NSPCC

Cruelty to children must stop. FULL STOP.

Child abuse deaths can slip through net, finds NSPCC

2nd September 2004

Child abuse deaths could be missed because hospitals lack a national system to identify them, according to an NSPCC report, published today 2nd September, 2004.

The report finds that child abuse is only identified as contributing to a child's death if firm evidence is in place such as clear indications of injury and a confession by a parent or carer.

Such evidence has to prove 'beyond all reasonable doubt' that a child has been abused, which is rarely possible in maltreatment cases (1).

The study also found that information about how the child came to be in hospital and what happens following their admittance is often fragmented. Parents sometimes change their accounts of what had happened, experts disagree on diagnosis and little guidance exists on what and where to record information when a child dies.

Corinne May-Chahal, author of the report, said: "Judging whether or not a child has ended up in hospital as a result of abuse is difficult. Such a decision can only be made on the fullest information possible and if maltreatment is routinely considered as a possible factor.

"Medical professionals dealing with child deaths are faced with tough decisions, often based on fragmented information. In an increasing climate of litigation they are becoming reluctant to identify child maltreatment, even when they believe it is probable."

The study further reveals:

- Inconsistent accounts (such as parents or carers changing their stories) most frequently alerted paediatricians to suspicious deaths (80%) followed by unusual bruising (62%) and the death of another child in the family (46%).
- Three quarters (75%) of paediatricians believe that the monitoring of children at risk needs to be better prioritised.
- 61% believe that better training for health professionals should be made a priority.

Mary Marsh, NSPCC chief executive, said: "The Government needs to introduce a national standard for collating information relevant to child deaths as a result of maltreatment, as a matter of urgency. Without such information, cases of children who die as a result of maltreatment could be missed and their siblings left at risk.

"As part of its FULL STOP Campaign, the NSPCC is calling for a systematic child death review process to find out the causes of child deaths in the UK. Lack of information on the causes and circumstances of unexpected or suspicious child

deaths means the full extent of child killings remain hidden."

The NSPCC believes that the death of every child, under any circumstances, needs to be thoroughly enquired into. In order to improve the process the study recommends:

- The extension of particular child death investigation procedures to take account of all case-specific information (such as the relationship between the child and their carers preceding the incident and the context in which children live).
- Better training for health professionals on identifying maltreatment
- Child Death Liaison Officers in every hospital to gather relevant information from staff and families when a child dies.

Mary Marsh, added: "Unless relevant information is collected on the causes and circumstances of all child deaths, it will be impossible to understand the true extent of child abuse deaths and how to better prevent them."

ENDS

For further information please contact Rachel Petty at the NSPCC press office: 020 7825 2713.

Notes to Editors

1. In 1999 the largest cause of death for 1-15 year olds in England and Wales was injury and poisoning (24%).

In 1999 the largest cause of death for infants under one year old were ill-defined conditions (23%).

The study included:

- A review of the research and literature on preventable child death.
- A national survey of paediatricians on information processes in unexpected child death.
- Non-participation observation was conducted in an A & E department.
- In-depth interviews focusing on staff experiences relating to child death from A & E and paediatric departments of two hospitals.
- Analysis of one hospital's records for child deaths in A & E.

The study also found examples of good practice such as the use of a health visitor to note all child deaths and ensuring they were discussed at regular child protection meetings. At one hospital, staff were given an information protocol to encourage them to record any suspicions about potential child abuse or simply that 'something wasn't right'.

The full version of the report is available, price £20, from the NSPCC Publications and Information Unit: 0207 825 2775. It can also be ordered online: www.nspcc.org.uk/inform.

The NSPCC's purpose is to end cruelty to children. Its vision is of a society where all children are loved, valued and able to fulfil their potential. We seek to achieve cultural, social and political change - influencing legislation, policy, practice, attitudes and behaviours for the benefit of children and young people.

"This release relates to the publication - 'The Relationship between child death and child maltreatment: A research study on the attribution of cause of death in hospital

settings', by Corinne May-Chahal, Stephen Hicks and Jo Tomlinson, (2004), published by the NSPCC."