

Correspondence

Medical evidence in child abuse

Sir,

Taitz and King suggest that the existence of 'speech delay' may be offered as evidence of serious deprivation in care proceedings.¹ We feel that the relations between language development, deprivation, and child abuse are more complex than Taitz and King imply.

(1) 'Speech delay' is an imprecise term. Does it refer to poor articulation, limited vocabulary, immature syntax, inadequate social use of language, or poor comprehension? When is 'delay' significant? Speech therapists report 'delay' at varying levels on language testing, from less than -1 to -2 standard deviations from the mean.

(2) There is wide variation in the rate of language acquisition even among normal children growing up in stable families,² and a substantial part of this variation is determined by genetic and constitutional factors.³

(3) Although much has been written in a descriptive sense about early language acquisition, little is known about the *minimum* environmental requirements for this process. There is, however, a strong body of opinion that language acquisition is a very robust function and the variance attributable to different levels of 'stimulation' may be quite small.⁴

(4) 'Speech delay' is a symptom calling for differential diagnosis. Some children with delayed speech development turn out to have a true language disorder, but the differential diagnosis from 'simple' speech delay can be very difficult in a young child.

(5) A child from a poor or potentially abusive family may be less able to reveal his full repertoire of language skills when attending a day care facility or when faced with the unfamiliar situation of a developmental assessment.

(6) It is unwise to assume that two developmental assessments separated by a period should give identical quotients. Substantial changes in scores in either direction are commonplace and must not automatically be attributed to environmental changes.

In clear cut cases of child abuse the presence of 'speech delay' may be of only marginal importance. When care proceedings are brought on less solid evidence, evidence on the quality of *parental care* is highly relevant, but the deduction that parental care is likely to be inadequate *because* the child shows 'speech delay' deserves to be treated with considerable caution by the courts. If such evidence is to be presented a thorough multidisciplinary review is essential.

References

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- ³ Pennington BF, Smith SD. Genetic influences on learning

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⁴ Wanner E, Gleitman LR, eds. *Language acquisition; the state of the art*. New York: Cambridge University Press, 1982.

D HALL, M BERGER, and P HILL
St George's Hospital Medical School,
P GRUNWELL
Leicester School of Speech Pathology,
P FLETCHER
Reading University

Apnoea monitoring and cot deaths

Sir,

The final conclusion in the report on apnoea monitoring,¹ 'apnoea monitoring has a place in highly selected situations', is more positive than previous articles but remains guarded. It would seem timely to attempt to redress this pessimistic approach. Experience over the past five years has shown that the loan of Graseby MR 10 monitors to 85 families (25 machines are available, bought almost exclusively from voluntary donations) has been successful and rewarding. With regular supervision at hospital paediatric clinics and by health visitors, the problems described by previous authors have not been seen. The monitors are reliable (only eight have been returned for servicing) and the number of false alarms diminish to negligible numbers after the first fortnight. Occasional alarms when the infant's breathing is very shallow are reassuring as they indicate that the monitor is functioning.

This service has been a demanding but not a formidable undertaking. The gratifying effects on parental anxiety, sleep patterns, and fostering confidence in their infants have been a remarkably positive aspect of the counselling and support system developed in Leicestershire. There have been no deaths on monitors but two parents are convinced that without monitors their infants would have died.

In the light of such experience it seems unfortunate that the authors of the paper on a comparison between apnoea monitoring on weighing scales² indulge in highly subjective interpretations of the results. For example, they found that 11% fewer symptoms in the infants were described by parents using apnoea monitoring as compared with weighing scales. Their interpretation was that babies on monitors are 'less closely observed and this could represent a hazard'. An equally valid interpretation would be that the parents using monitors were less pathologically anxious about their babies than about infants being weighed daily. This view is supported by the fact that monitors readily promoted reassurance in the immediate postnatal period, whereas weighing took some time to be accepted. No assessment was made in the study of parental night time anxiety, touching their sleeping infants and sleeping