Skin Over Blood Over Bones: Failure to Thrive

Susan S. Kreston[1]

Introduction. Failure to thrive is a general term that refers to children whose growth deviates significantly below the norms for their age and sex. The causes of failure to thrive (FTT) are organic and non-organic. Organic causes are medical in nature, such as cleft palate, and make it difficult or impossible for the child to eat.[2] Non-organic causes result from maltreatment, encompassing both intentional withholding of food from the child and negligent failure to ensure that the child has enough calories to sustain a healthy body. Criminal negligence may ensue if the caretaker is competent but nevertheless fails to obtain medical assistance for a child with organically induced FTT. Malnutrition is common to both types of FTT and all children who suffer from it should be, at a minimum, protected under civil child protection actions. Criminal prosecution should ensue if the child was intentionally malnourished or if the caretaker failed to correct an organic condition. This article primarily addresses the prosecution of caretakers intentionally inducing failure to thrive.

Failure to Thrive. FTT lays waste to the child by systematically robbing the body of the caloric and nutritional intake necessary to maintain normal growth and sustain life. When the body is denied sufficient nutrition, it will first deplete its fat stores. When the fat has been exhausted, the body will live off its muscle tissue. In the final stages, the biochemistry of the body becomes seriously deranged and eventually death will ensue. Even if they survive, FTT victims are at high risk for severe intellectual and developmental impairment. Victims in the final stages of FTT may be brought to the hospital in cardio-respiratory arrest. In some cases, the victim's weight at death is less than it was at birth. The child's body may be literally skin over blood over bones.

Non-organic FTT deaths can be mislabeled with a medical cause when chronic abuse or neglect has impaired the child's immune system and lowered the child's resistance to infection(s), such as pneumonia, resulting in the child's death. As noted by some experts, "[t]hese cases are properly labeled homicides, based on the probability that the child would not have contracted an infection and died had he or she not been abused."[3]

A child suffering from FTT is often a "targeted child," i.e., a child who is singled out for treatment both different from and below the standard of care exercised toward other children in the house. A child may be targeted for many reasons, including gender, age, stage of development, special needs or personality traits. In houses where only one biological parent is present, the absence of the child's other biological parent may also single the child out for abuse.

Crime Scene Management and Investigation.[4] When first responders approach the house of a child who is suspected to have suffered FTT, several

questions can guide the investigation: Is there age-appropriate food? Are there bottles, cans of formula, and mixing instructions? How fresh is the food, and is there any evidence of recent food purchases? Is there evidence that other children present in the house are well-fed? If there is a pet in the house, does the pet have food?

Look for pictures, current and past, of all the children present in the house. Pictures of the FTT child at the time he or she presents at the hospital are also a must. Past pictures may be used to contrast the target child's current appearance. If all other children have pictures but the FTT child does not, this information at trial will assist the prosecutor by showing the child was, in many ways, already gone in the eyes of the caretaker.

The victim's general living situation should also be investigated. What are the child's sleeping arrangements? Does the child have toys and clothes? If parenting books are present, this should also be noted. Additionally, note the overall condition of the house, including the presence or absence of diapers and dirty laundry.

Obtain medical information about the target child and any other relevant children, including any doctor appointments made, kept or missed, and any prescriptions written and whether they were filled. Possible preexisting medical conditions should be investigated through interviews with the child's doctor. Birth records, growth charts and old medical records should be reviewed, as well as any lab and/or autopsy reports. The estimated length of time the child has been deprived of food must also be assessed. Finally, financial information and insurance claims should be explored.

Suspect interviews should incorporate the following questions: What is the child's feeding history, especially within the last 24 hours? Where was the child fed, and by whom? What did the child eat, and what was the child's reaction to the food (e.g. vomiting, diarrhea, etc.)? When did the child start losing weight, and what was the suspect's reaction? A significant indicator of child physical abuse is a false history being given by the caretaker,[5] making the suspect interview a crucial component to successful handling of an FTT case.

When a case presenting as FTT hits the investigator's desk, the first thing to determine is whether there is an organic cause for the condition. If medical tests or history indicate there is or may be an organic cause, it obviously needs to be corrected before analyzing whether the suspect's ignorance of this condition and the ability to properly handle it was genuine or feigned. Factors to consider include: Was the caretaker legally competent? Did he or she understand the child needed medical attention? Was the child's condition obvious to a reasonable person? Has the caretaker attended parenting classes or successfully raised other children? Did the child have a history of good health

prior to the onset of FTT? Were there previous social service interventions or education concerning proper parenting skills? True ignorance may indicate a need for social services rather than criminal prosecution. Feigned or intentional ignorance should lead to prosecution.

Meeting Untrue Defenses. A whole host of untrue defenses may be raised in FTT cases. These include: (1) underlying medical condition; (2) poverty/lack of resources; (3) the child's refusal to eat; (4) congenital issues (everyone in the family is small); (5) recency of the condition; and (6) it wasn't the suspect's responsibility to feed the child. Each of these is addressed in turn.

Underlying medical condition may be met with a series of common sense steps. First, have the hospital perform any medical tests deemed reasonably necessary to rule out other medical conditions. Review the child's medical records once again at this stage. Simultaneously, have the child fed in a controlled environment and document the child's growth for 2-3 months. In FTT cases where the caretaker failed or refused to feed the child, simply hydrating and nourishing the child will lead to an increase in weight and overall health. Additionally, if the caretaker claims underlying medical condition, inquire what was done to address that condition. Did the caretaker seek medical advice or assistance? If so, what was said to the doctor or nurse? Was the child's "condition" discussed with anyone? Interviewing people with access to the child may also prove illuminating. Their statements to the caretaker may indicate that they noticed something was wrong with the child.

Poverty may be a genuine source of the child's FTT. This might be evidenced by the formula being mixed incorrectly, with too much water added to the powder to "extend" the amount of formula. Did the caretaker receive public assistance? How did the caretaker access resources for the child? Are free bus tickets or indigent transportation arrangements available? Did the caretaker ask a friend or call an ambulance to get to the hospital? These are obvious reactions to a child's illness. If poverty is truly the case, social services intervention may be the sole remedy needed and the case may not be appropriate for criminal prosecution. With an untrue defense of poverty, however, there may be evidence of money spent on non-necessities, such as alcohol, drugs, cigarettes or cable TV.

In the defense is that the child wouldn't eat, first determine that there was no medical reason for the child's behavior, such as a cleft palate. Barring this, and based on the age of the child, explore and be prepared to rebut untrue allegations of anorexia or bulimia. Interview the child and those involved in the child's life to assess the truth of these allegations of self-abuse. Finally, even if it is true that the child would not eat, what did the caretaker do about it? Did the caretaker take the child to a physician or counselor? Failure to reasonably respond to such a situation should give rise to criminal charges.

Should the defense claim that the child and all members of the family are "just small," initially have the physician adjust the standard growth chart for either premature birth or non-US born and raised children, if either of these factors is relevant. If not, the mere fact that a child is short does not explain wasting away. If the defense is that the child lost weight rapidly, a thorough medical workup should demonstrate whether the malnutrition is chronic (long-term) or acute (recent). It is very rare that emaciation occurs rapidly. This defense can also be countered by how quickly the child gained weight once food and water were administered. Finally, if the caretaker admits the child was emaciated, but claims that it wasn't his/her responsibility to feed the child, this defense may be refuted by the factual circumstances of the case. A duty of care analysis may also apply: even if someone else had primary responsibility for feeding the child, when that person abandoned the responsibility, it became that of the defendant.

Conclusion. Failure to thrive is a potentially lethal form of child abuse. Even in its less aggravated forms, FTT may leave a child permanently brain damaged or physically impaired. Only by understanding FTT cases, whether they stem from intentional abuse or from criminal failing to protect the child, can children targeted for this abuse be better protected.

---

[1] Deputy Director, APRI's National Center for Prosecution of Child Abuse. The author may be contacted at susan.kreston@ndaa-apri.org.

[2] *See generally* CHILD ABUSE: MEDICAL DIAGNOSIS AND MANAGEMENT, Reece & Ludwig, eds. (2d Edition, 2001).

[3] See Rob Parrish, *Death by Pneumonia is Murder? Child Homicide Without a "Fatal" Injury*, Update, Vol. 11, No. 6, 1998.

[4] The author wishes to acknowledge Dyanne C. Greer, Assistant United States Attorney, Phoenix, Arizona, for her contribution to this section of the article.

[5] *See e.g.,* John E.B. Myers, *Evidence in Child Abuse and Neglect Cases*, 3rd Ed. (1997), § 4.11; U.S. Department of Justice, Battered Child Syndrome: Investigating Physical Abuse and Homicide (1996); and C. Henry Kempe, et al., *The Battered Child Syndrome*, 181 JAMA 17 (1962).