Questions have been raised about how responsibility in such cases should be apportioned. Should the close family, neighbours, school teachers, family doctors and dentists share some responsibility? In this context, dentists must be aware of the problem of child abuse, be able to recognize such cases and to inform the proper authorities.

The legal obligation of the medical profession in Belgium

Until recently, Belgian physicians were not legally obliged to report an abused or neglected child. The Code of Medicine now contains Article 61, § 1 and 2, in which physicians are able to inform a confidential team or eventually, when necessary, official authorities. This text is as follows: *"Whenever a physician is of the opinion that a minor is being maltreated, undernourished or insufficiently cared for, he is obliged to inform the parents, the tutor or the judicial authorities. When the physician observes an arbitrary deprivation of personal freedom, he is obliged to inform the judicial authorities. In all these cases the physician acts in the first place to protect the victim."*[1] Nevertheless, the Code of Medicine is not legally binding.

A recently published law has also introduced some modifications to penal law in order to strengthen the protection of minors. Article 458bis of Belgian Penal law allows individuals (such as dentists) who are normally held to a legally binding obligation of confidentiality to put aside, under certain conditions, their duty of discretion in cases of either maltreatment or sexual offences towards minors. This article states textually: *"Anyone who, in virtue of his condition or his profession, is privy to secrets, and in this way obtains knowledge about an offence (as defined in articles 372 to 377, 392 to 394, 396 to 405ter, 409,423,425 or 426), committed on a minor, has the possibility, without affecting the obligations imposed on him by art. 422bis, to report the offence to the Public Prosecutor, provided that he has either examined the victim or has been taken into his trust, that there exists a serious and immediate threat to the mental or physical integrity of the person concerned, and that he is not in a position to protect this integrity either alone or with the help of others."* [Article 458bis Belgian Penal Code (Law regarding penal protection of minors) inserted by the Act of November 28th 2000 and published in Belgisch Staatsblad March 17th, 2001].

The moral and legal obligation of the dentist to inform the proper authorities about his suspicion or opinion

Under American law, which differs in many aspects from that of most European countries, dentists are obliged to report all cases of suspected child abuse. The Code of Professional Conduct of the American Dental Association expressed this as follows: "*Dentists shall be obliged to become familiar with the perioral signs of child abuse and to report suspected cases to the proper authorities consistent with state law*."[2]

In Belgium, the situation is different. Dentists are legally bound by professional confidentiality. Dentists who have knowledge of confidential information are not allowed to reveal this information to third parties, except in two cases where the breach is not punishable: firstly, legal obligation or subpoena by law and secondly, at the request of a parliamentary committee of inquiry. This may lead to an apparently contradictory situation: for instance, certain infectious diseases must be reported in the framework of national health statistics.[3] In Belgium there is no legal obligation to report a crime where a patient is either the victim or the perpetrator.

If a dentist suspects that a patient is the perpetrator of a crime then the legal system accepts that the dentist, in the community interest, should report the perpetrator to the police.[3]

When a minor is the victim of a crime it is also accepted in practice that the professional privacy codes may be violated. In this case the duty to assist a person in great danger has priority over confidentiality. The dentist may inform a provincial trust centre, which specialises in sheltering children who are the victims of child abuse.[1] In these cases, the trust centre in turn may alert the Office of the Public Prosecutor.

Detection of child maltreatment

Maltreatment of children includes physical, sexual or emotional abuse as well as child neglect. Physical abuse can best be defined as any non-accidental injury or trauma to the body of a child inflicted by a parent, guardian or sibling. It can either be the result of an occasional trauma or of a continuous behaviour pattern. Examples can include whipping, biting, burning, scalding and severe shaking.

Sexual abuse describes sexual activity with, or exploitation of, a minor. According to a modification of Belgian penal law of 1989, the legal definition of 'rape' is '*any act of sexual penetration, in any form or by any means, perpetrated on a person who does not consent to it.*' [Article 375-376 Belgian Penal Code (Law regarding penal protection of minors) modified by the Act of November 28th 2000 and published in Belgisch Staatsblad March 17th, 2001]. Examples can include intercourse (anal, vaginal or oral), incest, touching a child in the genital area, buttocks or breast area for a sexual purpose, inviting a child to touch for a sexual purpose or the use of a child for pornography or prostitution.

Emotional abuse is a pattern of behaviour consisting of unreasonable demands, constant belittling or criticising, and withholding of love, affection and guidance, so that it retards the development and self-esteem of the child.

Child neglect embraces a variety of failures to provide the basic needs of the child: to let it endure pain and suffering, to withhold the child the proper education, or basic medical or dental care. Neglect can be physical, educational or emotional. A severe form of maltreatment in infants is called "failure to thrive". This condition is identifiable by marked retardation or cessation of growth during the first 3 years of their life.

It is obvious that all cases of child abuse should be detected as soon as possible. Abuse of any kind disturbs the normal development of the child, and destroys its *'basic trust':* often, abused children develop a post-traumatic stress syndrome.[4]

Four diagnostic criteria help to identify this syndrome:
1. The child had lived through an experience that does not belong to the pattern of usual human experience.
2. The child relives the traumatic experience, e.g. hears anew certain sounds, or recognises the odour of the perpetrator.
3. Persistent avoidance of any stimulus that refers to the trauma, general dulling of the child's reactivity, or a diminished involvement in the outside world.
4. An increased level of irritability, e.g. sleep disorders, acute concentration troubles, partial amnesia, and distorted memories.

According to a study covering a five-year period, Becker et al.[5] found head and/or facial trauma in 65% of 260 documented cases of child abuse. These regions are often the easiest targets of abuse. The younger the children are, the more likely they are to be the victims of abuse (boys are abused more than girls by a ratio of 6 to 4).[6] Other risk factors leading to abuse are: premature birth, children with a social, physical, mental, emotional or intellectual handicap.[7] The parents also may have characteristics which increase the likelihood of abuse of the child, for example, parents who have been beaten or molested themselves, parents with a low self-esteem, parents who suffer a great deal of stress. Culture and religion may also play a role.

Dental health professionals have to be alert to a variety of physical and behavioural indicators to identify child abuse. Firstly they need to be made aware of the existence of child abuse, and of the fact that it may happen to one of their patients. The indicators that may be noticeable to the dental profession include trauma to the teeth and injuries to the mouth, lips, tongue or cheeks that are not consistent with an accident.[8] Adult bite marks may also indicate abuse. Lesions, irritation, swelling or bruising around the mouth, bruising of the hard palate, palatal petechiae, frequent sore throat, acid breakdown of enamel (sperm kept in the mouth over extended periods of time can result in cervical enamel erosion and buccal decay) and poor oral hygiene can indicate sexual abuse.[8] Behavioural indicators visible at the dentist's consultation can include fear of being touched around the mouth area. Neglect can be noticed by unattended tooth decay, gum disease and poor overall oral hygiene.[8] Table 1 gives an overview of head and face injuries for which the dentist should be alert.[9]

Table 1: *Overview of possible head and race injuries from Senn et al., 2001*

The Head	
Skull injuries	
Bald spots (pulling of the hair)	
Bruises behind ears (battle's sign)	
The Face	
Eyes	Retinal haemorrhage
	Blackened eyes (raccoon eyes)
Nose	Fractures
	Displacement
Lips	Bruises
	Lacerations
	Angular abrasions (gag marks)
Intraoral	Frenum tears (forced spoons)
	Palatal bruising (forced fellatio)
	Residual tooth roots
Maxilla/mandible	
	Fractures or improperly healed fractures
	Malocclusion from previous fractures
Teeth	Fractured, mobile, avulsed, or discoloured teeth in the absence of reasonable explanations
	Untreated rampant caries
	Untreated infections or bleedings

*Burns, patterned injuries caused by an object, such as a belt, and adult bite marks can be added to this list.

Whenever suspicions of child abuse arise, a routine protocol should be followed which includes questions about patient history and how the accident occurred, and all relevant information should be documented with radiographs, photographs and impressions when necessary.[8]

Reported cases in Belgium

In Flanders, the Dutch-speaking region of Belgium, which constitutes the Northern part of the country, for the years 2001 and 2002, 7112 and 8252 actual cases of maltreatment, neglect or abuse of minors were reported. However, this picture is incomplete since the various authorities that register the occurrences fail to centralise their data.

Table 2: *Number of cases of child maltreatment reported in Belgium [10-11]*

	2001		2002	
	Flanders	**Wallonia**	**Flanders**	**Wallonia**
Number of reports	5151	3417	6037	3434
Number of involved children	7112	n.a.	8252	n.a.

Table 3: *Breakdown of reported occurrences by category[10-11]*

	2001				2002			
	Flanders		**Wallonia**		**Flanders**		**Wallonia**	
		%		%		%		%
Physical abuse and neglect	1987	27.9	563	16.4	2424	29.4	570	16.6
Sexual abuse	1764	24.8	1195	35.0	1899	23.0	1059	38.8
Emotional abuse and neglect	1298	17.3	145	4.2	1458	17.7	253	7.4
Risk situation abuse and neglect	1142	16.1	856	25.0	1283	15.5	825	24.0
Other problem cases	991	13.9	658	19.4	1188	14.4	727	21.2
Total	7112	100.0	3417	100.0	8285	100.0	3434	100.0

Table 4: *Age distribution of the children (in %)*[10-11]

Years	2001		2002	
	Flanders	Wallonia	Flanders	Wallonia
Unborn	0.1	1.4	0.2	0.0
0 – 3	13.3	13.7	14.5	14.9
3 – 6	19.5	18.9	19.5	21.4
6 – 9	19.6	19.5	18.6	20.3
9 – 12	17.7	17.8	17.0	17.2
12 – 15	15.4	18.4	15.9	15.0
15 – 18	14.3	10.3	13.8	9.5
Unknown	0.2	0.0	0.5	1.7
	100.0	100.0	100.0	100.0

Table 5: *Reporting instances, by category (in %)*[10-11]

	2001		2002	
	Flanders	Wallonia	Flanders	Wallonia
Child's immediate environment	45.4	47.0	47.1	49.8
Professional reporting (*)	51.8	51.2	50.1	48.6
Others	2.8	1.8	2.8	1.6
	100.0	100.0	100.0	100.0

(*) Such as: care providers, justicial authorities, school and pre-school, social workers

Data could also be obtained for Wallonia, the Southern or French-speaking part of Belgium. Cases increased from 3417 in 2001 to 3434 in 2002, with the caveat that the number of reporting centres increased from 13 in the year 2001 to 14 in 2002. Although it is doubtful that a significant comparison can be made, we present the aggregate data nonetheless. (Table 2)

There appears to be a considerable increase in the number of reported cases especially in Flanders. It is possible that this reflects not so much an actual increase as a heightened awareness about child maltreatment, as well as an improvement in the collection mechanisms of statistical data. The Belgian Government has certainly contributed to this through a publicity campaign promoting the role of 'trust centres'.

Table 3 presents a breakdown of child abuse cases in their various forms. There appears to be a significant and persistent difference in the risk profile for both regions. This may be due either to a different interpretation of the statistical categories used, or to significant cultural differences. Either way, the fact that differences of this magnitude exist should warrant a thorough analysis.

The age distribution of the children reported in the previous tables is shown in Table 4. It is clear that the majority of reports concern children between the ages of 3 and 9. This is true in both Wallonia and Flanders. But it is also clear that child maltreatment occurs in all categories, so that no age class should be neglected.

Table 5 presents a breakdown of the reporting instances by category. From this table we conclude that the proportion of reports has slightly changed in both Flanders and Wallonia and that there is a marked increase of reports from the child's immediate environment. Therefore the importance of care providers from the health or social sectors is striking. It is clear that a major responsibility may be reserved for dentists, in that they should accurately report such cases to a trust centre.

Belgium still has a long way to go as far as collecting and analysing statistical data is concerned: the data collected by both the Flemish and Walloon regions are not mutually comparable, and thus are of little use to support a national policy to combat child abuse. No breakdown is available concerning the occurrences of physical injuries to the head and neck areas, which should be of particular interest to dentists.

CONCLUSION

Globally we should not deny that child abuse and neglect occur in our society, and as dentists we are in a position to detect the signs of abuse. It is important, however, to follow the right procedures, and to handle the eventual evidence in a responsible and thoughtful manner. This will be dictated by the legal obligations in each particular country.

Belgian Penal Law (art. 458 bis) allows dentists to bypass professional confidentiality and to report to the Office of the Public Prosecutor. Nevertheless, it is preferable at first to turn to a trust centre or to a health assistance organisation. In this way, confidentiality will in effect not be violated but shared.

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