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Personal practice

Medical evidence in child abuse

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In the light of recent fatalities and other unfortunate episodes where proper attention to medical evidence might have averted disaster, it is a timely moment to evaluate the sort of evidence paediatricians should present in child abuse cases and how to do so in such a way that it cannot be ignored, overlooked, or discounted. To make a maximum impact at case conferences and in court, it is essential that paediatricians are clear about three major issues:

(1) The nature of medical evidence in child abuse;
(2) The rules governing evidence presented in care proceedings;
(3) The central role of the paediatrician in representing the interest of the child above all else.

Child abuse is defined as the avoidable impairment of any aspect of development as well as physical well being. The areas in which the paediatrician has special expertise include physical injury; nutritional status; growth; and intellectual and psychological development. This expertise lies outside the sphere of social workers but is supplemented by the opinions of child psychiatrists, psychologists, and speech therapists. It is the paediatrician, however, who has the general responsibility for collating this evidence, which should have authority that can be challenged only by another expert, that is, another paediatrician. Thus, any abused child who comes under the care of a paediatrician should be assessed in all the areas listed so that the medical evidence can be built up. The complete picture, that is evidence of deficiencies in more than one of the parameters, is far more important than any one feature. While it is not possible, for example, to say that a child with speech delay must be neglected, if the speech delay is associated with physical injury or unexplained growth failure, it is reasonable to conclude that it is 'likely' that home circumstances are responsible for both deficiencies. The more deficiencies there are, the more likely the conclusion. The witness should not be deterred from maintaining such an opinion even if it is put to him or her that the finding could have some other explanation. Any doubts should be resolved in favour of ensuring that further abuse is prevented.

It is clear from previous studies that children living in abusing homes have, at best, an uncertain outlook, irrespective of the support offered to families,[1 2] with a considerable risk of death, serious illness or injury, education failure, emotional disturbance, and the likelihood of being taken into care in later childhood because of delinquency. Fear that medical evidence will lead to the break up of a family is not justified by the poor outlook for these families.

Growth failure is an important feature of child abuse.[3 4] Continued poor growth is associated with poor intellectual performance.[5 6] We have found that children who have failed to grow adequately in abusing families show poorer catch up growth if allowed to remain in those families[7] and that this poor growth is associated with evidence of more than one feature of child abuse. There is, therefore, a prima facie case for removal of these children into foster homes.

This case has been seriously weakened in the past by confusion over the outcome for children in care. They were often removed from their own parents late in childhood or subjected to repeated changes in rearing with the child being switched among children's homes, natural parents, and foster homes. The problem has been recently compounded by the influence of the 'parents' rights' lobby who have, by various means, made it increasingly difficult for children to be placed in long term care with a view to adoption. Little wonder that some have been led to conclude that natural homes are preferable to that. Yet early removal to permanent foster homes tells a very different story. At all events, paediatricians should not be tempted to 'soft pedal' their evidence or views because of such considerations.

Since the only objective evidence that the child is being abused comes from the medical evidence, it should be central to any decision making. It will,

however, only be so if the witness is clear of the strength of the case and understands how to present the information to the court. It is evident that for those children with more than one feature of abuse, the long term outlook is relatively poor, particularly when one of the features is growth failure and especially when catch up growth can be shown in hospital or in a foster home. In these cases, the paediatrician is entitled to conclude that on balance speech delay, or poor growth, or behaviour disturbance is due to inadequate rearing and that the long term consequences for the child if it continues to be reared in the same way are likely to be unfortunate.

This brings us to the crucial question of the nature of the evidence presented in court. In the first instance, the rules of evidence are those of the civil law. The paediatrician does not have to show beyond reasonable doubt that speech delay is due to neglect (a virtually impossible task) but merely on the balance of probability that this is so. Thus, a child who has failed to grow and shows speech delay in the absence of other causes can be said to be having its development avoidably impaired.

It is also important to recognise that some of the medical evidence is material, that is that the child has failed to grow, or is not talking, or has bruises etc; but that some of it is expert, that is the interpretation of the bruises, the relation between poor speech and growth failure, and the likely long term consequences if this is allowed to continue. It is vital that the consultant paediatrician should appear as a witness in cases of such complexity, and not a junior member of the consultant's staff. Only a person of some seniority can have the authority to express opinions of this kind directly to the judge or magistrate over the heads of solicitors or council. It is important to know that this is possible and that one is not restricted merely to answering questions during cross examination.

The paediatrician has two tasks, to present the evidence of abuse and then to express an opinion as to what would be required to prevent that abuse recurring. In cases where more than one form of abuse is evident, it is perfectly proper to state that medical evidence shows that on balance of probability home circumstances, whatever they are, are unsuitable for child rearing and that unless they can be substantially altered it would be unwise for the child to return home. This avoids the risk of being accused of hearsay evidence. If challenged, the response would be that poor home circumstances could be inferred from the condition of the child and was not based on hearsay. It can also be said with some confidence that current policy for the early return of seriously abused children under care or supervision orders while case work is carried out seems to have little basis in terms of results to support it, and this can be stated as an opinion if asked whether a case order or supervision order should be made. At the very least, paediatricians should insist on regular follow up for anthropometry, developmental testing, and speech delay, with appropriate action if the findings warrant them.

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