VIEWS & REVIEWS

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Margaret McCartney: After Rotherham—pattern spotting and child abuse

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Under my fingertips, indentations from a now obsolete typewriter flit like Braille. Medicine's recent past was typed or written by hand. Flicking through these fading paper records like a book, one of my jobs is to summarise them onto a computer. And sometimes there is a pattern.

Shortly after birth the baby is crying a lot, teething, unhappy. Something illegible is prescribed from the end of a fountain pen. A couple of years later, a broken bone. Someone tells the doctor that the child is behaving badly. A referral somewhere; it's unclear what happened. DNAs—"did not attends"—actually mean "child not brought by the adults responsible."

Vaccination schedules slip. Frequent presentations occur with one word outcomes, usually denoting a penicillin or paracetamol prescription. The copperplate swirls make no other comment. A head injury; another accident. A presentation to the emergency department with intoxication in late childhood. And then silence, which is later broken by anxiety, depression, or obsessional thoughts in the late teens and early 20s.

Consultations are then frequent—some in the emergency department, some with the out-of-hours service. A letter from the drugs and alcohol service, or a psychiatric nurse, after an intentional overdose. This may recur often. The patient may leave before a full assessment and then not be seen until the next crisis. Self harm is rife. And after that comes the devastation of sexual abuse in childhood.

Some 1400 cases of child sex abuse went unchecked in Rotherham from 1997 to 2013, the horrendous recent report details.¹ Half of these children had misused drugs or alcohol; a third had mental health problems; two thirds had emotional difficulties. Almost half came from a home with reports of domestic abuse, and two thirds had refused to go to school or been repeatedly reported as missing from home. Some children had been gang raped or threatened with guns. Some went on to become abusers themselves. This was against a backdrop of underfunded social and care services, impossibly long waiting

lists for counselling, and children afraid to give evidence against their abusers.

GPs are pattern spotters—but not every such pattern indicates a child at risk. And we should not want parents and carers to hesitate to take an injured child to the emergency department lest they be suspected of abuse.

Electronic records disjoint patients' narratives across separate documents, each a click away. Might this make patterns harder to spot? Either way, as GPs we need named social workers in our teams who we can talk to as regularly as our health visitors. And we need to fund health and social services properly, so that the most vulnerable children always get the priority they need.

Competing interests: I have read and understood the BMJ policy on declaration of interests and declare the following interests: I'm an NHS GP partner, with income partly dependent on Quality and Outcomes Framework points. I'm a part time undergraduate tutor at the University of Glasgow. I've written a book and earned from broadcast and written freelance journalism. I'm an unpaid patron of Healthwatch. I make a monthly donation to Keep Our NHS Public. I'm a member of Medact. I'm occasionally paid for time, travel, and accommodation to give talks or have locum fees paid to allow me to give talks but never for any drug or public relations company. I was elected to the national council of the Royal College of General Practitioners in 2013.

Patient consent not needed (patient anonymised, dead, or hypothetical).

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1 Jay A, Rotherham Metropolitan Borough Council. Independent inquiry into child sexual exploitation in Rotherham 1997-2013. 21 August 2014. www.rotherham.gov.uk/downloads/file/1407/independent_inquiry_cse_in_rotherham.

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