Current Practice

FORENSIC MEDICINE AND TOXICOLOGY

Cruelty to Children

G. M. FLEMING,* M.A., M.D., D.P.H.

A doctor, confronted with a child who has been wilfully injured, may be handicapped in procedure by two natural inclinations. Firstly, he will tend to be concerned with the nature and extent of the injury rather than the cause. Secondly, unless he has grounds for doing otherwise, he will be inclined to accept the history at its face value.

Either because the history is not altogether consistent with the lesions or because he doubts its reliability, the doctor may consider the possibility that the injuries have been inflicted by a parent or some other member of the household. On general diagnostic principles this is sound, but there are other compelling reasons for doing so.

Injuries caused in this way are more common than is generally realized, and there is a serious risk that they may be repeated. Indeed, it may well be that the child's life is in danger, and his removal from home, quite apart from the need for investigation and treatment, is a matter of urgency. And further, if the suspicion turns out to be correct, even if the harm suffered by the child is not severe, the family may be in need of social or psychiatric help or both.

Extent of Problem

The term "cruelty to children" may at first suggest something of the nature of a sadistic attack, but it should be regarded as much more broadly based. A Joint Committee of the British Medical Association and the Magistrates' Association examined[1] the question of cruelty and neglect in 1956, and concluded that the two were not really definable separately.

"Cruelty" can be taken to cover a wide range of harmful influences from material and emotional neglect or deprivation to anxiety-producing situations and actual physical violence. Though the doctor may be more directly concerned with violence, the possibility of the existence of the other and not so obvious forms of cruelty should be borne in mind.

The extent of the problem is not easy to estimate. In 1965 275 men and 265 women were found guilty in magistrates' courts, and seven men and three women in higher courts, of cruelty to children. Convictions for such offences are only the tip of the iceberg in relation to the total of maltreated children. This comes about partly from the difficulty of getting legal proof, but more significantly because the social agencies concerned, in particular local authority children's departments and also the National Society for the Prevention of Cruelty to Children, rely less on action through the courts than on positive casework with the family.

Thus, out of a total of 36,929 cases, including 4,182 of assault or ill-treatment, brought to the notice of the N.S.P.C.C. in 1965–6, 23,779 were dealt with by warnings and 11,314 by advice.[2] In the wider sphere of child neglect, during the period of 12 months ending 31 March 1965 11,213 children were received into care by local authorities because of various forms of family breakdown. There were also numerous other families under the supervision of local authority departments and volunteer agencies in which the children remained in their parents' care.

Nature of Injuries

Cruelty to children as a medico-legal problem has been widely recognized only in the last few years, though it is more than 20 years since Caffey[3] described a series of cases of infants suffering from chronic subdural haemorrhage associated with multiple fractures of the long bones for which he could offer no explanation except trauma, though this was not known to have occurred.

In 1955 Woolley and Evans,[4] in a study of 12 infants showing multiple areas of bone damage which appeared to have occurred over a long period, remarked that these cases came invariably from "injury-prone environments." Since then numerous similar studies have been made in which the factor of wilful violence has been increasingly evident.

Children of all ages may be subjected to cruel or neglectful treatment. It often happens that a particular child in a family is singled out as a target for abuse, while the others show no sign of ill-usage. Typical lesions that may be encountered are burns, multiple bruises, subdural haematoma (with or without fracture of the skull), fractures of limbs or ribs, damage to epiphyses, and multiple injuries ascribed to falls. Small children who fail to thrive may have been neglected and persistently underfed.

The "battered baby" type lesions may be found in infants ranging from a few weeks to about two years old, with a peak at about three months. In the cases described by Griffiths and Moynihan[5] the children were all under one year and typically showed an unexplained swelling in the region of the ends of long bones, with an elevation of temperature to about 101° F. (38.3° C.). *X*-ray examination showed changes in and around the metaphysis of the affected limb, and in some instances a fracture elsewhere.

Accident or Intention?

There is a natural reluctance, as has been noted, to attribute injuries of the kind just described to the violence of parents or guardians. It seems reasonable to suppose that the majority of injuries to children are accidental, and, even when a parent is to blame, may have been caused unwittingly. Among 25 cases of subdural haemorrhage in infancy Russell[6] found 11 with a history of postnatal head injury, in three of which it was considered probable that the children had been assaulted

* Senior Medical Inspector, Home Office, Children's Department.

and in the other eight it was believed that a legitimate accident had occurred.

Evaluation of a cause of injury depends on the probability of the story and the plausibility of witnesses, both of which may be quite misleading. Yet there is also the possibility of a pathological condition underlying some instances of apparent violence, as Fairburn and Hunt[7] have pointed out. It has been suggested that abnormality of bone structure, in the form of metaphysial fragility, might be a factor in unexplained multiple fractures in infancy.

In considering a series of cases with lesions of this kind, which they regarded as due to parental violence, Fairburn and Hunt concluded that there was nevertheless insufficient evidence to say whether or not a disease entity exists in which, in the absence of any known skeletal abnormality, spontaneous fractures, bruising, and subdural haemorrhage may appear. Acknowledging the danger of diagnosing a disease entity, they suggested that the best way to solve this problem would be to collect cases of injury in early childhood in which adequate radiological and pathological examinations have been made and a skilled psychiatric examination of the parents has been attempted.

Simpson,[8] however, voices the majority opinion and comes down firmly in the view that the battered-baby syndrome is "a serious and widespread crime that can only too easily escape detection."

Nature of Parents

There can be few parents who, at one time or another, have not been exasperated beyond endurance by the behaviour of their children. Happily for most of them expression of their exasperation stops short of real violence. It would be difficult for any doctor to predict which of his patients might, in extreme situations, dangerously exceed the bounds of accepted conduct.

Neglect and accidental injury, for which the parents can be indirectly blamed, as well as cases of cruelty occur in the large group of social problem families. Four other categories of potentially violent parents have been suggested by Fairburn and Hunt[7]: individuals showing violence as part of their cultural background; aggressive or schizoid psychopaths; irritable, emotionally labile individuals with episodic depressive illness, especially after childbirth; and psychotics.

In a psychiatric study of 32 men and seven women convicted of cruelty with violence, Gibbens and Walker[9] concluded that it was rejection, indifference, and hostility rather than cruelty in their own childhood which made cruel parents. In six cases there was a history of aggressive offences of various sorts, and intellectual dullness played a considerable part in violent as well as negectful cruelty. Five out of 16 who had an E.E.G. examination showed abnormal readings. With the younger children it was the child's persistently wet and dirty habits or sometimes incessant crying that triggered off the assault.

Gibbens and Walker observed that in two-thirds of the cases they studied the living conditions were reasonable and sometimes good, and this and other studies suggest that there is some overlap in the social and psychological elements that produce neglect or cruelty.

Action to be Taken

Action to be taken can be divided into immediate and long-term efforts to deal with the problem.

The doctor's first concern is the safety of the child, and if he suspects deliberate injury he must take steps to ensure that it is not repeated. Every child with suspected injuries of the battered-baby type should be admitted to hospital for confirmation of the diagnosis and to enable the background to be investigated. Examination of the child in hospital should include a skeletal *x*-ray survey.

It is important to obtain a detailed history, including treatment in various hospitals or departments of the same hospital. The general practitioner referring the child to hospital should pass on his suspicions to colleagues there so that social inquiries can be pursued.

The child's family may already be known to departments of the local authority or to the N.S.P.C.C., and, while some doctors would prefer to discuss a case with a medical colleague, such as the medical officer of health, it would be quite proper for a doctor to report direct to a children's officer or an N.S.P.C.C. inspector. The Medical Defence Union has stated[10] that it would support such action.

There is no question of making accusations in the initial stages, and it is no part of the doctor's role to make the parent admit liability. He must fulfil his responsibility to his patient—even, if necessary, without the consent of the parents. If the parents refuse to let the child go to hospital the children's officer or the police can, on the issue of a warrant by a justice of the peace, remove the child to hospital and have it detained there as in a "place of safety."

As for long-term treatment, the Joint Committee of the British Medical Association and Magistrates' Association recommended[1] that wherever possible the family should be dealt with as a whole, both in preventive measures and in other treatment. This view has been supported more recently by the British Paediatric Association in a memorandum[11] which discusses in detail the recognition and management of the battered baby. It advises the doctor that he can make his most useful contribution to the future of the child and family by consultation with the children's officer.

To assist in preventing family breakdown local authorities were given powers and duties under the Children and Young Persons Act, 1963, to provide advice, guidance, and assistance (including material aid) to promote the welfare of children by diminishing the need to receive them into care. This legislation provides an effective instrument for preventing or mitigating child neglect.

The prevention of wilful cruelty is a more complex problem and calls for attention to psychological stresses rather than to material needs. As Gibbens and Walker observed,[9] child-guidance treatment may be necessary to reduce the provoking behaviour of children and to help the parents to understand it.

Close co-operation between doctors and social agencies is essential at all stages. It is particularly important that cases should be followed up on the first suspicion of ill-treatment, when the general practitioner (or hospital doctor), by contact with the medical officer of health or the children's officer, can bring to bear on the family whichever of the local health and social services the situation demands.

The opinions expressed in this article do not necessarily represent the views of the Home Office.

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