Suspected Child Abuse Cases in Public Hospitals: an Interim Analysis of 494 Cases

Medical Coordinators on Child Abuse
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Summary

Since the designation of Medical Coordinators on Child Abuse (MCCAs) in the paediatric departments of public hospitals, a system of voluntary reporting on the handling of suspected cases of child abuse has been initiated. Between June 1997 and August 1999, 494 cases have been reported from 12 hospitals. Three hospitals contributed more than 50 patients each, accounting for 60% of the reported cases, and are arbitrarily designated as busy units. The suspected victims included 230 (47%) boys and 264 (53%) girls at a mean age of 7.5 (range 0-17.2) years. Children of suspected sexual abuse were more likely to be girls (94% vs. 48%, $p<0.001$) and younger in age (5.7 vs. 7.7, $p<0.001$) when compared with the non-sexual abuse cases. Among the whole group of patients, 288 (58%) were diagnosed as child abuse. The forms of maltreatment included physical abuse (n=211), neglect (n=8), psychological abuse (n=3), sexual abuse (n=22), and multiple abuse (n=44). Physical abuse, alone or in combination with other forms of abuse, accounted for the majority of cases (251/288, 87%). Either or both biological parents constituted 71% of the perpetrators. Concerning disposal, 67% cases were restored home, while the others required special placement. Five (1%) patients died as a result of serious head injury. Of the 452 cases where multi-disciplinary case conference was held, abuse was established in 254 (56%). The following factors are associated with a higher chance of establishing a case of child abuse in the conference: (1) non-sexual abuse case (59% vs. 36%, $p=0.004$), (2) victim of older age (8.0 vs. 7.2, $p=0.05$), (3) case previously known to an agency (77% vs. 49%, $p<0.001$), and (4) case admitted to a busy unit (67% vs. 39%, $p<0.001$). Thus, almost 500 cases of child abuse were handled in public hospitals in the last two years. The figure is likely an underestimate due to incomplete reporting. The pattern of abuse is different from that reported by the Social Welfare Department: (1) there is a higher proportion of physical abuse, (2) children of sexual abuse are much younger in age, and (3) death is seen. Handling of child abuse by the medical profession requires special expertise that deserves a high priority of attention.

Introduction

Since 1979 when the local government started looking into the matters associated with child abuse, official reports and recommendation on the handling of child victimisation were issued successively.[1] When the Procedures for Handling Child Sexual Abuse Cases was released in 1996,[2] Medical Coordinators on Child Sexual Abuse were designated in the ten paediatric departments of the Hospital Authority hospitals. This was gradually expanded to the paediatric units of all public hospitals under the Hospital Authority and the title was changed to Medical Coordinators on Child Abuse (MCCA) to reflect the full spectrum of work carried out by the designated professionals.[3]

Since January 1997, MCCA started meeting with each other at bimonthly intervals to share and review experience. It soon became apparent that the child abuse cases seen in the public hospitals were different from others quantitatively and qualitatively. A voluntary reporting system was commenced in July 1997 in which representatives from each hospital are encouraged to submit case reports on the cases they encountered. The report follows a pre-defined format without revealing the identity of the victim or suspected perpetrator (Table 1). The following report is an interim summary of the cases collected in the first two years.

Materials and Methods

Case reports submitted by the representatives from each hospital were collected at bimonthly intervals. All cases submitted before the end of August 1999 were included for analysis. Institutions from which more than 50 cases were submitted were designated as "busy" units arbitrarily, and the remaining were designated as "less busy" units. Data were analysed using the statistics package SPSS for Windows 7.0 to see if the pattern of abuse handled by the paediatric units was related to the age and sex of the victims, the initial and final allegation, the previous involvement of child care agency, and the kind of institution handling the case.

Results

A total of 494 completed case reports were received between the captioned period. The date of admission spanned from June 1997 to August 1999. Among the cases, there were 230 (47%) boys and 264 (53%) girls. The median age was 7.5 years (range 0-17.3). 128 (26%) of them had been known to a child care agency before. The cases were contributed by 12 paediatric departments. Three of them were arbitratily labeled as "busy" units and together they contributed 60.5% of the cases. The types of maltreatment at the initial suspicion and at the time of

Table 1 Child Abuse – Report Form

To include all suspected/confirmed cases of child abuse admitted to hospital

A. The Patient:

1. Case Ref: _____ (e.g. KWH1; No patient identitiy/hosp. no.)
2. Sex: ❑ Male ❑ Female
3. Age at admission: _____ year(s) _____ month(s)
4. Date of admission: _____ /_____ /_____(dd/mm/yy)
5. Existing records indicate previous reference to a child care agency?
   ❑ Yes ❑ No
6. If yes, specify the agency: CPSU/other: _____

B. The Abuse:

7-8. Form of abuse:	Initial suspicion	Final diagnosis
Physical abuse	❑	❑
Gross neglect	❑	❑
Psychological abuse	❑	❑
Sexual abuse	❑	❑
Not abuse/excessive punishment/ inappropriate discipline/others: _____		❑

9. Significant laboratory/radiological findings:
   _____
10. Case conference: ❑ Yes ❑ No

C. The Outcome:

11. Conclusion at conference: ❑ case established ❑ case refuted ❑ indeterminate (insufficient evidence to establish/refute)
12. Police involved/informed: ❑ Yes ❑ No
13. Child Protection Registry: ❑ included, abused ❑ included, at-risk ❑ not included
14. Placement to:
    ❑ Home ❑ Fostered care ❑ Small group home
    ❑ Relative (specify: _____) ❑ Institution (specify: _____)
    ❑ Others, specify: _____ ❑ Died
15. Anticipated long-term complications:
    _____
16. Follow-up care/servies:
    ❑ CPSU ❑ Family Service Ctr ❑ Paediatrician
    ❑ Clinical psychologist ❑ Other, specify:

D. The Perpetrator/Suspected perpetrator:

17. Relation(s): ❑ Father ❑ Mother ❑ Unknown ❑ Other, specify: _____
18-19. Sex/age: ❑ Male ❑ Female _____ years
20-21. Sex/age of 2nd abuser (if any): ❑ Male ❑ Female _____ years

E. The Contact Details:

For details, please contact the following doctor(s)/staff at the hospital concerned.

Name of doctor(s)/staff: _____

Hospital: _____

Signature of doctor: _____

disposal are tabulated in Table 2, respectively. After all, 288 (58.3%) of the cases were diagnosed as child abuse. The forms of maltreatment included physical abuse (n=211), neglect (n=8), psychological abuse (n=3), sexual abuse (n=22), and multiple abuse (n=44). The relationship of the perpetrators to the victim in confirmed cases of child abuse is listed in Table 3. Either parent or both accounted for 71.2% of the cases.

Physical abuse, either alone or in combination with other kinds of maltreatment, accounted for 85.6% of the cases admitted for evaluation and 87.2% (251/288) of the confirmed cases of abuse. Children of suspected sexual abuse were more likely to be girls (94% vs. 48%, $p< 0.001$) and younger in age (5.7 vs. 7.7, $p<0.001$) when compared with the non-sexual abuse cases. The type of abuse and whether case conference was called were not related to the "business" of the hospitals.

Case conference was held in 452 (91.5%) cases, from which 254 (56.2%) cases were established. 60 cases were classified as indeterminate and the remaining 138 cases were not established. The following factors are associated with a higher chance of establishing a case of child abuse in the conference: (1) non-sexual abuse case (59% vs. 36%, $p=0.004$), (2) victim of older age (8.0 vs. 7.2, $p=0.05$), (3) case previously known to an agency (77% vs. 49%, $p< 0.001$), and (4) case admitted to a busy unit (67% vs. 39%, $p<0.001$). The age of the perpetrator and the sex of the victim were not found to be related factors.

337 (67.2%) cases were entered into the Child Protection Registry. 85 were registered as "at risk" and 252 were registered as "abuse" cases. About two-thirds of the children were discharged home and the outcome of the other cases was listed in Table 4. There were five cases (1%) of death in this series of patients. All of them were remarked to have some kind of serious head injury that was compatible with the diagnosis of shaken baby syndrome.[4]

Table 2 The Types of Maltreatment Reported

Type	Initial Suspicion	Final Diagnosis
Physical abuse	396 (80.2%)	211 (42.7%)
Neglect	7 (1.4%)	8 (1.6%)
Psychological abuse	2 (0.4%)	3 (0.6%)
Sexual abuse	59 (11.9%)	22 (4.5%)
Physical abuse & neglect	8 (1.6%)	16 (3.2%)
Physical abuse & psychological abuse	13 (2.6%)	20 (4.0%)
Physical & sexual abuse	4 (0.8%)	0
Physical & psychological abuse and neglect	2 (0.4%)	4 (0.8%)
Other multiple abuse	3 (0.6%)	4 (0.8%)
Not abuse	0	206 (41.7%)
Total	**494**	**494**

Table 3 The Perpetrators in Confirmed Cases of Child Abuse

Related to Victim	Number	Percent
Father	121	42.0%
Mother	69	24.0%
Both parents	15	5.2%
Stepmothers	6	2.1%
Mother's boyfriend ± mother	9	3.1%
Uncle or aunt	8	2.7%
Sibling	4	1.4%
Fostered parent	2	0.7%
Maid	7	2.4%
Childminder	5	1.7%
Teacher	2	0.7%
Neighbour	2	0.7%
Other	12	4.2%
Unknown	26	9.0%

Table 4 The Placement of Children Evaluated for Suspected Child Abuse

The Placement/Outcome	Number of Cases	Percent
Home	332	67.2%
Fostered care	30	6.1%
Small group home	36	7.3%
Relatives	38	7.7%
Institutions	45	9.1%
Other	8	1.6%
Death	5	1.0%

Discussion

Statistics on the number of child abuse cases is collected by the Social Welfare Department by means of the Child Protection Registry (CPR). The main objective of the registry is to provide easy checking for government departments and non-government organizations to ascertain whether a case under investigation has been known to an organization before.[2,5] Children who are victims of abuse, or who are at risk for abuse, are reported by their respective caseworker. Their names will generally stay on the CPR for two years, after which they will be de-registered unless a request for continuation of registration is received. The data from the CPR are published annually in the form of a report,[6] which cover the demographic data of the victims and abusers, the characteristics of the abuse, and the distribution of the cases geographically. Such information is invaluable for understanding the overall pattern of abuse in the territory. However, the CPR does not contain any information on the severity of injuries sustained by the victimised children.

Children who died of abuse would not be included in general because checking would not be needed afterwards.

Children admitted into the hospital for suspected child abuse represent a special subset of cases[7,8] whose general characteristics may not be reflected by information available from the CPR. For instance, physical abuse and sexual abuse represent 47% and 38% of new cases reported to CPR in 1997, respectively. However, they correspond to 80% and 12% of the caseload handled in public hospital. The predominance of physical abuse is also reflected in the confirmed cases. We believe that this predominance represents a referral bias. Hospitals in Hong Kong are renowned for the management of acute medical conditions, whereas children with subtle or non-physical injuries may not be deemed necessary for admission.

The referral bias can be viewed from another perspective. Children admitted for suspected sexual abuse have a mean age of 5.7 years. However, over 71% of sexual abuse cases reported to the CPR are over the age of 9.[6] Thus, public hospitals are more likely to encounter the immature and dependent cases of suspected sexual abuse – a subgroup where interrogation is unlikely to be straightforward and spontaneous disclosure is uncommon.[9]

The present study also identifies other features in the management of child abuse that may not be apparent from the CPR reports. While the definition of child abuse does not seem to be dependent on age (other than ages beyond childhood) and the organization that the child may have come across,[10] the outcome of case conference appears to be determined by a number of factors. For instance, there is a lower chance of establishing a case if it involves sexual abuse. The finding is perhaps not surprising in view of the prohibitive nature of this kind of maltreatment. However, the current arrangement of interrogation that places heavy emphasis on a single video-recorded interview and a single case conference does not accommodate for the piecemeal nature of disclosure in young victim of sexual abuse.[9]

It is also interesting to note that cases in which the victims are previously known to an agency are most likely to be established. This feature probably identifies a vulnerable group of children by virtue of their social deficiency.

While inter-disciplinary disagreement on the interpretation of child abuse issues is common during case conference,[11] discrepancy arising within the same profession has not been examined. The fact that "busy" hospitals are more ready to establish a case compared with "less busy" units is intriguing. On the one hand, the degree of "business" may well reflect another kind of referral bias, with readily identifiable cases flooding to the "busy" department. On the other hand, the "busy" hospitals may be working on an operational basis that promotes the positive identification of cases. We speculate that the "busy" paediatric departments are more likely to have trained and experienced staff in the area of child protection, and are more likely to have established a close working relationship with the regional child protection workers. Further study on this aspect may help to strengthen the medical input in the multi-disciplinary management of child abuse in Hong Kong. As the decision making in case conference is often multi-disciplinary, it will be interesting to see if the same phenomenon is observed in other disciplines. However, we are not aware of any similar studies.

Because of the voluntary nature of reporting, under-reporting of cases certainly occurs. Because of the anonymity of the reported cases, it is hard to ascertain the missing cases. The Clinical Management System, which captures the disease coding of each patient under the care of the Hospital Authority, may provide an interface for ascertainment. However, it is unclear whether the disease coding was properly done at the first instance. The MCCA are currently looking into ways to improve the rate of reporting from each institution.

Despite the shortcomings, the current report gives an approximate idea of the amount of cases and the extent of injuries in relation to child abuse handled in the public hospitals. With close to 250 cases per annum, child abuse outnumbers childhood cancer by 67%.[12] Yet, the societal morbidity associated with childhood victimization may be much more persistent and significant.[13] While paediatric oncology is a well established medical subspecialty in Hong Kong, the same cannot be said of child abuse. Like treating cancer, the handling of child abuse by the medical profession requires special expertise in recognition, treatment and advocacy.[14] All deserves a high priority of attention.

Appendix

The Medical Coordinators on Child Abuse include A Tsang, E Kwan (Queen Mary Hospital), CM Yu, SM Tai (Pamela Youde Nethersole Eastern Hospital), P Ip, P Cheung (United Christian Hospital), PW Ko (Our Lady of Maryknoll Hospital), W Tse, S Ho, B But, WH Lee (Queen Elizabeth Hospital), SWW Cherk, LCK Leung, CS Ho (Kwong Wah Hospital), PWT Tse, JYC Chan (Caritas Medical Centre), PS Cheng, HL Wong (Prince of Wales Hospital), FT Yau, KP Lee, KL Yam (Alice Ho Miu Ling Nethersole Hospital), LP Lee, A Cheng, CB Chow (Princess Margaret Hospital), KF Huen, WC Mak (Yan Chai Hospital), KC Chan, KW Tsui, TW Wong (North District Hospital), ACW Lee, Y Ou, KT So (Tuen Mun Hospital), CC Lee (Kwai Chung Hospital).

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