



Community child health

Arch. Dis. Child. 2002;86;53-54
doi:10.1136/adc.86.suppl_1.A53

Updated information and services can be found at:
<http://adc.bmj.com>

These include:

Rapid responses

You can respond to this article at:
http://adc.bmj.com/cgi/eletter-submit/86/suppl_1/A53

Email alerting service

Receive free email alerts when new articles cite this article - sign up in the box at the top right corner of the article

Notes

To order reprints of this article go to:
<http://journals.bmj.com/cgi/reprintform>

To subscribe to *Archives of Disease in Childhood* go to:
<http://journals.bmj.com/subscriptions/>

Community child health

G155 A COMPARATIVE STUDY, USING FOCUS GROUPS, OF PRIMARY CARE PROFESSIONALS' ATTITUDES TO, AND KNOWLEDGE OF, DOMESTIC VIOLENCE AND ITS IMPACT UPON CHILDREN

R.M. Brooks, L.S. Wajszowicz, E.V.J. Webb. *Department of Child Health, University of Wales College of Medicine, Cardiff, UK*

Introduction: The new Working Together highlights domestic violence as an important area in child protection. Professionals in primary healthcare are best placed to identify the presence of domestic violence in families. Few studies have explored the knowledge base and attitudes of these groups, and none their understanding of the impact of domestic violence on children.

Aims: To explore primary care professionals attitudes to, and knowledge of domestic violence; to identify differences between professionals groups; to describe the impact of these differences on their professional practice.

Method: Comparative qualitative study of 4 professionally based focus groups using a grounded theoretical framework. The four groups comprised General Practitioners (GPs), Health Visitors (HVs), school nurses, and midwives.

Results: GPs and HVs had a more sophisticated understanding of the nature of domestic violence than did school nurses and midwives. All groups had misconceptions about prevalence and risk factors. GPs had very limited information on support services, which affected their practice—they were more reluctant to respond to domestic violence in the clinical setting than were other groups. When exploring the impact of domestic violence on children, GPs and midwives refocused the discussion on adults. Midwives seemed to see domestic violence only from a woman's perspective and only in terms of physical injury. No midwife had ever made a child protection referral despite identifying domestic violence. School nurses felt their changing role had limited their ability to respond to children at risk.

Conclusions: Primary care teams have inadequate knowledge of domestic violence. Professional education is required. This should be combined with child protection training, should include local referral pathways for support and refuge in the voluntary and statutory sectors, and be multi-disciplinary to eliminate professional bias.

G156 DO WE PROTECT ABUSED BABIES FROM FURTHER ABUSE? A COHORT STUDY

B. Ranton, E.H. Payne, K. Rolfe, A. Kemp, I. Butler, J.R. Sibert. *Dept of Child Health, University of Wales College of Medicine, UK*

Objectives: To ascertain how effective child protection services are in actually protecting abused babies from further abuse.

Methods: As part of a population based incidence study, we ascertained all cases of physical abuse in babies in Wales under a year for 1996–1998. Cases were ascertained by a paediatrician surveillance reporting system (the Welsh Paediatric Surveillance Unit) and from Child Protection Registers. We ascertained information on their placement and further abuse over three years after the incident from medical, case conference and social services records.

Results: We ascertained 69 babies over a two-year period: an incidence of physical abuse of 114/100,000 (CI + 11.8) per year. Of 69 babies, 5 died from the abuse. One child went to Australia and we have no information. Of the remaining 63, 14 were permanently removed from the home however one of these was re-abused during a contact visit. Of the remaining 49, 15 were further abused: a re-abuse rate of 31% (CI + 13%).

Conclusion: The risks of re-abuse of babies returned home after abuse are very high. We must focus child protection services more on actually protecting babies and less on reintroduction to families.

G157 INJURIES IN UNDER ONE YEAR OLDS—ARE WE MISSING NON-ACCIDENTAL INJURY?

J. Balfe, C. Egleston, A.J. Nicholson. *Departments of Accident and Emergency and Paediatrics, Our Lady of Lourdes Hospital, Drogheda, Ireland*

Aims: To study all injuries under 1 presenting to a regional paediatric department over a period of 3.75 years (1/98–9/01) and to highlight the nature and mode of injuries sustained and to analyse in

detail whether sufficient consideration was given to the possibility of non-accidental injury (NAI).

Methods: A prospective injury surveillance system commenced in January 1998 and parents of all injury attendees were requested to give information on the time, site and mechanism of injury which included a text description of events. All injury admissions who were under 1 were studied in detail re where and how the injury occurred, who was present at the time, the time gap between injury and attendance at the accident and emergency department and details of paediatric and social work input were sought. All data thereby obtained was entered onto an Epiinfo2000 database and later analysed.

Results: Of 542 under 1 year old attendees with injury, 95% of injuries occurred at home. Of 87 admissions, the mean age was 5.7 months (median age: 9 months). 28% of injuries occurred in the kitchen, 10% in the bedroom, 8.5% on the stairs and 8.5% in the sitting room. Peak injury occurrence was at 10.00 and 17.00 hrs mothers (57%) and fathers (5%) were the responsible person present at the time of the injury. In 61% of patients the time interval from the injury to hospital attendance was less than 4 hours and in just 4% was it over 24 hours. Of those admitted 40% had minor head injuries, 3% had skull fractures and 2% had burns/scalds with just 0.3% having a long bone fracture. Two deaths occurred, both unrestrained car passengers. Just 6% of all admitted had social worker involvement and 22% (19 patients) had direct paediatric involvement, usually at consultant level. 3 cases of NAI were confirmed: one had "shaken baby syndrome", one multiple rib fractures with a femoral spiral fracture and one had a torn frenulum with bruising. Two of these were subsequently taken into care.

Conclusions: Under-recognition of NAI seems certain and the above data point to a need for greater paediatric input and a higher index of suspicion among surgical trainees. We propose that all under 1 year olds should be carefully assessed if presenting with an injury and a standard proforma should be developed for same.

G158 SHAKEN BABY SYNDROME AND APNOEA

A. Kemp. *Department of Child Health, University of Wales College of Medicine, UK*

Recent research suggests that infants who die of shaken baby syndrome (SBS) have micro-pathological evidence of axonal injury at the cranio-cervical junction. These children present with apnoea. Research has suggested "it may not be necessary to shake infants very violently to produce shaking injury to the neuro axis".

Objectives: To ascertain what proportion of infants with subdural haemorrhage (SDH) have apnoea at presentation. To look at the long term outcome in this group of children and any associated clinical evidence to support mechanism of injury.

Method: From a case series of 90 children under 2 admitted to hospital with (SDH) between 1992–1998. We identified 65 children who meet the criteria of non-accidental head injury. From hospital, community, social services and legal case notes we identified details of clinical and radiological findings, child protection and legal outcome.

Results: Of 65 cases 22 children had evidence of apnoea at presentation. 10 (45%) children with apnoea died compared with 6 (14%) of 43 children who did not have apnoea. 83% (86% apnoea: 81% non apnoea) of all children in the series had evidence of extra-cranial injury. Children with apnoea had significantly more skull fractures (27% apnoea: 7% non apnoea) and more bruising to the head (50% apnoea: 70% non apnoea).

Conclusion: Infants with non-accidental SDH and apnoea at presentation have a poor outcome with a significantly higher mortality rate. These children have a high level of associated severe trauma with particular evidence of skull fractures and bruising to the head. There is evidence that they suffer from a significant level of violence when there are abused. We are still no further forward in identifying the least degree of shaking needed to cause SBS.

G159 DO FALLS DOWN STAIRS CAUSE SERIOUS INJURY IN PRESCHOOL CHILDREN?

C. Henson, N. Yousef, E. Curtis, C. de San Lazaro. *Royal Victoria Infirmary, Newcastle upon Tyne.*

Objectives: To determine the type, distribution and severity of injuries sustained when preschool children fall downstairs.

Method: We examined 14 212 Accident and Emergency records from a district general hospital to identify those children aged 4 years and under who presented between 1st January 1999 and 30th June

2001 following a fall downstairs. Data collected included age, gender, details of the fall, the type and site of the injuries and the outcome of the visit to Accident and Emergency.

Results: 437 children, 202 girls and 232 boys, were identified. 27 falls occurred in children under 9 months and 310 falls (71%) occurred in the early mobile age group (12 to 36 months). 387 falls (89%) occurred in the child's home. There were 402 injuries in 376 children. 28 children (6%) sustaining more than 1 injury. 287 injuries (71%) affected the head and the neck and 94 injuries, (23%) a distal

limb. Only 6 children (1%) sustained proximal limb fractures. There were no rib fracture. There were no deaths or severe injuries such as cerebral haemorrhages/tears, visceral trauma or spinal fractures.

Conclusions: Severe injuries and death do not occur as a result of falls down stairs. The pattern of injury is peripheral with sparing of the trunk. Multiple injuries are rare. Therefore the presence of severe injury or multiple injuries, especially those involving the trunk, should be viewed with suspicion.