12 MONTH AUDIT OF CHILDREN REFERRED TO ROYAL LANCASTER INFIRMARY FOR MEDICAL EXAMINATION FOLLOWING ALLEGED ABUSE

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INTRODUCTION

Serious cases of child abuse requiring a public inquiry seem to occur with uncomfortable regularity. There have been over 70 cases nationally since 1945, the latest of which was the unfortunate case of Victoria Climbie. The conclusions of the inquiries are often similar and share concerns about similar areas for improvement. These commonly involve poor documentation of the circumstances, poor ownership of decision-making and poor communication between professionals and agencies. In the most serious cases abuse is often suspected prior to death but limited awareness of child protection issues or uncoordinated responses may prevent timely action being taken.

In the Morecambe Bay area we have a significant number of children at risk. Absolute numbers are low compared to some of the larger adjacent urban centres but the figures for cases per head of paediatric population are comparable. The current number of children on the Child Protection Register (CPR) is 68, the slight majority of these being in and around Barrow-in-Furness. Particular local challenges arise from the large area, covered by different health organisations, pockets of significant deprivation, a large transient family population, and residential schools for children with social and behavioural problems.

As a result of Lord Laming's recommendations and an audit by the Commission for Health Improvement (CHI, now CHAI) there was a restructuring of the way in which child abuse referrals to the paediatric services at Lancaster were organised. The implementation of a 'hot week' consultant responsible for acute referrals, including CP cases, and the adoption of a standardised proforma for note-keeping at the Royal Lancaster Infirmary (RLI) led to a better service provision and improved communication with the other child protection agencies. The proforma documentation allows review of the findings.

This article summarises some of the statistics from the local audit for one year between February 2003 and January 2004. During this time a set protocol for history-taking, examination, documentation and sending out medical reports was implemented. A system whereby feedback from allied agencies such as the social services department was also introduced.

RESULTS AND DISCUSSION

During this period, 47 children were felt to require a review by the acute paediatricians at the RLI for an overt child protection matter. Details for this audit were available for 43 children whose records were identified. The children and young people were roughly equal in sex distribution (22 girls, 21 boys).

Age distribution

Children under the age of three were the largest presenting group with a generally equal incidence of presentation in the older age groups. The table below summarises the age frequency at presentation.

This is generally in keeping with what is described nationally and internationally, with the younger, more vulnerable sections of society being particularly at risk. In the older age groups after 12 years there was a seeming preponderance of females, quite often presenting after arguments with their parents, usually the mother.

0-2.9 years	–	10
3-5.9 years	–	7
6-8.9 years	–	7
9-11.9 years	–	5
12-14.9 years	–	9
15-17.9 years	–	5

Table 1 Age at presentation

ROUTE OF DISCLOSURE OF ABUSE

The method of coming to the attention of the paediatric services was also noted. There appeared to be no recorded cases of GP-initiated referral. Most referrals seem to have been directly by the child or by a close family member presenting to social services departments who directed the child for a medical examination to the paediatrician. Interestingly, only a small number were identified as an additional feature while attending hospital for another cause.

Self/family member	17	(40%)
Mum	4	(10%)
Dad	2	(5%)
Health visitor	3	(7.5%)
School teacher	3	(7.5%)
Police	2	(5%)
A&E	1	(2%)
Sibling	2	(5%)
Social services	2	(5%)
Mum's friend	1	(2%)
Other	6	(15%)

Table 2 Who made the initial discovery/disclosure?

FAMILY STRUCTURE

It was felt to be of interest to categorise aspects of the social circumstances of the children coming for examination. The basic family structure suggested that only 28% of the children were living with both biological parents and 56% were living with one biological parent with or without another parent. Children attending local residential schools for children with behavioural problems accounted for 9% of the children seen.

Future audits will aim to analyse the employment details as well as associated misuse of social and other drugs.

Both parents	12	(28%)
Mother mainly	19	(44%)
Father mainly	5	(12%)
Looked after, fostered	4	(9%)
Grandparents	1	(2.5%)
Not documented	2	(5%)
	1	(2.5%)

Table 3 The number of children living with type of carer

Types of abuse

The most frequent reason for referral was alleged physical abuse, accounting for 63% of cases. Alleged sexual abuse alone was an uncommon referral, as these go directly to the forensic medical examination services via the police services.

The figures identified here are a definite underestimate of those that are referred. The specific nature of the system also tends grossly to underestimate the children with less overt forms of abuse, such as those with issues of neglect and emotional abuse. These children may already be known to health and social services professionals. Their management is not necessarily that of acute assessment after a specific event. The assessment of these cases takes greater time generally with close observation of the child with the family. However, specific thresholds for child protection measures need to be defined for clear decision-making even in these cases.

Emotional abuse alone is harder to ascertain, and is usually seen in the context of another form of abuse. Neglect remains as the largest category of abuse.

Slapped	4	(10%)
Non-specific 'hit'	9	(21%)
Kicked	3	(7%)
Fall/thrown down	4	(9.3%)
Blow to head	1	(2.3%)
Pulled hair	1	(2.3%)
Thrown object	1	(2.3%)
Whipped	1	(2.3%)
Shaken	1	(2.3%)
Burns	1	(2.3%)
Large head? Sub-dural bleed	1	(2.3%)
Sexual assault	1	(2.3%)
Bite	1	(2.3%)
Forceful holding	1	(2.3%)
Neglect	9	(21%)
Not known	4	(9.3%)

Table 4 Main causes of alleged or suspected injury leading to referral

Perpetrator

In over half the cases of alleged abuse the person(s) responsible was one or both of the child's biological parents. Stepfathers were the next largest group. In many cases the cause of the injuries themselves may remain unexplained with an unknown assailant(s). In almost one-fifth of cases no definite perpetrator was identified at presentation.

Both parents	6	(14%)
Mother	6	(14%)
Father	10	(23%)
Stepfather	3	(7%)
Teacher	2	(4.6%)
Self	1	(2.3%)
Other carer	3	(7%)
Family friend	1	(2.3%)
Not known	8	(18.6%)
Not applicable	4	(9%)

Table 5 Those allegedly responsible for the abuse

ASSOCIATED DEVELOPMENTAL AND BEHAVIOURAL FEATURES

There were no definite trends of underlying developmental problems or disability identified amongst the group, nor any preponderance of children with chronic health problems. A documented history of behavioural problems was noted in six of the children (14%).

OUTCOME OF MEDICAL ASSESSMENT

The figure below illustrates the responsible adult the children were discharged to following the medical assessment.

Most children were sent home with a family member, including a social services-supported placement with a grandparent. Fourteen of the children had either foster carer placements immediately or other non-specified social services provision on discharge.

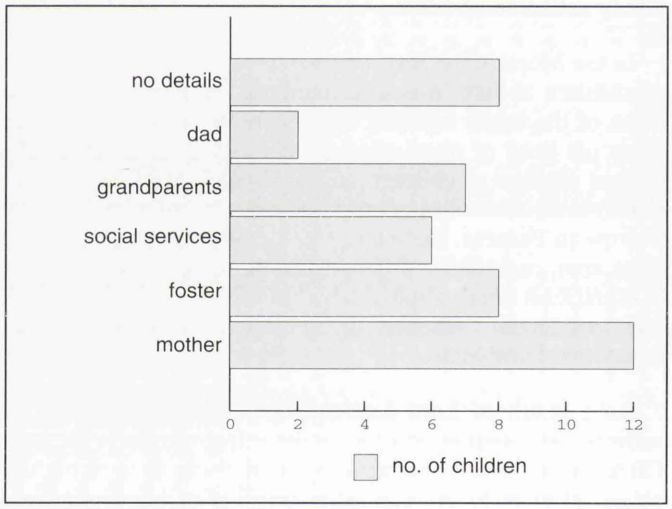

Figure 1.

DISCUSSION/CONCLUSIONS

The use of an assessment and documentation tool 'proforma' as a basis for audit does have certain limitations. The accuracy depends very much on whether and how it is completed by the professionals.

The numbers of children in the audit probably include all social services referrals. It is, however, an underestimate of the number of children referred to the paediatric department with the possibility of child abuse from within the hospital, for example presenting to A&E, orthopaedics and surgery. The number of children investigated for subdural bleeds or fractures but found to be normal, for example, is not detailed. If the opinion is that this is not 'abuse', and the child is not considered to be at particular risk, then a different recording method may be used.

Neglected children may well be known to the social services department and CPT previously, but not require a secondary centre referral.

The primary care team does take a lot of responsibility for child protection, so it was therefore surprising that there were no direct referrals for assessment from GPs during the audit period. The abused children all had a GP but the abuse seemingly had not been brought to their attention.

A high level of awareness continues to be demanded. Nationally, most children in the 'serious cases' review resulting in the death of a child had some or even significant contact with the GP prior to death, whereas fewer than half had any contact with the paediatrician. The primary care team continues to have a special role in the possible prevention and early detection of children at risk. The age group most commonly seen in GP contacts, other than the elderly, is the preschool age (under four years). Our audit figures reflect the national figures, showing this group to be particularly at risk.

The Morecambe Bay area has a varied population with some of the UK's poorest rural and urban populations. In these pockets there is significant childhood poverty, higher than average street crime and drug and alcohol misuse. Social deprivation is linked to a greater risk of child abuse. The audit did not specifically examine the social circumstances of the children referred. No conclusions could therefore be drawn as to the state of employment, housing or inebriation of the children's carers. Fewer than one-third of the children referred were living with both parents. Stepfathers were less likely to be the instigators of abuse than natural fathers.

The audit did illustrate an improvement in information sharing with the social services department and should lead to continued progress in child protection team working. This requires a continual awareness of child protection issues throughout the PCT. In this regard further information of local procedures, training courses and government documents such as 'Safeguarding Children: What to do if you think a child is being abused' are available on the child protection pages of the PCT website.

THEN AND NOW – CHILD DISCIPLINE

1953 – Character Building
"A properly administered spanking consists of turning the child over one's knee and holding his head down by firm pressure on the back of his neck. The parent's other leg may be used to clamp the child's wriggling legs firmly down. With his free hand the parent administers ten hard blows with a hair brush or similar instrument, to the bare buttocks of the child. A spanking administered with clothing really does not hurt . . . The human buttocks are admirably designed for character building purposes".
(American Psychiatrist)

June, 2004 – On Smacking Children
"The Government is under pressure from inside the Labour Party to outlaw smacking. More than 200 peers and MPs want to amend the Children Bill, which is going through Parliament. The bill would introduce a ban except in exceptional circumstances, such as when a child was in danger or might hurt another child".
(Daily Telegraph)

HOW TO DISCIPLINE WITHOUT SMACKING

Reported effects of smacking

- Aggression, disruptive, delinquent and anti-social behaviour, violent offending and low peer status
- Poor academic achievement including lower IQ, poorer performance on achievement tests, poorer adjustment to school, more attention-deficit symptoms and poorer self-esteem
- Diminished quality of parent-child relationships, with children less likely to be securely attached to parents, and to feel fearful or hostile towards them
- Increased anxiety, depression, suicidal ideation and psychiatry disorders.

Effective discipline

- Parental warmth, involvement and affectionate relationships
- Clear communication and messages, age-appropriate, as to why their behaviour is acceptable or not
- Providing fair, reasonable and clearly-defined rules, boundaries and expectations for behaviour
- Consistently following behaviours with appropriate consequences, rewards or mild non-physical punishments such as time out.