Assessment of child abuse

Sir,

Your recent correspondence includes debate on the case conference, the basic instrument of child abuse assessment recommended at Tunbridge Wells. A more pertinent topic might be the scenario after deregistration.

Unless one hears anachronistic 'go-it-alone' philosophy as in The Swing of the Pendulum or the rejection of case conference by the Society of Clinical Psychiatrists, medical megalomania masquerading as purist ethic may go unchallenged. Even if one takes the arguments of Drs Chapman and Woodmansey seriously, it is neither practical for child psychiatrists to take the central role regularly, nor acceptable that they decry all multidisciplinary conclusions—perhaps not even attend case conference!

It is apparent that much child abuse care remains parent orientated and that the persistence of far from 'good enough' parenting rather than physical trauma, accounts for the sad sequelae of the acute syndrome for the child, and a legacy of child abuse for the next generation. The preoccupation of social work protocol is still with non-accidental injury and expedience, avoiding having too many names on the 'at risk' register, deregistering, and closing the case as promptly as possible—not only for logistic reasons—seemingly without much awareness of, or intention to break, the cycle of underlying emotional deprivation. The truth of the latter suggestion is seen at case conference in the absence of any regular account of the abusers' childhood experience of parenting and the facility with which grandparental or foster abused grandchildren. Completing the protocol, deregistration, leaves the child in a dangerous vacuum and encourages parents to evade consultant surveillance, while the passage of years reduces the role of the primary health care team and often sees the end of non-accidental injury and failure to thrive, which may be more related to the child's age than to therapeutic intervention; the child enters school, and, hey presto, his problem is no longer medical but educational. The hard data of growth charts and physical injury give way to the subtleties of conduct disorder and intellectual delay—the hiatus in professional contact leaves the educational team unaware, or perhaps unseen, to pursue the key aetiological factor, continuing emotional deprivation.

A handicapped child with rubella embryopathy or cerebral palsy from birth injury at once enters a defined system of assessment and care, formally supervised into the school years. By contrast, a child with social handicap, called child abuse, is subject to a flurry of attention after non-accidental injury but very soon drifts into oblivion despite his probable permanent handicap(s). Perhaps rather than struggling to prevent social services departments prematurely deregistering children—perhaps even with a new baby imminent—one should see the paraphernalia of case conference and registration simply as a rather brief management interlude to be followed by further formal consecutive process, thus recognising the time scale of child abuse and the limited resources of social services departments?

The title 'battered child syndrome' has subserved its purpose. Debate on balance at case conference and training of professionals is less important than filling the vacuum after deregistration: let the educationalists emerge from their statementing libraries and give us a declaration of intent on child abuse; let their role be formally guaranteed.

References


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Medium chain triglyceride diet in epilepsy

Sir,

Sills et al.1 provide further important information about the use of a medium chain triglyceride diet in epileptic children, but the value of their study would increase with answers to the following questions:

1 How common were seizures before treatment?
2 After what period of time did the beneficial effect of the diet become apparent?
3 Over what periods were the post-treatment seizure rates assessed?
4 Was there a length of time following which improvement on continuing the diet was unlikely?

Reference


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