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THE BATTERED BABY

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THE BATTERED BABY

Summary

The clinical condition known as the battered baby or battered child syndrome results from serious physical maltreatment of young children by their parents or other adults. Attention should be alerted when a child is seen with a fracture of any bone, subdural haematoma, failure to thrive, soft tissue swelling or skin bruising, repeated injuries, or in any sudden death of a young child, and suspicions aroused when the degree and type of injury is at variance with the history.

Wilful physical injury may be repeated on the same child, or on siblings if preventive measures are not taken.

Many of the adults who injure children have long standing emotional problems, which may be remediable, and their behaviour may be a cry for help. Such adults may come from any social class.

This memorandum is aimed at increasing professional awareness of the syndrome and recommends action to deal with its problems. It stresses the importance of early recognition in which an important role can be played by all those who visit children in their own homes —especially general practitioners, health visitors and social workers —and by doctors in accident and emergency departments of hospitals. Early case finding, with subsequent treatment and protection of the injured child and aid to the family, should reduce the risk of further incidents.

A description is given of the circumstances in which the suspicions of health visitors, social workers, general practitioners and hospital doctors may be raised that a battering situation exists. The need for a detailed history is emphasized and it is made clear that knowledge of a case can be considered complete only when the Medical Officer of Health and Children's Officer has been consulted and the information that they are able to provide has been taken into account. Other agencies may have been in contact with the child's family and may be able to provide additional information. The Children's Officer has an important part to play and can bring to bear the various services which the individual situation demands.

A multiplicity of professional staff may be involved in the care of these families and co-ordination and joint effort between them is essential if the already existing family stresses are not to be intensified by multiple visits or by differing advice from various agencies. The need is stressed for local arrangements to be made to meet the situation and keep it under review, and, for these purposes the Children's Officer and Medical Officer of Health jointly should bring together those involved.

Introduction

The term "battered baby syndrome" is well known and is used to describe serious physical maltreatment of young children by their parents and others.

Children have been subjected to maltreatment throughout the ages, but the current interest in the problem dates from 1946 when Caffey, J. drew attention to the association of multiple fractures in the long bones of children suffering from chronic subdural haematoma. Woolley, P. V., and Evans, W. A. (1955) reported that previously unsuspected fractures or sub-periosteal haematomata discovered by radiology were in many cases due to wilful violence. In 1962 Kempe, C. H. and his colleagues directed attention to the prevalence and gravity of the situation, described the syndrome more completely than before and termed it the "battered child syndrome".

Attention was drawn to the syndrome in this country by Griffiths, D. L. and Moynihan, F. J. (1963) and in 1966 a memorandum on "The Battered Baby", prepared by the Special Standing Committee on Accidents in Childhood of the British Paediatric Association, was published which made comprehensive recommendations on action to be taken when there was suspicion of wilful injury to a child. Advice on action was reiterated by Fleming, G. M. (1967).

In September 1969 the report "78 battered children—a retrospective study" was published by the National Society for the Prevention of Cruelty to Children. This resulted from a study undertaken by the Battered Child Research Department of the Society and related to an analysis of the case records of 78 battered children who came to the notice of the N.S.P.C.C. in one year, from 1st July 1967 to 30th June 1968, and who had been physically injured to an extent serious enough to warrant medical attention. It gave pointers to the detection of families at risk and made recommendations on possible future action.

The findings of this last report suggest that there is still some lack of awareness of the syndrome, or reluctance to become involved with it, and that the published recommendations on possible action have not been fully effective.

Incidence

Despite increasing awareness of the syndrome a recent authoritative work on the battered child from the U.S.A. (Helfer and Kempe, 1968) states that "readers . . . may be discouraged to learn how little is known about incidence rates and distribution patterns

of child abuse . . . Substantive information and opinions presented (in the chapter) must be viewed as educated guesses based on non-representative observations and not as definite facts".

The frequency of the syndrome in this country is not known. Figures for 1967 from the Registrar General detail a total of 71 deaths under the age of 5 years due to "homicide and injury purposely inflicted by other person"; 43 of these deaths occurred in the first year of life.

In a study of 679 postneonatal deaths (those occurring from 4 weeks to one year of age) 6 infants died as a result of proven wilful violence and in a similar number the circumstances were suggestive of the syndrome. Relating the former group to all postneonatal deaths in England and Wales suggests that there could be some 40 infant deaths per annum from wilful violence in this age-group alone.

It is clear that the 78 incidents in the N.S.P.C.C. study only represent the tip of the iceberg; in that series one child died in the period of study as a result of the injuries, a mortality of 1·5 per cent.; mortality in some other series from abroad has been reported at considerably higher levels than 1·5 per cent.

Aetiology

The battered child syndrome may occur at any age but the younger the child the more likely he is to be harmed—and the more severe the injuries. More boys than girls tend to be involved and the N.S.P.C.C. report points to a higher than expected incidence in children who were "premature" at birth.

Most incidents occur at home and involve parents or guardians. The adults in the N.S.P.C.C. study were in most cases between 20 and 30 years old, married, more females than males were involved and in many instances the women responsible were pregnant or recently confined at the time of infliction of the injuries. Many of the adults who injure children have long-standing emotional or social problems.

Kempe, C. H. (1962) refers to reports about the parents, some of whom may be of low intelligence. "Often they are described as psychopathic or sociopathic characters. Alcoholism, sexual promiscuity, unstable marriages, and minor criminal activities are reportedly common amongst them. They are immature, impulsive, self-centred, hypersensitive, and quick to react with poorly controlled aggression. Data in some cases indicate that such attacking parents had themselves been subject to some degree of attack from their parents in their own childhood. Beating of children, however, is not

confined to people with psychopathic personality or of borderline socioeconomic status. It also occurs among people with good education and stable financial and social background. However . . . it would appear that in these cases, too, there is a defect in character structure which allows aggressive impulses to be expressed too freely. There is also some suggestion that the parent was subjected to similar abuse in childhood".

Gibbens, T. C. N. and Walker, A. (1956) were of the opinion that cruel parents were so because of rejection, indifference and hostility rather than cruelty in their own childhood.

In considering the emotional problems of the adults involved, the N.S.P.C.C. report refers to the work of Bryant, H. D. (1963) but divides its own sample into two groups viz:—(1) those who are habitually aggressive, and (2) those whose impoverished personalities cannot sustain a child nurturing relationship. The latter group is subdivided into (a) those whose unmet dependency needs result in a continuing search for attention and affection, and who are distraught and disappointed that the baby does not initially offer such rewards, and (b) the rigid and controlling group whose precarious stability depends on their being in control of people and circumstance, and who become distraught by babyish behaviour which is not amenable to such control.

It is also recognised that the circumstances in which parents find themselves may lead to the infliction of the injuries. Normal people who have problems in dealing with their children may be overwhelmed at times by stress and sleepless nights and hit out at the baby.

There are two important risk factors in families in which a child has been harmed by the parents. The child who has been injured once in this way is at considerable risk of repeated physical maltreatment, whilst in addition there is the possibility of injury to subsequent children in the family.

The Clinical Picture

Most injuries in young children are accidental, but some result from serious physical maltreatment; this latter group requires the particular attention of all those professionally concerned with the care of children.

The clinical manifestations of the battered baby syndrome vary widely in nature and degree, and Kempe, C. H. (1962) has suggested that the syndrome should be considered in any child exhibiting evidence of fracture of any bone, subdural haematoma, failure to thrive, soft tissue swelling or skin bruising, in any child who dies

suddenly, or where the degree or type of injury is at variance with the history given.

Injuries are commonly multiple, although not necessarily all severe, and bruises are the most constant manifestation. Clinical or radiological evidence may be obtained that injuries have occurred at different times and this dissemination of injuries in space and time is important.

Difficulties arise in diagnosis from the presentation of seemingly convincing histories by the parents and there is a tendency for the adult responsible to be supported in this by the non-active partner. The clinical condition of the child needs to be looked at carefully in the light of such stories as "falling downstairs", "crushed by other children when playing" or "grasped firmly when slipping in the bath", etc.

In assessing the history there are certain points which may be useful. The interval between the alleged accident and the presentation of the child for advice may be significant; in a simple accident the child is usually rushed to family doctor or hospital, but with battered babies there is often an admitted interval of hours or days. Cases brought at night should be treated with suspicion. The clinical and radiological signs sometimes clearly indicate that the time of occurrence given by the informant is wrong. It may be unprofitable to spend much time on details of the alleged "accident" and time may be better spent in ascertaining whether the child has "ever hurt himself before", and in matters pertinent to the mother-child relationship.

The possibility of previous injury should be borne in mind and physical or radiological stigmata, as well as earlier records, may be of value in this respect.

Management—Individual

Firm diagnosis is rarely possible at the earliest stage, but a suspicion of the syndrome may be aroused in the minds of any of those who made the first professional contact with the child—in particular the health visitor, with her statutory duty to visit parents with young children, the general practitioner, the hospital casualty officer, or the social worker in contact with the family. Child care officers supervising foster children may bring suspected cases to light as may matrons of day nurseries.

The suspicions of the *health visitor* being alerted she should communicate them to the family doctor concerned and to her nursing officer. The latter should apprise the Medical Officer of Health, and discussion, at this stage, between general practitioner,

medical officer of the local authority, nursing officer and health visitor could be directed to the further action considered desirable in the particular case; knowledge of the family by the Children's Officer may be of value. A similar course of action could be taken by other non-medical professional staff.

First concern must be for the safety of the child and, in view of the continuing risk to a child who has been battered, the *general practitioner*, suspicious of a case, will wish to consider reference of the child to hospital whilst investigations are made. Amongst other considerations the hospital consultant does not have the same ongoing relationship with the family and is perhaps less inhibited by the circumstances of the family doctor/patient relationship than is his general practitioner colleague. It is easier for a consultant to act more freely in this situation than for a family doctor and if the former accepts the onus of the enquiry the family doctor can come back into the situation as a family counsellor without the family losing confidence in him. If such action is refused by the parents full details of the incident should be sought and especially of the need for medical attendance in the past—previous hospital records and reports may be revealing. Contact should be made with the Medical Officer of Health who may be able to provide significant information about the family, especially in its social setting, and will have contact with the Children's Officer and with other agencies who may have knowledge of the family. If as a result of his enquiries the general practitioner's suspicions of deliberate maltreatment are sustained contact should be made directly, or through the Medical Officer of Health, with the Children's Officer of the local authority, who can, in concert with the general practitioner and the Medical Officer of Health, decide what best can be done for the child and the family utilising supportive and protective services. Psychiatric knowledge of the problem is limited but there is no doubt that psychiatric investigation of and support to the parents is desirable in all cases and is welcomed by some. Highly skilled social work and an ongoing professional relationship is needed by these families if the future of the battered child and its siblings is to be safeguarded.

Casualty officers, and others in hospital performing duties in the accident and emergency department, must be alert to the possibility and frequency of the syndrome. If suspicious that a child's injuries do not tally with the given story there should be consultation with a senior member of the medical staff who would then assume responsibility. If such consultation is not conveniently practicable, the child should be admitted and if the parents will not agree to this the family doctor should be told of the situation. Contact with the general practitioner should be made whatever action is taken.

When a child suspected of being the subject of physical maltreatment is admitted to hospital either by direct reference from the general practitioner or through the accident and emergency or

out-patient departments, a similar line of action to that detailed above for the general practitioner applies. Throughout, the parents must be told repeatedly that the first concern of the doctor is to make their child better and secondly "to make sure that it does not happen again". If during the interview the doctor is preoccupied with aetiology or assumes the role of prosecutor the parents will refuse co-operation. A detailed history is essential, a meticulous written description of visible injuries and, when possible, good clinical photographs are important, and the possibility of previous injury should be investigated. The consultant personally, or through a member of his medical team, should seek from the family doctor and from the Medical Officer of Health information about the family background which would lend weight to or dispel suspicion. The Medical Officer of Health will have contact with the Children's Officer and other agencies who may have knowledge of the family. When all available information has been obtained and in the event of the suspicion of deliberate injury to the child being sustained, an interview should be held with the parents in the presence of the medical social worker or senior nurse. This is the critical point at which the decision on further action is made and communicated to the parents. "At the interview the doctor should explain to the parents that the child's condition cannot be accounted for by any disease; that the injuries do not conform to the explanation given; and that there are grounds for suspecting that they may have been caused by some person in the child's home and environment. In the circumstances the doctor is proposing to inform the Children's Officer of the local authority so that the matter may be properly investigated. The doctor should state that in the meantime he proposes to keep the child in hospital" (B.P.A. memorandum). Then, with the knowledge of the family doctor, the aid of the Children's Officer of the local authority should be enlisted. The Children's Officer has a duty to enquire into situations suggesting that a child may be in need of protection and is in a position to make provision which will best help the child and deal with the family situation; he has a duty to bring the child before the juvenile court if that is necessary to ensure that the child is adequately protected, and generally it will be on him that the decision will lie to inform the police when considered necessary. The relevant legal provisions are fully set out in the B.P.A. memorandum. The administration of the hospital should be informed of this action or of difficulties with the parents.

In the event of a child's death in suspicious circumstances the coroner should be informed and given details of the circumstances of the death and of the suspicions.

Although normally contact should be made with the Children's Officer of the local authority it could be that some other social agency, such as a medical social worker, might have a particularly

effective part to play in some individual case. The National Society for the Prevention of Cruelty to Children, in particular, has played an important role in this matter, and some doctors may wish to enlist the Society's aid directly, informing the Children's Officer that this has been done.

The Medical Defence Union (1960) has stated that the Medical Officer of Health, the Children's Officer of the local authority, and the officers of the National Society for the Prevention of Cruelty to Children, are all appropriate persons to whom a doctor can impart information.

Management—General

Many individual agencies in a local area, concerned with child care, may be involved with the battered child and there is need for a team approach if protection is to be given to the child and aid to the family. Children's Officers and Medical Officers of Health have been asked to consult together and to bring into the discussions others involved—representatives of the Local Medical Committee, paediatricians, consultants responsible for accident and emergency services, and other local agencies (Appendix). Such a group should review the local situation regarding battered babies and decide what arrangements should be made to ensure that all necessary assistance can be made to the child, others at risk in the family, and to the adults involved. It would foster a wider appreciation of the part that the various agencies represented have to play, what their resources are and what they can do, and could facilitate exchange of information. Such a group could have a continuing function in reviewing the local situation from time to time. From such local effort information about incidence might emerge.

Co-ordination of information is of essential importance. An assaulted child, or children in the same family, may be treated in different departments of the same hospital or in different hospitals in the same area. There is value in the setting up of a registry of injuries to children which are not satisfactorily explained, so that information can be made available readily to hospital medical staff about injury sustained by one or more children in a family.

The group recommended above is to be concerned with the pattern of organisation required locally to deal with the battered baby problem. It could consider the setting-up of a small committee to keep individual cases of battering or potential battering under review. This could minimise breakdown in communication, allow an assessment of the individual situation and its needs to be made by a knowledgeable group, and ensure an effective follow-up so that the children would be adequately protected.

Co-ordinated case conferences before discharge, bringing together all the appropriate agencies, are helpful in allowing an exchange of information and the formulation of an agreed place of management for the individual child in his family setting.

Prevention

It would be an ideal situation if the possibility of a first battering could be anticipated, but this is rarely possible. Early case finding holds an important place in prevention. An awareness by all professionally concerned of the syndrome and of the characteristics of the parents, with rousing of suspicions when childhood injuries are encountered, is the first stage in the prevention of further injury to the child and possible risk to its siblings. By the utilisation of the services of the Children's Officer—both protective and supportive—and by the use of psychiatric and skilled social help for the parents, children at risk may be protected from further maltreatment.

The importance of the continuing risk must be stressed and the N.S.P.C.C. report in particular, points to the unsatisfactory aftercare arrangements which have been made by many hospitals despite the evidence of repeated, unexplained injury in childhood. A co-ordinated local organisation should remedy this. Awareness of the syndrome, its background and implications, and the effective management of the case by a co-operative effort from all agencies who have a part to play, must pay dividends in preventing childhood distress and death.

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APPENDIX

To Medical Officers of Health and
Children's Officers of
County Councils, County Boroughs,
London Boroughs and authorities
with delegated functions.

9th February 1970

Dear Doctor/Children's Officer

BATTERED BABIES

In recent years there has been increasing awareness of the problem of young children who are injured by their parents. If no preventive action is taken when these cases come to light the child may be at risk of further injury and subsequent children in the family may be similarly at risk.

In 1966 the British Paediatric Association published a memorandum on "The Battered Baby" (British Medical Journal, 5th March 1966, pages 601-603) giving advice on action which might be taken when deliberate injury to a child was suspected and quoting extracts from the statutes which may be relevant in dealing with such situations. Copies of this memorandum were circulated from our Departments to Medical Officers of Health, Chairmen of Local Medical Committees and Local Authority Children's Departments.

A report, "78 Battered Children", published on 14th September 1969 by the National Society for the Prevention of Cruelty to Children, gives an account of 78 children under 4 who had received serious physical abuse. The findings of the N.S.P.C.C. Report are based on cases reported to its social workers during the year 1st July 1967 to 30th June 1968. These findings and other information available to us suggest that there is still some lack of awareness of the syndrome and that local discussions among those concerned with a view to the adoption of procedures on the lines recommended by the B.P.A. would be valuable.

All agencies concerned with child care and the police may be involved in the problems associated with the battered child. We are therefore writing jointly to Children's Officers and Medical Officers of Health to ask you to consult together and to bring into your discussions the others involved—representatives of the Local Medical Committee, paediatricians and consultants responsible for accident and emergency departments, since hospital casualty officers are frequently the first doctors involved. It is desirable that the police should be brought into your discussions; and there will be

other local people or social agencies, such as the N.S.P.C.C., whom you may wish to involve. The group could review the situation in your area and decide what further arrangements should be made to ensure that all necessary protection and assistance can be made available to the child, others at risk in the family and to the parents and other adults. Such a group could have a continuing function in reviewing the local situation from time to time.

It is known that local schemes exist already and reference to one of these was made in the Annual Report for 1968 of the Medical Defence Union. We would be glad to learn of existing schemes and of their effect. Such information will be of value to the Standing Medical Advisory Committee in the formulating of further advice. In any case we would like you to prepare jointly by 1st October 1970 a progress report on the local consultation we are asking you to arrange and send a copy to each of us.

We have suggested these consultations because we think that there is much that can be done by local co-operation, by the fostering of an increased medical and social awareness of the problem and through an appreciation by all concerned of the resources available to help and protect children. We hope that you are able to help in this.

Yours sincerely,

G. E. GODBER,
Chief Medical Officer,
Department of Health and
Social Security and Home Office.

MISS J. D. COOPER,
Chief Inspector,
Children's Department, Home Office.

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