

MEDICAL PRACTICE

Contemporary Themes

Non-accidental Injury in Children

Introductory Comment from B.P.A. and B.A.P.S.

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In 1966 the British Paediatric Association published a report from its standing committee on accidents in childhood on "The Battered Baby."^{*} At that time the attention of paediatricians, neurosurgeons, orthopaedic surgeons, and accident and casualty officers was being drawn to the possibility that among the many babies and children with obvious trauma might be a few injured deliberately by one or both parents or by some other person responsible for their care. The clinical observations that should arouse suspicion were described and advice was given about appropriate action when such injury was suspected, advice which still stands. At this time the medical profession was reluctant to accept that a considerable number of injuries arose in this way.

Since 1966 much has been talked and written on the subject. Not only babies but older children may suffer and the physical injury is only part of a picture that includes deprivation as well as abuse. The diagnostic label has evolved from "battered baby" through "child abuse" to "non-accidental injury in children." Epidemiological studies of accidents have begun to reveal patterns which suggest that recognizable aetiological factors are present in accidents of all kinds; poisoning, falls, traffic accidents, burns, and scalds and non-accidental injury. While the standards of diagnosis and treatment for accidents in general are improving with the increase in properly organized accident and emergency departments and with firmer links between these and departments of paediatrics, this is not yet true for non-accidental injury.

Studies are also in progress about violence and intra-familial aggression, and about the results of deprivation and ineffective mothering upon the development of the child. Paediatricians have come to recognize increasingly the harm done by emotional deprivation to the child's emotional adjustment and behaviour and more recent studies have shown, in addition, stunting of physical growth (in height and weight) and slowing of intellectual development. Nurturing failure, especially in the early years of life, is now seen to be responsible for much damage to growing and developing children.

If our aim is the prevention of such damage, the scope of

studies and observations must be wide, linking the subject of battered babies to accidents in general on the one hand and to family pathology on the other. And this is concerned not only with the intrinsic psychopathology of the family and of the individuals who compose it, but also with the socioeconomic stresses playing upon the family from the environment in which the members live and work. The mother may have a below average intelligence, the father or step-father may be an aggressive psychopath, but defective housing, unemployment, and the hostility of neighbours may also form part of the aetiology, though deprivation and abuse are not confined to families in the lower social groups. Today, "non-accidental injury in children" is seen to take its place in the wide context of social disorders in which defective care within the family leads to developmental failure, injury, or death.

In practice the management and treatment of "non-accidental injury" present in the first instance clinical problems for which the doctor must assume clinical responsibility. His primary aim is to treat the injury and to protect the child from any repetition; his ultimate aim is to rehabilitate the family. But these aims cannot be achieved alone, and unfortunately in present circumstances and, in some cases, neither complete protection nor lasting rehabilitation is attainable. It was because of these stubborn realities that the Tunbridge Wells Study Group was called into being, and no doubt it was because of the size of the problem, between 4,000 and 5,000 children a year in Britain, together with the continuing series of deaths, that the Department of Health and Social Security gave the widest possible circulation to the Report and Resolutions of the Study Group.[†]

Meanwhile success in preventing both serious injury and any repetition of injury depends on two prerequisites. Firstly, in every locality a working system must be devised to ensure that children receive adequate protection and families receive relevant help. Secondly, all the professional workers in the locality must be prepared to use the system once their suspicions have been aroused.

The Department of Health and Social Security[‡] has suggested a two-tiered system: of case conferences about in-

[†]Non-accidental Injury in Children, *British Medical Journal*, 1973, 4, 96.

[‡]Department of Health and Social Security, *Battered Babies*, C.M.O. 10/72 London, D.H.S.S., 1972.

^{*}British Paediatric Association, *British Medical Journal*, 1966, 1, 601.

dividual families and of area review committees to oversee the general feasibility of plans. The Tunbridge Wells Study Group strongly supported these suggestions while recommending a clearer description of functions and some modification of composition. The two associations, through a special committee, are keeping the whole subject under continuing review, and they are seeking their members' comments on the study group's resolutions. What is important is to know whether the resolutions meet with general support in the field and, if they do, whether any special difficulties are experienced or foreseen in carrying them out. At the same time, the liaison committee of the two associations believes that there is an essential medical contribution which must not be lost sight of and it is for this reason that they recommend a careful study of the following guide to management originating in Newcastle in 1968 and modified from time to time during the ensuing five years. The authors intend this as a guide and not a stereotype and we know that comparable schemes are operating in many parts of the country. The need is for all concerned to learn from each other.

But the establishment of management systems, of case conferences, and of area review committees, important as they are, will not prevent continuing injuries and deaths unless they are properly used. After a child has died, the matter is likely to be in the hands of the police and the courts. When there is only rumour of physical injury, the matter may rest in the hands of the social services department or of the N.S.P.C.C. In the search for improved methods of management the conclusion seems inevitable that all the professionals in any locality should work together, so that through whatever professional channel the family first comes under suspicion, the way into a case conference should always be open. This can happen only when mutual confidence has grown up between the different services and when each worker respects the professional skill of his colleagues. Certainly the statutory responsibility for child protection by social

services departments has to be respected as well as the legal obligations of the police; so too has the clinical responsibility of the doctor. Consultation has to replace unilateral action. That this is difficult to achieve cannot be denied but progress will be impossible and the best-devised machinery will rust from disuse unless this aim is agreed upon and the difficulties frankly and openly faced.

Three main areas of difficulty exist: the doctor's problems with confidentiality; the policeman's reputed preoccupation with convictions; and the obstacles which the social worker's personal involvement with a family may place in the way of her objective assessment of a situation.

The general practitioner is less often consulted by these families because they tend to go directly to hospital. Nevertheless, he should be familiar with the type of family in which abuse may occur, and if his suspicions are roused he would be well advised to channel his patient into the system either through his attached health visitor or directly to his local paediatric department for immediate admission for protection and diagnosis. Sometimes with older children the school teacher or the educational welfare officer may be the first person to become concerned. The school medical service may then be the channel of entry directly through the general practitioner, or, in the future, through the paediatrician with community responsibility.

What follows is not a considered agreed statement by the two associations. It is a local code of professional practice which, once established, should go a long way towards improving management and developing the essential co-operation between all the professional workers involved.

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A Guide on Management

Prepared by a Working Party in the Department of Child Health
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Introduction

In the United Kingdom up to 4,500 children may be battered each year, between 10% and 17% of them dying from their injuries and some 30% being permanently handicapped from brain damage.

The size and complexity of the problem presented by these difficult and deeply troubled families were recognized in Newcastle six years ago. A working party was set up in the university department of child health to consider all aspects of the problem and to reach a common understanding on its management. The working party has met every few months during these years, on five occasions with representatives of the police, and once with a clerk to the justices.

A series of memoranda have been presented to members of the university department of child health and to paediatricians in the region who have been helpful in suggesting modifications.

This memorandum represents the present common thinking of the working party and offers a practical guide to the management of battered children and their families. Though

the details have been agreed specifically for the City of Newcastle, it is hoped that the memorandum will prove of value in other centres also.

Medical Management: Diagnosis

Suspect Any Injury in Young Children and Admit if Doubtful

Any injury, including burns and suspected poisoning, in an infant or young child should be a cause for concern and a full history of the accident and why and how it happened should be carefully compared with the clinical findings so that a discrepant history is noticed at once. Repeated injuries are suspect. Abnormal parental attitudes and social problems should be noted and the child admitted to hospital at once for diagnosis and for his own safety when there is any suspicion of non-accidental injury or of severe maternal anxiety. A delay in reporting the accident should increase suspicion. The physical signs in the child, the discrepant history, and the abnormal parental attitudes and behaviour are the keys to the diagnosis. Stressful social conditions add further weight. Sometimes the injury itself, but sometimes other problems, such as failure to thrive or the possibility of coagulation defects or bone disease, will be given to parents as the reason for admission by the referring doctor, health visitor, or social worker, who should contact the paediatric registrar for admissions at the hospital by telephone.

Members of the Working Party: Professor John Webb, Chairman since September 1972, Paediatrician; Dr. Christine Cooper, Secretary, Paediatrician; Dr. Hugh Jackson, Paediatrician; Dr. Israel Kolvin, Child Psychiatrist; Mr. Brian Roycroft, Director of Social Services; Dr. David Wilson, Medical Officer of Health.