REPORT OF
COMMITTEE
ON
NON-ACCIDENTAL
INJURY TO CHILDREN
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REPORT OF COMMITTEE

on

NON-ACCIDENTAL INJURY TO CHILDREN

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SUMMARY OF MAIN RECOMMENDATIONS

The main recommendations made by the Committee are as follows:—

1. Every injury to a child under 2 years of age, apart from road traffic accidents, and any injury not readily explained in older children should be a cause of concern (Par. 2.1).

2. Likely indications of non-accidental injury have been identified in paragraphs 2.2 ad 2.3 and recommendations regarding the investigation and initial management of suspected cases are made in paragraphs 2.5 and 2.6. Subsequent management of a case of suspected non-accidental injury should be regarded as a team effort. Case conferences should be an essential part of this team effort (Paragraphs 3.1 and 3.2).

3. The establishment of a central registry of cases should be a vital element in the arrangements for dealing with the problem of non-accidental injury to children (Par. 4.1).

4. A training plan should be developed to ensure that staff involved in their work with young children and their families should have the necessary knowledge, awareness and vigilance to enable them to cope better with the problem of non-accidental injury (Par. 5.1).

5. Legislation should be considered with a view to giving wider powers and legal immunity to staff engaged in the management and prevention of non-accidental injury (Par. 5.4).

6. Every effort should be made to provide adequate community care services to the families involved (Par. 5.5).

7. The Department of Health should be the co-ordinating authority for the services at central level and health boards should be the co-ordinating authorities at local level (Par. 5.6).

8. Health boards should consider the establishment of area committees comprising appropriate staff of the health boards and representatives of hospitals and other bodies to ensure the necessary cooperation and liaison in dealing with the problem of non-accidental injury (Par. 5.7).
SUMMARY OF MAIN RECOMMENDATIONS

The main recommendations made by the Commission are as follows:

1. Reclaim urgency to a child under 5 years of age from its environment, and any involvement of other children should be

2. In the case of concern (Section I)

...
CHAPTER 1
INTRODUCTION

1.1 Background

Following discussions with Professor E. E. Doyle, Department of Paediatrics, University of Dublin and the National Children's Hospital, Harcourt Street regarding non-accidental injury to children, Dr. Joyce, Chief Medical Officer, Department of Health, invited interested parties to a meeting in the Department on 1st May, 1975 to discuss the problem of non-accidental injury to children. A list of those who attended is at Appendix A.

The problem was discussed generally at the meeting. It was agreed at this meeting (i) that there was a significant problem of non-accidental injury to children in Ireland, (ii) that the position should be examined and procedures suggested for dealing with such cases and for ensuring the co-operation of parties dealing with such cases and (iii) that a central register of such cases should be established.

1.2 Formation of Committee

It was decided at the meeting that a Committee should be set up to consider the problem of non-accidental injury to children with the following terms of reference:—

(a) exchange of information as to the extent of the problem of non-accidental injuries to children;

(b) procedure for the identification of such injuries;

(c) the feasibility of establishing a central register of such cases and its location;

(d) co-ordination of the efforts of the parties involved with such cases;

(e) the management and prevention of such cases.

It was decided that the Committee should comprise the following:—

Professor E. E. Doyle, (Chairman), Department of Paediatrics, University of Dublin.

Professor N. O'Doherty, Consultant Paediatrician, St. Joseph's Hospital for Sick Children, Temple Street, Dublin.
1.3 Extent of Problem

The Committee exchanged information available to the members as to the extent of the problem in Ireland. It was unanimously agreed that a significant problem exists and that co-ordinated efforts should be made to remedy the position. However, it was accepted that it would be difficult to be specific regarding the numbers of such cases—that there are probably 300 to 400 cases of non-accidental injury to children occurring in Ireland each year, at least 100 of these being in the Dublin area. One difficulty in assessing the number of cases is that all the children, even those brought to hospital, are not recognised as being cases of non-accidental injury.

It was also agreed that the work of the Committee should concentrate initially on the problem in the Dublin area and that most of its recommendations could then be applied (with modifications, if necessary) to the rest of the country, particularly in the light of experience of the operation of recommended procedures etc., in Dublin.

The Committee considered the matter under three main headings:—

(a) the identification, investigation and initial management of cases of non-accidental injury;

(b) the establishment and maintenance of a central registry and a system of registration of such cases; and

(c) the general management and prevention of non-accidental injuries to children.

1.4 Working Group

At the third meeting of the Committee on 28th May, 1975 it was decided that a small working group, comprising members of the Committee should be formed to draw up a detailed memorandum on the
matters considered by the Committee. This memorandum would be submitted to the Committee members for their consideration and would form the basis of the Committee's report to the Department. The members of the working group were:—Professor E. Doyle (Chairman), Dr. A. Corboy, Miss C. Delaney, Miss S. Smith and Mr. S. Hensey.

1.5 Information obtained from British authorities

It was suggested that the working group should obtain information from centres in Britain on arrangements for dealing with the problem of non-accidental injury to children, particularly in relation to the establishment and maintenance of registers of such cases. Information was obtained from Dr. Christine Cooper, Consultant Paediatrician, Royal Victoria Infirmary, Newcastle-on-Tyne and discussions in relation to non-accidental injury to children were held with the following:—

(i) the British Department of Health and Social Security;
(ii) Mr. Ray Castle, N.S.P.C.C. Denver House;
(iii) the Surrey Area Health Authority, Guildford;
(iv) the Area Health Authority (Teaching) for the Ealing, Hammersmith and Hounslow area.

The information obtained as a result of these discussions was presented to the Committee and has been taken into account in the preparation of its Report. This Report was considered by the Committee on 27th November 1975 and agreed at its final meeting on 16th January 1976.
CHAPTER 2
IDENTIFICATION AND INVESTIGATION

2.1 General
Every injury to a child under two years of age apart from road traffic accidents and any injury not readily explained in older children should be a cause of concern and the full history of how the injury occurred should be compared with the physical findings. Discrepancy should lead to suspicion and, where child abuse is suspected, the child should be admitted to hospital. Suspicions should be checked by enquiry from the central registry of cases of non-accidental injury (see Chapter 4). A list of possible indicators of child abuse is set out below. It should be noted that non-accidental injury includes not only physical injury, but also nutritional deprivation, neglect and emotional deprivation and trauma.

2.2 Index of Suspicion
(i) Parents’ story at variance with clinical findings.
(ii) Repeated injury.
(iii) Visits to different hospitals or to different general medical practitioners.
(iv) Reluctance of parents to give information.
(v) Child brought to a hospital during evening hours.
(vi) Child brought to a hospital for complaint other than injury—headache, fever, abdominal pain, etc.
(vii) Lapse of time between injury and attendance at doctor’s surgery or hospital.
(viii) Obvious familial discord, stress, etc.
(ix) Parents’ refusal to give consent for investigation.
(x) Nutritional deprivation.
(xi) Retardation.
(xii) Signs of general neglect.
2.3 Suggestive features on Clinical Examination

(i) **Bruises**
(a) Any bruises on a baby less than one year of age.
(b) Bruising from human bites.
(c) Black eyes.
(d) Bruising of ear and surrounding scalp.
(e) Petechial haemorrhages.
(f) "Finger and thumb mark" bruises on face, trunk or limbs, especially on trunk of young baby who has been firmly held and shaken.

(ii) **Fractures**
(a) Any fracture in the first year (unsuspected fractures of clavicle, ribs and long bones may be present even in a healthy-looking child).

(iii) **Joints**
A tender swollen joint or limb which is normal on x-ray may show calcified periosteal haemorrhage on repeat x-ray two weeks later.

(iv) **Burns and Scalds**
(a) detailed study of history and findings;
(b) circular blebs, sores or scars from cigarette burns—these are often found in clusters and may be of different ages.

(v) **Injuries to Mouth**
(a) Small blood clot on gum or tongue.
(b) Minute tears of the frenulum.
(c) Cuts, scratches, excoriations or sores around the mouth.

(vi) **Injuries to Eyes and Brain**
(a) Retinal haemorrhages from chest compression or shaking.
(b) Subdural haematomas (when small and chronic this may present as vomiting, irritability and failure to thrive).

(vii) **Visceral Injuries**
Injuries to a solid or hollow organ may be present without any external bruising.
Poisoning may not always be accidental or due to carelessness.

Cot Deaths
Some cases of "cot-deaths" are non-accidental.

2.4 Admission to Hospital
Suspected cases of non-accidental injury should, if possible, be admitted to hospital. In each case, the hospital paediatrician or other designated doctor familiar with the procedure for such cases should be contacted and admission arranged or if the child is brought to the hospital direct, the paediatrician or doctor should be notified of the admission. Examination and investigation should follow along the lines indicated below.

2.5 Examination
(i) Detailed description of all injuries, e.g., site and colour of bruising.
(ii) Fundus examination—preferably by an Ophthalmologist.
(iii) General nutrition.
(iv) Burns and scalds.
(v) Evidence of "poisoning".
(vi) Evidence of fracture—(skull, clavicle, ribs and long bones).
(vii) Evidence of retardation.

2.6 Investigation
(i) X-ray—skeletal survey (excluding spine and pelvis, unless clinically indicated)—immediately and in three to four weeks. The following x-ray signs are suspicious or diagnostic:
(a) multiple bone injuries especially near joints;
(b) fractures in varying stages of healing;
(c) epiphyseal displacement or metaphyseal fragmentation or both;
(d) evulsion of parts of the provisional zone or calcification;
(e) cortical thickening;
(f) single fracture in a young baby;
(g) spinal fracture in a young child;
(ii) Coagulation screening if there is bruising or bleeding.
(iii) Photography.
(iv) Consultation with paediatrician and medical social worker.
(v) Contact with family doctor for information and also public health nurse and community social worker.
(vi) Contact with central registry and possibly child care section of the health board or the I.S.P.C.C.
CHAPTER 3
MANAGEMENT OF CASES

3.1 Team Effort
The Committee considers that the investigation and subsequent management of a case of suspected non-accidental injury should be regarded as a team effort.

3.2 Case Conference
(a) The case conference is an essential part of this team effort. It is realised that with the demands on their time it will be sometimes difficult for all the persons concerned to attend. It is essential, however, to the success of the conference that as many as possible of those involved should attend. A case conference should be arranged as soon as practicable after the child is admitted to hospital—normally after consultation between the various disciplines involved.

(b) If the child is not admitted to hospital but is taken into care by the health board or placed in the charge of a “fit” person (under the Children Acts) or even if the suspicion is not strong enough to warrant removal from home, a case conference should also be called.

(c) It is important that one person should be responsible for calling the case conference and that the professionals and others dealing with the case know who this person is and where he or she can be contacted by telephone. It is suggested that the Director, Community Care of the particular area in which the child resides should be the person responsible for ensuring that the case conference is called. The Director could, of course, delegate this function to a senior member of his medical staff. Furthermore, these directors may not be available at present and in the interim some other person could be assigned this responsibility by the health board, for example, the doctor in charge of the central registry.
(d) Thus, where there is a confirmed case of non-accidental injury or where there is reasonable suspicion of such, the paediatrician or doctor in charge of the child should inform the Director of Community Care as soon as possible; the Director will then arrange a case conference. Similarly, where a case is being dealt with in the community, the person dealing with the case (general medical practitioner, public health nurse, social worker, etc.), should inform the Director as soon as possible.

[Miss Smith and Miss Delaney expressed the view that the “Director of Community Care and/or the Senior Community Social Worker” should be responsible for ensuring the case conference is called and should also arrange such conference.]

### 3.3 Participants in Case Conference

The team involved in the case conference could comprise:

(a) *where the child is admitted to or attending hospital:*

The doctor who admitted the child and took the initial history.
The consultant under whose care the child was admitted (usually a surgeon).
Paediatrician.
Ward Sister.
Medical Social Worker.
A Child Psychiatrist and, if necessary, an Adult Psychiatrist.
The Director, Community Care for the area.
The family doctor.
The local child health doctor from the Health Board.
Public Health Nurse.
Health Board senior social worker for the area concerned.
Other Social Workers (may be I.S.P.C.C.).
Where indicated, the child’s teacher (if of school going age).
The involvement of the Gárdaí in the case conference (including where appropriate the Juvenile Liaison Service and the Court Welfare Service) should be considered having regard to the circumstances of the individual case.

(b) The hospital staff would not normally be involved in the case conference where a child is not admitted to or not attending hospital.

### 3.4 General Management

(a) The purpose of the case conference is to bring together all those who have a responsibility for the safety of the child or are responsible for providing services, to ensure that all relevant information regarding the child and his family is available and to ensure that action is formulated for the future well-being of the child and family.
(b) The case conference should identify the authority with prime responsibility for the management of the case. That authority should designate the key person responsible for the case. This key person will be a member of a small team which is expected to take responsibility for the care and rehabilitation of the family concerned. The key person will usually be a social worker but he/she should always have a doctor available for consultation as a member of the team.

(c) The Director, Community Care and the Senior Social Worker should be kept informed of developments and in all cases of serious injury or neglect another case conference should be called to review the situation within a reasonable period. The management of cases of non-accidental injury is essentially a team effort and it is important that each member of the team is fully aware of his or her role and that independent action be avoided, if possible—see paragraph 5.5 regarding community care services.

Many parents need on-going psychiatric assessment and care. This should be made available as soon as the child is removed to a hospital or a place of safety to enable decisions to be made regarding the future placement of the child as speedily as possible.

3.5 Availability of Competent Legal Advice

It is important that competent legal advice should be available to professionals and others involved in their duties in such cases as undoubtedly legal problems will arise from time to time.
CHAPTER 4

ESTABLISHMENT AND MAINTENANCE OF A CENTRAL REGISTRY

4.1 General Principles

The establishment, maintenance and staffing of a central registry of cases and also the procedure for registration were considered. A central register of cases is considered to be a vital element in the arrangements for dealing with the problem of non-accidental injury. One of the aims of the registry would be to act as a reference for personnel concerned to ascertain whether a child was already widely known to different medical practitioners, hospitals or social workers as a case of suspected or diagnosed non-accidental injury. The registry would also form the source of valuable information on the child and the family for those deciding on the course of action to be taken in a particular case.

4.2 Maintenance of Register

The register could conceivably be kept in the paediatric department of a hospital, by the child care section of the health board, by the child health section of the health board or by the I.S.P.C.C. In some areas in Britain the registers are associated with hospitals and in seven health authority areas they are kept by the National Society for the Prevention of Cruelty to Children but generally the registers appear to be kept by the child health sections of the area health authorities under the direction and control of a senior medical officer in each case.

It is recommended that in the Dublin area the registry should be administered by a senior medical officer in the child health section of the Eastern Health Board. This would facilitate the operation of the registry in view of the medical involvement in such cases and the issue of medical confidentiality. In the event of registers being established at a later date in other areas it is recommended that they be based on Health Board areas. Reporting to the registry should be on a voluntary basis as it is felt that the registry would operate more effectively with an acceptable voluntary system than with a mandatory system which might not be accepted.
4.3 Reporting of Cases

All accidents (including poisonings) except road accidents, happening to children under two years of age should be reported to the registry. In addition, all accidents (including poisonings) happening to older children and not readily explainable should also be reported. It does not necessarily follow that further action will be required in respect of all cases reported to the registry. It is envisaged that cases will be reported to the registry by:—

(a) hospitals (both general and children’s hospitals).
(b) general medical practitioners and child health doctors.
(c) I.S.P.C.C.
(d) Children’s officers and social workers.
(e) Public health nurses.
(f) Teachers.

4.4 Relevant Information to be supplied to the central registry

The information submitted to the central registry should be on a uniform basis and a form for this purpose should be prepared and issued for the use of those concerned in the reporting of cases to the central registry. The information to be provided for on the form should include:—

(a) child’s surname:
(b) child’s first names:
(c) date of birth:
(d) parent’s names:
(e) parent’s present address:
(f) parent’s previous addresses:
(g) parent’s employment:
(h) siblings:
(i) deceased siblings:
(j) short description of the injuries to the child:
(k) placement of child—whether at home, retained in hospital residential care, or otherwise:
(l) the date of the case conference (if held) and the decision arrived at:
(m) the name of the person directly concerned (“key” person) and the agency now taking care of the child.

The information on the form should be used in conjunction with the case conference and subsequent follow-up of each case.
4.5 Information to be given from the central registry and to whom

The information to be given from the central registry should be left to the discretion of the doctor in charge of the registry. However, the fullest possible information should be given having regard to the circumstances of the case, particularly to the case conference. It is considered that information should be given from the registry on enquiry to hospitals, general medical practitioners, health board child health doctors, I.S.P.C.C. social workers, health board social workers, children's officers, other qualified social workers and public health nurses. Before information is furnished in response to a telephone enquiry the bona­fides of the caller should be established, say, by calling back the caller’s number. It is not envisaged that information from the registry would normally be given to teachers or to the Gárdaí.

4.6 Staffing of the Registry

Having regard to the reported incidence of non-accidental injury occurring in this country and to experience in the operation of registers in the United Kingdom, it is estimated that a very substantial number of cases would be reported to the registry in Dublin each year. With records to be assimilated and subsequent enquiries to be answered, it is considered that the following additional heads of staff would be required:—

1 full-time Medical Officer
2 part-time Medical Officers (1 for research on data possibly funded through research grant)
1 full-time professionally trained Social Worker with experience in the field of child abuse
1 public health nurse
1 clerk typist.

However, the specific staff requirements could perhaps best be assessed following discussions between the medical officer concerned and the Eastern Health Board, and in any event reviewed from time to time in the light of experience.

4.7 Working Arrangements

A direct telephone line with a recognisable number should be provided for the registry. Ideally, the registry should be open on a 24 hour-a-day basis, but it is appreciated that this would not be feasible at present. Besides, it is not clearly essential that the registry should operate on such a basis. Most injured children suspected of non-accidental injury will be admitted to hospital and if this occurs when the registry is closed the enquiry to the registry could be made the next morning. All cases, whether from a hospital or from the community should be reported to the registry immediately after the full facts have been
established—in the case of a child admitted to hospital this would normally be following full clinical examination and consideration of the case.
The question as to whether there should be two registers—one for definitely established cases and another for suspect cases, was considered and it was considered that initially there should be only one register for all cases and that consideration to the question of splitting the register could be given at a later stage in the light of the operation of the register.

4.8 Confidentiality

It is essential that all the information obtained on specific cases in relation to the operation of the register should be treated with the utmost confidentiality by those in charge of the register and those obtaining information from it.

4.9 Possible Legal Implications Arising from the Operation of the Registry

The following questions should be carefully considered in relation to the operation of the register:

(a) The obligation to disclose information from the register to the Gardaí and the implications of such disclosure. (This does not appear to have arisen as a practical problem in the U.K. to date.)

(b) The liability of persons reporting cases to the register or those in charge of the register being open to legal action by parents of the children involved.

(i) in respect of the initial report for the purposes of the register, or

(ii) in respect of information furnished to another party from the register.

The advice which we have received is that the information from the register should generally be disclosed only to professional people for example, doctors, nurses, social workers, etc., and that once the information is being disclosed in the interests of the child to prevent further injury or to safeguard the child the person giving the information or having it in the register could claim privilege. It appears that no liability would arise if the information were given in good faith and in the interests of the child.

This question, however, requires further consideration. While generally in the United Kingdom opinion on the matter is on the lines of the preceding paragraph the question is still under active consideration by the Department of Health and Social Security. [One member of the Committee (Miss Sona Smith) expressed reservations regarding the practicability of the proposed case conference and questioned the value of a central register for various reasons including the cost of staffing and maintaining such a register.]
5.1 Training of Staff

It is important that those involved in their work with young children and their families should be aware of the problem of non-accidental injury, of the procedures for dealing with such cases and of the early warning signs. This will involve the development of a training plan to ensure that the personnel have the necessary knowledge, awareness and vigilance. The following would be among those to be considered in relation to such training:

(a) Relevant hospital staffs, particularly in children’s hospitals and in casualty departments of general hospitals.
(b) Doctors in child health services.
(c) General medical practitioners.
(d) Public health nurses.
(e) Social Workers (including I.S.P.C.C.) and Children’s Officers in health boards.
(f) Teachers (particularly those in charge of young children).
(g) Staff of day care nurseries.

The training should be a continuous process both to ensure that new staff are aware of the problem and to provide refresher courses for existing staff (see paragraphs 5.6 and 5.7 in relation to authority responsible for implementing arrangements for training).

5.2 General Review by Agencies

Health boards, other statutory agencies and voluntary agencies engaged in the field of child care should review their work in the light of the problem of non-accidental injury and see what more can be done.

5.3 Informing the public of the problem of non-accidental injury

A greater understanding by the public of the problem of non-accidental injury could also be an important factor in preventing such injury.
Suitable information on the nature and extent of the problem might benefit parents who are under stress and likely to abuse their child. An understanding of their position and of the services and agencies which are available might help them with their difficulties.

5.4 Need for Additional Legislation

It is appreciated that the Task Force on Child Care Services is considering the preparation of new legislation on child care. We urge that this work should be pushed ahead as rapidly as possible. The Committee considers that in relation to non-accidental injury, legislation on the following matters should be considered:

(i) The right of entry to private premises by professional workers in the course of their duties, where child abuse is suspected.

(ii) The power to remove a child from his home, to retain him in a safe place, or to prevent him from being removed from hospital.

(iii) Supervision orders—the need for supervision orders which would give professional workers the statutory authority to supervise a child in his own home. It is envisaged that the frequency of visiting the home and the length of time for which the child is to be supervised, should be decided by the Court. It is felt that the Court should have the power to make it incumbent on a parent to bring his/her child to day-care or five-day residential nursery or other place of care as may be decided.

(iv) The need to clarify the present uncertain situation on the right of health boards to be "fit persons". The 1908 Act states that "a fit person includes any society or body corporate established for the reception or protection of poor children or the prevention of cruelty to children", but this is not mentioned in the Health Acts and people are confused on the question of the actual legal powers of the health boards. A Fit Person Order nominating a health board as fit person offers the child a wider variety of caring situations than does a Court Commital Order.

(v) Provision should be made for family courts for these cases and for hearings being held in camera. Furthermore, we consider that everyone involved in treatment or care should be prepared to give evidence and be consulted by the family court as to the decisions to be made. It would appear desirable that justices involved in such courts should have some special training in the field of child care.

(vi) The arrangements in relation to a "Place of Safety Order" might follow the system in England (under Section 28(2) of the Children and Young Persons Act 1969) which in certain circumstances allows a police officer to make arrangements for a child's detention in a place of safety for up to eight days. The present position in
this country is that the case must be brought to the High Court in order to prevent the child being taken away by one parent or other person.

(vii) Legal immunity in relation to bona-fide reporting to a central registry and the furnishing of information from the register.

5.5 Community Care Service

It is important that adequate community care services be available for the follow up of established or suspected cases of child abuse and for the support of families where such abuse is likely to occur. Paragraph 3.3 refers to the nomination of a key person with responsibility for each case and of the need for the Director of Community Care and the Senior Community Social Worker to keep themselves informed of developments in cases. Child abuse generally seems to occur in families which have many problems. Such abuse is one symptom of family crisis, one aspect of violence and of the low level of tolerance of some parents. The aim should be to help the family as well as to protect the child.

Such families need considerable social help to relieve stress and tension within the family, social work counselling, liaison with other services—supervision and support by social workers, public health nurses, doctors, etc., including psychiatric or medical help for the parents where required. It is essential that workers experienced in the field of child abuse be available for consultation, particularly for the young and inexperienced personnel working with the family. It is stressed that these families need a home of their own and advice in home management and home economics. An important factor in the management of such cases and in helping families at risk is the availability of good residential placement and foster-care. Day nurseries, creches for infants, and other centres where “at-risk” parents can leave their children are of great importance. In this respect, consideration should be given to five day residential care and care for children at risk during week-ends.

Nursery care serves two purposes: firstly the child is seen daily for any signs of abuse; also inadequate parents are relieved of the full stress of responsibility which can build up a situation of aggressive behaviour. Health education, counselling services, etc., can play an important role in preventing child abuse by preparing young persons for the responsibilities of marriage and in enlightening young married couples in such spheres as inter-personal relationships, responsibilities, and child rearing.

5.6 Role of Department of Health: Co-Ordination

The Department of Health should be the co-ordinating authority at central level. The Department should issue a circular to health boards, hospitals, and appropriate voluntary agencies incorporating the recommendations of this Committee in relation to the recognition and management of cases of non-accidental injury to children. It is appreciated that
the problem in the Dublin area is being considered initially and, according-­‐ingly, only the Eastern Health Board would be involved at this stage. The Department should also take steps to ensure that the training of those involved in child care is adequately provided for, as recommended in paragraph 5.1.

5.7 Role of Health Board

(a) Co-­‐Ordinating Authority

There should be a co-­‐ordinating authority at local level to ensure that the arrangements for dealing with non-­‐accidental injury to children are satisfactory and to keep these arrangements under review.

(b) Liaison

This authority described at (a) above should also ensure that there is satisfactory liaison and co-­‐operation between the various relevant bodies in the area, for example, the child care department of the health board, hospitals, voluntary agencies, etc.

It is recommended that this role of co-­‐ordination and liaison should be undertaken by the local health boards (in the Dublin area, the Eastern Health Board). Health boards have statutory responsibilities for child health and child care and have the necessary administrative structures to enable them to undertake the role.

(c) Area Committees

The health boards should consider the establishment of area committees comprising appropriate staff of the health board, and representatives of hospitals and other bodies to ensure the necessary co-­‐operation and liaison in dealing with non-­‐accidental injuries.

(d) Training of Staff

The health boards would also have an active role to play in the training of those involved in child care on the lines recommended in paragraph 5.1.

5.8 Staffing implications

It has not been possible for the Committee to assess in detail the staffing implications of the above proposals but it is clear that at present, duties in relation to non-­‐accidental injury to children are placing a burden on certain hospital staff. The question of the need for necessary additional staff should be considered as soon as possible.
APPENDIX A

List of persons who attended a meeting in the Conference Room, Hawkins House, on 1st May, 1915 to discuss the problem of non-accidental injuries to children.

Dr. Rosarie Bang — St. Ultan’s Hospital
Miss F. Clandillon — Social Work Adviser, Child Care Services, Department of Health.
Dr. Victoria P. Coffey — St. James’s Hospital
*Dr. Catherine B. Corboy — Child Guidance Clinic, Rathgar.
*Dr. Alice Corboy — Deputy Chief Medical Officer, Child Health Service, Eastern Health Board.

Mrs. L. Dear — Committee of the North Dublin Social Workers and the I.S.P.C.C.
*Miss Colette Delaney — Senior Case Consultant, I.S.P.C.C.
*Professor Eric Doyle — National Children’s Hospital.
*Dr. T. Fitzgerald — Medical Officer, Department of Health.
Mrs. Nuala Harmey — Temple Street Hospital (Social Worker)
*Mr. S. Hensey — Principal Officer, Department of Health.
Dr. Joyce — Chief Medical Officer, Department of Health.

Miss Niav O’Daly — Senior Social Worker, Eastern Health Board.
*Prof. Niall O’Doherty — Consultant Paediatrician, Temple St., Hospital:
*Dr. Maura O’Dwyer — East of Ireland Faculty, Royal College of General Practitioners.

Miss Breid Rutledge — Social Worker, Children’s Section, Eastern Health Board.
Mr. P. M. Sheehan — Children’s Section, Eastern Health Board.
*Miss Sona Smith — Medical Social Worker, Our Lady’s Hospital for Sick Children, Crumlin.
Dr. Edward Tempany — Our Lady’s Hospital for Sick Children, Crumlin.

*Appointed to a Committee under the Chairmanship of Professor Doyle with the following terms of reference:—

1. Exchange of information as to the extent of the problem.
3. Feasibility of establishing a central register of such cases and its location.
4. Co-ordination of efforts of the parties involved with such cases.
5. Management and prevention of such cases.

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