A Guide on Management

Prepared by a Working Party in the Department of Child Health University of Newcastle upon Tyne

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.

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.

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.

Staff Avoid Antagonizing Parents or Caretakers

The medical and nursing staff in the accident and emergency department and children's ward should do all they can to avoid antagonizing the family or asking probing questions at first contact. Terror, guilt, and remorse in the parents makes them particularly awkward to handle, but a gentle and sympathetic approach, however difficult, will help to initiate an atmosphere where the correct diagnosis can be made and a rational plan of management can begin.

Take Full History of Family Background

In taking the patient's history, but not necessarily at first contact, the family's previous addresses and doctors and the parents' names and former names should be tactfully obtained to facilitate inquiries about previous illness, injury, and family background. Details about the social and family background should also be obtained, and former accidents to siblings should be noted with their names and places of treatment, in order that extended inquiries can be made about these.

Inform Paediatricians Immediately

The consultant paediatrician should be informed immediately a child is admitted, and in most cases will see the patient and his parents without delay. His appearance on the scene and his "routine" discussion of the history and findings with the resident and parents should help to establish an atmosphere of confidence. At no time should any accusations be made or an accusing tone used, but rather the parents should understand that all accidents to young children are a cause for the doctor's concern and that certain cases seem puzzling at first. At suitable stages in the first two or three days tactful and unobstrusive discussions can begin to build up a picture of the family psychodynamics. The parents may be told that sometimes injuries to young children indicate family difficulties which the doctor is anxious to discover in order to offer appropriate help. Relief of parental distress is as important as the immediate treatment of the injury in working towards prevention of further injuries to the child and siblings and, when safe, rehabilitation of the child in his own family.

Measure and Chart Injuries

At the admission examination all injuries should be recorded in detail and measured, and the colour of the bruises noted. Bruises resulting from human bites and small cigarette burns should be especially looked for. The fundi must be carefully examined for retinal haemorrhages. A chart of all the lesions on one of the outline charts provided should be made in every case.

Photographs

Photographs in colour and black and white of the child and of the injuries should be made within 24 hours of admission. If parents question this the paediatrician will naturally say that this is normal practice in many clinical conditions.

Skeletal X-ray Survey

A complete skeletal *x*-ray survey including the fingers and toes (but excluding spine and pelvis except when clinically indicated) should be done on admission to exclude fractures and bone disease. In most cases. when negative at first the *x*-ray examinations should be repeated in two to three weeks as fresh epiphyseal or periosteal lesions will not show on the early films. The following *x*-ray signs are suspicious or diagnostic: (*a*) multiple bone injuries especially near joints, (*b*) fractures in varying stages of healing, (*c*) epiphyseal displacement or metaphyseal fragmentation or both (*d*) avulsion of parts of the provisional zone of calcification, (e) cortical thickening, (*f*) a single fracture in a young baby, (*g*) a spiral fracture in a young child.

Exclude Coagulation Defects when Bleeding or Bruising Present

When bleeding or bruising is present, blood clotting disorders should be excluded by the following investigations: estimation of haemoglobin, examination of blood film, platelet count, bleeding time, one-stage prothrombin time, and partial thromboplastin time.

Consultations With Other Workers

Immediately on admission in the day time, or early next day if the child is admitted at night, the family doctor, medical officer of health, health visitor, and area director of the department of social services should be contacted by telephone to discuss information already known about the family's health, former accidents, or social problems. It is advisable to check any previous accidents to the child or its siblings in one's own accident and emergency department and others in the area. Where appropriate other agencies already in touch with the family, such as the N.S.P.C.C., the probation service, or other hospitals who have treated the child or his family should be consulted without delay and asked to send a written note in confirmation. The paediatrician will then send a brief note of his findings and opinion to the medical officer of health, the general practitioner, and the area director of social services. The director of social services will consult with the police at this early stage if abuse is strongly suspected.

Home Visit

An early home visit is often desirable to help diagnosis. The purpose is to ascertain the facts surrounding the injury and to uncover family circumstances including parental attitudes and personality. Speed is necessary in certain cases to collect evidence before it is no longer available. The most appropriate person to visit the home will be decided by the paediatrician, family doctor, health visitor, and area director of social services in discussion. In general this will be the family doctor or health visitor or a social worker who already knows the family well. In some very difficult cases a senior member of the department of social services or the police will be asked to conduct this visit. The parents must then be informed of this beforehand and helped to understand the reason for it.

Observe Parental Attitudes

During visiting at hospital, which is unrestricted, observations of parental attitudes and behaviour with the child and the staff should be recorded from day to day in the case notes. Informed discussions about the child's condition and progress by a senior member of the medical and nursing staff with the parents during visiting gives the family encouragement and an opportunity to reveal feelings as well as facts. This will do much to help uncover the true history, and the family problems. In some cases the mother will also be admitted with one or two of her young children, and the father or consort encouraged to visit whenever possible.

Keep Careful Records

Careful records should be kept of the conversations with parents, and a note made of all telephone conversations and discussions with social workers, etc., and the relevant facts recorded.

Place of Safety Order

A place of safety order may have to be obtained through the department of social services, N.S.P.C.C., or police.

If a parent threatens to remove the child before investigations are complete, the paediatrician in charge should always be called to see the parents. He may need to point out to to them that if they persist in their decision to remove the child the police may have to be informed immediately.

Psychiatric Help

Psychiatric investigation and help for the parents are desirable in nearly every case, as a thorough diagnosis of the family psychopathology is needed to plan effective management. At this stage a psychiatrist should be informed of the problem and will indicate what contribution the child psychiatry team can make. Arrangements for this inquiry need to be very flexible as such parents fail to keep appointments or to respond to formal procedures.

Further Management

Case Conference

Within a few days of admission the medical and social investigations should be complete and a case conference should be called where paediatrician, psychiatrist, health visitor, family doctor, senior member of the social services staff (and sometimes their lawyer), other involved social workers, and sometimes the police can discuss the diagnosis, the causes of the injuries, and the related family problems. A plan of management can then be evolved. Three types of case emerge at this stage:

Children where inflicted injury seems certain though the person(s) who caused it may not be obvious. Action in the juvenile court for a care order will usually be needed in this type of case to ensure protection for the child and help for the family. In many cases the child may be returned home under supervision after a period of time. Senior medical staff must be prepared to give evidence in court to support such cases where necessary. In some of these cases the police will be involved, and prosecution in the adult court may occasionally be deemed necessary.

Children where inflicted injury seems very likely but hard to prove.—They usually have moderate or minor injuries at this stage, but the typical family problems exist and the history of injury seems unsatisfactory. A real dilemma is presented to both doctors and social workers in this type of case and much time and legal advice from the local authority's legal department will be needed to reach an effective plan of management. A care order is desirable for the child's protection but the evidence available may not be sufficiently convincing for the magistrates to make such an order. In the meantime, the child should remain in hospital if the parents agree, but if he is taken home the family should be visited and supported often by the appropriate social worker. Police involvement in such cases will be decided at the case committee.

Children where it is decided that actual inflicted injury is unlikely, though carelessness, neglect, or other family problems may be present and need help. Understanding "motherly" support for the parents should help to prevent further injury in most of these families, but psychopathic or dull parents present taxing problems in decision making for both medical and social work staffs.

Further case conferences are needed at intervals for many families.

Inform Parents at each Stage

The information we give to the parents is progressive. At the beginning we are concerned to see how they see the injury and how they feel about it. At the same time we must help them understand that an injury in a young child is always taken seriously. They should be notified in advance of any formal home visit and this gives the doctor a further opportunity of discussing with them the need for help in families with injuries to young children. They can be told that it is the department of health's and the hospital's rule that a home visit is paid in such cases especially when injuries are not fully explained. As far as possible the parents should understand that it is no part of the doctor's job to accuse or condemn and that his concern is for the safety of the child and the well-being of the family.

After the case conference two main courses of action are open. If inflicted injury seems certain then the parents must be told plainly but sympathetically that this is the doctor's diagnosis. Naturally no accusations are made, but some parents feel able to give further information at this point. The parents must be told in appropriate cases that a care order will be sought in the court for the welfare of their child, and the meaning of this must be explained to them. They should understand that the decision has been reached after joint consultation by all concerned, and in certain cases that the child may return home at a later date, after family difficulties have been resolved.

Alternatively, if it is decided that there is insufficient evidence with which to obtain a court order, the child may be received into care voluntarily while the family obtains help, or returned home when well enough and the family offered appropriate support. The particular "home visitor" through whom all help and support is channelled will be decided at the case conference.

Criminal Court

We believe that in most cases proceedings against the parents in the criminal court are not helpful. They may be necessary in a very small group of cases where parents have exceptionally aggressive tendencies. In most cases paediatricians and child psychiatrists see "battering" as a symptom of severe family stress and disordered personalities needing urgent help and support, rather than as due to parental wickedness. Nevertheless permanent placement of the injured child away from home is needed in certain families and careful supervision of the other children in those families.

Juvenile Court

Proceedings in the juvenile court are usually desirable to protect the child. More suitable forms of legislation are urgently needed, but at present a care order is the appropriate means of protection and greater co-operation by the parents may thus be ensured. When the doctor is a witness in court he should, whenever possible, discuss the procedure with the parents beforehand and help them to see that action is being taken "for" the injured child and his family rather than "against" the parents. Voluntary supervision has the serious drawback that parents may cease to co-operate or move away as soon as the child leaves hospital. Sometimes, however, it is the only means of giving help to the family in the milder or unproved cases.

Discharge

Normally the child should only be discharged from hospital when the best possible plans for continued help and supervision have been achieved. During his stay unrestricted visiting or the admission of his mother helps to prevent separation anxiety. With skilled and sympathetic management in hospital it is uncommon for parents to remove their child against advice. If this does happen and there is insufficient evidence to take a place of safety order, our best course is to ask the health visitor, social workers, or N.S.P.C.C. to continue visiting the family.

Follow-up

Medical follow-up of the child will be needed in most cases, and where head injuries have occurred long-term assessment of development is essential, whether the child is with his family or in the care of the local authority. The parents should see and understand that the helpful association between the doctors and social workers concerned is for their benefit. Particular attention should be paid to the rapid transfer of information when a family where "abuse" is known or suspected moves to another area. This could best be done by the medical officer of health informing the paediatrician caring for the child so that he too can consult with his colleague in the new area and arrange for the child to be followed up. If a child under a care order is moved or returned home, this should always be after joint consultation at a case committee of those still involved with the family. Family planning advice is often urgently needed and the "home visitor" will encourage the parents to attend for this help, which will already have been discussed with them while the child is in the ward.

Management by the Department of Social Services

Receive and Record Details from Doctors

Receive details and record cases of suspected non-accidental injury from the hospital.

Collect Information on Family

The social services department should collect all relevant information about a family from statutory bodies in their own and other areas where the family has lived, such as local authority departments of health, education, probation, housing, etc. Voluntary bodies like N.S.P.C.C. should, however, be contacted for information only and not for action.

Arrange Home Visit

Arrange (after consultation) an early home visit to the family by the most appropriate experienced worker to discuss the injuries and family problems. Report on these visits.

Send Report to Doctors

The department should send a detailed report based on information gathered from local authority departments and visits, on home circumstances and history to the hospital soon as possible and correlate the information with the doctor's history.

Decisions on Safety of Child and Siblings

A decision should be made by the director of social services on any necessary legal action to secure the safety of the child in ho pital and any siblings remaining at home.

A place of safety order may be made upon the hospital when parents threaten to take the child home before the case study is complete. The child's safety is the legal responsibility of the director of social services.

Case Conference with Medical and Social Work Staff

A member of the department should attend the case conference with those immediately concerned with the child and the family to collate all information on the evidence of ill-treatment and decide on further action. The local authority's legal adviser may also attend.

Contact with Police

If non-accidental injury is strongly suspected the director of social services or the local authority's solicitor will inform the police.

Courses of Further Action

Several courses of action are open to the director of social services: he may take a place of safety order which could then either be allowed to lapse or develop into action in the juvenile court to secure the care and protection of the child. Alternatively he could take action in the juvenile court at once on the grounds that the child is in need of care and protection, which may result in a care order placing the child in the care of the local authority, a supervision order, or the case being dismissed on insufficient evidence.

Under a care order the child is usually removed from the family, but the director of social services has the authority to return the child to his family at any time for a trial period should the problems seem to be resolving. The care order remains in force until the child reaches the age of 18 years, unless revoked earlier before a junvenile court and this will be done only when the family problems have been resolved.

A supervision order is usually placed on the child for one to three years, and the child is returned home.

Other alternatives open to the director of social services are to receive the child into care under the Children Act 1948—section I—that is by voluntary arrangement with the parents. This may either allow inquiries to proceed before action in the juvenile court, or permit the family an opportunity to co-operate in treatment of their difficulties, or the director can arrange for informal supervision of the family by the most appropriate social worker. He may ask a voluntary society to undertake this work.

Ensure Decisions are Relayed to Doctors Involved

The department should ensure that the decisions have been relayed to the hospital and other appropriate departments, particularly the health department.

Follow-up Arrangements with Medical and Social Work Staffs

Further management should be discussed with the paediatrician, health visitor, and family doctor, and regular reports should be made by the visiting social worker. The case should be reviewed after about three months and then again when appropriate, for the decisions on the future management of the case. The parents should feel there is a helpful association between the doctors and social workers concerned, and each should exchange communications on family progress.