

Violence against minors. Analysis of the phenomenon based on forensic medical examinations performed at the Department of Forensic Medicine in Poznan in 2015-2020

Przemoc wobec nieletnich. Analiza zjawiska na podstawie badań sądowo-lekarskich wykonanych w Zakładzie Medycyny Sądowej w Poznaniu w latach 2015-2020

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Abstract

Introduction. Forensic medical opinions are central to classifying offences against health. Examinations determine whether violence resulted in bodily harm; in many cases, the victims are minors.

Methods and results: We analyzed 670 incidents of violence against minors in the Wielkopolska region (2015–2020) using anonymized forensic examinations commissioned by the police or requested by victims/legal guardians. Minors were defined as individuals aged <18 years. Descriptive statistics (mean, median, SD, IQR, range) and chi-square/Fisher tests were used; significance was set at $p=0.05$. Victims and perpetrators were predominantly male. Bruises were the most common injury, and the head was the most frequently affected region. More than half of incidents occurred in public spaces.

Discussion: An estimated one billion children worldwide experience violence each year; the true burden is likely higher because of underreporting. Many incidents never reach law enforcement, limiting available data. Although numerous social and preventive programs aim to reduce violence against children, its persistence indicates a need for broader, more comprehensive prevention.

Conclusions: Violence against minors remains a major public health and social concern. Large-scale prevention programs are needed, and training for healthcare and educational professionals is crucial because they are often the first to recognize abuse and initiate appropriate intervention.

Keywords

violence; child abuse; forensic medicine

Introduction

Physical violence is a widespread social problem with multifactorial causes. Victims may face additional barriers, including inadequate legal protection, limited access to education, persistent stereotypes, and victim-blaming attitudes.

Forensic Medical Examination

A forensic medical opinion is a key element in classifying offences against health [1]. Under applicable regulations, a forensic medical examination provides the basis for issuing such an opinion [2]. The examination includes assessment of the injuries and their anatomical location [2]. Based on the findings, the expert prepares a medico-legal report that addresses the severity of injuries and any questions posed by the investigating authority [2,3]. The examination and opinion are documented in a protocol submitted to the competent authority. Proper preparation requires an impartial expert with knowledge of injury mechanisms and relevant legal provisions and their application [4]. Particular attention is needed when assessing possible long-term consequences, including effects that extend beyond measurable biological harm [5].

Legal Aspects

Violence is a multifaceted phenomenon that can be examined from social, psychological, and legal perspectives. Domestic violence is a distinct category. Violence may take many forms, including bodily harm, a broad medico-legal concept encompassing impairment of organs and a range of health disorders. Polish law distinguishes three levels of injury severity: severe, moderate, and minor, each constituting a separate offence.

In its basic form, severe bodily injury is regulated in Article 156 §1 of the Criminal Code. The provision specifies two categories of conduct: (1) deprivation of sight, hearing, speech, or reproductive capacity, and (2) causing other forms of severe disability; an incurable or long-term illness; a life-threatening condition; permanent mental illness; significant incapacity for professional activity; or permanent and significant disfigurement. As of March 2025, female genital mutilation has been explicitly included in this category, a circumstance that previously had not been addressed in forensic medical assessments.

Injuries other than those described in Article 156 of the Criminal Code are divided into two groups based on the duration of impairment. Impairment of bodily function or a health disorder lasting up to 7 days is classified as minor bodily injury (Article 157 §2), whereas impairment lasting more than 7 days is classified as moderate bodily injury (Article 157 §1). Both may be committed intentionally or unintentionally.

Legal frameworks and cooperation between forensic physicians and law enforcement vary by country. Nevertheless, some standards are shared across European Union Member States and derive from international instruments and EU

strategies. One widely recognized legal instrument in Europe is the Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention, 2011) [6].

Materials and methods

We analyzed 670 incidents of violence against minors (2015–2023) in the area covered by the Provincial Police Headquarters in Poznań. The study was based on anonymized reports from forensic examinations performed at the Department of Forensic Medicine in Poznań, commissioned by the police (89.7%) or requested privately by the victim or legal guardian (10.3%).

We summarized cases by injury type and location, mechanism of injury, perpetrator–victim relationship, perpetrator sex, and other variables; results are presented as percentages.

Descriptive statistics included the mean, median, standard deviation (SD), interquartile range (IQR), and range. Associations between categorical variables were tested using the chi-square test or Fisher's exact test, as appropriate.

The significance level was set at $p=0.05$; results meeting $p<0.01$ and $p<0.001$ thresholds are also indicated. Statistically significant p -values are shown in bold; values $p<0.0001$ are reported as $p<0.001$.

All calculations and graphs were made using the statistical package R v. 4.0.2.

Results

Among the 670 victims, 29.70% were female and 70.30% were male. Most perpetrators were male (76.14%); females accounted for 13.52%, and in 10.34% of cases the perpetrator's sex was unknown.

Victim age ranged from 0 to 17 years; the mean age was 12 years and the median was 14 years. (Figure 1)

Most incidents occurred in public places (58.80%). Violence at home was reported in 28.20% of cases, and at the place of education in 13.00%.

The most common injuries occurred in the head and neck area (39.3%). (Table 1)

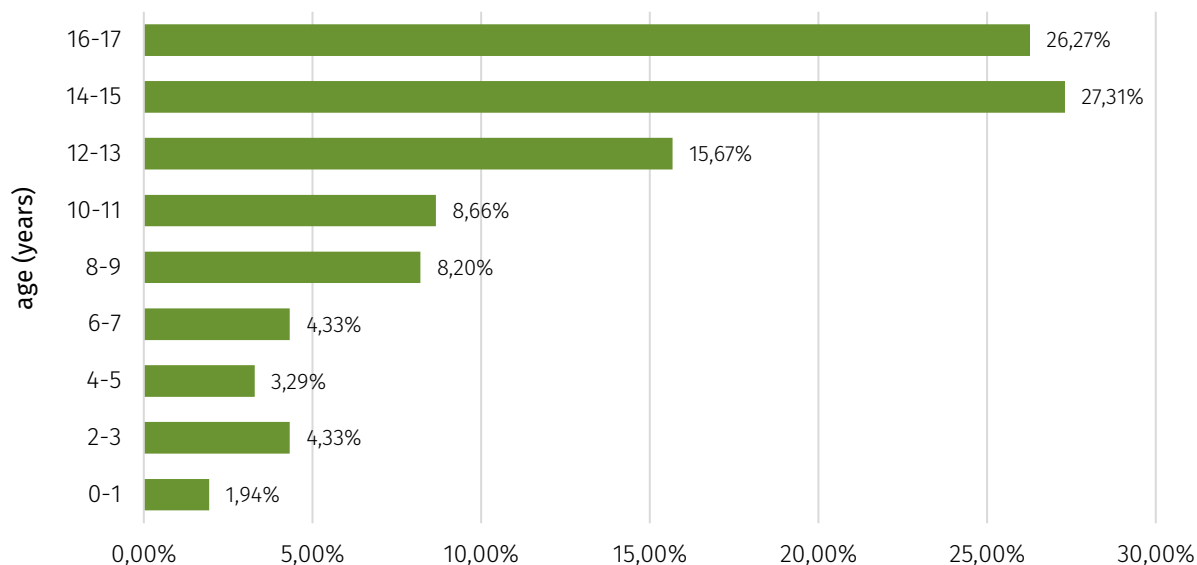


Fig. 1. Victim age distribution

Tab. I. Location of injury

Variable	Parameter	Total (N=1090)
	Head and neck	39.3% (N=385)
	Shoulder (up to elbow + shoulder girdle)	13.9% (N=136)
	Forearm (and hand)	13.4% (N=131)
	Lower leg (and foot)	10.6% (N=104)
	Thigh (knee + hip)	9.6% (N=94)
	Back, buttocks	5.1% (N=50)
	Thorax	4% (N=39)
	Torso	4% (N=39)
	Sexual organs	0.1% (N=1)

The most common injuries were bruises/contusions (47.3%) and superficial abrasions, erythema, and discoloration/hyperpigmentation (30.2%) (Table 2). In this dataset, “discoloration” refers to permanent skin discoloration after cosmetic procedures; although it is not an injury in the medico-legal sense, such cases were referred for forensic examination and were therefore included in the analysis. The number of injury categories exceeds the number of victims because a single victim could sustain multiple injury types.

Tab. II. Damage type

Variable	Parameter	Total (n=857)
Injury Type	Bruise, contusion	47.2% (N=405)
	Abrasion of the surface, erythema, discoloration	30.2% (N=259)
	A bruising wound	6% (N=51)
	Bone fracture	5.4% (N=46)
	Dental injuries	4.7% (N=41)
	Iatrogenic injuries	1.3% (N=11)
	Concussion	1.3% (N=11)
	Incised wound	0.9% (N=8)
	Sprain, joint sprain	0.8% (N=7)
	Hair loss	0.5% (N=4)
	Thermal burn	0.4% (N=3)
	Laceration	0.4% (N=3)
	Amputation	0.4% (N=3)
	Chemical burn	0.2% (N=2)
	Gunshot wound	0.2% (N=2)
	Internal damage	0.1% (N=1)

The highest number of examinations was recorded in 2019 (N=143) and the lowest in 2015 (N=67). From 2016 to 2019, the annual number of examinations remained relatively stable (Figure 2).

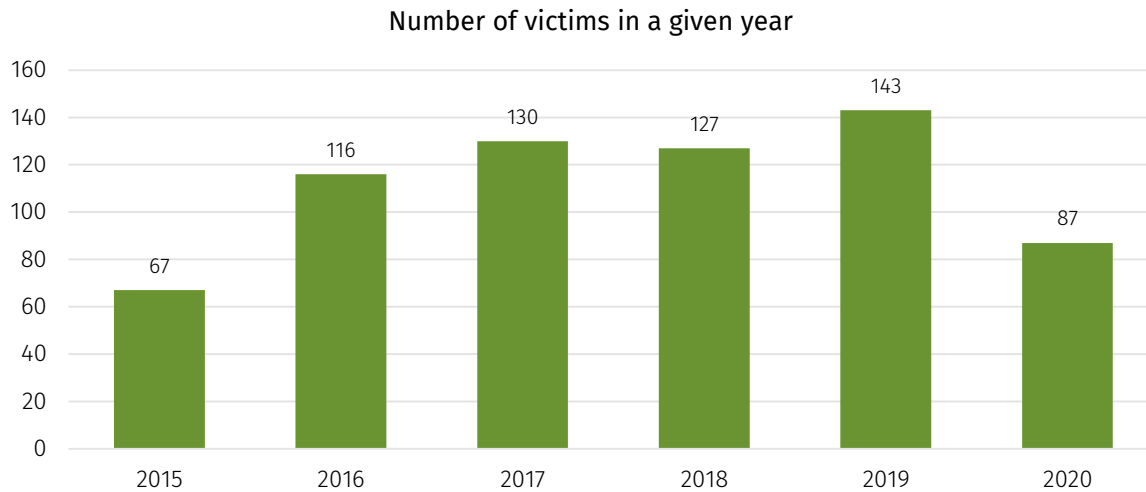


Fig. 2. The number of victims in a given year

The most common mechanisms were punches with a fist (26.3%) and forceful tugging, pushing, hair pulling, twisting, and strong gripping (23.3%). The number of mechanisms exceeds the number of victims because multiple mechanisms could be reported for a single case (Table 3).

Tab. III. The method of dealing damage

Variable	Parameter	Total (n=1105)
	Fist	26.4% (N=291)
	Tugging, pushing, hair pulling, twisting, strong gripping	23.3% (N=258)
	Kicking	15.2% (N=168)
	Open palm	7.9% (N=87)
	Hard, blunt-edged	6.2% (N=69)
	Strangling	4.9% (N=54)
	Unknown mechanism	4.5% (N=50)
	Sexual violence	1.7% (N=19)
	Biting	1.6% (N=18)
	Irritants (e.g., pepper spray)	1.2% (N=13)
	Being hit, dragged behind a car	1.1% (N=12)
	Thermal damage	0.7% (N=8)
	Headbutt	0.7% (N=8)
	Elbow or shoulder blow	0.6% (N=7)
	Leather belt, cable, rope	0.6% (N=7)
	Falling from a height	0.6% (N=7)
	Sharp-edged (e.g., knife, axe)	0.5% (N=6)

Variable	Parameter	Total (n=1105)
	Screwing into the mechanism (e.g., escalators, machines)	0.5% (N=5)
	Playing sports	0.4% (N=4)
	Communication event	0.4% (N=4)
	Stun gun, electric shock damage	0.4% (N=4)
	Firearms	0.2% (N=2)
	Contact with infectious material (e.g., blood, saliva)	0.4% (N=4)

Based on the examinations, 9.55% of victims had injuries consistent with Article 157 §1 of the Criminal Code (bodily harm lasting >7 days). Polish law also recognizes exposure to harm to health, which may include both moderate and severe harm. Most examined victims (80.9%) were not classified as exposed to harm under Article 157 §1 or Articles 156/160 of the Criminal Code (Table 4).

Tab. IV. Legal classification (Legal definition of severe bodily harm (Articles 156 and 160 of the Criminal Code) includes, among others, loss of sight, hearing, speech, reproductive capacity, or other severe disability; a serious incurable illness or an illness that is truly life-threatening; permanent or significant incapacity to work in one's profession; and permanent, considerable disfigurement or deformation of the body)

Parameter	Bodily harm lasting more than 7 days (Article 157 of the Criminal Code)			Exposure to moderate (Article 157 §1) and severe (Articles 156/160) harm to health			
	Yes	No	Not specified	Article 157 §1 of the Criminal Code	Articles 156/160 of the Criminal Code	No	Not specified
N	64	600	6	43	81	542	4
%	9.55%	89.55%	0.90%	6.42%	12.08%	80.90%	0.60%

More than half of victims sought help at a hospital emergency department (55.1%); however, most did not require hospitalization (90.7%). Hospitalization was defined as admission to a hospital ward for observation or treatment, including surgery. In most cases, the perpetrator was known to the victim, but the specific relationship was not recorded in the forensic documentation (41.8%). This category may include family members. In 34.8% of incidents, the perpetrator was unknown to the victim, and in 13.4% the perpetrator was a parent (Table 5).

Tab. V. Relationship to the perpetrator

Variable	Parameter	Total (n=686)
	Known (relationship not specified)	41.8% (N=287)
	Unknown	34.8% (N=239)
Relationship with the perpetrator	Parent	13.4% (N=92)
	Parent's partner	3.2% (N=22)
	Animal	1.7% (N=12)
	Partner	1.4% (N=9)
	Other close family	1.4% (N=9)
	Extended family	1.2% (N=8)
	Police officer, municipal guard, or security staff	0.4% (N=3)
	Accident at the educational institution or workplace	0.3% (N=2)
	Ex-partner	0.3% (N=2)
	Healthcare professionals	0.1% (N=1)

We observed an association between perpetrator category and incident location. "Relatives" included a parent, parent's partner, the victim's partner or ex-partner, or other close family members. For minors, "workplace" referred to the educational institution attended (school, kindergarten, or crèche). Other perpetrators included animals, healthcare professionals, and self-harm.

Overall, 88.8% of incidents perpetrated by relatives occurred at the victim's residence. When the perpetrator was unknown, violence most often occurred in public places (87.4%). In cases where the perpetrator was known but unspecified, incidents occurred mainly in public places (58.5%) or at the victim's educational institution (24.7%) (Figure 3).

In 21.2% of acts of violence committed against a minor, the perpetrator was also a minor.

Discussion

Forensic examinations of minors conducted at the Department of Forensic Medicine in Poznań (2015–2020) highlight the public health and legal significance of child maltreatment. Injury documentation, analysis of injury mechanisms, and assessment of consistency with the reported circumstances support judicial proceedings and child-protection measures. This approach helps identify patterns of violence and risk of recurrence, linking clinical findings with criminal justice and safeguarding procedures.

Polish data

In Poland, official statistics on violence rely largely on the "Blue Card" procedure, introduced in 1998 to identify and monitor families affected by domestic violence. The police most often initiate the procedure, but teachers, healthcare workers, and social services are also authorized to do so [1]. In 2022, 61,645 "Blue Card – A" forms were completed (52,569 new cases and 9,076 follow-ups), covering 71,631 suspected victims, including 10,982 minors. In 2021, social services removed 1,335 children from families because of direct threats to life or health [2]. In our study, 670 minors underwent forensic examination between 2015 and 2020, far fewer than the annual number of Blue Cards involving minors. In many regions of Poland, examinations of injured persons (including minors) are rarely performed by forensic specialists because of staff shortages, which may hinder injury classification, assessment of the injury mechanism, and, consequently, legal proceedings.

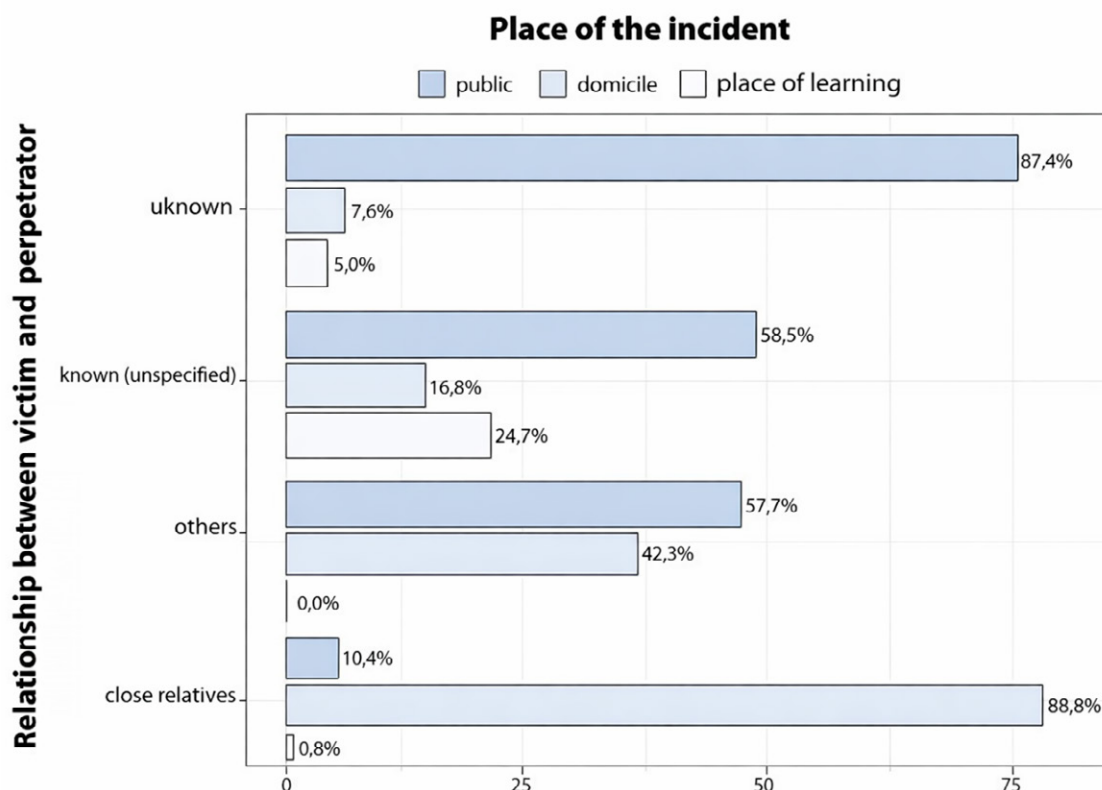


Fig. 3. Incident location by perpetrator category (relative, unknown, or known—relationship not specified)

However, these statistics do not fully reflect the scale of the problem [3]. Studies using broader definitions of violence report substantially higher prevalence. The Empowering Children Foundation's nationwide survey (2013) found that 71% of adolescents aged 11–17 had experienced at least one form of violence, most commonly peer violence (59%); 34% reported violence by adults. In forensic examination reports, perpetrator–victim relationships are difficult to assess because the perpetrator is often not identified at the time of examination. In a related study from the same region and period, 142 cases involved minor perpetrators; 129 were classified as peer violence [7]. Compared with our findings, this suggests that peer violence may be underreported in the study area, whereas reports more often involve adult-perpetrated violence against children.

In the same survey, 27% of respondents reported vandalism, robbery, or assault; 9% reported non-contact sexual abuse and 6% contact sexual abuse. Neglect was reported by 6%, and 18% had witnessed violence [4]. Reporting remains low; cases often come to light only after severe injury or prolonged abuse. Child-to-parent violence is considered particularly underreported and socially sensitive, and peer violence is often minimized by caregivers unless it results in visible injuries [1–4].

Comparable survey-based studies are scarce in Poland. In our cohort, adolescents aged 14–17 years were the most frequently examined. Both victims and perpetrators were predominantly male, and incidents most often occurred in public places.

National statistics are often based on the number of “Blue Card” procedures initiated. In 2022, nearly 11,000 procedures involved children, whereas only 670 minors underwent forensic examination in our department during 2015–2020 (approximately 6% of the 2022 figure alone). Some additional cases may have been assessed from case files without in-person examination or during on-call duties outside the unit, but the gap remains substantial. Importantly, the Blue Card procedure can be initiated on suspicion of violence even without injury; therefore, a forensic examination is not always performed. In the authors' view, particularly outside major urban centers where forensic specialists are scarce, clinical forensic examinations are still too infrequent. Injury descriptions and legal qualification are often prepared by physicians without forensic training (e.g., primary care doctors, surgeons, pediatricians), which likely contributes to underuse of specialist forensic services.

An increase in examinations was observed from 2016 onward. This may reflect growing public awareness and evolving European policy initiatives (e.g., the Council of Europe Strategy on the Rights of the Child 2016–2021), as well as local prevention programs (e.g., “Safe School” 2014–2016) [5]. Notably, national Blue Card statistics for minors decreased from 2015 (17,392) to 2016 (14,223) and continued to decline thereafter [2], which does not mirror the increase in local forensic reporting after 2015. This discrepancy may suggest improved recognition and reporting of incidents occurring outside the home (including by teachers and healthcare staff).

The decline in 2020 likely reflects the COVID-19 pandemic and temporary limitations in service availability. In our material, no incidents at the place of education were recorded in 2020, consistent with school closures during the pandemic.

Causes of violence against minors

Violence against minors is influenced by complex social, psychological, and economic factors. Parental substance use, financial instability, and limited social support increase the risk of child maltreatment [8]. Intergenerational transmission is also important: caregivers who experienced violence in childhood are more likely to repeat such behaviors [9]. Caregiver mental health problems, particularly depression and emotion dysregulation, are associated with higher rates of violence toward children [10]. These findings underscore the need for preventive strategies and targeted interventions for vulnerable families.

Mental health of minor victims

Children who experience maltreatment are at increased risk of psychiatric disorders. Victims of emotional, physical, or sexual abuse are more likely to develop depression, anxiety, post-traumatic stress disorder (PTSD), and attention-related difficulties [11]. A systematic review found high rates of major depression, anxiety disorders, and PTSD among maltreated children [12], and other studies report long-term psychiatric risks persisting into adolescence and adulthood [13,14]. These sequelae highlight the importance of early assessment and trauma-informed interventions for minors identified during forensic examinations.

Physical health of minor victims

In our study, fewer than 10% of minors sustained injuries that, under Polish law, constituted bodily harm lasting more than 7 days. Most injuries had a short-term impact on physical health: 47.2% were bruises/contusions and 30.2% abrasions/erythema/discoloration. Violence against minors has both immediate and long-term health consequences. Early-life maltreatment is associated with asthma, infections, somatic complaints, sleep disruption, and abnormal weight trajectories [15]. Childhood violence is also linked to chronic conditions in adulthood, including hypertension, diabetes, obesity, and cardiovascular disease, often with higher healthcare use and

costs [16]. This underscores the importance of thorough medical evaluation and long-term follow-up of minor victims.

Worldwide

Globally, violence affects over one billion children annually. According to UNICEF (2017), approximately 300 million children aged 2–4 experience psychological or physical abuse at home. Studies from multiple countries indicate that nearly 10% of infants under 12 months are beaten on the head or neck, while one in four children in this age group face physical punishment. Around 176 million children under five live with mothers who themselves are victims of intimate partner violence [17]. Data from the United States similarly show that one in four children is exposed to domestic violence [18].

Despite bans in more than 125 countries, corporal punishment in schools persists. A 2015 study in India, Peru, Vietnam, and Ethiopia showed that over 50% of eight-year-olds in Peru and Vietnam, 75% in Ethiopia, and up to 90% in India experienced corporal punishment within the week preceding the study [18]. Younger children were disproportionately affected, being more than twice as likely to face punishment compared with adolescents [19]. In addition, peer violence is widespread. WHO reports that one in three students aged 11–13 has experienced bullying, and one in three aged 13–15 has been involved in physical fights. Sexual violence also remains prevalent: around 15 million adolescent girls aged 15–19 have been forced into sexual intercourse or other abuse, with perpetrators most often known to the victim [17]. Reports from six countries confirm that adolescent boys are most often abused by acquaintances, friends, or partners.

Differences in legal obligations and procedures for reporting violence against minors should be considered. In many countries, certain professionals are required to report suspected child abuse. In Poland, the Criminal Code imposes a duty to report specific offences, and failure to report may be punishable in certain circumstances. Healthcare workers, social workers, teachers, and some other professional groups must report suspected offences identified in the course of their duties. Similar rules exist in other European countries (e.g., Italy, Croatia, and the United Kingdom) [20]. Documentation practices also vary. For example, Finland uses the PAKE Abuse and Body Map form (PAKE) [21], whereas in Poland such standardized tools are uncommon. In Germany, as in Poland, medical documentation is not differentiated by the alleged cause of injury [21].

A persistent problem in Poland and across Europe is insufficient training of healthcare staff in the description of injuries and forensic photography, particularly when examinations are performed by non-forensic physicians, which is common [6,22,23]. Victims often consult family doctors or emergency departments before seeing a forensic specialist; when possible, injuries should be documented at first contact, as this

may be crucial for subsequent legal steps. German data suggest that up to half of examinations performed by non-forensic physicians do not include a full-body assessment [22]. Because forensic evaluation is not the primary focus of most clinicians' work (including pediatricians), difficulties may arise when assessing whether injuries are consistent with violence [23]. Clinical forensic medicine should therefore be incorporated into medical training, warning signs should be emphasized, and examination procedures should be standardized for both victims and perpetrators [24].

Comparison with adults

Between 2015 and 2020, 7,689 incidents of domestic violence were documented in the Wielkopolska region; 670 involved minors examined at the Department of Forensic Medicine in Poznań. In both minors and adults, males predominated among victims (70.2% and 59.5%, respectively). The mean age was 12.44 years in minors and 36.73 years in adults. Bruising was the most common injury in both groups (47.3% vs. 45.1%), followed by hyperpigmentation (30.2% vs. 29.4%). Injuries were most often localized to the head and neck (39.3% vs. 30.6%), and punching was the most frequent mechanism (26.3% vs. 26.9%) [25].

In both groups, most victims were not classified under Article 157 §1 or Articles 156/160 of the Criminal Code, whereas a smaller proportion met criteria under these provisions. Most perpetrators were male and were often unknown to the victim (32% in minors; 40% in adults), although many were acquaintances (41.8% in minors; 34.8% in adults). In 2020, pandemic restrictions led to a marked decline in forensic examinations, partly because of temporary closure of the department and fear of SARS-CoV-2 exposure [25].

National and regional programs

Efforts to address domestic violence in Poland include national and regional programs and NGO initiatives. The first National Program for the Prevention of Domestic Violence was introduced in 2005 and later revised. Measures include public campaigns; training for healthcare, education, police, and judicial staff; establishment of support centers; monitoring systems; and legal reforms. A dedicated hotline for victims, operated by the "Blue Line" within the Polish Psychological Association, provides psychological and legal support [26–28].

Non-governmental organizations play a key role. The Empowering Children Foundation (formerly the Nobody's Children Foundation) provides psychological, legal, social, and medical support; runs educational campaigns; operates helplines for children and parents; and manages Children's Advocacy Centers [29,30]. Other associations address the links between domestic violence and substance use by offering therapy, training, and family support [31].

In Wielkopolska, regional initiatives include the Wielkopolska Program for Counteracting Domestic Violence, which focuses on prevention, monitoring, and victim support, and the "Safe School" initiative led by the Provincial Police Headquarters in Poznań [32–34]. The Poznań Centre for Social Prevention provides crisis intervention, information, referrals, and long-term support services [35].

Conclusions

Despite extensive programs, violence against children remains a major social problem in Poland and worldwide. Official statistics underestimate its prevalence because of underreporting, and the COVID-19 pandemic further limited victims' ability to seek help. In Poland, reliable data on the number of minors affected by violence are still lacking. In addition, relatively few forensic medical examinations are ordered, and documentation is sometimes prepared by clinicians without forensic training. Addressing this problem requires both accountability for perpetrators and systematic psychological and social support for victims. Peer violence, which is often overlooked, warrants targeted school-based interventions (e.g., conflict resolution and anti-bullying strategies). Healthcare and educational professionals, often the first to encounter victims, should be trained to recognize warning signs and respond appropriately.

Further research on violence against minors is needed, along with greater awareness among law enforcement of the role of forensic physicians in case assessment. Training of healthcare and educational professionals in recognizing and reporting suspected crimes against minors should also be strengthened.

Author Contributions:

Aleksandra Bielecka – Study conception and design; coordination of the research project; manuscript drafting.

Bartosz Burchardt – Data collection from forensic medical records; preparation of datasets; initial analysis.

Julia Linke – Statistical analysis; interpretation of results; preparation of tables and figures.

Klaudia Dolińska-Kaczmarek – Critical revision of forensic and medical aspects; interpretation of injury classification.

Karolina Nitschke – Literature review; drafting of discussion and contextualization of findings.

Szymon Rzepczyk – Statistical analysis; drafting of the discussion and contextualization of findings.

Czesław Żaba – Critical revision for important intellectual content; final approval of the manuscript; overall supervision.

All authors confirm that they have read and approved the final version of the manuscript and agree to its submission to the journal.

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