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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 unchal-
lenged. 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 accept-
able that they decry all multidisciplinary conclusions— 
perhaps not even attend case conference!

It is apparent that much child abuse care remains parent 
orientated1 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.2 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 
tention to break, the cycle of underlying emotional 
depression. The truth of the latter suggestion is seen at 
conference in the absence of any regular account of the 
abusers’ childhood experience of parenting and the 
facility with which grandparents are proposed to foster 
abused grandchildren. Completing the protocol, deregis-
tration, 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 depart-
ments 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
2 Society of Clinical Psychiatrists. Case conference for child 
3 Lynch MA. Robert’s J. Consequences of child abuse. London: 

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Medium chain triglyceride diet in 
epilepsy

Sir,
Sills et al1 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?

References
1 Sills MA, Forsythe WI, Haidukewych D, MacDonald A, 
Robinson M. The medium chain triglyceride diet and intractable 

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