The Royal College of Psychiatrists

EVIDENCE TO THE SELECT COMMITTEE ON VIOLENCE IN THE FAMILY

INTRODUCTION

1 Historically there is little indication of the quality of childhood in past centuries. Such as there is, suggests that in mediaeval times the concept of childhood was hardly recognised and that if babyhood was survived the child was treated as a little adult and a convenient source of labour. Instances of the barbarous treatment of children, infanticide, exploitation, starvation, floggings, mutilation abound (152) and seemed to be accepted at least until quite recently. The task it seems is gradually to overcome the back-log of appalling ignorance and punitiveness in child rearing which has been present for so long and which constantly floods over into the next generation.

2 Even those from favoured homes are to some extent disappointed in childhood and are thus surprisingly insensitive to the miseries of the less fortunate and to the "apprenticeships of distress and wretchedness"(3) which even superficial enquiry reveals amongst children of today.

3 The dramatic term 'battered baby syndrome', coined by Kempe in 1962, was a useful means of drawing the attention of a blinkered world to the size and seriousness of the problem. The great amount of work which has been subsequently completed shows that there is not one but a whole range of syndromes, so that there is no single type of battering parent, nor of the battered child, nor of the causes, nor of the treatment.

4 Confusion may be avoided if it is accepted that the abuse of children is a description of behaviour not of any clinical entity. The study of child abuse is following very closely the stages through which the study of crime and delinquency have laboriously passed.

5 The hard won lessons from these sources can usefully be applied to child abuse: the absence of any stereotype; the elusiveness of clear causative factors which may only become operative when potentiated by other factors in the individual, the victim or the environment; the difficulty in prediction; the presence of a large penumbra of mild, easily controlled cases which shade off into ordinary public morality (ordinary punitive child rearing) together with a small hard-core of very resistant, malignant cases; the pattern of factors in the families reveals clustering of disorders as in Robins' delinquent children (123) or Oliver's (14) battering families which showed a similar clustering of social and psychiatric pathology, or Newcombe's (117) finding that the sibs of battered children show a greatly increased incidence of a variety of accidents, poisonings violence and other disaster; just as undetected and formes frustes of delinquency and crime are rife, so are unreported and minor assaults on children (the Newsons (153) in their study of child rearing practices and the community find that 62% of children at 1 year of age and 97% at 4 years are subject to physical modes of correction, 8% of them daily). A further similarity between crime and delinquency on the one hand and child abuse on the other, lies in the area of treatment. On the whole individual psychotherapeutic endeavours with both are proving less effective than broad supportive measures and especially self-help within the community. In all probability the use of fellow sufferers and voluntary workers (perhaps led by a trained agent and having immediate access to professional help) and nurseries for at risk children, will be the direction in which treatment will develop.

DEFINITION

6 For general purposes it is now better to drop the formerly useful term battered baby and its implication of deliberate wilful assault, in favour of the simple definition: any non-accidental injury to a child, but researchers must be permitted (and expected) to define the term differently for the purposes of their own enquiry.

7 Fairburn (5) and his colleagues in Bath use two categories:

'B' group (severe risk - monthly review)

Families in which the parents are known to have injured a child or in which severe injury has occurred in the past.

Families strongly suspected of currently inflicting injury

Families with the now generally recognized heavy weighting of predisposing social factors, including certain types of potential personality disorder.

The health visitor and social worker responsible for these B families send in an up-to-date report immediately before the monthly meeting.

'O' group (low risk - quarterly review)

All children under 3 with a bone fracture from any cause.

Children under 1 year bruised "more than could reasonably be expected" at this age

Families in which suspicion of injury or predisposing factors were not sufficiently strong for the severe risk 'B' group classification.

Families may of course need to be re-classified

8 Dr. Oliver in his researches (14) defines Assault Cases and neglect/ill-usage cases. The Assault Cases ranged from blatant and/or prolonged battering, to irate or unjustified damaging blows to a baby, toddler or young child, which caused professional involvement. The neglect cases ranged from starved, or repeatedly dehydrated or abandoned young children, to those irresponsibly left on their own, deprived of the minimum essentials of parental care, or otherwise treated in a blatantly irresponsible manner, such as to necessitate professional involvement on behalf of the children.

9 To classify by means of motivation is useful but hazardous. Some attempt is made by Scott to narrow the field of battering and to distinguish this from other forms of child assault (113, 114). In brief there are parents whose aim is to be rid of an encumberance (elimination) to relieve suffering (mercy killings), parents whose battering is directly attributable to the disordered thinking of frank mental illness, parents who are displacing onto children anger, frustration, retaliation arising elsewhere (the Medea situation), and parents in whom the immediate stimulus for their aggression arises in the child (the classical Battering situation). These groups have very different treatment indications.

THE SCALE OF THE PROBLEM

10 Violence (which is no more than aggression concentrated into brief duration) is easy to recognize and dramatic in its effects, but not necessarily more dangerous or damaging than continual extensive aggression even if of lesser degree. There are many possible indications of incompeter parental care - the 70,000 children in care (28, 29, 30, 31, 32, 33, 34) children ascertained as maladjusted pupils, delinquent and "in need of care, protection or control" children appearing before juvenile courts or attending child guidance clinics.

11 There are advantages however in concentrating effort upon some small band of this extensive spectrum, which can be reasonably accurately defined and thus susceptible to epidemiological and comparative studies. For this reason only actual physical non-accidental injury is considered. Even so the numbers are very great: in the USA, Kempe (65) estimates the incidence of non-accidental injury at 6 per 1,000 which implies 40,000 ascertained cases per year. In the UK a LANCET communication (112) suggests 3,000 cases a year. Dr. White Franklin (122) has written more recently about the statistics of non-accidental injury.

12 Oliver's (14) survey in N. Wilts, started in 1971, concerned children who have suffered very severe ill-treatment. For inclusion these 'severe abuse cases' were required to show one or more of the following factors:

1. Prolonged assaults of such severity that death ensued.
2. Skull or facial bone fractures
3. Bleeding into or around the brain; brain damage with consequent inpairment of either intellect of the functioning of one of the senses, or damage to the central nervous system or visual apparatus.
4. Two or more mutilations requiring medical attention (including bites, burns, crushes, cuts)
5. Three or more separate instances of fracture, and or severe bruising requiring medical attention.
6. Multiple fractures and/or severe internal injuries.

13 The rate of severe abuse by these criteria was one new battered child per 1000 children under 4 years old per year. The death rate (by mid 1973) was 10%. This rate, for England and Wales as a whole, would entail referral for over 3,000 children aged 0-3 years annually. Although this rate shows an increase of 2,5 times as compared with the previous 7 years, Dr. Oliver considered that there were clinical indications of residual under reporting and that the true rate is almost certainly higher.

14 The following 3 tables have been compiled by Dr. J. Oliver to give some indication of the ascertainment rates in Britain and other countries. These are of course likely to be minimum estimates and may possibly increase with changes in the awareness and sophistication of medical practitioners and those who refer cases to them.

LOCALITY	REF	Type of Population	Ages of Children	Total Pop. Nos.	Cases recorded in Relation to the Years of Study.	Nos. P.A. Per Mill. Total Pop.	Rate in Children.	Comment
Birmingham	24 115	Urban	Mostly under 2 years	1,000,000	69 cases in Birmingham in 2 years (1971 and 1972).	35	Unstated.	Data predominantly from Hospital sources only.
Lambeth (London)	111	Urban	3 years and under	300,000	28 in 1972	93	"An incidence of 2 per 1000 in children (aged 3 years and under" (per year).	Short report. Cases possibly less severe than those in the Wilts. and Birmingham studies. Data mostly from local authority sources.
N.E. Wilts.	4	Mixed Rural and Urban	Children under 4; more than 75% under 1 year.	200,000	22 between Jan 1972 and June 73.	75	"1 new case per 1000 children under 4 years old per year..." Also 4 (very severely battered babies) per 1000 live births per annum.	Very severe cases, often with repeated injuries. Data from multiple sources.
Preston and environs.	110	Mixed Rural and Urban	Unstated, mostly under 3 years.	300,000	45 cases in 1969 and 1970	75	Unstated.	Data from Emergency Dept. only.
Leeds and Manchester Metropolitan Districts	36a	Urban	Children under 4; 33% under 1 year.	77,000 children under 4	89 cases in 1974	Unstated	1•12 New cases per 1000 children under 4 years old per year	1. Discussion on the value of registers. 2. Repetitions and rebatterings considered

16 Proportions of children seen in routine medical practice who are the victims of violence or ill-usage at the hands of their parents or guardians

Ref.	94	Lauer et al (1974)	USA	Admissions to San Francisco General Hospital.	3% of total admissions are due to child abuse.
"	64	Kempe (1969)	USA	Children under 5 seen in Emergency Room.	15% of the children seen are the victims of child abuse.
"	65	Kempe (1971)	USA	Children under 2 seen with Fractures.	25% of the children seen are the victims of child abuse.
"	103	Fried (1973)	CANADA	Young children and babies with Fractures.	15% of the children seen are the victims of child abuse.
"	103	Fried (1973)	CANADA	Young children and babies seen with Trauma in the Hospital Emergency Room.	25% of the children seen are the victims of child abuse.
"	47	Okell C, (1971)	UK.	Children under 3 attending the Casualty Department.	6.7% of total children are victims of physical abuse. 8.9% are victims of obvious neglect.
"	37	British Med. Journal (1973)	UK.	Casualties in children under 2 years.	10% of total children are victims of physical abuse.
"	37	British Med. Journal (1973)	UK.	Fractures in children under 2 years.	25% of total children are victims of physical abuse.
"	46	Jackson (1972)	UK.	London Children seen with physical injury at Kings College Hospital, London.	18% of total children are victims of physical abuse.
"	50	Ounsted C et al(1975)	UK.	Paediatric Referrals to Park Hospital, Oxford.	11% of total children are victims of physical abuse.

17 Percentages of total attacked children who are killed by parents.

U.K. : NSPCC (1969) 1.3%, 53; MacKeith (1974) 1.3 - 13%, 12
Hall, M.H. (1972) 10%. 110; Oliver J.E. et al (1974) 12%, 14
Smith S.M. and Hanson R.(1974) 16%,* 24

U.S.A. : Gil. D.G. (1969) California Pilot Study 1.4%, 8; Ebbin A.J. et al (1969) 2.8%, 57; Gil G. (1970) 3.4%, 92; Lauer B. et al (1974) 4.4%, 94; Helfer R.E. & Pollock C.B. (1968) 5%, 93; Kempe C.H. (1974) 5%** 18; Simons R. et al (1966) 5%, 71 Brown R.H. (1973) 10% 116; Silver L. (1968) 11%, 98; Kempe C.H. et al (1962) 11%, 63; Fontana V.J. (1971) 10-25% 58 59; Elmer E. (1967) 14%, 90; Schloesser, P. (1964) 17%, 97; Zalba S.R. (1966) 21%, 100; Gil (1969) - Press Clipping Survey - 33%, 8.

AUSTRALIA : Colclough, I.R. (1972) 23%, 84.

*8% after excluding cases where parents had gone to prison.

**"Initial mortality" only, of 70,000 children battered annually in U.S.A.

WHAT HAPPENS TO SURVIVING BATTERED CHILDREN

18 We emphasise the importance of research under this heading because the existing studies drive home most forcefully the consequences of battering and are likely to alert the nation to the seriousness of the problem and the need for action.

19 It is likely that as doctors and social workers become aware of the delayed effects of early abuse, as they learn what to look for in the early history and as better clinical records are kept for longer periods (Social Service departments, we are told, destroy records after 6 years) then a variety of hitherto unrecognized or improperly diagnosed adults will be accepted as surviving battered children, instead of relegated as psychopaths. Practitioners in prisons and remand centres begin to be aware of the link between crime and early abuse. Tragically sometimes the crime is against the next generation; even clinical histories tend to repeat themselves Oliver and Taylor (151) describe five generations of ill treated children from the same extended family. Battered babies and abused children also tend to concentrate in subnormality hospitals, and some severely mentally handicapped children are in this condition as a consequence of violence in the home.

20 Guthkelch (124) and Caffey (132) described the intracranial damage which may follow vigorous shaking of a small child whose heavy head is alternately sharply decelerated on chest and back. Skulls are often fractured by direct blows, and Oliver (15) has described how shaking, swinging, hitting and throwing of babies may cause micro-cephaly with permanent residence in subnormality hospitals. Blindness (both central and retinal)may follow trauma (133, 134, 135).

21 It is estimated that between 2% and 4% of children in subnormality hospitals are brain-damaged following assaults by their parents. Ann Buchanan has shown that at least 2.5% of severely mentally handicapped children in Burderop and Pewsey Hospital were in this condition as a result of shaking or battering (137).

22. Four out of 140 children in the N. Wilts study (14) suffered unequivocal brain damage and severe mental retardation as a consequence of assaults by their parents and 3 of these were known to be normal before the assaults.

23 From the findings of Birrell (13), and Oliver et al. (14) at least one quarter of the severely attacked young children are intellectually damaged, subnormal or severely subnormal as a result of battering. Thus if 75 young children per million of total population are severely attacked each year, then 18-19 per million could suffer intellectual impairment each year, often of profound degree.

24 Ronald MacKeith (12) estimates that about 50 children in the UK survive each year with chronic incapacity due to non-accidental injury. "It seems that there may be 400 new cases a year of chronic brain damage due to child abuse. In such cases, cerebral palsy could only arise from brain injury (by contusion); mental handicap could arise from brain injury or from deprivation".

25 The relationship between physical injury, under-nutrition and psychological neglect (failure to communicate with, failure to play with, failure to provide a secure relationship from which the child can explore a reasonably varied environment) needs some elaboration. It is particularly difficult to study because all three factors often fall into the same constellation. Nevertheless there is a great deal of evidence both ethological and human that each factor, acting alone, may impair (possibly permanently) physical, intellectual and emotional

development, and furthermore that combinations of these factors may be synergistic (amounting to more than the sum of their separate expected effects). Critical periods of development and learning are a reality and tend to be concentrated within the periods of rapid growth. From the scientific side-lines it seems that the central nervous system needs a degree of stimulation and even of stress (previously misnamed 'gentling') and that too little or too much, especially at certain critical periods is deleterious. The literature in this area is of course enormous and controversial at some points, but the answers are already sufficiently firm to indicate where priorities of prevention and early treatment should be.

26 Professor Tizard's editorial 'Nutrition, growth and development' (138) and J. Stewart's article 'How malnutrition handicaps children' (139) are useful introductions in this area. Even though not amounting to physical physical violence these forms of neglect are not only of immense indirect but also of some direct importance to our present considerations; undernourishment or other forms of stress or illness in pregnancy may

27 1) produce a handicapped child who is more dependant, more difficult to manage and less gratifying to the parent.

The Cambridge studies (140, 141) have shown that restless, sleepless, crying babies may be identified at birth or even during pregnancy and thus permit the early application of support.

2) We know that maternal ill health and exhaustion correlate highly with child abuse and that ill, premature and underweight children attract battering (60, 142, 143, 144)

3) Our endeavours to help, for example by trying simultaneously to relieve the battering parents, the foster parents and the child (which is usually impossible for the needs of these parties may be directly opposed) may also result in a long period of traumatic uncertainty and deprivation for a very young child, which may be just as damaging as the battering and which may act synergistically with it to produce greater problems for the future. Martin (146) shows that of his 17 child subjects, 34% had from 3 to 8 home changes from the time of idenfitication of abuse. The more serious the maladjustment the more frequent the moves.

28 Baher and the NSPCC group are hopeful about the effects of intensive therapeutic intervention, which they found was of value to abusive parents and seemed to effect a restoration to the child's developmental status in most cases, especially those in the therapeutic day nursery.

The authors conclude "we now feel that our dual and interlinked emphasis on treatment of the parents and protection of the children, neglected an important area, the psychotherapeutic treatment of the children, which could well be provided in a day-care setting"

DIFFICULTIES IN ASCERTAINMENT

29 Incomplete and misinterpreted facts due to

ignorance of what to look for and what to ask;
shortage of time;
fear of arousing anger, litigation or alienation in a client or patient;
wish to maintain confidentiality;
incapacity to face the concept of open aggression by parents;
being deceived by parents who are often plausible and skillful at misleading.

30 Available but uncollected information

mobility of families involved;
deliberate changes of doctor or hospital to cover successive assaults;
inaccurate identification of the child concerned (different names or dates of birth given);
lack of standardization of records;
failure to make one person responsible for collection

31 Unavailable information

the privacy of homes favour concealment;
except possibly from neighbours who should therefore be utilized more effectively;
the tradition of helping and protecting the client or patient (parent) may obscure the needs of the child.

32 Abuse of children is not a disease entity but a pattern of behaviour and like all other such patterns it has a multiplicity of paths by which it is reached. It is of primary importance therefore to cease to look for a stereotype and to accept that physically abusing parents are sometimes manifestly mentally ill, but are also sometimes apparently well integrated persons. Between these extremes lie a host of very different sorts of parents in terms of varying social class, intelligence, attractiveness, mental stability and personality type. It is thus possible for a neat and attractive young mother, with an engaging, open manner, in charge of a well cared for beautifully dressed child, to have already killed one child and to be currently abusing her surviving child, who clings to her in an apparently loving manner.

33 The following are Points of Suspicion in the examination of the child

Look for a succession of injuries especially bruises of different ages, and especially in very young children. Some of the injuries may be bizarre - bites, burns, pinch-bruises. Serious injury to the brain, retina, bones, abdominal organs can occur without bruising or skin injury. Failure to think, unexplained vomiting and pyrexia and coma, may be due to abuse. All fractures in children under 2 years must be viewed with great suspicion. Skeletal X-ray and retinal examination are important diagnostic aids. The child must be undressed for a proper examination.

34 "Frozen watchfulness" and the "knowing wise look" are characteristic of some battered children. A child may have intense fearfulness of certain adults, e.g. will urinate or vomit when the returning father's voice is heard. Ill-treated children may be less likely to look to parents for comfort and may not clamour to be taken home. Such children may be wary of physical approval from one or other parent and may show apprehension when an adult approaches another crying child. Older children may show the well known reversed caring - anxious watching of mother, offering her one of her cigarettes, or patting her. The most recent studies of the development of these children has been carried out by Martin and Beezley (146); they record these frequently occurring findings: impaired ability for enjoyment, behavioural adjustment symptoms, low self-esteem, withdrawal, opposition, hypervigilance, compulsivity, pseudo-adult behaviour, school learning problems. Over 50% of these abused children had poor self-concepts, and were sorrowful and unpopular children.

35 Abusing parents are less likely to volunteer information about the child's illness or injury, and may be evasive or contradictory. Battering husbands or cohabitees often prevent the mother from taking the child to hospital until too late and then instruct her what to say. Abusing parents may show (and genuinely feel) great distress but are less likely to ask about how long the child will be kept in hospital or about follow-up care. Such parents may be critical of the child or even angered with him for being injured. They show 'distant, mechanical handling', best seen in the dressing and undressing of the child, where the lack of sympathy in the parent and apprehensiveness of the child is apparent. There may be lack of confidence in performing, or frank revulsion from, ordinary parental duties (changing nappies, feeding playing with).

36 Collusion between parents is usual either willingly, under duress, or more subtly by gradual stages of identification as described by Professor Millgram (29) in his book OBEDIENCE TO AUTHORITY.

37 Pollock (42) has suggested relevant areas of questioning. They centre about the parents anxiety and self-confidence in the parental role and cover attitudes to crying, refusal of the baby to be comforted, being left alone with the baby, being observed while caring for the baby and how realistic their expectations of the baby proved to be.

38 The essential need for good communication between different branches of the caring services is now well recognised and was greatly and properly stressed at the NHS Conference on 19 June, 1974 (Non-Accidental Injury to Children, HMSO, 1975). The regional and area Review Committees are central in this respect and should form the focus of interchange of information, records and communication in every aspect of this problem.

PREVENTION

39 The long dependency of childhood is both our strength and weakness. It permits relegation of instinct in favour of learned and highly adaptive behaviour, but it renders the child dependent upon protecting and loving parents, and if these fail the outcome may be disastrous.

It is a general biological truth that organisms and organs undergoing rapid growth are particularly vulnerable. Linked with this are the embryological and developmental facts that growth proceeds in spurts and plateaux, and has critical periods which if interfered with may not recover and thus lead to incomplete development.

These are compelling reasons for giving priority in all services to mothers and children. Prevention therefore basically is a matter of cultural, economic and political aspects of child rearing practices.

40 Of the primary prevention services - those which are applied to healthy people in order to keep them so - two reach everybody, or very nearly so; these are health visiting and education, and closely behind these are the primary health teams led by the general practitioners, and the antenatal and well baby clinics, for these services are primarily concerned with maintaining good health not with treating illness. The same may be said of pre-school play groups and nurseries. If by anology, we are to aim at preventing cholera rather than devising clever ways of treating it, then these five services are the nearest we can get to removing (like Dr. Snow) the pump handle and eradicating the trouble.

41 The DHSS has recently stated its priorities (125) and recognizes the importance of Health Visitors. "In particular the growth envisaged for the primary care services as a whole, and for health visitors in particular, who devote a significant proportion of their time to preventive measures for families, should enable more resources to be devoted to prevention" (p.22). "Hospital assessment services for newly

born and very young children have an important preventive role, and they too should be developed ...." Handicapped children including abused and neglected children, are recognized as "one of today's chief problems in health" (p.62). The expansion of the health visiting service is to be increased from their present strength of about 4,000, to over 7,000 as a "high priority" (p.64).

42 Such measures are necessary, and to be effective there should be a closer link between health visitors, general practitioners, family planning services, teachers, play-group personnel and community leaders, so that each may raise the understanding of the others. An excellent focus for such meetings is the group practice health centre. An Oxford primary health team which was described to us, has its own attached health visitor and social worker, runs groups for mothers with babies, and conducts lunch time seminars involving key figures in combating baby battering.

43 The schools may be a child's first experience of non-punitive handling and democratic relationships. In it a child who is not too damaged may, if the regime is sound, learn to respect others and value himself. This aspect of education is more important than later didactic teaching. Programmes of simple developmental psychology (the basic needs of children) and, later, parent craft should be organized. Older children could work in play groups,with mutual advantages.

44 The media of communication could be utilized for adult education and for enlisting voluntary workers. Although it may not influence established battering parents, people generally should be aware of the consequences of severe punishment, not only physically (e.g. the fact that shaking a young baby may cause brain damage, blindness, mental subnormality, and possibly death) but also psychologically.

It has been suggested that the long human period of gestation, during which the prospective mother is naturally interested in preparation, should be used for her and perhaps her husband's education. Such endeavours are already made in France and Sweden (126, 127, 128) and in some of our own antenatal clinics, and could with advantage be improved and increased.

45 Megan Jobling (154) in her excellent annotated bibliography mentions that Kent County Council is mounting a poster programme as a means of appealing to the public and the London Borough of Merton has arranged for police cadets to spend 3 months working with experienced social workers before starting their police training. Several Councils and Voluntary Services (notably the Samaritans) have established 24-hour "hot lines" or "life lines" for parents who feel at risk. In the United States and Canada self-help groups on the lines of Alcoholics Anonymous have proliferated.

46 The doctors like everyone else not only need to be educated but to have the lessons periodically repeated, for there is that about the misery of the battering situation which tends to be denied. Obviously medical students must know the facts and share part of the education with lawyers and social workers, and in turn be prepared to instruct others. Key figures in the medical scene are the general practitioners, the casualty officer and the paediatric registrar (who decides whether or not to make one of his precious beds available in a doubtful case). Emphasis needs to be placed on the casualty department particularly in big hospitals which may not have a paediatric department (because there will be a separate paediatric hospital elsewhere in the locality. These casualty departments may be manned by doctors who have as yet little experience of the culture. The Accident Officer may have an important part to play. Hospital psychiatrists sometimes work closely with the self-poisoning units, and might develop a similar relationship with the accident unit.

47 Wynn (129) points out that our infant mortality rates lag behind other European countries. In Finland and Sweden a baby under 12 months is visited on average between 3.5 and 3.1 times, a rate which is more than three times that achieved in Britain. Countries with the lowest infant mortality favour major branches of the medical and nursing professions specializing in work with children both in the community and hospitals (129). The British trend away from nurses specialized in health care of young children is retrograde "Health visitors are surely the only possible nucleus for such a service in the community"

48 France has succeeded in improving the frequency of examination of children, particularly in backward areas, by making family allowances contingent upon a certificate of examination of the child, before 8 weeks, at 9 months and at 2 years. French law prescribes 17 other examinations but not requiring certificates (129). It is possible that this French legislation has achieved its results, or part of them, by influencing backward local services, as well as through stimulating parents, but there can be no doubt of the effectiveness of an improved home visiting service to children. Scandinavian countries have achieved this without linking allowances with examination. The Thomas Coram Research Unit (130) has shown in an area of London that systematic home visiting by health visitors can reach 97% of children. The French Medical Inspectorate has recommended a substantial increase in home visiting of pre-school children and a corresponding increase in suitably trained staff (129).

49 Wynn draws 4 important conclusions:

"(1) The children of those nations do best who have a preventive health service for pre-school children established by legislation. There should be child health centres as local centres of the national service in every community, where possible combined with health centres."

"(2) A main aim of such centres should be the highest possible coverage of all pre-school children in the community. This aim can only be achieved by adequate home visiting. Health visitors should not be used for duties other than preventive child health, their original purpose.

"(3) There should be community consultant paediatricians in every area with responsibility for the child health centres including health visitors and home visiting.

"(4) A main role of a community child health service is to provide parents with all the help and advice they can use in rearing their children. This is the primary purpose of home visiting by health visitors. We have not yet taken the measure of how much help parents need or wouldwwelcome, if we include the concept of child health care normal development, common childhood illnesses and the special needs of children with different degrees of handicap, frailty or behavioural disorders". (129)

50 We subscribe to these four conclusions and would only add that some endeavour should be made, perhaps through a 'centre of excellence' (i.e. an area in which the effects of a child care organization which is as nearly as possible ideal can be researched), to introduce self help into the screening services for children, not only because our capacity to proliferate services is limited, but also because such a move may be positively advantageous. Such a scheme would probably depend upon defining neighbourhood units sufficiently small to permit individual families to identify themselves therewith. The health visitor sould be concerned with promoting as association of mothers in that unit, and although the individual home visit would be the basis of the system, there would also be group meetings in which parents could be

encouraged to help one another and perhaps (without snooping) give some indication of how to draw in or at least identify the small hard core of isolated, hesitant families which is so important in considerations of violence and other social failures within the family. The Maria Calwell report demonstrated very clearly that neighbours know what is going on. It is up to us to provide a channel along which they may communicate. It should be one of the duties of Area Review Committees to provide communication at all levels: inter professional, community to services and services to community. All concerned should know the whereabouts of the Area and District Review Committees, which should be the centre of this communication.

LEGAL ASPECTS

51 There is no single jurisdiction to deal with family problems which may be dealt with in High Courts, County Courts, Magistrates' Courts or juveniles courts.

52 The Juvenile Court is largely concerned (in the present context) with cases under the Chlldren and Young Persons Act 1969. Many cases of child abuse are complex and highly contended and the facts are not always easily uncovered. The following complaints have been strongly and repeatedly made

1) the psychiatrist giving evidence frequently feels that he is unable to give the relevant important facts.

2) Solicitors appearing before these cours are inexperienced and unable to help the medical witness to state his case; the necessary facts have often not been collected or presented.

3) The court is unable to transfer the case for hearing by a High Court judge if the complexity becomes too great.

4) The child has no separate legal representation; it sometimes appears that legal aid is granted to parents and then used against the best interests of the child, with no proper opportunity to combat it.

5) Social Workers make their reports but are not qualified to represent the child.

6) Magistrates are sometimes poorly informed in the applied social services they may sometimes simply want to be informed by the psychiatrist whether or not the parent is "mentally normal" and bases his decision upon that.

53 Many of these difficulties would be met if the whole of the Childrens Act of 1975 were to be implemented (providing a guardian and better legal aid for the child).

54 It has been argued that the services of the Official Solicitor should be available to juvenile magistrates' and county courts in order to provide an independent legal representative capable of making his own investigation of the facts and of organising witnesses.

55 The report of Justice (149) recommends family courts staffed by professional judges and magistrates with special qualifications, experienced and interested in the work - all to be subjected to suitable training. It would include amongst its staff a new officer, trained in law and social services, to act as overseer of children's interests in custody suits, and to be called the "Children's Ombudsman".

56 Michael King (Lecturer in Law, University of Warwick) (15) makes the following recommendations

57 "The special selection of magistrates who are to sit in domestic courts;

"The introduction of compulsory, government approved training courses for magistrates selected to sit in juvenile or domestic courts, such courses to include teaching of the principles of child welfare:

"The withdrawal from the domestic courts of their power to make custody and access in respect of young children until properly selected and trained panels of magistrates have been formed.

58 "The development of a court welfare service, from the probation service and local authority social services department, to include psychologists, child psychiatrists and social workers who could be called upon by the court whenever the need arose for expert investigation or expert opinion. Members of the court welfare service should be required to have a knowledge of the law relating to children and they should also have received training in advocacy.

59 "A broader based education for trainee barristers and solicitors to include teaching in child welfare principles;

"A clear statutory statement that in any court case where a child's welfare is involved, the judge or magistrates should have a duty to ensure that the child's interests are adequately protected and that all available information concerning the child and adults responsible for his welfare is presented to the court."

60 A possible additional function of the Area Review Committee should be the keeping of a list of experienced experts in these matters.

61 We are informed that Wardship procedures might be more effectively and frequently used. Any person having a genuine interest in a child may issue a summons and make the child a ward of court. The procedure is commonly supposed to be a slow and cumbersome (probably because of the image built up in the novels of Charles Dickens and his fictitious solicitors, Jarndice & Jarndice). Chancery courts are already able to appoint the official solicitor to act for the child, and are able quickly to block any attempt to remove the child from the jursidiction of the court.

62 It is observed that sometimes the child is kept with foster parents or in a Home, under repeated interim care orders, pending the hearing of criminal proceedings against the parent, and we feel that it may be better to complete the juvenile court proceedings not only to reduce uncertainty for the child but also in the hope that the protection of the child under a court order may avoid the usually useless and unproductive punishment of the parent.

63 AREAS OF RECOMMENDATION

	Para. Nos.
Voluntary workers and self help	5
Some form of operative classification is necessary to conserve effort	7, 8, 12
Further follow-up studies and research on prediction	10, 11, 18-28
Further education	
of the public	43, 44
of doctors and social workers	29-37, 46
of police	45
Basic importance of cultural, economic and political aspects	38, 39, 40
Priority of Health Visitors	41
The need for a system of specialized pre-school screening	46-50
Training and community function for health visitor	50

31 May, 1976

REFERENCES

1. Light R.J. (1973) Abused and Neglected Children in America: A Study of Alternative Policies. Harvard Educational Review Vol.43 No. 4. Nov. 1973. ps.556-598.

2. Chesser, E. (1951). Cruelty to Children. Victor Gollancz Ltd. London, 1951.

3. Clegg, A. and Megson, B. (1968). Children in Distress. Penguin Press.

4. Trube-Becker E. (1973) "Child Abuse and its Consequences. Paediat. Prax. 12/3 (389-399). (English Summary in the Journal "Psychiatric Briefs", Vol.7 No. 6., page 70 Nov/Dec. 1974.

5. Fairburn, A.C. Jones, S. and Moore C. 1975. Child Abuse - a scheme of inter-disciplinary linkage and co-ordination. (Submitted for publication, July 1975).

6. Mindlin R.L. (1974) "Child Abuse and Neglect: The role of the Pediatrician and the Academy". Pediatrics Vol. 54 No. 4 ps 393-395.

7. Kempe C.H. (1972) Paper Presented to Harvard interfaculty Seminar on Child Rearing in Urban America.

8. Gil, D.G. (1968). Incidence of Child Abuse and Demographic Characteristics of Persons involved. Chapter 2 and Appendix A of "The Battered Child" edited by Helfer, R.E. and Kempe, C.H. University of Chicago Press 1968.

9. Nazzaro J. (1974) "Child Abuse and Neglect". Exceptional Children Vol.40 ps. 351-354.

10. Bonjer, A.J. (1974 Director (Vereniging tegen kindermishandeling) Personal Communication, April 75.

11. Annual Report, Holland. (Jaaverslag 1973), betreffende het experiment vertrouwensartsen inzake kindersishandeling (only in the Dutch language).

12. MacKeith, R. (1974) "Speculations on Non-Accidental Injury as a Cause of Chronic Brain Disorder". Developmental Medicine and Child Neurology. Vol.16 pp. 216-218.

13. Birrell, A.G. & Birrell, J.H.W. (1968). The Maltreatment Syndrome in Children: a hospital survey. Medical Journal of Australia, Vol.2, No. 23, ps. 1023-1029.

14. Oliver, J.E. Cox, J. Taylor A. and Baldwin J.A. (1974). Severely ill-treated Young Children in North-East Wiltshire. Unit of Clinical Epidemiology. Oxford Record Linkage Study. Oxford Regional Health Authority. Research Report No. 4. August 1974.

15. Oliver J.E. (1975). "Microcephaly following Baby Battering and Shaking". British Medical Journal, 3 May 1975, 2, 262-264.

16. Martin, H.P. (1975) "The Effect of Child Abuse on the Neurologic and Personality Development of Children". (Paper given during the Annual Meeting for Cerebral Palsy, 1974) Developmental Medicine and Child Neurology, June 1975 page 389.

17. Cooper, C. (1975) The Doctors Dilemma. Chapter 3 of the Book "Concerning Child Abuse", edited by A.W. Franklin; Churchill - Livingstone. Edinburgh, London and New York 1975.

18. Kempe, C.H. (1974). "Duty to Report Child Abuse". Editorial in The Western Journal of Medicine. Vol 121 P.224 September 1974.

19. Smith S. and Noble N. (1973) "Battered Children and their Parents". New Society Vol.26 No. 580 pp. 393-395.

20. The Battered Baby (1970) Prepared by The Standing Medical Advisory Committee for the Central Health Services Council, England and Wales. Dept. of Health and Social Security. Publication February 1970.

21. The Tunbridge Wells Study Group 1973 "Non-Accidental Injury to Children". Compiled by Alfred White Franklin.

22. Trube-Becker E. (1971); Autopsy of Children who have died suddenly. Medizinische Klinik 66 ps. 58-59. (English Summary in the Journal "Annales Nestlé" Vol. 27 p.67, 1972)

23. Rodenburg M. (1971) Child Murder by Depressed Parents. Canadian Psychiatric Association Journal, Vol. 16 ps. 41-48.

24. Smith S.M. and Hanson R. (1974). "134 Battered Children: A Medical and Psychological Study". British Medical Journal 1974 Vol. 3, 666-670.

25. Weston, J.T. (1968) The Pathology of Child Abuse. Ch. 5 and Appendix B of the book "The Battered Child", edited by Helfer R.E., and Kempe C.H. University of Chicago Press. Chicago and London (1968).

26. Rood-de-Boer M. 1971. Child Care in the Netherlands. National Federation for Child Welfare, The Hague. (In English, Dutch, German, French language).

27. Directie Kinder Bescherming (Ministerie van Justitie Holland), Directie Kinderbescherming Staatsuitgeverij's- Gravenhage, 1973 (in Dutch. Only footnotes and summaries in English).

28. Children in Care in England and Wales, March 1973, DHSS and the Welsh Office, Command Paper, 5815, HMSO.

29. Pringle M.L.K. (1971) "Deprivation and Education". Studies in Child Development; National Bureau for Co-operation in Child Care. Longman Group. London (Second Edition 1971).

30. Children in Care in England and Wales, March 1969. Home Office Command Paper 4263, reprinted 1972, HMSO.

31. Children in Care in England and Wales, March 1970 Home Office Command Paper 4559; HMSO.

32. Children in Care in England and Wales, March 1971 DHSS and the Welsh Office, Command Paper 5100, HMSO;

33. Children in Care in England and Wales, March 1973, DHSS and the Welsh Office, Command Paper 5434, HMSO.

34. Montagu, N.L.J. (1975) Personal Communication, 5.2.75.

35. Annual Report (1972) National Society for the Prevention of Cruelty to Children.

36. Annual Report (1973). National Society for the Prevention of Cruelty to Children.

37. British Medical Journal (1973). Deliberate Injury of Children. British Medical Journal, Vol.4, No. 5884 Ps.61-62.

38. Cameron, J.M. (1972). The Battered Baby Syndrome. The Practitioner, 109, 302-310.

39. Castle R.L. and Kerr, A.M. (1972). A study of suspected child abuse. National Society for the Prevention of cruelty to Children, publication September 1972.

40. Court, J. (1969). Battered child research project. Child Care News 2-4.

41. Court, J. (1969) The Battered Child. Part 1: Historical and Diagnostic Reflections. Medical Social Work, 22 11-20.

42. Court J. (1971). The Battered Child Syndrome: 1. The Need for a Multi-disciplinary approach. Nursing Times, 67, 659-667.

43. Diggle G. and Jackson G. (1973). Child injury intensive monitoring system. British Medical Journal, 3, 334-336.

44. Franklin, A.W. (1975) "Concerning Child Abuse". Churchill Livingstone: Edinburgh, London and New York 1975.

45. Howells, J.G. (1974). "Remember Maria". Butterworth & Co.Ltd.1974.

46. Jackson, G. (1972). Child Abuse Syndrome: The Cases we Miss. British Medical Journal 2, 756-757.

47. Okell, C. (1971). Childhood accidents and Child Abuse. Community Medicine Vol. 126. No. 8. 124-127.

48. Okell, C. (1972). The Battered Baby Syndrome: (a) Recent Research and Implications for Treatment. Royal Society of Health Congress.

49. Oliver, J.E. and Cox J. (1973). A family kindred with ill-used children: the burden on the community. British Journal of Psychiatry, 123, 81-90.

50. Ounsted C. Oppenheimer R. Lindsay J. (1974). Aspects of Bonding Failure: The Psychopathology and Psychotherapeutic Treatment of Families of Battered Children. Developmental Medicine and Child Neurology Vol. 16 ps. 447-456.

51. Parker G.E. (1965). The Battered Child Syndrome. Medicine, Science and the Law, 8, 160-339.

52. Renvoize J. (1974) "Children in Danger". Routledge and Kegan Paul Ltd. London.

53. Skinner, A.E. and Castle R.L. (1969). 78 Battered Children: A retrospective Study. National Society for the Prevention of Cruelty to Children. Publication September 1969.

54. Stark, J. (1969). The Battered Child: Does Britain need a Reporting Law? Public Law 48-63.

55. Avery, J.C. (1973). The Battered Child. Mental Hygiene 57 40-43

56. Dodge, P.R. (1962). "Medical Implications of Physical Abuse of Children". Part of "Protecting the Battered Child". American Humane Association Publication, pages 23-25.

57. Ebbin, A.J., Gollub, M.H. Stein, A.M. and Wilson M.G.(1969). Battered Child Syndrome at the Los Angeles County General Hospital, Amer. J. Dis.Child Vol. 118 ps. 660-667.

58. Fontana, V.J. (1971). The Maltreated Child. Illinois: Charles C. Thomas.

59. Fontana, V.J. (1971). The diagnosis of the maltreatment syndrome in children. Symposium on Child Abuse. New York University Medical Centre. June 15th 1971. Published in Pediatrics Vol.51 No. 4 Part II April 1973.

60. Gregg, G.S. and Elmer, E. (1969). Infant injuries: accident or abuse Pediatrics, 44, 434-439.

61. Helfer R.E. and Kempe C.H. (1968). The battered child. The University of Chicago Press.

62. Holter J.C. and Friedman, S.B. (1968). Child abuse: early case-finding in the emergency department. Pediatrics 42, 128-138.

63. Kempe, C.H. Silverman, F.N. Steele, B.F. Droegemueller W. and Silver H.K. (1962). The battered Child Syndrome. Journal of the American Medical Association, Vol. 181, No. 1 ps. 17-23.

64. Kempe C.H. (1969) "The battered child and the hospital". Hospital Practice Vol. 4, 44-57.

65. Kempe C.H. (1971) "Paediatric Implications of the Battered Baby Syndrome". Archives of Disease in Childhood Vol. 46, 28-37.

66. Murdock, C.G. (1970). The Abused Child and the School System. American Journal of Public Health 60, 105-109.

67. Pickett, L.K. (1972). The Role of the Surgeon in the Detection of Child Abuse. Connecticut Medicine, 36, 513-514.

68. Reeb, K.G. Melli, M.S., Wald, M. and Wesenberg R. (1972). A conference on Child Abuse. Wisconsin Medical Journal, 71,226-229.

69. Silver L.B., Barton W., and Dublin, C.C. (1967). Child Abuse Laws: Are they Enough? Journal of the American Association 199, 101-104.

70. Silver, L.B. Dublin, C.C. and Lourie R.S. (1969). Child Abuse Syndrome: the "Grey Areas" in establishing a diagnosis. Pediatrics, 44, 594-600.

71. Simons, B. Downs E.F. Hurster, M.M. and Archer M. (1966) Child Abuse: Epidemiologic Study of Medically Reported Cases. New York State Journal of Medicine Vol. 66 ps. 2783-2787.

72. Verbeeck, J. (1971). The Physician Confronted by Unloved Children. Medicine et Hygiene, 29, 362-364.

73. Vesterdal, J. (1972). The Battered Child Syndrome. Annales Nestle, No. 27. 5-12.

74. Moszer, M. and Bach Ch. (1969). The Battered Child Syndrome. "Le Syndrome des Enfants Maltraites". Progress Medical 97,303-307.

75. Neimann, N. and Rabouille D. (1969). Maltreated Children. Revue du Praticien, 19, 3879-3888.

76. Straus P. and Wolf, A. (1970). A topical question: Maltreated Children. La Psychiatrie de L'Enfant, 12, 577-628.

77. Kottgen, U. Greinacher, I., and Hofmann (1968). Radiological Diagnosis of Maltreatment of Children (Battered Child Syndrome). Zeitschrift fur Kinderheilkunde, 6, 384-392.

78. Nau, E. (1967) Maltreated Children. Monatsschrift fur Kinderheilkunde, 115, 192-195.

79. Underhill E. (1974) "The Child and His Surroundings. The Strange Silence of Teachers, Doctors and Social Worders in the Face of Cruelty to Children". International Child Welfare Review (Geneva) No. 21 ps. 16-21 (In English).

80. Bwibo.N.O, (1972). Battered Child Syndrome. East African Medical Journal, 49, 934-938.

81. Irwin, C. (1974) "Specialists on Child Battering". Golden Jubilee of the South African National Council for Child Welfare. Pretoria 21-25 October 1974. Reported in Child Welfare (Kindersorg) Dec.'74

82. Hwang W.T., Leng L.K. and Chin C. (1974) "Battered Child Syndrome in a Malaysian Hospital". Medical Journal of Malaysia Vol. 28 No.4 ps 239-243.

83. Bialestock, D. (1973). Custody of Children. The Medical Journal of Australia 2, 1128 Dec.

84. Colclough, I.R. (1972). Victorian Government's report on Child Abuse. The Medical Journal of Australia, Vol. 2, 1491-1497.

85. Gibson G.H., Watson, J.V. (1973). Battered Baby Syndrome. The Medical Journal of Australia. Letter of 8th December, 1973.

86. Adelson, L. "Slaughter of the Innocents". New England Journal of Medicine, Vol. 264 No. 26 ps. 1345-1349.

87. Akbarnia, B., Torg, J.S., Kirkpatrick, J., and Sussman, S. (1975) Manifestations of the Battered-Child Syndrome. The Journal of Bone and Joint Surgery. Vol. 56-A. No. 6. ps. 1159-1166.

88. Blumberg, M.L. (1974) Psychopathology of the Abusing Parent. American Journal of Psychotherapy. Vol. 28 ps 21-29.

89. Bryant H.D. Billingsley A. Kerry G.A. Leefman W.F. Merrill E.J. Senecal G.R. and Walsh B.G. (1963). Physical Abuse of Children. An Agency Study. Child Welfare Vol. 42 ps. 125-130

90. Elmer E. (1967) Children in Jeopardy. A Study of Abused Minors and their Families. University of Pittsburgh Press.

91. George J.E. (1973) "Spare the Rod: A Survey of the Battered Child Syndrome". Forensic Science Vol. 2 ps 129-167.

92. Gil, D.G. (1970) Violence Against Children. Harvard University Press. Cambridge, Massachusetts.

93. Helfer R.E. and Pollock C.B. (1968). "The Battered Child Syndrome" Advances in Pediatrics. Vol. 15 ps 9-27.

94. Lauer, B. Broeck E.T. and Grossman, M. (1974). Battered Child Syndrome: Review of 130 Patients with Controls. From the Dept. of Pediatrics, San Francisco General Hospital and University of California, San Francisco. Pediatrics Vol. 54 No. 1 July 1974 ps. 67-70.

95. Merrill E.J. (1962). Protecting the Battered Child: Part I. Physical Abuse of Children. American Humane Association, Childrens Division report for the 89th Annual Forum of the National Conference on Social Welfare, New York City, May 31st 1962.

96. Morse, C.W. Sahler O.J.Z. and Friedman S.B. (1970). A Three Year follow-up study of Abused and Neglected Children. American Journal of Diseases of Children. Vol. 120 ps. 439-446.

97. Schloessner P.T. (1964). "The Abused Child". Bulletin of the Menninger Clinic. Vol.28 ps 260-268.

98. Silver L.B. (1968). "Child Abuse Syndrome: A Review". Medical Times Vol.96 No. 8 ps 803-820.

99. Solomon, T. (1971). History and Demograohy of Child Abuse. Symposium on Child Abuse. New York University Medical Centre. June 15th 1971. Published in Pediatrics Vol. 51 No. 4 Part II April 1973.

100. Zalba, S.R. (1966). The Abused Child. A Survey of the Problem. Social Work. Vol.II ps. 3-16.

101. Dawe K.E. (1973). "Maltreated Children at Home and Overseas". Royal Children's Hospital, Melbourne Australia. Australian Paediatric Journal Vol.9 177-184.

102. Dawe K.E. (1973). "Child Abuse in Nova Scotia". Australian Paediatric Journal Vol. 9 294-296.

103. Fried C. . (1973) "Child Abuse is a Family Social Disease". Canadian Family Physician. Aug. 1973 ps. 53-56 incl.

104. McRae, K.N. Ferguson C.A. and Lederman, R.S. (1973). Medical Practice Canadian Medical Association Journal April 7, 1973. Vol. 108 pp 859-867.

105. Jacobziner J: The Maltreated Child: The Maltreatment Syndrome in Children, Springfield, Illinois, Charles C.Thomas 1964.

106. Planning for the Protection and Care of Neglected Children in California Sacramento. National Study Service. 1964.

107. Preventive and Protective Services to Children. A responsibility of the Public Welfare Agency. Chicago. American Public Welfare Association. 1958.

108. Gil, D.G. (1969). Physical Abuse of Children. Findings and Implications of a Nationwide Survey. Pediatrics Vol.44 ps.857-864

109. De Francis V. (1963). Child Abuse: Preview of a Nationwide Survey. Denver: American Humane Association. Children's Division.

110. Hall M.H. (1972) Non-Accidental Injuries in Children. Royal Society of Health Congress.

111. Holman R.R. and Kanwar S. (1975) "Early Life of the Battered Child". Archives of Diseases in Childhood. January 1975. Pages 78-80.

112. Lancet (Editorial) (1971) "Violent Parents". Vol.2 No.7732 (Nov.1971) Ps 1017-1018.

113. Scott, P.D. 1973. "Parents Who Kill their Children". Medicine, Science and the Law. Vol.13 No.2 pp. 120-126.

114. Scott, P.D. 1973. "Fatal Battered Baby Cases". Medicine, Science and the Law. Vol.13 No.3 pp 197-206.

115. Smith S.M. (1975) Personal Communication January 1975.

116. Brown R.H. (1973) "The Battered Child". Chicago Medical Society Bulletin, March 1973.

117. Newcombe H.B. (1966). Familial tendencies in diseases of children. British Journal of Preventive and Social Medicine, 20, 49-57.

118. Howells J.G. (1975) Deaths from Non-accidental Injuries in Childhood. British Medical Journal (September 13.) p.651-652

119. Peckham C.S. (21 June 1975) Deaths from Non-accidental Injuries in Childhood. British Medical Journal P.686.

120. Oliver J.E. (12th July 1975). Statistics of Child Abuse. British Medical Journal p.99.

121. Farn, K.T. (9th August 1975) Deaths from Non-accidental Injuries in Childhood. British Medical Journal p. 370-371.

122. White Franklin A (12th July 1975) Statistics of Child Abuse. British Medical Journal p. 98-99.

123. Robins L. (1965) Deviant Children Grown-up, London Livingstone.

124. Guthkelch, R.N. (1971) Brit.Med.J. 2. 430.

125. DHSS (1976) Priorities for Health & Personal Social Services in England: a consultative document. London HMSO.

126. Mande, R. (1974). Concours Medicale 96. 3087.

127. Kohler E.M. & Kohler L. (1975) Acta Paediatrica Scand.64. 225

128. Sundelin, C. (1973) Scandinavian J.Soc.Med. 1. 133

129. Wynn, A. (1976) Heaven came for Pre School Children. The Royal Society of Medicine 69. 340-343.

130. Thomas Coram Research Unit (1975) Health Visitor 48. 298.

131. Kempe C.H. Silverman F.N. Swede B.F. Droegemuller W. Silver H.K. (1962) The Battered Child Syndrome J.Am.Med.Assocn. 181 17.

132. Caffey J. (1974) The Whiplash Shaken Infant Syndrome. Pediatrics 54. 396-403.

133. Harcourt B. & Hopkins D (1971) Opthalmic Manifestations of the Battered Baby Syndrome. Brit.Med.J. 3 398-401.

134. Harcourt B. & Hopkins D. (1973) Permanent Chorio-Retinal Lesions in Childhood of Suspected Traumatic Origin. Transactions Opthalmalogical Soc. of United Kingdom. 93. 199-205.

135. Mushin J.S. (1971) Ocular Damage in the Battered Baby Syndrome Brit. Med. J. 3 402-404.

136. Sarsfield, J.K. (1974) The Neurological Sequelae of non-accidental Injury. Developmental Medicine Neurology 16 annatation.

137. Buchanan A (1976) personal communication from the North Wiltshire research which is continuing.

138. Tizard J. (1976) Nutrition, growth & development: editorial. Psychological Medicine 6. 1-5 (20 refs).

139. Stewart (1975) How Malnutrition handicaps Children. New.Society 13.2.75 p. 328-380.

140. Richards, M.P.M. Bernal J.F. (1972). A Study of Mother-Infant Interaction in N. Blurton Jones (Ed). Ethological Studies of Child Behaviour. Cambridge Univ. Press.

141. Richards, M. (1975) Non-Accidental Injury to Children: An Ecological Perspective, in Non-Accidental Injury to Children. London HMSO pp 5-12.

142. Elmer E & Gregg G.D. (1967) Development Characterisations of abused children. Pediatrics 40. 596-602.

143. Klein M. & Stewart (1971) Low Birth right and The Battered Child Syndrome. Am.J.Dis.Child. 122 15-18.

144. Lynch M. (1975) Ill health and Child Abuse. Lancet 2. 312-319.

145. Widdowson, E.M. (1951) Medical Committment and Physical Growth Lancet 1. 1316-1318

146. Martin, H.P. Beezley P (1976) The Emotional Development of Abused Children. Development: Medical Child Neurol. in press idem (1974) Prevention and Consequences of Child Abuse. J.operational Psychiatrist 6. 68-77.

147. Baher E. Hyman C. Jones C. Jones R. Kerr A. Michael R. (1976) At Risk, Routledge Kegan Paul.

148. Ford D. (1975) The Law Nursing Mirror p.58.

149. Justice, a report by (1975) Parental Right's and Duties & Custody suits. London. Stevens.

150. King, M. (1975) Will a child really benefit from having his own lawyer. Times July 18th p.5.

151. Oliver J.E. & Taylor A (1971) Five Generations of ill-treated children in one family pedigree. Brit.J.Psychiat.119. 473-80.

152. de Mause, L. (Ed) (1976) The History of Childhood. Souvenir.

153. Newson J. & Newson E. (1965) Patterns of Infant Care in an Urban Community. Penguin.

154. Jobling, M. (1976) The Abused Child. An Annotated Bibligraphy London. National Children's Bureau.

END