CASE CONFERENCES

Jill McMurray

In 1980 the Department of Health and Social Security issued a circular that gave advice to social services and other agencies on setting up a more systematic approach to the management of child abuse. It included new extended criteria for registering children who had been or were suspected of being abused and also extended the upper age range to 17 years. It recommended that issues be discussed by an interagency "case conference" (not to be confused with the informal meetings known as case discussions). The circular emphasised particularly the responsibility of all agencies concerned with children to consider the interests of children as paramount and gave special directions to agencies in which child protection was a major part of their work.

There are three agencies with statutory responsibility for child protection: the local authority (through the social service departments), the National Society for the Prevention of Cruelty to Children, and the police.

If information is received by any of these agencies that a child has been or is likely to be ill treated it has a duty and responsibility to investigate and if necessary take steps to protect the child.

A case conference is called as soon as possible when abuse has been confirmed or is suspected (in Scotland no further major changes concerning the child may be made, including reviewing the child, without a subsequent case conference being called).

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The ABC of Child Abuse has been edited by Professor Roy Meadow.

Case conferences

Case conferences are valuable in bringing people together with relevant information, and in including them in planning and decision making. A case conference may be requested by any professional, but the decision to hold one is usually taken by the chairman (check who chairs and convenes in areas you cover). He or she has responsibility for invitations to case conferences but tell him or her if you are aware of people with contributions to make—for example, radiologists, ward sisters, or nurses. The chairman will need a medical report from doctor(s) who examined the child(ren).

Check if a child or children in the family have previously attended a hospital, including an accident and emergency department. Advise the chairman that copies of your report should not be circulated without your permission.

Check if parents are allowed to attend. Most are not.

The Scottish circular emphasises how important it is that consultants recognise the interests of children as paramount and how vital it is for general practitioners, health visitors, consultants, etc, to attend case conferences. It also advises that case conferences should be held "before a child leaves hospital for home or any place of safety." The recommendation of compulsory measures requires the conference to refer the case to the reporter for consideration about whether it should go before a children's hearing.

Child protection register

One of the commonest outcomes of a case conference is for the child to be placed on the child protection register (formerly called the "at risk register"). Sometimes other children within the household will also be placed on the register at the same time. The register is kept by the social services department and any doctor may telephone the local social services department at any time of the day or night to check whether a particular child is on it. This is a helpful diagnostic procedure when a doctor encounters a child for the first time in whom he suspects possible abuse. Even if the family move to another locality the child will be transferred automatically to the child protection register in the new locality.

Doctors cannot be compelled to attend case conferences.

Information exchanged at a case conference has no guarantee of confidentiality.

A breach of confidence to the child and his parents may be justified if it is believed to be in the child's best interests.

CATHERINE JAMES, *Journal of the Medical Defence Union*, 1988

Emergency procedures

If you think that a child will probably be reinjured or removed from hospital or the area by his or her parents you can request any of the three agencies with statutory responsibilities to seek a place of safety order, which currently may last up to a maximum of 28 days but is often shorter. (A report will be needed from a doctor.) The National Society for the Prevention of Cruelty to Children or social services will usually interview the parents and discuss the case with you before obtaining the order.

The request is taken to a magistrate, who will decide if an order should be granted. A copy of the order should be kept in the ward if the child is in hospital. The parents will also receive a copy.

A decision not to apply for care proceedings by the agency or case conference will allow a place of safety order to lapse. To apply for care

Tasks of case conferences

- To examine information and evidence of abuse and being at risk (from medical and social work reports)
- To consider whether legal action is needed immediately to protect the child
- To consider the position of other children in the family
- To consider families' ability to protect children and to cooperate with the help offered
- To assess type of help available to the family—for example, day nursery, family aide, counselling, voluntary supervision
- To make provisional plans for working with the family
- To decide on registration of child(ren) and category
- To appoint a focal agency
- To decide who will inform the parents of case conference decisions
- To arrange for review and follow up (including medical when necessary)

proceedings, however, the juvenile court will fix a date for the hearing. Courts vary in whether they require you to attend. The court can (*a*) make a care order that applies until the child is 18 years of age unless it is revoked earlier (children may be returned home while remaining under the jurisdiction of a care order), (*b*) make a supervision order (child usually returns home), or (*c*) dismiss the case.

Other children in family may be committed to care if the case is proved for the first child.

Children appearing in care proceedings often have a guardian ad litem appointed and a solicitor to look after their interests and not those of the parents, the social services department, or the National Society for the Prevention of Cruelty to Children. The police no longer takes children to court under this act but hands over to the social services department after taking out a place of safety order.

Unlike in a criminal court, it is not necessary to prove who caused the injuries but only that they were probably caused non-accidentally or, in the case of neglect or ill treatment, that someone failed to give the child the care and protection needed.

Composition of case conferences

Chairman—The person who chairs the conference is usually a senior member of the staff of the social services department. The recent draft from the Department of Social Security suggests that people in direct line management do not chair case conferences.

National Society for the Prevention of Cruelty to Children—Some staff attend as observers or consultants when they are directly concerned with the case. Officers in some areas have child protection teams. Some have family centres, nursery provision, and family counselling. The National Society for the Prevention of Cruelty to Children works closely with the social services department and provides lectures and training exercises for voluntary and statutory organisations.

Social worker and team leader—The social worker attending a case conference is usually the one who has carried out the investigation. The family's long term social worker may also be included. The social worker presents the background on the family, if known, as well as the current state. The team leader attends in support and as the social worker's supervisor. The team leader may help the chairman to ensure that everyone with relevant information on the case has been contacted or invited to the case conference.

Education welfare officer often attends case conferences and acts as a liaison for school staff and a link with the head teacher at reviews, etc. Increasing numbers of education welfare officers are becoming involved when a child discloses details of abuse to a member of the school staff. The officers may know the family already. The expectations of what they do in their everyday work varies among local authorities.

Police—Usually community affairs or juvenile liaison officers attend case conferences. Violence or sexual assaults on a child will often bring in the Vice Squad, or Criminal Investigation Department so all may attend. Police officers will usually give relevant information on any suspected person discussed at the case conference but will often not attend or give this information if parents attend the case conference. Police officers may have spoken to the child directly or interviewed the parents or suspected abuser. Serious assault on a child should be viewed as similar to that on an adult and the police informed so that the officers can investigate as soon as possible.

Health visitor, school nurse, nurse manager—Reports received or circulated will have the general practitioner's views if communication is good. Health visitors may take on a primary role after a case conference—for example, if the child is failing to thrive—by working on an agreed "contract" with the parents about diet, feeding, and attending clinics. School nurses are playing a more prominent part as more children tell of sexual abuse they have experienced within the family. The nurse manager attends to support the health visitor and school nurse and to be aware of decisions for supervising aspects of training of staff, etc.

General practitioners—The general practitioner is in a key position to make a vital contribution to the case conference, and the findings of the case conference are extremely important to the general practitioner. Though more case conferences are currently attended by general practitioners than was the case five years ago, it is still common for general practitioners not to attend a case conference. Some give verbal reports before the case conference, others use health visitors for conveying their opinion or some information. Other members of the case conference usually find the general practitioner's attendance helpful, and general practitioners usually learn a surprising amount about the family, which should be helpful.

Consultant or registrar may attend to speak, to report, and to participate in decision making.

Points to remember about case discussions

- You or any professional can arrange a case discussion
- Check if the family is known to any agency already and invite
- Social services often have resources such as day nurseries and family aides to help
- Consider inviting parents—it is easier for them to face smaller groups than large ones
- Consider whether it is necessary or appropriate to invite the police
- It is useful to keep notes so that participants can refresh their memory when necessary

Child abuse coordinator or adviser is usually responsible for the child abuse (child protection) register and is one of the few impartial members at the meeting. Such coordinators can ask objective questions and advise on criteria for, and standardisation of, decisions throughout the area. The role varies throughout the country. Such posts are usually funded by social services departments alone or jointly with the NHS.

Solicitor—A solicitor from the local authority may attend to give guidance to the case conference.

Occasional members as appropriate—A teacher or teachers may be asked to attend a case conference, including a teacher of a sibling of the child being discussed. When the child attends day nursery or nursery school a nursery teacher may be asked to attend. When the family receives benefit a member of the social security department can be extremely helpful; sometimes some stress can be eased by sorting out financial and debt problems. Similarly, when there are housing problems a member of the housing department may be helpful. The family may be overcrowded, in arrears with rent payments, or about to be evicted. Appropriate help may be considered by the housing department if the case conference recommends it. Members from voluntary agencies—for example, the Family Service Unit, Catholic Welfare, Dr Barnardo's—and statutory services such as the probation service may also be helpful at a case conference.

Statutory and voluntary agencies will generally give priority to recommendations made by case conferences.

Both general practitioners and hospital doctors may claim a standard fee (advised by the BMA) for attending a case conference.

Although not a statutory or rigid meeting, the case conference is formal and is usually viewed as a valid and responsible form of communication and decision making. The minutes are usually available to the local area review committee and are circulated to concerned professionals, even when they are not present.

Case discussions

The other type of meeting usually arranged when there is concern for a child is a case discussion.

Case discussions are much more informal than case conferences and can be called by any professional who recognises that they would be useful for a few concerned people—possibly including the parents—to meet and hear what others know of the problems and difficulties.

A typical reason could be a child who seems not to be progressing well but shows no clinical condition. There may be missing pieces of a jigsaw that someone could provide that will help, ranging from problems of childhood jealousy to sexual abuse. A case discussion can also be used if a child is failing to thrive, the parents could actively cooperate in feeding regimens or in accepting guidance on handling and playing with their infant.

Further reading

Jones DN, ed. *Understanding child abuse.* London: Hodder and Stoughton, 1982.

British Association of Social Workers. *The management of child abuse.* Birmingham: BASW, 1988. (Available from BASW, 16 Kent Street, Birmingham B5 6RD.)

Department of Health and Social Security and Welsh Office. *Working together. A guide for inter-agency cooperation for the protection of children from abuse.* London: HMSO, 1988.

Standing Nursing and Midwifery Advisory Committee of the Department of Health and Social Security. *Child protection: guidance for senior nurses, health visitors and midwives.* London: HMSO, 1988.

ANY QUESTIONS

What are the advantages and hazards of using evacuated containers for taking blood samples?

The advantages of using evacuated containers are, firstly, the cost. Large financial savings can be made as the use of syringes is omitted. Secondly, the quality of the sample is improved. Sample tubes containing liquid anticoagulant are less susceptible to evaporation, leakage, or microbial contamination than screwcapped containers. Furthermore, the correct ratio of sample to anticoagulant should be obtained. Thirdly, they are safer. Evacuated containers reduce the risk of contamination during venepuncture as no transfer from syringe to container is required. The needle does not need to be removed from the syringe. Many laboratories now have automated equipment that allows direct sampling from an otherwise unopened evacuated container. A sealed system is available for measuring erythrocyte sedimentation rates.

The major hazards from the use of evacuated containers are related either to poor familiarity or to misuse of the system.

The cost saving and the safety advantages of the system are lost if samples are taken with a syringe and the blood then transferred to the evacuated system. This increases the hazard for the person taking the sample and for all those subsequently handling it. Containers may become pressurised and explode, causing dangerous splattering of blood. Adapters are available for use with the system, allowing the use of different needles and direct connection to Luer adapters.

Excessive discomfort or bruising associated with venepuncture is usually related to lack of familiarity with the technique. Most phlebotomists, once they are used to the system, would not wish to change back to a syringe and separate sample bottle system.—R D HUTTON, *senior lecturer in haematology, Cardiff*