THE BATTERED CHILD SYNDROME

Medical, Legal and Social Work Machinery for Dealing with the Battered Child Syndrome is Critically examined.

by

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ABSTRACT

The focus of this thesis is to assess the existing "machinery" of the Medical, Social Work and Legal professions in the Vancouver area, as they combine their services to cope with the recently identified problem of the Battered and Abused Child Syndrome.

Knowledge of this social problem is of paramount importance in the field of child protection as the greater proportion of victims are babies of three months and younger. The swiftness and destructiveness of this syndrome, which sometimes results in death to the victim, makes early detection and immediate protection of the child imperative. Therefore the three affected professions in each community must devise a definite and cooperative pattern of response to the syndrome. Each profession must shoulder a share of the responsibility as the services of all three are necessary for the ultimate goal of protection for a helpless child.

A three-pronged approach involving each discipline was selected. Files of victims were provided for examination by a local hospital and child protection agency. Information was transferred to a predesigned schedule, and tables constructed depicting injuries and other characteristics of the victims and also common parental traits within the battering families. Due to the time element and difficulty in locating actual cases that had been before the courts, examination as to legal involvement was restricted to case studies.

Results of the study indicate that present machinery is adequate and that each discipline has become more adept and thorough at handling such situations within the last few years. Definite recognition must be given to the planned establishment of a Battered Child Registry in Victoria. The Protection of Children Act is, as it stands, a proper vehicle for bringing cases of battered children before the court. Individual professionals must be aware of any subjective emotional reaction that could prevent their objective handling of such cases.

This is one social problem in which rehabilitation and treatment of the family must take a subordinate position to the absolute protection of a single family member. Medical evidence in court should be focused on establishing persistence of abuse, and social work evidence should portray the existence of an unsafe environment. More follow up work must be done with the families even after permanent removal of a child, in hopes of rendering the family safe for the care of future children. The emotional impact felt by the family on the removal of such a child is yet to be documented and resultant behavior noted. Care must be taken by Child Welfare authorities to follow the emotional development of the victims, documenting the resultant adult personality type and any treatment found necessary during the formative years and its degree of success.
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CHAPTER 1.

THE BATTERED CHILD SYNDROME

LITERATURE REVIEW

Introduction

The clinical symptomatology of physical abuse of children has been noted by the medical profession for some years but has been obscured by differential diagnosis. The Battered and Abused Child Syndrome, although not widely recognized, is, however, still subject to a great deal of medical debate.

The purpose of this thesis is to focus attention on this medical syndrome as a means of studying the etiology of the physical abuse of children. Recent recognition of X-ray indications has led to the naming of the syndrome, and has suggested that the social environment of these children is an important causal factor.

This study will be concerned with:

(1) the resulting co-ordination of the services of three professions as they move to cope with this newly identified social problem, and

(2) hopefully will add to the understanding of the etiology of the problem by further identification of common social factors in the affected families.

The Syndrome

The Battered and Abused Child Syndrome is a medical description of damage to the skeletal structure of children,
resulting from force applied by parents, siblings or caretakers, in twisting or jerking of the child's limbs, plus other forms of maltreatment.¹

X-ray analysis conclusively demonstrates the traumatic nature of the damage, plus the persistence of maltreatment, in revealing bone fractures, epiphysial injuries and subdural hematomas (often chronic) in various stages of healing.² The combination of injuries plus the fact that they are revealed at different stages of self-repair excludes the possibility of a single household accident as their cause.

Dr. C. Henry Kempe, a Professor of Pediatrics in Denver, Colorado, was first to use the term "The Battered Child Syndrome". This term is now widely used by medical and social work personnel in describing the clinical condition of young children who have been victims of traumatic physical abuse, generally at the hands of a parent.

Symptoms alerting doctors to the syndrome are:³

Age: Abuse can occur at any age but is usually found in children under three years. Some researchers have noted a peak in incidence up to three months, and also indications


³ Kempe, et al., op. cit., pp. 17, 18 and 22.
that the incidence then decreases as the age increases.\footnote{4} True childhood accidents are minimal below the age of nine months, then begin a sharp climb reaching a peak between two and three years.\footnote{5}

**Epiphysial Injuries:** The long bones (arm and leg bones) of a child differ from those of an adult in having at their ends, masses of cartilage, known as epiphyses. The epiphyses are in the process of becoming new bone, and can be easily displaced by a jerking or twisting motion. When displaced, the epiphyses pull loose a membrane, called the periosteum, which covers the bone end. A hemorrhage then occurs between bone and membrane. The function of the periosteum is to produce new bone, and this it continues to do. Therefore, twelve to fourteen days after the injury the new bone growth shows up on the X-ray as a cloudy thickened mass.\footnote{6} Epiphysial injuries also happen in true accidents, if a parent jerks or twists the child's extremities in saving him from a fall or by roughly pulling on the arms in helping him up a step.

**Bone fractures in different stages of healing:** These include those of the long bones, ribs, skull, clavicle, etc. The different stages of healing indicate that the injuries were sustained at different times, and not in one single

\footnote{4}{Harold Jacobinzer, "Rescuing the Battered Child," *American Journal of Nursing*, Vol. 64, June 1964, p. 93.}


\footnote{6}{Griffiths and Moynihan, op. cit., p. 1560.}
accident.

**Subdural Hematoma**: This is a hemorrhage of the membrane between the skull and the brain. Such a blood clot can cause permanent brain injury and resulting functional impairment.

**Multiple soft tissue injuries**: bruises, blackened eyes, etc.

**General health below par** including poor skin hygiene.

**Malnutrition**

**Burns** usually by cigarettes or hot liquids

**No new injuries in hospital**

**Discrepancies between clinical findings and parents explanations**

Malnutrition is present in the syndrome in varying degrees. While the other symptoms are the result of active aggression and abuse, this is the result of passive neglect. The degree of severity of effect ranges from health slightly below par to death by starvation. The victims of physical abuse are taken to hospital again and again, but often those suffering from malnutrition arrive dead or dying. Our changing culture is partly responsible for creating parents capable of such neglect and abuse.

**Etiology of the Syndrome: Cultural Trends**

Society's structure is in a state of flux. The Industrial Revolution has contributed to the creation of a

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geographically mobile population which separates familial generations, and subjects the primary family unit to new psychological stresses and strains. Families now live in impersonal urban centers, where it is increasingly easy for social disadvantaged families to become emotionally isolated from the surrounding community. The study of the Massachusetts SPCC revealed that the majority of the abusing families had lived in their communities for years, and had not moved extensively about in the area. However, 50% had no formal group association, and 28% had only one group association (usually the church). In addition to this they were not fully accepted by the other people within the community.

The education system has failed to provide additional academic support to individuals of restricted interests, opportunity and intellectual ability. This has lead to the widespread problem of school drop-outs. The cultural trend of early marriage and illegitimate pregnancies has culminated in parents who are immature and inadequate socially, emotionally, and economically. Some individuals have been able to adapt

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to the rapid changes within our culture. To others such changes have resulted in additional stress and frustration in everyday living.

**Parental Personality Traits**

Some investigators have attempted to identify common parental character traits in battering families. In the high incidence groups are included the actively or fleetingly psychotic, those with low I. Q., the alcoholic, the psychopathic personality, and the character disorder.\(^\text{12,13}\)

Kaufman indicates that parental physical abuse implies distortion of reality which is found in some types of schizophrenia.\(^\text{14}\) The child may come to represent a symbolic or delusional figure, or a projection of the parents own personality defects which the parent wishes to control or destroy. Therefore the child may, unconsciously, become identified with a hated parent or sibling from the parent's own childhood.\(^\text{15}\)

In the case of projection the parents see reflected in the child that portion of himself that he hates and mistrusts. This produces overwhelming anxiety within the parent, which he attempts to overcome by externalizing this

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destructive force, and attacking or killing the innocent child.\textsuperscript{16}

A complete reversal of dependency roles occurs in situations in which the parents are impulse-ridden character disorders.\textsuperscript{17} These parents seem to have perceived and experienced their own parents as cruel, unloving and brutal, and consequently their ego functions at an infantile level. The normal dependency needs of an infant child are perceived as assultive acts on their physical and mental energies. They experience the child as taking from them rather than giving to them. They retaliate to this "attack" with infantile, uncontrolled, explosive feelings and actions. This retaliation may be phrased passively in neglect or actively in physical abuse. These parents are lacking in social role competence.

Many battering mothers are described as depressed or in a state of despair.\textsuperscript{18} Some battering fathers have been physically disabled, and at home caring for the children while his spouse earned the family living.\textsuperscript{19} Other parents maintained that they were just disciplining the child, for

\begin{itemize}
\item \textsuperscript{16} Kaufman, \textit{op. cit.}, p. 19.
\item \textsuperscript{19} Edgar J. Merrill, "Physical Abuse of Children - An Agency Study," \textit{Protecting the Battered Child}, Children's Division, American Humane Association, 1962, p. 5.
\end{itemize}
suspected wrong-doing. However, the data collected in a recent study in the U. S. does not support the proposition that abuse reflects parental harshness in discipline.

In other incidences the battering parent felt he (or she) was competing with the children for the love of the other parent. Some battered children have been the result of unwanted or pre-marital pregnancies. In other families, birth has followed birth, in rapid succession.

Environmental pressures were found in many families: legal and/or financial difficulties, poor housing, unfaithful spouses or promiscuity. However, it must be noted that these families come from a cross-section of society, with high income and professional persons represented as well as those from the lower socio-economic levels.

The alarming feature is the generational carry-over from some experience in the parents’ own childhood. Either they were brutally beaten themselves as children, or their relationships with parents or siblings have caused seemingly irrepairable psychic damage. Kempe et al. note that child

20 Ten Bensel and Raile, op. cit., p. 981.
22 Bryant, et al., op. cit., p. 128.
24 Loc. cit.
25 Kempe, et al., op. cit., p. 18.
rearing practices, good and bad, are handed down from one generation to the next in relatively unchanged form.\textsuperscript{26} Identification with the aggressive parent occurs despite strong wishes of the individual to be different.

The profession of Social Work has not yet matured to the point of helping all troubled parents. Barbero et al. have recorded techniques of casework intervention which have proven successful in some cases involving nutritionally battered babies.\textsuperscript{27} Extensive research must still be undertaken to distinguish successful intervention methods for the parents who express their incompetencies in the more active and brutal form. The profession cannot ignore the fact that there are some persons for whom the most highly skilled professional staff cannot now effect change in time for the parents to safely fulfill their responsibilities to their children. The syndrome is not a new phenomenon, but one that has been with us for many decades. Failure in proper diagnosis made it possible for the cause of the syndrome to remain undetected.

\textbf{Differential Diagnostic Practice}

Since Caffey first recorded the syndrome in 1946, it has been mistaken for symptoms of recognized diseases.\textsuperscript{28} This

\begin{itemize}
\item \textsuperscript{26} Loc. cit.
\item \textsuperscript{28} J. Caffey, "Multiple Fractures in the Lone Bones of Infants Suffering from Chronic Subdural Hematoma," \textit{American Journal of Roentgenology}, Vol. 56, No. 2, August 1946, pp. 163-173.
\end{itemize}
resulted in a fruitless search for physical cause. Exhaustive laboratory and clinical testing was carried out in an attempt to diagnose scurvy, Barlow's disease, congenital syphilis, osteogenesis imperfecta, and many other known diseases, as well as birth injuries. Griffiths and Moynihan even speculate that "many textbooks on radiology and orthopedics which purport to show typical changes in scurvy are in fact examples of this syndrome of epiphysial trauma".  

In other words the medical profession may be subconsciously rejecting the evidence shown in the X-rays. It has now been suggested that any reference to the word "parents", calls forth subjective reactions to individuals at all levels of society. This reaction extends to the well educated professionals as well as lay people. The idea that parents would mistreat their child to such an extent is repugnant, and therefore is frequently rejected.  

Disastrous consequences are attendant upon late recognition of the syndrome.

Indications of Prevalence

The American Humane Association survey indicated that 662 cases of child abuse were recorded in the press in forty-eight states and the District of Columbia in 1962. The victims of this vicious syndrome are often too young to speak for themselves. More than half the number noted in the press

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29 Griffiths and Moynihan, op. cit., p. 1560.

survey were under four years of age. One hundred and seventy-eight died as a result of injuries. Parents were found responsible for 73% of the injuries and 79% of the fatalities. Assuming that the syndrome is sometimes unrecognized, other cases probably occurred, but were not recorded. The tortures inflicted on these children are unbelievable.

Types of Abuse

Most were beaten; by bare fists, straps, electric cords, television aerials, ropes, rubber hose, fan belts, sticks, wooden spoons, pool cues, bottles, broom handles, baseball bats, chair legs, and in one case a sculling oar. Less imaginative, but equally effective was plain kicking with street shoes or heavy work boots. Some were burned with lighted cigarettes, open flames, electric irons and hot pokers. Others were strangled or suffocated by pillows or plastic bags. A number were drowned in bath tubs, and one was buried alive. In addition, children were stabbed, bitten, shot, subjected to electric shock, thrown violently on the floor or against the wall, were jumped on, and one child had pepper forced down his throat. It has been estimated that the total number of battered children in the United States in any single year would number close to 10,000 if all could be detected.

31 Ten Bensel and Raile, op. cit., p. 977.
Canada a survey undertaken by the Canadian Welfare Council, between April 1, 1963 and March 31, 1964, revealed 300 cases of child abuse. However, it must be noted that several provinces have not yet separated these cases from those of general neglect. Case descriptions are now appearing in the medical and social work literature.

Case Descriptions from the Literature

Ten Bensel and Raile describe twins brought to hospital, one dead on arrival, with X-ray evidence of five old fractures, the survivor having a total of eleven fractures in all extremities. The ease with which arms and legs can be used as handles for flinging a child about is felt to be the reason for the great number of fractures of the extremities. Boardman reports "a nine month old baby who had had three previous hospitalizations at two other hospitals, for treatment of skull fracture, a fractured arm and other injuries. On admission to Children's Hospital (Pittsburg) she was found to have sustained a second skull fracture and showed evidence of seven other injuries, to the bones, of different ages." Morris et al. tell of "Jack Burt, three years old, dead on arrival, with continuous welts around both arms, across his back, a large swelling on his head, old burn scars from chest

34 George Caldwell, Associate Executive Secretary, Canadian Welfare Council, Family and Child Welfare Division, letter to Mr. G. Wickett, October 27, 1964.

35 Ten Bensel and Raile, op. cit., p. 979.

to lower abdomen." A search of hospital records revealed that Jack's sister, Rita, age three months had been admitted to hospital eleven months previously with a head injury. Cause of injury was recorded as falling off a bed. One cannot escape the realization that the victims of such brutal abuse, suffer consequences both devastating and generational in effect.

**Consequences of the Syndrome**

The victims of the syndrome can suffer loss of life, loss of natural family, impaired intellectual ability, and impairments emotionally that can be handed down from generation to generation, once they themselves become parents. The Children's Hospital of Pittsburg has carried out a study of fifty former patients whose diagnoses included multiple bone injuries, at various stages of healing. This study concluded that a child with multiple bone injuries has a fifty percent chance of being reinjured should he return to his usual habitat following hospitalization. At the time of hospitalization, seventeen of these children were under three months of age when multiple bone injuries were detected, and nine were aged from three to six months. Of the 42 former patients on whom information was available over half are deceased, handicapped, institutionalized or have required rehospitalization as the aftermath of physical abuse by parents.

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Of the children who died following discharge from hospital, two were slain by their mothers, a third was brought dead to hospital, (coroner stated cause of death as malnutrition), a fourth died of causes unknown, two weeks after she was returned to her home, when an application for wardship was denied. It is also noted that other deaths could have occurred without being known to the hospital. One child was readmitted to hospital with a fractured jaw. She had been temporarily returned to her parents pending foster home arrangements. Another child lost an eye, due to an injury received in the course of a beating from her mother, and the circumstances of the injury to a third child were not known. Of the remaining children, eight have not returned to this hospital and nineteen have shown no physical or intellectual impairment.

Two were rehospitalized for prolonged treatment of subdural hematoma, seven had serious physical defects on return to hospital, and four were mentally retarded, when multiple bone injuries were discovered. This was discerned at the ages of five, eight, and twelve months. It was impossible to tell if the retardation preceded or was the result of the injuries. This syndrome is so newly recognized that very little documentation of resulting personality disturbance has yet been recorded.

**Emotional Disturbance as a Concomitant to Physical Abuse**

Even if the victims of the syndrome can be assured permanent government guardianship and classified by law as adoptable, physical and mental handicaps may make them
unacceptable to adopting parents. Thus some of them must join the ever increasing number of foster children, to whom one permanent life-long home cannot be assured. The emotional impairment of any foster child due to moving from home to home has been documented elsewhere. Abused children are not easily placed in substitute homes, as their early experiences may cause them to distrust all adults and prevent them from establishing meaningful relationships so necessary for mental health.

Kaufman suggests that a type of childhood schizophrenia often develops in children who have been exposed to violently abusive parents, who demonstrate uncontrollable, aggressive behavior and who are unconsciously isolated from the community at large. A child raised in such an environment often reflects a portion of the parents' uncontrolled personality, and his later behavior may be such as to call forth aggressive behavior from well-meaning caretakers.

Duncan et al. have conducted a study in an attempt to identify common factors in life histories of persons convicted of first degree murder. They selected for study only those responsible for an individual, impulsive, isolated murder with no record of other violent crimes. Six men

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39 Children's Division, American Humane Association, Protecting the Battered Child, American Humane Association, P. O. Box 1260, Denver, Colorado, 1962, p. 18.

imprisoned for life in the Minnesota State Prison, and their parents were interviewed in order to record the parental attitudes and behavior toward the murderer as a child. Two of the men were later excluded as they were found to be psychotic at the time the act was committed. All four of the remaining subjects were found to have suffered continuous remorseless brutality at the hands of one parent, while the other remained acquiescent to such actions. The prisoners, through imitation and identification, behaved like their past brutal aggressors and had learned by conscious example that violence was a solution to frustration.

Curtis has presented an overview of Duncan's study plus others. He cites the study of Bender and Curran in 1940 concerning the etiology of children and adolescents who kill or who had committed murderous aggression. The most common social factor found in this study was the child's tendency to identify with an aggressive adult and pattern after their behavior. Curtis also calls attention to the conclusions of Esson and Stienhilber, in their investigations of eight boys who were guilty of murderous assaults, one successful. In two cases there was a clear history of habitual brutal beatings by a parent, and in three others there was evidence of possible, concealed brutality.

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Curtis states that one possible consequence of physical abuse is "the probable tendency of children so treated to become tomorrow's murderers and perpetrators of other crimes of violence, if they survive. Theoretically a child so treated should have an unusual degree of hostility toward the parents and toward the world in general. The control and channeling of this hostility into non destructive avenues of release would pose a problem both for the child and society. In addition the child would be presented with parental objects for identification who provided an example of the destructive and uncontrolled release of hostile aggression." However, he does caution that there is no one-to-one relationship between child abuse and later crimes of violence and therefore we cannot assume that all physically abused children will later commit such crimes. Nevertheless, he does suggest that early intervention by a physician might be the means of preventing a later violent criminal act. Considering the possible devastating consequences it is of value to trace the path of recognition and reaction of the affected professions to the syndrome.

Evidence of Recognition of the Problem in the Literature

The first published article in the medical periodicals appeared in 1946 when Caffey made a connection between subdural hematoma and fractures of the long bones in infants.

He was not able to obtain a history of injury from the parents and offered no indication as to the cause of the injuries. In 1950 the same author speculated that such injuries were due to parental negligence or maltreatment. Silverman, in 1953, stated that physical trauma was the most common bone "disease" of infancy, and noted the strong resistance of the medical profession to the interpretation of parental mismanagement as the basis of childhood injuries. In 1955 Woolley and Evans related the injuries of twelve infants to an "injury-prone environment". The following year Bakwin agreed that the skeletal changes in infants was due to trauma rather than disease. In 1957 Jones and Davis reviewed forty-two cases, emphasized the importance of early recognition of the possibility of trauma, suggested that unnecessary and costly diagnostic procedures could be curtailed and the child removed from the offending environment when necessary.


suggests careful history taking by doctors, avoiding an accusing attitude, when attending cases of fractures in children accompanied by multiple soft tissues injuries. Since this time more articles have appeared in the medical literature, concurring with the cause of the syndrome and suggesting referral to a law enforcement or social agency for follow up.

The path of professional recognition then clearly follows the progress of referral of the victims of the syndrome. In 1960, Elmer contributed an article to the social work literature. The concern was passed from medical social workers to child welfare workers. As individual workers sought protection from the courts, in extreme situations, the syndrome became known to a few judges and lawyers. The ambivalence of doctors toward referral of such cases to the authorities has been resolved in the United States by making the procedure mandatory under the law, in many states. The Children's Bureau, Department of Health, Education and Welfare, Washington, D. C. formulated suggested state legislation in 1962:

1 that it be mandatory for physicians and hospitals to report suspected cases of child abuse to authorities
2 that an oral report should be followed as soon as possible by a written report
3 that the physician shall have immunity from civil or criminal action in respect to evidence given in any resulting court proceedings
4 that the physicians evidence is not privileged due to the fact that the child is the patient not the parents

50 Donald S. Miller, "Fractures Among Children I. Parental Assault as Causative Agent," Minnesota Medicine, Vol. 42, No. 9, Sept. 1959, p. 1211.

That failure to report makes the physician guilty of a misdemeanor. 52

Twenty-one states have already enacted some form of the suggested law. 53 Popular magazines and newspapers have forced public recognition of the syndrome by sensational articles. 54, 55, 56, 57

Accompanying the proof of professional recognition, portrayed by the presence of the articles in the medical and social work literature is the disquieting evidence that individual practitioners in all disciplines, as well as the public at large, discount the necessity of prompt intervention and continuing protection when they are confronted with abusive parents in actual practice. The legal removal of children from the offending environment, which is often the end result, does not rest well on their conscience. They become uncomfortable when the rights of the child come into conflict with the rights of a parent.

In the Massachusetts Study referrals were made by doctors in only 9% of the cases even though they had been

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52 Pediatrics, Vol. 31, No. 6, June 1963, (Editor's Note) p. 897.

53 Time, op. cit., p. 33.


56 "When They're Angry," Newsweek, April 16, 1962, p. 74.

involved in 30%.\textsuperscript{58} The Deputy Chief of the Children's Bureau, Washington, D. C. attributed the failure of physicians to act on behalf of victims of the syndrome to: maldiagnosis, as few doctors are aware of the syndrome; an abhorrence to the idea of parental abuse, and therefore a denial of the existing facts; an absence of the existence of a social conscience, on the part of a few; a tendency to hide behind the fear of court proceedings, adverse publicity, and possible legal suits for false accusation; or simply the fact that there is no recognized policy of procedure in their locality.\textsuperscript{59}

Social workers, as well, have been guilty of wishful thinking and the supposed right of the parents to another chance before removal of the children is affected. Such thinking is dangerous and can expose the child to reinjury or even death, unless the parents show undeniable evidence of change.

In actual practice some judges and lawyers have a tendency to assume that a warning will magically change the reaction patterns of parents, and thus result in a safe environment for the child. Neighbors, although willing to make the initial complaint, are most reluctant to carry through their obligation, and testify in child welfare hearings. In doing so, they place the continued good will of the parents before the safety of the child. The readers of

\textsuperscript{58} Bryant et al., \textit{op. cit.}, p. 127.

the newspaper and magazine articles tend to regard the actions of abusive parents as something within the realm of possibility but not within their town or their circle of acquaintances. Recent newspaper coverage reports that even Caffey, who made the initial conclusion between syndrome and cause, is now cautioning against the premature removal of children from an injury-prone environment, and the unnecessary breakup of the family.\(^{60}\) Therefore we can only conclude that the values inherent in our culture perpetuate the existence of a taboo of abuse and gross neglect by parents.

**Values Supporting the Existence of the Problem**

The codes of ethics of three professions support the problem in that they classify verbal communication between the client and the professional as "confidential". However, it is professionally unethical not to take steps to prevent a tiny child from further abuse or even death.

The high income bracket or professional status of some abusive parents also perpetuates the problem.\(^{61}\) The image of success becomes synonymous with that of a good citizen and other obvious physical and social signs of the abusive pattern of behavior are rejected as incompatible in such a life situation.

However, the existence of the problem receives its greatest support from any individual's subjective reaction to

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\(^{60}\) Toronto Globe and Mail, Feb. 17, 1965.

the word 'parent' or any other family member. 62 This is a positively charged word calling forth forgotten feelings and memories of dependency, comfort and love. This is particularly true when the parent is a 'mother'. Schoepfer even suggests to child welfare workers that they use the word 'mother' as sparingly as possible in such proceedings to guard against subjective reactions on the part of the judge. 63 Society has not always placed such a value on the inherent rights of children.

Changes in Child Rearing Practices

At an earlier point in time such abusive practices would not have merited more than passing attention from other members of society. Radical changes have taken place in the child rearing practices of the western world within the last hundred and fifty years. In ancient Rome the father was afforded by law the absolute power over his children even into adulthood, allowing torture, death or selling into bondage (Patria Potestas). 64 Eskimos once practiced infanticide, as a means of regulating population to the available food supply. 65 In the United States the early colonists regarded

62 Morris and Gould, op. cit., p. 35.


incorrigibility as just cause for the death penalty for children over sixteen. A century and a half ago the stirring of public conscience on behalf of children began. This movement culminated in the passing of Child Welfare Laws and more recently in the United Nations Children's Charter. Since 1960 several organizations have been spurred into activity as a consequence to the recognition of the social causes of the syndrome.

Professional Response to the Syndrome

The national child welfare organizations in the United States have made valuable literature available to social workers in the field of child protection. The syndrome was discussed at the Academy of Pediatrics in Chicago, (October 1961). The U. S. Children's Bureau has had several conferences since 1962, producing the guidelines for legislation and an up-to-date bibliography on the Battered Child. As previously


67 Children's Division, American Humane Association, Protecting the Battered Child, American Humane Association, P. O. Box 1266, Denver, Colo., 1962.


69 Katherine Bain, op. cit., p. 895.


mentioned twenty-one states have adopted some sort of legislation in regard to the physicians reporting the syndrome.\textsuperscript{72}

The most profitable interdisciplinary projects have taken place in hospital settings. The Fifty Families Project of the Pittsburg Children's Hospital graphically portrays the physical and intellectual consequences to the victims.\textsuperscript{73} The Children's Hospital of Philadelphia has differentiated between the reactions and attitudes of neglecting battering parents and those of protecting parents, who bring children to hospital.\textsuperscript{74} The Massachusetts Society for the Prevention of Cruelty to Children has pinpointed the reluctance of doctors to refer such cases, and isolated common social factors in the battering families.\textsuperscript{75}

In Canada a panel discussion was undertaken at the Annual Conference of the Canadian Welfare Council in Ottawa in June 1964.\textsuperscript{76} At the present time the Canadian Association of Social Workers is contemplating a study on the abused child.\textsuperscript{77} Considerable interest and concern has been generated in the province of Ontario, due to the deaths of a

\textsuperscript{72} \textit{Time}, \textit{op. cit.}, p. 33.

\textsuperscript{73} Elmer, \textit{op. cit.}, pp. 98-102.

\textsuperscript{74} Marion G. Morris \textit{et al.}, \textit{op. cit.}, pp. 55-60.

\textsuperscript{75} Harold D. Bryant, \textit{et al.}, \textit{op. cit.}, pp. 125-130.

\textsuperscript{76} George Caldwell, \textit{op. cit.}.

\textsuperscript{77} Florence L. Philpott, Executive Director, Canadian Association of Social Workers, Letter to writer, December 9, 1964.
number of children and an outspoken coroner, Dr. H. G. Cotnam. As few articles have been written in Canada, Canadians are forced to draw on the literature and research being produced in the United States.

In British Columbia the Child Welfare Branch is contemplating a province wide registry for battered children in Victoria. The Vancouver Council of Community Services held a meeting of interested persons on February 2, 1965.

Because of the swiftness and destructiveness of the syndrome the response at the local level must be immediate and effective. As previously noted the greatest number of victims are infants three months and under. Their complete helplessness at this stage of development cannot be ignored. Responsible adults must act on their behalf. Physicians must recognize the serious syndrome and refer to the proper authority for social investigation. Social workers must be aware of the devastating consequences and initiate their share of protective action. Members of the legal profession must utilize the law as a protection to the child and not as a bulwark for the rights of parenthood. These parents by their actions are sometimes unconsciously proclaiming their inadequacies and requesting release from overburdening responsibilities.

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80 Morris, et al., op. cit., p. 56.
Although the amount of literature on the battered and abused child is growing, there has not yet been one study that has compared these families with families of children who have not been abused.

Criticism of the Literature

In a true experimental study, one group is exposed to the assumed causal variable while the control group is not. The researchers should then be able to show that certain physical and emotional consequences occur only when subjects have been exposed to battering and do not occur when abuse is not present. The absence of a control group in any of these studies, raises the serious question of validity of the conclusions reached. Therefore we cannot say whether the characteristics so far attributed to abusive parents are not also common to other parents who do not abuse their children. Until we know this we are unable to say that because a parent has such and such characteristics the children are not safe in this home.

Focus of Present Study

Because the services of several professions are needed to cope with this special problem, our group chose to focus on the resulting co-operation and co-ordination of three disciplines as they move to meet the challenge of the Battered and Abused Child Syndrome, in this particular area of Canada. Thus we selected a three pronged approach involving the professions of medicine, social work and law.
Hypothesis

Medical, social work and legal machinery is adequate for the prevention, detection and treatment of the Battered Child Syndrome in the Greater Vancouver area.

A second aim of the study is to further identify the common social factors which are present in the abusive families. Hopefully, identification of such social factors may prove useful in isolating high risk families even before battering takes place. Therefore early referral to appropriate community resources for counselling would become an actual preventative measure and might greatly reduce the incidence of the syndrome in the future.

Study Design

One hospital in the Vancouver area was approached and made conversant with the aims of our study by letter and subsequent personal contact. This general hospital serves primarily a white, urban population. The hospital administrator made available 26 medical charts and social service records for the examination of a research person. Pertinent information was then entered in a schedule for later analysis (see Appendix B for schedule).

One child protection agency was also approached in a similar manner. This agency is restricted in its service geographically and to one broad religious denomination by statute. The researcher was granted access to an agency selected sample involving 12 children. Pertinent information from these files was also transferred to the schedule for later analysis (see Appendix for schedule).
In looking at cases from the point of view of the legal profession, two problems were encountered: (1) discovery of cases actually designated as the Battered Child Syndrome, that have been before the courts; and (2) availability of court records for study. Because of limited time for this project and extreme difficulty in locating such cases, only two were deemed available and accessible. This limited the study design and focus to that of case studies. The actual court transcript was available in only one case, so that the researcher had to utilize personal interviews with the two attorneys who presented the cases to the court on behalf of the Superintendent of Child Welfare.

Conclusions

This study again points up one of the difficulties in doing scientific research as we were not able to conduct random sampling of available files, but had to depend on an agency selected sample in both the hospital and child protection setting.

In understanding a broad overview of the three professions, the machinery to detect, and then protect, the victims of the syndrome is definitely in existence at the present time. This study did not reveal any evidence of attempts to prevent the syndrome by early recognition of family symptoms and subsequent referral for counselling before actual abuse has taken place.

The present Protection of Children Act is a proper and adequate vehicle for bringing such cases before the
court. However, the act is subject to much individual interpretation by social workers, lawyers and judges themselves. The law profession has the least exposure to such cases and it is therefore the responsibility of child welfare workers to acquaint their counsel with enough facts concerning the syndrome, to enable them to question witnesses in such a manner as to place the most revealing facts before the court.

Medical evidence placed before the court should be focused on proving persistence of abuse and social work evidence should be focused on the unsafe elements present in the familial environment. Special effort should be made by child welfare personnel to mark the files of battered children, who have been granted the protection of ward care, so that subsequent workers can make progressive observations about their emotional state of health, in order that consequences of the syndrome can be recognized.

At the present time follow up treatment and supervision is only offered to families who have other small children who may be considered by the community as in danger. Continuing case work service should be offered to all families where battering has occurred to improve the homeostatic balance of such families and thus make the environment safe for even future children.

We are not aware of any mention in the literature of the emotional impact felt by the family upon the removal of such a child, and the consequences of this impact as revealed in the resultant behavior of the family. It is possible that treatment at this point is best offered by a non-authorative agency, and that all communities should be prepared to offer this additional service.
CHAPTER 2.

THE HOSPITAL TREATS THE BATTERED CHILD

Purpose of Chapter

The purpose of this chapter is two-fold. First of all, an attempt is made to evaluate twenty-five hospital records of children who had suffered abuse. Perusal of the literature on the subject of the Battered Child Syndrome resulted in the formation of certain expectations. To find out whether or not these expectations, outlined in theory and supported in other studies would also be supported in ours was the basis for the evaluation of cases. Thus, contrasts and comparisons between the findings of others and our own findings are constantly drawn.

Secondly, an attempt is made to evaluate the validity of our hypothesis - namely, that medical, social work and legal machinery is adequate for the prevention, detection, and treatment of the Battered Child Syndrome in the greater Vancouver area.

Sample Source

The hospital approached for research material, a two thousand bed general hospital serving primarily a white, urban population granted the student access to twenty-five selected medical charts and social service files$^1$ of children who had been abused.

$^1$ Appreciation for granting the student access to these records is extended to the Vancouver General Hospital and particularly, Miss A. Pumphrey, Director of Social Services and Dr. L. E. Ranta, Associate (Medical) Director.
Sample Design

The Social Service Department staff at the Vancouver General Hospital is constantly engaged in several projects which are pursued for the purpose of developing the knowledge of individual social workers. As literature on the Battered Child Syndrome increased, workers in the Health Centre for Children became interested in doing some research on the subject for one of their "staff development projects." As a consequence, they investigated all the social service files of children and chose those they believed indicated the syndrome. They then called the corresponding medical charts and asked the hospital's Associate (Medical) Director to ascertain whether or not the child subject of each chart, in fact, had been physically abused. The sample cases the student studied were some of those that the Associate (Medical) Director concluded did illustrate the Battered Child Syndrome.

Because the sample used was not a random one, limitations were placed on the study from the outset. For example, because the sample population was not representative of a normal population, no conclusions could be drawn regarding either incidence or prevalence of the Battered Child Syndrome.

Schedule

A schedule was developed for the purpose of providing structure for the gathering of pertinent information as it was outlined and suggested in the existing
literature. The first two pages and the face sheet were designed to elicit information about family structure, socio-economic status, and stability. The fourth page was designed to produce a physical, psychological and social picture of the abused child as well as interaction patterns of the family members. Page five was reserved for information that would either prove or disprove our hypothesis - that the existing medical, social work and legal machinery is adequate for the prevention, detection, and treatment of the Battered Child Syndrome.

The schedule was developed to secure information identifying abused children and not to accommodate any particular recording.

Definition of the Battered Child Syndrome and Its Significance for Those Involved With It

The "battered child syndrome" takes its name from the fact that the child's injuries are the result of twisting, throwing, knocking around, or some other form of "battering" by the abusive person. The injuries include bruises, hematoma and one or a combination of fractures of the arms, legs, skull or ribs. In many instances poor skin hygiene and some degree of malnutrition are also evident. X-rays of the child often reveal other fractures in various stages of healing, indicating that such abuse has been repetitive.

2 See Appendix A.

infliction - and when a child's bones were broken. Fractures of the limbs, head and ribs are common features of the battered child syndrome. In the cases studied 15 out of 25 or sixty percent of the patients suffered fractures. When X-rays indicate that fractures at various stages of healing are present in a particular child, doctors can say with certainty that the child has been abused. By noting the kind of fracture a child has, also, the doctor can assess whether or not the injury is the result of an accident. For example, a parietal bone of a child will not be fractured without severe trauma. In any kind of usual accident, it would be impossible for a child to receive injuries to both parietal bones. However, it would be quite possible for a child who had received a beating about the head, to have both the bones involved. Thus, a diagnosis of the syndrome can be made after a thorough investigation of a child's fractures.

However, the doctor need not rely solely on X-ray evidence before he can make a diagnosis of the Battered Child Syndrome. When a child is covered with bruises and is not suffering from a coagulation defect, the syndrome must be

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4 See Table B.


considered. The brain of a battered child is the most commonly injured organ. A blow to the chin transmits force through the middle fossa to the brain. Blows to the feet or buttocks transmit force through the spinal cord to the base of the brain. A direct blow to the head can result in subdural hematoma. In the 25 cases studied, 10 had a diagnosis of subdural hematoma - forty percent. The diagnosis of the brain hemorrhage does not lead directly and automatically to a diagnosis of the battered child syndrome, but in the face of other evidence of neglect such as malnutrition, failure to thrive and the like, its etiology should be questioned.

If a doctor wishes to find additional non-physical support for the diagnosis of the battered child syndrome he can turn to the parents of his patient, for it is said that parents who beat their children exhibit certain definite characteristics. They do not willingly give information about the child's illness or injury. They often try to avoid the doctor's question, "How did it happen?" and will contradict themselves if asked the question at different times. They show no concern about the injury, treatment, or prognosis and give no indication that they feel guilty about what had happened to their child. If anything, they seem angry with the child for being injured and causing so much trouble. They visit their child in hospital not at all or rarely. When they do, they do not touch the child and often do not even

7 Loc. cit.
8 See Table B.
look at him. They constantly criticize the child and never mention any good qualities he might have. If a doctor is reluctant to make a diagnosis of the syndrome, then, an interview with the parents may influence him to do so.

Consequences of the Syndrome for the Doctor

At this point the question arises, "Why would the doctor be reluctant to make a diagnosis of the syndrome? In other words, what are the implications of the syndrome for the doctor involved with a battered and abused child.

It has been suggested that doctors find the idea that parents abuse their children so bizarre and unbelievable, that they tend to deny the fact. They cannot accept such behavior and, as a result, try to explain the physical signs presented by the patient as manifestations of some rare disease. Extensive subperiostial hemorrhage often associated with areas of radiolucency in the metaphyses and displacement of epiphyses may lead to the diagnoses or questionable diagnoses of such conditions as scurvy, congenital syphilis, infantile cortical hyperostosis, osteogenesis imperfecta, rickets or neoplasm. In Table B the diagnoses given are those of the patients current admission in hospital.


Unfortunately, the author did not record with consistency diagnoses of previous admissions. However, in earlier admissions it was noted that case number 218 was diagnosed with scurvy and traumatic infantile hyperostosis on two different occasions - in spite of the family doctor's report that the infant had had several previous injuries. Whether or not the doctors working on this case did not diagnose the Battered Child Syndrome because they could not believe that parents do, on occasion, beat their children or whether they did not diagnose it for some other reason is an interesting question.

Table B indicates that not once was the Battered Child Syndrome diagnosed. As soon as a doctor makes such a diagnosis he also makes a serious charge possible against whoever has abused the child. In a hospital such as the one from which the research material was drawn, such a diagnosis would probably lead to intervention by the medical social worker and, ultimately, involvement of the city's Child Protection Agency. The outcome of such activity may well be lengthy court procedures, possible adverse publicity for the doctor if the newspaper reporters are able to secure any information, or even a suit for false accusation.¹² A doctor must not only be positive in his diagnosis of the Battered Child Syndrome, he must also be prepared to risk his reputation and his practice.

It has been suggested that a doctor may not diagnose the syndrome readily if he lacks the knowledge of what

can be done about it.\textsuperscript{13} It is difficult to say whether or not such is the case in the medical setting in which the research was conducted. However, since the hospital is staffed by residents from all over the world, interns from various medical schools, and by private doctors with visiting privileges, it is possible that they are not familiar with procedures which have been developed for the investigation and handling of battered children. The Social Service Department has found that it is of the utmost importance to engage in a continual program of educating doctors as to the functions of the social worker as many doctors - particularly those who have not trained in the province, have not the slightest idea of their abilities or what they are supposed to do. Since this is the case, it is certainly reasonable to suppose that they do not know how the social worker might help in the case of a battered child.

It is not too difficult to understand why the practitioner - faced with the problem of a battered child which often is dangerous to his position, "foreign to his experience and repulsive to his sensitivity"\textsuperscript{14} will tend to depend on the confidentiality as a defense against doing something to protect his patient from further abuse. Jacobziner has said, however, that "unwillingness to become involved is unpardonable


and not in keeping with the ethics of the medical profession."15

The Canadian Medical Association's Code of Ethics reads:

... Their (patients) confidences are safe in his (doctor's) keeping, except in those rare instances when the safeguarding of society exposes a higher law ...16

If a doctor interprets protection of the battered child as a higher law then he will not use confidentiality as a defense.

In most hospitals, and the one under study is no exception, there is a constant demand for beds. If a battered child has been admitted, his condition recognized, and the doctor in charge has decided to "become involved," then it will probably be necessary to keep the child in hospital until some decision is reached regarding his discharge - whether the patient in question actually needs, for medical reasons to remain in hospital or not. The doctor may rationalize that to deal with the battered child would be to deprive another child or children of a bed - or he may not wish to irritate those others who are pressuring him to empty beds faster than he is doing. In one of the records studied, one doctor was asked by another why he did not make a diagnosis of the Battered Child Syndrome. The doctor replied that he felt that his focus should be on dealing with the patient's lesion in order to discharge him as soon as possible. He did not perceive it as his duty - or did not want to perceive it as his duty - to do more. Indeed, it might be argued that if the doctor did do

more, parents would become fearful of prosecution for wilful cruelty, and would avoid taking their child to the doctor at all and then the child would only suffer more.  

Consequence of the Syndrome for Parents

What does the syndrome mean to the battering parents? It has been stated that parents who batter their children demonstrate little guilt about their actions. Unlike normal parents whose child has been injured, they do not tend to blame themselves for not watching their child more carefully. Rather, they tend to blame the child for what has happened, or someone else. Do they place the blame elsewhere to defend themselves against their own guilt feelings or to defend themselves against prosecution? The same question might be asked in regard to why parents often fail to bring their battered children for medical attention immediately after the injury was sustained. In the cases studied, evidence available showed that at least in three cases parents did not seek medical aid until some time after the injury was sustained and in at least twelve cases they tried, at first, at least, to blame either the child or a person other than themselves for the injury. Conversation with a doctor who had dealt with battered children revealed that when he had asked parents directly whether they had beaten their child, they would deny that they had but would also break down

17 James H. Gray, "Looking at the 'Battered Baby Syndrome'," Time, April 21, 1964.

and cry. It would seem that the parent who was intent only on protecting himself would not cry. However, one that was guilty as well as apprehensive about what would happen to him might do so. Although the parents of battered children often do not verbalize their guilt, it does not mean to say that they do not have guilt feelings and demonstrate them in other ways. At any rate, as Table D illustrates, ten families admitted abuse and in several of these, the abusing parent was most upset about what he or she had done. Guilt feelings may not be a consequence of the syndrome for all parents but our findings indicate that it certainly is for some.

Guilt feelings may be a consequence of the syndrome for the parents if their behavior is discovered or not. If it is discovered, the syndrome may have other consequences as well. In six of the cases studied, the abused child was taken from the parents and placed in a foster home. In another sixteen cases, parents were subjected to follow-up services by either health or welfare agency workers. In one case, the abusing parent, a fifteen year-old unmarried mother was convicted and sentenced to jail. In the remaining cases, the parents either managed to escape the authorities by moving or else there was no information available to indicate what exactly the consequences of the syndrome had been for them.

19 See Table D.

20 See Table D.
Consequences of the Syndrome for Its Victims

As Table A indicates nineteen of the cases studied involved children two years of age and under. In other words, in seventy-six percent of the cases, the victims of the syndrome were too young to defend themselves or offer resistance to their adult assailants. What then, does the syndrome mean for its primarily helpless victims? In one study, it was found that one quarter of the battered children died as a result of injuries. In our study, no child died. However, bearing in mind the selected characteristic of the sample, such a finding cannot be considered indicative of what happens in an actual population of battered children.

In seven cases or twenty-eight percent, the abused child was noted to have suffered irreparable physical damage. In one case it was malformation of the legs, in another deformity of the knees and in others it was permanent brain damage.

In four cases, the abused child's development was noted to be retarded as a result, not of neurological causes, but of what was felt to be maternal deprivation.

The implications of the syndrome for the victim in terms of psychological damage that will affect him for the rest of his life cannot be measured. Suffice it to say that the space in the schedule left for "Description of child" was filled with statements to the effect that the child was


22 See Appendix A.
unable to draw human figures, was not responsive, looked away from parents when they visited, was overactive and tense, exhibited fear in presence of mother, or engaged constantly in attention-getting behavior.

Presuming the battered child manages to escape the constant threat of death, brain damage, and physical deformity marries and has children, how does he raise his children? It has been suggested that parents who were brutally treated in their youth tend to look to their children for the nurturing and protection that their own children need from them. Natural infant-child dependency is perceived by such parents as assaultive acts upon themselves and they retaliate either passively by neglecting their children or actively by battering them. And so it is that those who write about the syndrome often speak of "the chain which ... leads the once abused and neglected child to neglect and abuse his own child" and the implications of the syndrome for a new generation must be considered over again.

Consequences of the Syndrome for Society

The fact of child abuse is an anomaly in our child-centered, family oriented society. It has been most


difficult for people to accept the fact that child abuse does occur and when it is encountered, it is encountered with horror and surprise. Since Caffey described the Battered Child Syndrome in 1946\textsuperscript{26} however, there has been a mushrooming of literature on the subject both in popular magazines and professional journals. Out of this has come the discovery that society is not able to cope adequately with the problem. As a result, legislation and the roles of the court, police, school, church, doctor, hospital and social agencies have been examined in regard to what they are contributing to the protection of the child. Suggestions have been offered and in some areas they have been instituted. The consequences of the syndrome so far then, has been to force analysis of it as a social problem and the development of suggested protective legislation.

**Expectations of Data and Research Findings**

It was discovered that all information sought and felt to be pertinent to the syndrome, and for which space had been provided in the schedule, was not always available in either the medical charts or the corresponding social service files.

The lack of what was felt to be pertinent information can be attributed to several factors. First of all, medical charts, by nature, are concerned primarily with the medical condition of the patient himself. In the charts studied more information than usual was given regarding the

\textsuperscript{26} J. Caffey, "Multiple Fractures in the Long Bones of Infants Suffering from Chronic Subdural Hematoma," *American Journal of Roentgenology*, (August 1946), vol. 56, #2, pp. 163-173.
patient's home situation. However, how much information was available was almost wholly dependent on the fullness with which the social worker recorded. In some cases, there was no evidence that a social worker had been called to work on the case and on these charts, information was scarce indeed. What information was available was focused often on the patient exclusive of his significant others. For example, on the admission slip which is an integral part of every medical chart, there is a space for the religion of the patient, in this study, the child. There is no space set aside for the religion of mother and of father, however. Unless the social worker had recorded that religious differences were a source of constant stress in the family, there was no way of knowing whether or not the parents of the battered child were or could be experiencing difficulty in the religious area of their life - the focus in the chart was on the patient. In some cases, the information on the social service file supplemented that on the medical chart to some degree, but this was not always so.

Another reason for the unavailability of what was considered by the author to be pertinent information may lie in the fact that the term, the Battered Child Syndrome, is a relatively new one and often those writing the charts were not sufficiently familiar with it to know the characteristics of it that should be recorded. Caffey \(^{27}\) first noted the syndrome in 1946 but it is only as studies on the subject are

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\(^{27}\) Loc. cit.
conducted, recorded, and subsequently made available in the professional literature of doctors, nurses, and social workers that those who are most likely to be in contact with the syndrome recognize first, that it exists, and second that there are various symptoms - both physical and social - by which it might be diagnosed. The cases studied here ranged in time from the middle 1950's to the early 1960's. In the earlier cases, the information for which the schedule made provision was not nearly as available as it was in later cases when more had been published about the syndrome.

In particular areas of the schedule, information was consistently lacking. The education, race, and religion of parents was available only rarely. At the end of a case review, the page set aside for information on the father was always much less complete than the one set aside for information on the mother. Even if the battered and abused child had several siblings, only occasionally was mention made of the interaction between them and their parents.

Thus, not only was the study limited by the lack of a design for the sample but also by the unavailability of desired material. It was impossible to contact all but one of the workers to supplement information on charts as they had left the city. There was no need to contact the one available as her recordings were fairly comprehensive.

**Characteristics of the Abused Child**

Studies have indicated that, by and large, the battered child is too young to defend himself either by
telling others what is happening to him and securing their help or by using force to stop his assailants. Talfce A shows that nineteen battered children were three years of age or under. Thus, our finding regarding the age of the battered child would tend to support the findings of others for the most part although it should be noted that six battered children were over three years old.

It has been noted that a doctor must be aware of and then extremely certain before he diagnoses the Battered Child Syndrome. As a result, it might be expected that many battered children will have received medical attention several times before it is recognized that they are being abused. As Table B indicates, eleven children were known to have more than one hospital admission. This figure is by no means an accurate one as parents might "shop for medical care after each injury of their child from different hospitals and doctors." The medical charts studied usually indicated only the admissions in the hospital under study. Suffice it to say that almost fifty percent of the patients were known to have received medical attention - sometimes as many as seven times - in most cases before the medical social service worker was called in to investigate the family situation.


Vincent de Francis\textsuperscript{30} has outlined the injuries most often experienced by abused children. They include contusions, broken bones, head injuries, and internal injuries. All these kinds of injuries are represented in Table B. However, these were not the only injuries sustained by the battered children studied. One mother severely scalded her child by placing her in a basin of hot water and another mother fed her daughter vanilla until she lapsed into a coma.

It has been suggested that physical abuse and neglect are similar in that both kinds of behavior are precipitated by parents who will satisfy their own impulses before they care for the needs of their children.\textsuperscript{31} If this is so, then, it is to be expected that abused or battered children will also show evidences of neglect. As Table D indicates, sixteen of the twenty-five children studied were known to have suffered neglect in the form of either malnutrition, failure to thrive, serious diaper rash, or psychological damage. As the information secured was dependent on the accuracy of recording, as was previously mentioned, the number of children actually neglected could not be determined. In other words, all that could be determined was that there were at least sixteen children neglected as well as physically abused.

\textsuperscript{30} Vincent de Francis, Child Abuse, Children's Division of the American Humane Association, 1963, p. 5.

It has been found that frequently only one child in a family is singled out to be abused. Sometimes this child is intolerable himself - for example, he may be a "colicky" baby - and, as a consequence may be crying constantly. However, this need not be the only reason he is abused. He may represent a symbol to the abusing parent, some sort of frustration for which an outlet can be provided through his physical mistreatment. 

Fourteen of the families studied had more than one child in the home. In four cases more than one child was abused and in five cases it was not known how many were abused. Therefore, in the remaining five, one child was definitely singled out for mistreatment. In case 217, the patient's mother had been pregnant with him at the time her husband was having an affair with another woman and agitating for divorce. In case 216, the mother felt exhausted throughout her pregnancy with the patient and after the birth, she required so much more care than the mother's other children had done, that the mother had felt exhausted ever since. In case 223, the abusing mother resented the birth of the patient as he arrived too soon after her first child whom she did not feel competent as yet to care for. At the time of his birth, she was also having difficulties with her parents-in-law which were disturbing her greatly. Thus, it is not difficult to see how these abused children could become symbols of frustration and unhappiness to their abusing parents.

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Characteristics of the Families of Battered Children

Nurse stated that none of the abusing parents she had studied seemed to have had positive relationships as children which could have served them as constructive parental models. It was difficult to determine exactly whether or not the abusing parents in the study under discussion did lack appropriate parental models. However, it was possible to determine that in thirteen of the twenty-five cases, information was present in the charts or files that indicated that the abusing parents' families of orientation were disrupted either structurally or psychologically, thus making the possibility of deficiency of appropriate role models more likely. In the twelve remaining cases, there was no indication of the abusing parent having lived either a damaging or healthy early life.

It has been found that parents charged with child abuse often are mentally ill or retarded. In twelve of the cases under analysis, the charts and files indicated that the abusing parent was either mentally deficient or mentally ill.

It has been stated that parents who abuse their children do not admit being responsible for what has happened.


34 See Table C.

35 Shirly Nurse, op. cit., p. 16.

They will blame the child for getting hurt because he is clumsy or they will blame another sibling or a neighbor's child for hurting him. Other explanations include such things as child "fell out of bed," "off the car seat" or "hit his head on the coffee table." If asked at different times for an explanation, the parents will often contradict themselves by giving different stories. Our study did not bear out the expectation that parents never admitted abusing their children. As Table D indicates, ten parents admitted that their child's injuries were a result of beating. Some of these parents did not admit the abuse initially but did after one or two interviews. In one case, the mother repeatedly denied having abused her child until the child was apprehended. When the worker told her what the court had decided to do, she broke down and wept, saying that she was thankful that they had decided to take her child because she was afraid of what she might do to her had she not been apprehended.

Because it was found in the literature that few parents admitted abusing their children physically, it was not expected that our study would uncover parents who went one step beyond admitting the abuse and requested some kind of counselling service. Yet, as Table C indicates, five families asked for some kind of help with their problems - before they abused their children even more than they had already done. Of these five parents, some actually spoke of getting help before they killed their children. It seemed as if they were just as horrified by their actions as an outsider would have been, and yet were powerless about doing anything about them,
by themselves.

Other studies have concluded that the Battered Child Syndrome is not limited particularly to any one race, socio-economic group, educational level or religious sect, but can be found in all strata of society. In this study, no mention was made of the abusing parents being anything other than white, save in one case where the abusing mother was reported to have been East Indian.

In Table A, it is shown that four fathers were absent from the home. Two were serving sentences for criminal offences. In one case the mother was unmarried and was not living with the father of her baby. In the other case the parents of the abused child were separated. None of these mothers had adequate financial support. In eleven cases the fathers were unemployed and had financial worries. In the remaining ten cases, the father was employed but usually received a minimal wage. The occupations included those of soldier (in two cases); service station attendant, the salary of which was one hundred eight dollars a month; store-clerk; barber, the salary which amounted to two hundred and seventy-five dollars a month; truck driver (in two cases) in which the salary was approximately three hundred dollars a month; post office employee; and shipper. In none of these twenty-five cases then, could it be said that the families under analysis were in the upper socio-economic bracket of society. Does such a finding mean that in

the Vancouver area, middle class parents abuse their children only rarely as compared to lower class parents? Such would not necessarily be the case. Knowing how difficult doctors find it to believe that parents do abuse their children because they tend to identify with the parents of the child, it is quite probable that they would find it easier to believe that parents quite unlike themselves in terms of class would be far more likely to beat their children than would middle-class parents like themselves. If this were so, then it would be likely that more lower class than middle class families would arouse the doctor's suspicion that trauma was the cause of injury. They would also be reported to the Social Service Department more often. Also, if abuse and neglect are the same kind of thing, as some contend, is it not possible that middle class parents would neglect rather than abuse their child as they are less likely to succumb to physical expression? Would doctors be more threatened by suggesting that middle class parents beat their children than by suggesting lower class ones did because the former would be better prepared to secure competent legal council if necessary? How much a part these factors play is unknown, but the possibility of their playing a part must be considered if the full implication of the finding is to be evaluated.


Information on the religion of abusing parents was not readily available as has been mentioned previously, and so no evidence could be drawn to support the expectation that the battering of children occurs in families of all denominations.

**System Used in the Hospital to Deal With the Battered Child Syndrome**

In reading through the medical charts and files of battered children, it became evident that a system had grown up by which the Battered Child Syndrome was handled.

The onus was on the doctor responsible for the case to initiate action. If he felt that there was a possibility that a child had been beaten, he would refer the case to a social worker, who would investigate the home and family situation and report back to him. If it still appeared that there was a strong possibility that physical abuse might be the cause of injuries suffered, then the social worker would contact the Children's Aid Society. The Children's Aid Society would decide if there was enough evidence available to warrant taking the case into court and having the child apprehended. If the case was taken into court and the child made a ward, then he would become the responsibility of the Superintendent of Child Welfare. If the child was not made a ward and was returned to the home, the medical social worker would arrange to have the family supervised by either a Children's Aid worker, a public health nurse, a city or provincial social worker (depending on the area in which the child lived) if the family was willing.
Evaluation of the Machinery

The reasons for the doctor's reluctance to diagnose the Battered Child Syndrome have been outlined. Yet on his recognition and statement that there is a possibility of a patient suffering injuries as a result of beating, depends the very life of that patient. In a hospital such as the one studied, a social worker is not involved in a case until the doctor refers it to the Social Service Department. If a doctor is aware first, of the battered child syndrome and second, of the role the social worker plays, and if he interprets it as his duty to do something more than merely treat the child's physical injuries, then machinery as outlined in the above section would be adequate for the prevention, treatment, and detection of the syndrome in the hospital setting. However, it is unlikely that all doctors will have the knowledge or the interpretation of duty outlined, to set the machinery in motion.

There is no way of knowing how many battered children never obtain medical treatment. Thus, if all those suffering from the syndrome are to be detected, society cannot rely solely on doctors to do the detecting. School teachers, public health nurses, and the society as a whole must be educated as to what the syndrome involves, and must also be imbued with a sense of responsibility for the helpless victims of the syndrome.
CHAPTER 3.

THE BATTERED CHILD AND SOCIAL WORK -
AN AGENCY STUDY

Introduction

Whose responsibility is it to protect the rights and privileges of children? The family has long been the prime protector and safeguard of dependent and helpless children. However, when the family structure fails to provide protection, safety and care for the child, outside influences are often called in on behalf of the child. This third party intervention on behalf of the innocent is not a new concept. Greek mythology describes the goddess Artemis who was always careful to preserve the young and became the "protectress of dewy youth" everywhere.\(^1\) The expression of concern for youth in classical Greece, however, differs strikingly from the way concern is expressed in contemporary society. The Greeks placed their faith in the gods to protect their children. Today the rights and privileges of childhood are protected by social legislation and societies created for the avowed purpose of protecting children.

This chapter deals with the social agency's involvement in the protection of the battered child as defined in the opening chapter. The plan of the chapter is first of all, to present something of the history of child

protection services in Canada and then to formulate their philosophy and goals. Secondly, the literature dealing with the specific problems and difficulties of working with protection case loads will be reviewed in order that some expectations for the study of protective agency files might be presented. Then the chapter will describe the research sample used in this study along with the schedule that was developed for researching the case files. Finally, the findings and conclusions of the study will be presented. Against this backdrop the hypothesis that medical, social work, and legal machinery is adequate for the prevention, detection, and treatment of the Battered Child Syndrome in the greater Vancouver area, will be weighed.

History of Child Protection Services

Acts established for the protection of the physically abused child date back to the latter part of the nineteenth century. Concern which resulted in the enactment of such legislation occurred in Britain and America at approximately the same time.

A case recorded in the United States around 1870-1880 illustrates how societies and laws came into existence. A little girl was found chained to a bed, badly abused and starved. An interested woman called the police who investigated but said there was nothing they could do since there were no laws against cruelty to children. The woman did not give up easily however and persisted until she finally had the child removed under a law that prohibited cruelty to
animals. Removal was based on the philosophical grounds that the child was also an animal and therefore should have the right not to be treated cruelly. From this incident grew The Society for the Prevention of Cruelty to Children.\(^2\)

In Canada, the Ontario Act of 1893 embodying, "An Act for the Prevention of Cruelty to and Better Protection of Children," marks the beginning of child protection legislation.\(^3\) The act was a combination of provisions relating to the abused child, the neglected child and the delinquent. It stressed the punishment of parents and guardians who were responsible for the mistreatment or the neglect of children. The Ontario Act was important for its definition of the "neglected child" and took for its model a Scottish act of 1854. The Canadian act with its considered definition and provision for children not physically mistreated or delinquent but in need of protective care was in advance of child protection legislation elsewhere.

The other provinces patterned their child protection acts after the Ontario act including the provision for the establishment and sanctioning of children's aid societies.\(^4\) Consequently Canada has a certain uniformity in legislation although there are variations in administration. The ultimate


\(^3\) Canadian Welfare Council, Child Protection in Canada, Ottawa, 1961, p. 5.

\(^4\) Loc. cit.
responsibility for the prevention of child neglect and for the finding of homes for children taken out of a neglect situation rests with the superintendent of child welfare. In carrying out his duties the superintendent of child welfare depended in the first place upon children's aid societies and, in a sense, supervised their work.

In Ontario and the Maritimes these societies were organized on a county basis throughout the individual provinces. In Quebec there were no protection laws until 1944 and the actual implementation of the legislation had not occurred as late as 1954. In Manitoba the organization was on a regional basis. The westernmost provinces of Saskatchewan, Alberta and British Columbia faced the difficulty of having large tracts of sparsely populated, unorganized territory that compelled them to be content with relatively few children's aid societies which were located in the large urban areas. The children in non-organized areas were later given direct service through government social welfare offices.

The western provinces have tended toward inclusive public welfare programs for children. The children's aid societies have thus become agents of the government or have turned to more specialized voluntary work. The financing of child welfare work is fundamentally undertaken by government although, for example, in Vancouver the Children's Aid Society retaining its own private board and supplies a portion of the cost through its Community Chest grant or from other

5 Loc. cit.
Throughout this discussion of the development of children's aid societies and laws pertaining to the rights of children, the phrase "protection of children" has been used. Child protection has been defined by the Ontario Association of Children's Aid Societies thus:

... a service on behalf of children, undertaken by an agency upon receipt of information which indicates that parental responsibilities toward those children are not being effectively met. The service is based on law, and is supported by community standards. Its purpose is the protection of children through strengthening the home or, failing that, making other plans for their care and custody through the court.6

The role of the children's aid society then is seen from this definition of the services they are seeking to render.

The philosophy of the children's aid society in seeking the protection of children is best stated by quoting from the pamphlet entitled "Child Protection in Canada".

Our philosophy in the field of child protection must be based upon the conviction that the family is the basic unit of society in our culture. We know that the fundamental needs of children are most fully met within the family group. As a general rule the needs of children are best served by guarding the rights of parents. We do not accept, however, the extreme view that parents have absolute rights over their children as Roman Law and English Common Law assumed. Nor do we allow that the state should have absolute rights over children. We seek to achieve in legislation and professional social work practice a balance between protecting the parents' rights sufficiently and guarding against abuse of the children. Realizing the danger of removing too many parental rights, we tend to give parents greater rather than less control when we are in doubt.7

Further, the child protection agency is empowered by the state and the people of the state "to supplement and substitute for

6 Ibid., p. 8.
7 Ibid., p. 31.
parental efforts whenever needed to further the best interests and welfare of the child. [It is] guided and supported by legislation and community concern, [and] believes in its responsibility to remove children from unfit parents."

The goals of a sound child care program are twofold. One is to strengthen, encourage and support wholesome family life. The second is to provide homes or other resources for children when a situation prompts the child protection agency to intervene on behalf of the child. In the provision of substitute homes the thinking has, from the beginning, been in the form of "suitable foster homes" or "properly selected foster homes". Institutions, shelters and schools were to be used on a temporary basis only. In some cases the legislation surrounding the use of foster homes preceded actual initiation. British Columbia had legislation for the establishment of foster home placement of children in 1901 but it was not until after the British Columbia Child Welfare Survey of 1927 that such a program was begun.

Review of Literature

Nurse indicates that until 1960 there was little social research or professional literature published in the

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8 Loc. cit.
9 Ibid., p. 6.
10 Loc. cit.
U. S. that dealt with the physical abuse of children. Why this should be so is difficult to explain, except that there is a reluctance to become involved on the part of doctors, social workers and members of law enforcement agencies and the legal profession. Boardman,¹² in her study conducted in the children's Hospital of Los Angeles attributes some of the reluctance to guilt on behalf of the professionals because they feel they may have failed to safeguard the health and welfare of these children. Elmer¹³ recognizes a tendency for professionals to identify with the parents and accentuate any positives they may have. She feels the reluctance to study this problem is due in part to a desire to avoid that which is unpleasant. Young¹⁴ also notes in her doctoral thesis that there is a strong tendency to avoid personal involvement in such cases.

Boardman¹⁵ in 1962 reported on a project conducted in the Los Angeles Children's Hospital to protect the battered child. On the basis of twelve cases she raises four points. The first is that the nature of the injuries must be stated clearly on behalf of the child, since for the infant the


¹⁵ Boardman, op. cit., pp. 45-46.
attending physician is the only person who can initiate action. Secondly, the abusing adult is reacting not to the child's behavior but to his or her own feelings. Thirdly, abusing adults are likely to repeat and therefore the child should be considered in grave danger unless the environment can be proved safe before return. Finally, for these reasons the community needs to define the point at which the right of the child to good health supersedes the rights of the parents. This study also defines the dilemma of the doctor faced with diagnosing what he suspects is abuse.

Elmer, in 1963, published an article based upon findings in the Children's Hospital of Pittsburgh. An examination of all available X-rays taken of children admitted to hospital revealed certain characteristics that might be used in identifying battered and abused children. The study points out that multiple bone injuries will not be found in the "great majority of abused children...For every child hospitalized with skeletal injuries, there are probably many more whose injuries heal without hospital care." Thus the need for detecting old injuries using X-rays.

Three very important points are made in regard to the use of X-rays. First, they provide a permanent record of skeletal injuries, although they do not supply information regarding more subtle forms of abuse, such as malnutrition.


17 Ibid., p. 184.
Secondly, the varied stages of bone healing seen in X-rays is proof of injuries occurring over a period of time. To attribute all bone lesions to a series of accidents is not plausible, especially for infants unable to walk. Thirdly, the "clinical nature of the bone findings releases professional persons from undue dependence on hearsay about the care of the child."\(^{18}\)

Delsordo,\(^{19}\) also publishing an article in 1963, attempts to provide clues for protective casework for abused children. He approaches the whole problem of abuse by attempting to categorize five causes: (1) parents' acute mental illness, (2) an overflow from the parents' aimless way of life, (3) a nonspecific disturbance in the parent resulting in severe battering of the child, (4) parents' harshness in disciplining children, and (5) parents' misplaced conflicts. Delsordo speaks of the battered child syndrome occurring under category number three. This is the only article known to the writer which attempts this kind of distinction.

The article is written with the aim of providing a guide for casework with abusing parents and victimized children. The research sample contained eighty cases handled by the Pennsylvania Society To Protect Children from Cruelty over a three-year period. Cases were selected on the basis of bodily harm done to children which resulted in an agency rendering service designed to protect the child. Delsordo classifies

\(^{18}\) Ibid., p. 182.

eight cases of the total as examples of the "battered child syndrome". He indicates that this symptom is manifested most often in infants and children too young to speak.

Delsordo's approach to the problem of child abuse is very helpful. One difficulty in Delsordo's approach, however, is that perhaps the abused children categorized in other than the "battered child" category could in fact be "battered children" who have survived infancy.

Another study by Morris et al. conducted in the Children's Hospital of Philadelphia by the social work department of the hospital is helpful for social workers attempting to prevent child abuse. The study makes some comparisons between protective parents and neglecting, battering parents, which are useful for purposes of identifying cases of abuse. Similarly the reactions of well-cared-for children entering hospital are compared to children who have suffered from abuse and neglect. The material presented also offers the social worker some guidelines for interviewing with an eye to assessment and case management. Because of their significance to social workers concerned with protection they are worth listing.

1. What is a parent's own estimate of current life needs as they are filled or threatened by children's needs for care?
2. Did this parent have positive role connections with society before his parenthood?
3. What are this parent's feelings about his own childhood?
4. What are this parent's feelings about his own parents?
5. Has this parent ever identified with the nurturing parent role?

6. How strong is this parent's motivation to be connected to society by a social role? which role? as an adult 'child', a worker, a parent?
7. How does this parent respond to a child's everyday needs? as natural and acceptable? as simple interference? as assaultive and oppressive?
8. Does this parent attribute irrational degrees of motivation, responsibility, and judgment to an infant or a young child?
9. Do these parents expect a child to protect THEM instead of their protecting HIM?
10. Does this parent admit any responsibility in the child's neglect and abuse?
11. Is this child held completely responsible for the neglect and abuse? 

One of the most recent studies to be done on this problem is a thesis by Shirley Nurse, reported in Smith College Studies in Social Work. The study reports on five variables derived from examining 20 cases of 45 abuse cases. These were identified by the researcher from the files of the New York County Family Court, Juvenile Term for 1957. Only 20 were studied closely because of the long term contact and therefore the most complete files on these particular families.

The five variables were: (1) aspects of abuse, (2) parental family history, (3) marital status, (4) family life, and (5) outside contacts. The first variable describes the nature of parental abuse in the sample. The second made the point that none of the aggressors had had positive childhood experiences themselves and therefore lacked constructive parental models. Marital status revealed no definite pattern although at the time of abuse Nurse says the marriage relationships were fairly stable. However, it would seem that past.

21 Ibid., p. 56.
22 Shirley Nurse, op. cit., pp. 11-25.
histories showed less stability. The family life variable revealed histories of mental illness, alcoholism, pathological loyalty to partner even when the aggressor abused both child and adult, and acting-out behavior. Finally, Nurse points out the social isolation of these families in the community. The point she makes here is that the "isolation coupled with the apparent absence of remorse precludes any routine influence by the community or by prevailing cultural standards of child care."^23

In her concluding discussion Nurse points out some of the features of the study. She indicates that on the whole it was consistent with other studies. In nearly all cases one child was selected as the victim. The abuse was not the result of provocation on the child's part or overly harsh disciplinary methods. The parents were seen as being emotionally deprived in childhood and the abuse resulted from the needs of the parent. One other fact which emerged from this study was that injuries were quite apparent and abuse had evidently occurred over a long period of time and yet no neighbour and some cases no welfare agent or teacher had taken any action. The "withdrawal of the community", says Nurse, "multiplies the partners to abuse a thousandfold."^24 In studying these findings it must be kept in mind that the sample consisted of only 20 cases, and therefore is somewhat limited in application.

^23 Ibid., pp. 24-25.
^24 Ibid., p. 25.
Expectations of the Data

Child protection workers have a difficult and demanding job. The most crucial issue involved in such work is determining when the rights of parents allow them a degree of freedom with their children that is harmful to the children. The child protection agency exists to preserve the rights of children. The Child Welfare League of America Standards for Child Protective Services quotes the Children's Bill of Rights prepared in 1949 by the New York State Youth Commission. They are:

- For each child, regardless of race, colour or creed--
  - The right to the affection and intelligent guidance of understanding parents
  - The right to be raised in a decent home in which he or she is adequately fed, clothed and sheltered
  - The right to the benefits of religious guidance and training
  - The right to a school program which, in addition to sound academic training, offers maximum opportunity for individual development and preparation for living.
  - The right to receive constructive discipline for the proper development of good character, conduct and habits
  - The right to be secure in his or her community against all influences detrimental to proper and wholesome development
  - The right to the individual selection of free and wholesome recreation
  - The right to live in a community in which adults practice the belief that the welfare of their children is of primary importance
  - The right to receive good adult example
  - The right to a job commensurate with his or her ability, training and experience, and protection against physical or moral employment hazards which adversely affect wholesome development
  - The right to early diagnosis and treatment of physical handicaps and mental and social maladjustment, at public expense whenever necessary.

Similarly, parents have rights and responsibilities which the League also states. Until their children can care for themselves, the parents must provide:

adequate food, shelter, clothing
- medical care
- education
- supervision and protection
- moral and social guidance

Parents have the right to determine what happens to their children so long as they discharge their obligations as parents. In making most decisions, parents are free to follow their own judgment. However, when a conflict between the rights of parents and those of children affects the welfare of the children, the rights of children have precedence. When the child's welfare requires it, the state, as the ultimate authority responsible for children, assumes the right to intervene in regard to parental rights.

The rights of parents may be limited or abrogated by reason of parental failure or incompetence. The rights of parents or child can be limited, in their own or society's interests, only in accordance with due process of law, and only to the extent and for the period of time that is necessary to insure the child's and the public's protection.

It should not be necessary, as a requisite for removal of a child from the custody of his parents, to bring any criminal action against parents for violation of any law relating to duties and responsibilities of such parents.26

The dilemma of the protection worker is determining when the rights of the child are being violated. In the case of determining whether a child is manifesting symptoms of the battered child syndrome the protection worker's task is made more difficult by several factors. There is the matter of urgency, since parents tend to repeat abuse often to the point of death for the child. The observation made by Nurse which indicates that the community is hesitant to become involved, if true, means that the child protection worker may not be notified that such situations exist. Then, if he is informed, the necessity of proving abuse to a court of law in order to protect the child when members of the community do not want to appear in court as witnesses frustrates his work.

26 Ibid., pp. 5-6.
Another of the difficulties experienced by the protective caseworker is that he cannot leave a client free to accept or reject his services. He must be aggressive in defending the rights of the child over the opposition of the child's parents. It is necessary, therefore, for the child protection worker to have a solid belief in his role that enables him to step into cases of abuse with firmness. In dealing with the battered child syndrome the social worker may represent the child's hope for life.

Description of Sample

Data for this study was obtained from the Vancouver Children's Aid Society who, for purposes of this research, allowed the researcher to read the files of twelve cases considered by the agency to be examples of the battered child syndrome. Since the agency selected the cases little can be said of the actual selection process. It is understood, however, that selection was made on the basis of memory, since no separate record has been kept of cases having these characteristics. At present a central registry has been established for the province. The Children's Aid Society is also keeping a separate record of these cases themselves.

The Vancouver Children's Aid Society is a private agency carrying out the task of child protection in Vancouver. It is one of two such agencies in Vancouver, the other being the Catholic Children's Aid Society. The C. A. S. can apprehend only in Vancouver. Child protection is not the sole function of the agency. Finding and supervising foster homes, work with
unmarried mothers and adoption placement are other functions of the Children's Aid Society.

Of the twelve cases, ten were active with the agency at some time between 1959 and 1964. The other two cases were of children adopted privately that resulted in apprehensions during 1947 and 1948. Since these two cases were much earlier than the others it was decided not to include them in the sample since they might introduce other variables.

Description of Research Schedule

A schedule (see Appendix B) was drawn up without prior knowledge of what information would be available from the agency files. The schedule consisted of a face sheet, a page for information about the mother and one for the father, a data page for the child and a page which sought facts about how the particular agency dealt with the problem. With this schedule the medical researcher and the social work researcher approached their sample cases in order to obtain what information was available. It was considered that some of the information sought might not be available but this itself could be significant in terms of understanding the syndrome. The reasons for choosing the areas of study listed in the schedule were derived from studying the literature and were in keeping with the study hypothesis.

The last page entitled "agency intervention" was to be the prime focus of this chapter. The intent was to examine two aspects of child protection. The first was the role of the community and the second was the role of the Children's Aid Society as a child protection agency.
Findings

Introduction: In examining the findings of this study, one must be cautioned to avoid making generalizations about these cases. In the first place the sample group is too small. Thus one case represents ten percent of the sample population, which allows a single case to weight the findings disproportionately even though the case may be a peculiar one not often met when dealing with the battered child syndrome. There may be many reasons why the sample is so small. For instance, it might indicate that cases of this syndrome are very rare, or it might indicate that they are not easily recognized, or, again, it might indicate that the agency is hesitant to allow free access to files for any one of a number of reasons. This is something that cannot be determined, but must be stated by way of explaining the limitations of the particular sample group.

Secondly, it is to be pointed out that there is no control group with which to compare this research sample. One cannot say therefore that these characteristics of family life style, parental characteristics and histories, or these roles of the community and the Children's Aid Society are peculiar to cases where the battered child syndrome appears. It might be that the findings described under these headings would not differ in many ways to a random sample of cases handled by the Children's Aid Society. Having thus pointed out the weaknesses of the study, let us consider the following data.

Characteristics of Family Life Style: There are two tables which have relevance to a discussion of the
family life style. (See Appendix A) Table E indicates the socio-economic status of the sample families by occupation, since this information was more frequently found than the actual family income. As the table shows, the occupations represented make low educational demands. The only exception is the primary school teacher. Little can be determined about the work history of this group. Little or no information was available about the past employment of the men. More information was available about the women's work history. It is significant to note that nine of the ten women were full time housewives at the time of the abuse. The primary school teacher again was the only exception.

Table F reveals that in seven out of ten cases there were two adults in the home. In the other three cases, one husband was dead, one was in jail, although he and his wife had not lived together for long, and the third was a common-law union that had never been a stable relationship. As can be seen, no pattern emerges about the number of children in the home, since this varies from one to six. Similarly, the age of the abused child varies, as does his position with regard to age among the other children.

In nearly all of the cases there is a history of marital difficulties. Common-law relationships at some period in the life of one or both of the partners together at the time the child was abused was fairly common. Promiscuity occurred in some cases and fighting between husband and wife was indicated in others.
The majority of families in this sample were of white origin. One mother was Indian, and one couple were each part Indian. In other cases this information was not available from the files.

A question to be considered is whether or not these families have other problems besides those of child rearing. Five of the ten families did and had contact with other social agencies. However, more of the families may in fact qualify, but cannot be judged because this information might not be recorded in the Children's Aid Society files.

Movement from place to place occurred among these families fairly frequently. Two families came from other cities where child welfare authorities had been forced to take action of various kinds before. In both these cases there was a great deal of hostility expressed toward the workers.

Information regarding the families' isolation from the community was lacking in the files. The families' frequent movement, however, may be a factor of their rootlessness and their social isolation.

Parental Characteristics and Histories: Table G indicates the abusing parents' attitude towards their acts of abuse. The literature maintains that the parents do not acknowledge their own responsibility for the child's condition and they show no remorse. This would indicate a lack of commitment to the mores of the larger society in regard to child rearing practices.

In the sample under study here, however, this characteristic of the abusing parent was not common to the majority
of parents. Four of the ten sample cases showed no remorse, and did not acknowledge their own responsibility for the protection of the child. The other six parents acknowledged their responsibility for the child's condition. In three cases the parents felt guilty and expressed their fear that they would harm the child again. In these cases they asked the Children's Aid Society to take the child away from them. In the three other cases the parents rationalized their behavior. In one case the mother, an alcoholic, claimed she could not remember mistreating the child because she was drunk. In another, the father pleaded guilty to the Assault With Intent to Cause Bodily Harm charge, but showed no sign of remorse, claiming it was discipline designed for the child's best interest. The third case was much the same as the last. The father, in this case however, pleaded not guilty to the same charge, claiming he could not recall exactly how he struck the boy by way of punishment, because of his rage.

The largest grouping of cases having all things common, therefore, is the grouping of individuals who did not acknowledge their own responsibility for the child's condition, and who do not show remorse. Those who acknowledge their responsibility really fall into two groups of three. The one acknowledges responsibility and shows remorse, the other acknowledges responsibility, but rationalizes behavior.

Pathological loyalty to partners, as noted in the literature, was generally supported by the cases examined.

In examining the mental health of the parents, the picture is generally one of two disturbed individuals. In
some cases an individual had been under psychiatric care, in others psychiatric care had been recommended to an individual who refused treatment. In other cases the behavior of the individual indicated an emotionally disturbed person. Promiscuity, alcoholism or heavy drinking, blind rages, jail sentences or trouble with the law for such things as assault, creating a disturbance and the abduction of a child, frequent quitting of jobs, confused and immature thought processes, extreme anxiety, or some combination of these factors were noted for virtually all parents in the study.

An examination of file data relating to the childhood experience of the parents showed many had had deprived childhoods themselves. The files could not supply much information here, though, so it is not possible to show any trends.

A description of the parents of battered children is important for a knowledge of how to deal with them. Are they to be seen as cruel, mean and sadistic individuals by design, who should be punished? If not, are they to be considered deprived, sick or immature individuals who need some form of treatment in order to overcome their dangerous activities? If so, what should be the nature of the treatment?

Role of the Community: This section together with the next were to be the primary focus of this chapter. That is, how the child protection agency intervenes in cases of physical abuse and what consequences this has for the child.

The table entitled "Community Involvement in Laying a Complaint on Behalf of the Child," (see Table H) indicates how, in these ten sample cases, abuse was drawn to the
attention of authorities who took measures to protect the child from further danger. Notice especially that the two eldest children in the sample went to the police themselves for help. There are several observations to be made about this fact.

In the case of the oldest child a child protection agency had had prior contact with the family in another city. By moving, the family avoided the watchful eye of that agency who were aware that such an incident might recur.

In the other case there were no prior agency contacts although it was apparent that the abuse had extended over a long period of time. This might indicate that the community is either unwilling to become involved in these cases or secondly, that such abuse can be carefully hidden by parents. If either of these facts is correct then it is possible that such abuse may be more prevalent than is generally thought. Not all children would have the courage to seek the help of outsiders even if old enough. The infant cannot run nor tell of abuse he might suffer at the hands of his parents.

Another noteworthy fact is that in four of the ten cases the police were directly involved. An article in Federal Probation has this to say about police involvement in the protection of children:

While it is generally recognized that police departments have an important function in protecting children who are neglected in most communities, no agreement has been reached by either police departments or community agencies as to the appropriate role of the police. Nor has there been effective coordination of police activities with activities of other agencies.27

It has been pointed out by Norris E. Class\(^{28}\) that the role of the police has not been fully appreciated nor defined. In support of his argument he cites the Child Welfare League of America's failure to deal sufficiently with this police function in their *Standards for Child Protective Service*.

The question of how well defined police function is in the protection of abused children in Vancouver cannot be determined from this study. The observation that the police were involved in four out of ten cases, however, indicates that they do play an important part in this work. Therefore it would seem mandatory that effective lines of communication between the C.A.S. and the police be established if they are not now. With this should be mutual appreciation and acknowledgement of function and role.

The table also shows that in two cases out of ten a medical facility contacted the C.A.S. on its own. This is rather surprising since these children undoubtedly receive medical treatment at some time. However, in one other case the medical authorities contacted the C.A.S. apart from contact received by the C.A.S. from within the child's family. In another case it was unclear as to whether the police or the hospital contacted the C.A.S.

By contrast, in three cases neighbors or private citizens made the initial complaint that finally resulted in apprehension. It is to be noted, however, that in one case the complaint was anonymous which could make effective intervention ineffective.

difficult.

The point to be made here is that private citizens may be much freer to report what they suspect is abuse because they do not have to make the final judgement. Secondly, they are not subject to retaliation by wrathful parents in the same way in which a professional person may be. Undoubtedly, however, neighbors may be intimated by abusive parents.

Another finding that is appropriate to mention in this section is that in no case were X-rays mentioned in the files. Old scars and the children's claims of other incidents of abuse were noted as were known unexplained or suspect injuries but X-rays were either not taken or the results were not known to the C.A.S.

In three cases out of five school age children, the school authorities played a part in the eventual apprehension of the child. The metropolitan health nurse is in a position that allows her to examine the child and contact the home. With teachers supporting her role by sending the child to the nurse when an injury is apparent a record of the child's physical condition could be kept.

Role of the Children's Aid Society: In all cases the child was apprehended. Table I indicates what happened to the child after his apprehension. Three children eventually returned to their homes. Six remained wards of the provincial child welfare division and one was placed for adoption.

It is interesting to look at the six who remained provincial wards. The oldest three aged 10, 9 and 7
respectively could not settle in a foster home setting and eventually were placed in a group home setting. The other three aged 7, 5 and 1½ were able to settle into a foster home. These facts might indicate the age beyond which abused children suffer severe emotional damage that makes placement difficult. It would be useful to do a follow-up study on these same six children in five years to determine how well they were able to adapt or how permanent their emotional difficulties tended to be.

As can be seen from Table I the C.A.S. did not seek to punish the abusing parents. In cases where the abuse of siblings was suspected the C.A.S. worker maintained contact with these parents after the abused child was apprehended. Attempts were made to help these abusing parents learn control through continued contact. It was not acknowledged by the social workers, however, that perhaps legal measures brought against the parents could be helpful also. For example, probation workers could supervise in cases such as these or legal measures taken to ensure psychiatric help for these disturbed parents might be useful. Such measures should not be seen as punishment. However, the first move should be the apprehension and protection of the child.

Data available from the files showed a willingness for the hospital authorities and C.A.S. workers to meet and discuss cases common to both. This was also true for the school officials and health workers. This was especially so in the most recent cases. Where cases were common to the police and the C.A.S. this willingness to meet together was not evident.
In all cases agency workers invested with power to apprehend apprehended these children under sections "k" and "o" of the B. C. Protection of Children Act. The section entitled "Apprehension of Children in Need of Protection" says:

The Superintendent and every person who is authorized in writing by the Superintendent, every constable or officer of the Provincial police or of any municipal police, and every Probation Officer, may apprehend, without warrant, and bring before a Judge, as needing protection, any child apparently under the age of eighteen years who is within any of the following classes or descriptions:

(a) ... (j)
(k) Whose home by reason of neglect, cruelty, or depravity is an unfit place for the child, or who has no proper guardianship, or who has no parent capable of exercising proper parental control.
(l) ... (n)
(o) Who is ill-treated so as to be in peril in respect of life, health, or morality by continued personal injury, or by grave misconduct or habitual intemperance of the parents.29

The difficulties which were outlined above under expectations were generally found to be borne out in this sample. Resistive parents who tend to be transient, anonymous complaints, and difficulty in obtaining proof of abuse were encountered even in this small sample.

Conclusions

The conclusions of the study can be drawn from what has gone before. The writer agrees that the machinery for the protection of the battered child is adequate but that it is not always put in motion in the most efficient manner. The child protection agency needs to have a clear definition of the battered child syndrome, recognizing the importance of

29 British Columbia Protection of Children Act, Chapter 303, 1960, pp. 3751-3752.
X-rays in diagnosis. An issue of major significance is the need for cooperation and coordination between all persons dealing with this problem. This includes police officers, lawyers, magistrates, social workers, doctors, teachers and nurses. For the social worker a knowledge of the typical characteristics of parents and children as outlined by Morris et al. is important for assessment. These things should be recorded and used in court presentations. Finally, the social worker should also be aggressive and quick to move on these cases since death for the child is a very real danger.

30 Morris, et al., op. cit., p. 56.
CHAPTER 4.

THE BATTERED CHILD SYNDROME INVOLVES THE LAW

It is one of the marks of a civilized culture that it has devised legal procedures that minimize the impact of emotional reactions and strive for calm and rational disposition.¹

The whole matter of the Battered Child Syndrome is so fraught with conflicting emotions that it is sometimes difficult to examine the core issues dispassionately. This thesis is developed from the hypothesis that medical, social work and legal machinery is adequate for the protection, detection and treatment of the Battered Child Syndrome in the Greater Vancouver area. This chapter is focused on the legal ramifications of that hypothesis. Since other aspects of the problem are so interwoven and interdependent some medical and social aspects will also be considered.

Areas of Concern

Children's Legal Rights

It is becoming apparent that as children evolve as legal entities in our Western culture their legal rights will have to be defined and machinery refined or developed to safeguard those rights. Under the present system the necessity of interpreting all evidence in court in terms of rights and duties of parents and/or versus rights and duties of children seems to rule out most evidence which appears to be highly

subjective. This greatly limits the number and types of cases that should be tested or disposed of through the courts. It is increasingly evident that the three professions - medicine, social work and the law - need to crystallize their ideas as to what is desirable in a good parent-child relationship so as to formulate a reasonably clear statement of minimal parental duties with respect to ensuring their children's rights.\(^2\)

**Evidence of Abuse**

For dealing with those victims of the Battered Child Syndrome who are brought before the courts, the main problem appears to be effecting co-operation and co-ordination in understandable terms between the court and other concerned disciplines.\(^3\) The medical profession originally recognized and defined the syndrome.\(^4\) Medical evidence is in terms of expert interpretation of physical symptoms observed from X-ray examination of a child, together with pertinent, related information obtained from observation and questioning of the parents about the child-parent relationship. There are some expert radiologists among medical practitioners who claim they can positively identify symptoms exhibited in and on the person of a battered child resulting from non-accidental means. This was stated


\(^3\) Bain, Boardman, Jacobiziner, Kemp *et al.*, Moris *et al*.

a. Medical Evidence: In courts-of-law, expert medical opinion is not always accepted and is frequently challenged. Other medical opinion can be obtained to refute or confuse the medical evidence of the prosecution. Judges and lawyers have limited medical knowledge. Sometimes this confusion is reflected in the levels and areas of law at which and in which the cases are contested. Before an uninformed court, and with poorly prepared prosecution cases, the issue of trauma can be confused by suggesting bone diseases or other diagnoses. This apparently need not be.

Congenital or acquired underlying diseases of children which lead to pathological disturbances of bone are not too mysterious to identify.6

Biochemical testing to disclose the reason for bruising, hemorrhages, ecchymoses and fractures on the presumption that they are of pathologic origin is wasteful when the cause is plain at the outset to the alert examiner.7

The other area of medical competence that has been questioned is that of reporting non-medical facts from the case history the medical practitioner takes on admitting a child to treatment.

Because orthopedic problems are often emergencies, surely for the welfare of the patient, but particularly for self


7 Ibid.
protection against malpractice suits, a thorough and detailed history should be carefully filed in the hospital records.  

These detailed facts are really the only admissible evidence the doctor has in suspected cases of Battered Child Syndrome.

b. **Details of Necessary Medical Evidence:**

1. The X-ray pictures taken from sufficient positions so as to be readily interpreted by experts.

2. The child's external symptoms of bruising, skin congestion, stiffness of joints, pain of movement, discomfort, can be noted and witnessed by the nurse.

3. The child's emotional state as compared to normal; apathy, fearfulness, trembling and cowering, or similar symptoms, can be described and confirmed by an alert doctor-nurse team.

4. The story given first hand by the parents to the doctor in explaining the etiology of the trauma is admissible. If the doctor has evidence that there were a series of traumas, his questioning should be so directed as to allow parents full explanation. The doctor should recognize that although this situation is an emergency, he will not again be permitted a similar opportunity to question these parents or guardians for they will never be as willing to discuss the case as they are under the stress of the moment. They will be more likely to talk about problems bothering them. The ease with which parents or caretakers volunteer information; observation as to the

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parents' emotional state (weeping, shouting, anger) and its appropriateness can be introduced to guide the court.

5. The concern the parents have for their child's condition as evidenced by their number of enquiries about his health, number of visits and length of stay.

If this evidence is documented in the doctor's records, carefully dated, timed and witnessed where possible, the doctor has reported facts that should give him little concern for malpractice suits. If the evidence resembles the Battered Child Syndrome he is quite within his legal rights to take steps to protect the child. The main focus for such physician action however, is clearly explained in the following quotation:

It is the multiplicity of injuries from aggressive assault that casts doubt on the story of accidental occurrence told by the parents or guardian.

c. Social Work Evidence: With this "reasonable doubt" supported by the doctor's systematized and organized evidence, the social worker co-operating on the case should proceed, not as a master detective but as a professional carefully investigating the etiology of the abuse. As a child protection officer, his focus has to be mainly on establishing whether or not the child's environment is safe to live in. On the surface this appears to be a highly subjective matter. If, in fact, the child appears to be in grave danger in his present circumstances, to effect

9 Interviews with Mr. Stewart Clyne and Mr. G. McFarlane, Lawyers.

any change, the court will have to be involved and the court may have difficulty in accepting the doctor's evidence alone.\textsuperscript{11, 12}

A clear, convincing statement of facts in any petition is necessary in preparing a case for court.

d. Details of Social History Evidence:

1. Is the respondent, the claimed parent, a legally responsible person?

2. Has the respondent the ability to provide now the care that the petition declares should be provided?

3. The law requires that the alleged neglect be shown as wilful. It is not necessary that neglect was intended but that the parents knew or should have known what was expected of them.

4. Is the standard of care imposed on the parents reasonable, considering their socio-economic circumstances?

5. The court must be shown that the child is and will be damaged in this environment and this proved by proper evidence. Legal neglect arises out of certain reported situations based on facts, observations, experiences and knowledge, leading

\begin{itemize}
\item \textsuperscript{11} R. M. Mulford, \textit{et al.}, Caseworker and Judge in Neglect Cases, N. Y., \textit{Child Welfare League of America Inc.}, August 1956, p. 10.
\item \textsuperscript{12} Courts and the public will accept a medical diagnosis of measles, small pox and so on without question. From that diagnosis they are prepared to enforce community standards to isolate or treat or remove a child. Contracting the communicable disease might have been the end result of child neglect yet the diagnosis is an accepted area of medical competency without any suggestion of wilful perpetration.
\end{itemize}
the court to conclude on its own that there has been neglect.

We are considering a pattern of behavior rather than a single act or omission. During the testimony there should be a reasonable explanation of what the parents could and should have done, their duty, the facts of the violation of their duty and the resultant or anticipated damage to the child.\textsuperscript{13}

\textbf{Child's Safety Versus Parental Punishment}

In modern jurisprudence there is a tendency to treat guilt with punishment. Treatment of offenders is still not a well accepted response for certain offences. Cases are introduced to Family Court, not to establish guilt or innocence (that is for the jurisdiction of the Criminal Courts if serious enough), but to establish if the child's environment is safe and if not, what steps can be taken to make it safe. However, the court is equated with innocence or guilt and punishment, and parents and relatives approach and fight the case of child protection from that basis. Issues may be distorted and often the child is forgotten in the struggle and the possibility of treatment disappears.

\textbf{Standard of Proof}

Having to prove a case beyond a reasonable doubt by Criminal Court standards rather than Civil Court standards imposes controversial constraint on proceedings of any Battered

Child Syndrome cases.¹⁴ If Criminal Court standards of evidence continue to govern any hearings of such cases, translating subjective feelings into admissible evidence is a core problem. Because hearings concerned with the Battered Child Syndrome ... trespass to an almost shocking degree upon the liberty of the individual, both parent and child....¹⁵ the standard of proof required is that required in a criminal case. Any case has to be proved beyond a reasonable doubt through the presentation of legally acceptable evidence. What constitutes acceptable evidence varies greatly with whether professional counsel is present in court or not.¹⁶ Normally, the Canada Evidence Act governs the type of evidence considered. Such points as hearsay evidence, and spouses being competent, but not compellable witnesses, are two areas especially vulnerable to varied interpretation in cases of the Battered Child Syndrome.

Each discipline's competence must support the others. Straightforward, well documented, supported, objective evidence will have little difficulty being understood by the courts.¹⁷ To produce this type of evidence requires the closest team work and understanding of the respective competencies involved.


¹⁵ Ibid.

¹⁶ Personal communications, Stewart Clyne, B. Howie and G. McFarlane.

¹⁷ R. M. Mulford, op. cit., p. 10.
Conflicting Codes of Professional Ethics

Our cultural stress on independence is very apparent in the independence of the different professions. Examining their respective codes of ethics reflects their standards of values. Conflicting concepts of confidentiality seem to support the existence of many of the problems. Doctors' codes of ethics seem to inhibit their reporting of suspected cases. It definitely inhibits their appearing in court or acting on behalf of the child against his parents. No less do the social work tenets of confidentiality come in for some severe testing. Hospitals and medical boards reflect the doctors' professional confusion over confidentiality. For example, investigators, social workers or solicitors, retained for their own cases, may be refused access to medical records in part or in whole. (See Case #1.)

Absence of Protective Legislation for the Battered Child

There are no legal definitions that are specifically related to the protection of children under these extreme circumstances. Medical and social evidence of the Battered Child Syndrome has to be presented in courts of law in the light of the present interpretations of existing appropriate acts. Sections of general all-inclusive acts, acts developed in earlier days for a very different kind of child protection, are expected

to provide the needed protection. If all the evidence and arguments can be forced into terms dictated by these "all purpose" acts, the courts see no need for any change of this facet of the present "machinery."

The Administration of Justice in British Columbia

Another problem, perhaps peculiar to British Columbia, is the fact that Battered Child cases, concerned with the protection of the child facet of the case, are usually heard in the Family Court. In this legal jurisdiction, in many smaller centers at least, the magistrates are laymen. In many ways Family Courts are different from other jurisdictions (see page 98) and these differences are not fully understood by many who appear before these courts, even many lawyers. In this type of court, police, lawyers, magistrates, judges and social workers have to act on a little understood medical syndrome. This problem therefore requires carefully co-ordinated effort.

Definitions of Relevant Terms Under Law

Medical Definition - The Battered Child Syndrome

... is a medical description of damage to the skeletal structure of children resulting from force applied by parents, siblings or caretakers in twisting or jerking of the child's limbs or other forms of maltreatment.

19 Chapter 303, Protection of Children Act of British Columbia, R. S. 1948, C. 47 s. 1; Chapter 75, Control of Employment of Children Act of British Columbia, R. S. 1948, C. 45, s. 1; Chapter 250, Mothers' Allowance Act, R. S. 1948, C. 225, s. 1.

20 Interview with S. Clyne, G. McLean and B. Howie.
X-ray analysis conclusively demonstrates the traumatic nature of the damage and the persistence of maltreatment with characteristic bone fractures and subdural haematoma (often chronic) showing in various stages of healing.21

LEGALLY the court cases turn on the fact that a parent has a duty to nurture, protect and educate his child.22 This duty has been violated when it can be proved that the parent, by commission or omission, has wilfully or indifferently disregarded the execution of this duty to his child. This duty, beyond the few words used above, is not defined legally.

Rights of children are just beginning to receive attention. Their rights to life and to natural parents appears to be becoming established in American Case Law at least.23 The community may interfere and protect a child's rights even in the parental relationship.24

HISTORICALLY, the evolvement of the consciousness of children as human beings and later their emergence as legal entities with legal rights and status, is of recent origin. One of the first references to rights of children we have discovered was by Sir William Blackstone (1723-1780) the English

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jurist and author of Commentaries on the Laws of England. He held that a father's rights flowed from his duties of maintenance, care, education and control and he raised the question as to whether the courts would enforce this right if a man did not perform his duties as a father. He further expounded that a father should maintain his children as a principle of Natural Law laid on him by his act of bringing them into the world. Then he proceeded to lay down fourteen specific conditions by which a parent could be disinherited from his children.

... for the policies of our laws, which are ever watchful to promote industry, did not mean to compel a father to maintain his idle and lazy children in ease and indolence.25

From Blackstone's inference it was the child's worth as a unit of labor that seemed to be of chief concern to the State. This was reflected in the fact that all original Child Protection Laws were introduced to protect the child against inhuman labor practices rather than inhuman treatment to which he might be subjected by his parents or guardians. It is interesting to learn from Miss Abbott that in 1930, Richard Osler, who had led the fight against Black Slavery, had to have his attention drawn to English child slavery, a situation actually far worse than that of the East Indians. However, per labor unit the East Indians gave greater returns than did the English children and it was the economic, not the humanistic, consideration that dominated the thinking of the times. The Society for the Prevention of Cruelty to Animals was in existence half a

century before a similar organization was formed for the protection of Children.26

C. H. Payne, in his book, "The Child in Human Progress," claims that although the human race is some 240,000 years old, man as a humane creature concerned with others has existed for not more than a few hundred years. In fact he suggests that it is only in the last one hundred years that any definite policies and laws concerning the rights of children have come into being, prompting him to name this the "Century of Children."

When acts for the protection of children were first adopted there was no concept of juvenile delinquency or of the possibility of parental abuse. The chief concern was to protect the child from unfair labor exploitation and from the severity of the adult Criminal Code. It was not until 1893 that an act to protect children from physical abuse and from the criminal law was introduced in Ontario. Similar laws had been introduced in America and England about the same time.27 The broader idea of the neglected child who was not necessarily either physically mistreated or delinquent but was without proper care and guardianship developed a little earlier in Scotland and in Canada.28

With the advent of legal protection, child care and appropriate legislation have ceased to be as important as they were when children were exploited as producers of wealth, were

26 John Crosby, The British are Funny About Children, Vancouver Sun, 4 March 1964, London date line.
28 Ibid., p. 2.
in competition with adults for jobs, or were subjected to extremes of degrading mistreatment. As people become more and more secure they tend to insulate themselves from what they feel are minority problems which do not affect them personally.

Until the 19th Century the Common Law gave parents absolute right over their children and most people assume this right has been only slightly modified. It is generally assumed that the best protection of the child's needs and rights comes through the observance of parents' rights. When closely examined some of these parental rights are undergoing erosion. The State now enforces education of all children, regulates child labor, dictates minimum standards of home environment. While recognizing a responsibility to protect and respect parental "sovereign" rights, the community assumes the right to be concerned with the child's welfare.

Reflecting this concern, we have the Protection of Children Act of British Columbia, which is very similar to acts in other Canadian provinces. This act is British Columbia's

29 Ibid., p. 12.


31 Protection of Children Act, R. S. 1948, C. 27, s 1, Section #7. The Superintendent and every person who is authorized in writing by the superintendent, every constable or officer of the Provincial Police or of any municipal police, and every Probation Officer, may apprehend, without warrant, and bring before a Judge, as needing protection, any child apparently under the age of eighteen years who is within any of the following classes or descriptions: (The appropriate descriptions under which most Battered Child Syndrome cases are contested are cited.) (k) Whose home by reason of neglect, cruelty, or depravity is an unfit place for the child, or who has no proper
main source of information for prosecuting the Battered Child Syndrome cases. When pressed, court representatives claim the terms under the act are purposely left broad to allow the court ample room for interpretation. Terms used such as "neglect", "cruelty", depravity", "no fit parent", and so on, depend on the daily interpretation of the different magistrates. Preparing a case with these unknown standards presents some difficulties.

Realizing the danger of removing too many parental rights, we tend to give parents greater rather than less control when we are in doubt.32

The protecting agency of local government in Vancouver, the Children's Aid Society, guided and supported by legislation and community concern, believes it has a responsibility to remove children from unfit parents. As a general policy they deny parental rights only when all efforts to salvage families have failed.

What a good, wise parent would desire for his own children that a nation must desire for all children.33

guardianship or who has no parent capable of exercising proper parental control:
(1) Who is subject to such blindness, deafness, feeblemindedness or physical disability as is likely to make him a charge upon the public, or who is exposed to infection from Tuberculosis or from any venereal disease where proper precautions to prevent infection are not taken, or who is suffering from such a lack of medical or surgical care as is likely to interfere with his normal development:
(o) Who is ill-treated so as to be in peril in respect to life, health or morality by continued personal injury, or by grave misconduct or habitual intemperance of the parents.

32 Child Protection in Canada, op. cit., p. 31.
33 Ibid.
Physical Abuse has been defined as:

... any situation in which a child is physically mistreated by an adult to the point that care or protection by a source outside the family is needed. The action may be deliberate or accidental and the damage may be done by commission or omission. 34

This definition has no legal status and again provides ample room for individual interpretation.

Liability for Results of Personal Actions: A point which seems to have been overlooked or ignored but which presents some useful possibilities is that if the injury was not accidental, then in law it is considered to be the result of a voluntary act done with the purpose of injury. If, in fact, the injury was intended, it is not necessary that the act intended to cause a bone fracture, it is enough that physical pain was inflicted to an unreasonable degree and by unreasonable means. 35

Acts of Omission are equally dangerous to children's welfare and are equally culpable under the law. 36

Family Court is an informal hearing in spite of the attempts of many lawyers to make it a trial court. This court is presided over by a magistrate who, outside of the larger metropolitan areas, may be a layman. The Family Court does not hear Criminal Code cases, therefore more freedom is taken

of action and interpretation. Hearings are conducted in a relaxed atmosphere and there is supposed to be no cross examination. The only resemblance of this court to other hearings is in the fact that it is bound by the Canada Evidence Act. There are no formal records of proceedings available as with criminal and civil action courts. The only material available for study and reference, for researchers or lawyers, is from the occasional case that has been appealed.

Victims of the Syndrome

Victims are infants (under twelve months) and/or children (usually under fourteen years although the act protects them until the age of eighteen) who cannot defend themselves from the very person entrusted with their care and custody. Usually they cannot testify (if they could and did, it would not be admissible evidence unless substantiated by an adult or irrefutable physical evidence). The only evidence they can present is their physical and emotional condition and this has to be interpreted and presented in court by experts - the physicians, psychiatrists and/or social workers. The paradox is that the helplessness of a child which makes it appealing, also makes it the prime target of his distressed parents. Medically, all signs may point to wilful, repeated injury of the helpless child. In this modern age, however, with parents so mobile and unstable, homes so temporary, stresses and frustrations borne by families in isolation, any plausible explanation for the trauma may be allowed and create doubt about the accusation suggested in the
Battered Child Syndrome evidence. When experts are pressed by defending counsel in court they may admit that some accidents might produce similar symptoms. Hearings become contests for proving the guilt or innocence of the parents, rather than proving the safety or otherwise of the child's environment. Because well-meaning social workers and doctors do not fully understand the syndrome in legal terms, cases may fall apart and the children subjected to double jeopardy by being returned to their former hazardous environment. The parents' "vindication" by the failure to find them guilty of child abuse may be viewed as a license to continue the mistreatment.

Recognition and Diagnosis of the Battered Child Syndrome

Doctors, hospital staff and social workers intuitively sense something is wrong when symptoms are gathered and interpreted. The medical evidence alone signals that the child's environment is unsafe. Documented statistics of accidents to children in "normal" safe surroundings place the mathematical odds against "normal" children suffering repeated accidents.37,38

Under our present system of dealing with the Battered Child Syndrome through Family Courts, there is no concerted


38 Statistical Bulletin, Metropolitan Life Insurance Co. Vol. 45, June 1964, p. 6. Hospitalization of Children ... for non surgical causes. Report on 4 year period of employee participation in health plan, report only one infant accident; 2.8% of all causes of hospitalization of children three years and under were due to accidents.
attempt to build case law to serve future decisions of the courts. Each case is a brand new one, judged as the court currently wishes to interpret it. When the evidence of the physical examination is measured against the explanations given by the parents and subsequent social history of these parents, much subjective intuitive evidence could be turned into admissible objective evidence if the court had an accessible body of Case Law to which to refer.

It is difficult to understand parental violence towards children. Judges, magistrates, lawyers, coroners, physicians and/or social workers may refuse to interpret or see evidence contrary to their beliefs or biases about parental behavior.

**Current Recognition and Diagnosis of the Battered Child Syndrome**

Ontario's Coroner, Dr. H. B. Cotnam, recently stated that in his first thirteen months in office, deaths of twelve children from battering had been reported to his various provincial offices and this count did not include obvious murders. He estimated that for each child reported dead there were a hundred being battered by their parents or guardians. This report by Dr. Cotnam was widely quoted in British Columbia during the meeting of the Canadian Medical Association held in Vancouver in June 1964. The annual report (1963-64) of the Family and Child Welfare Division of the Canadian Welfare Council reported that Ontario and British Columbia were the only two Canadian provinces indicating any recognition or interest in the syndrome.

at the present time.

At a recent meeting of a committee of the Community Chest and Council of Greater Vancouver a local police inspector had records of one hundred and twenty cases of child neglect and abuse during 1964 to which he was prepared to refer. This meeting, made up of a very knowledgeable cross-section of the concerned community, displayed a surprising lack of information about or understanding of, the Battered Child Syndrome.

Recognition of the Battered Child Syndrome is of such recent origin that very few cases designated as such come to the notice of the general public. Most local knowledge stems from reading the available literature of the various concerned disciplines. Cases available for research are scarce. If allowed access to appropriate records researchers would possibly discover a large number of these cases have been designated as neglect, cruelty, murder, unexplained accident, undiagnosed disease or whatever the recorder felt to be appropriate.

The study of representative cases seemed to be the best method of attempting an understanding of what the current situation in British Columbia is with respect to the legal perception and understanding of the Battered Child Syndrome and how other concerned disciplines related to that understanding. By careful examination of case examples it was hoped that current knowledge, thinking and attitudes about the syndrome might

be revealed, the appropriateness and the relevance of the areas of concern listed above could be tested and/or highlighted.

Under the present understanding of the syndrome only two criteria of case selection could be applied: 1. Discovery of designated Battered Child Syndrome Cases that had been before the British Columbia Courts; 2. Accessibility of such cases for the study of its records.

One proves nothing when, as so often happens, one is content to show by more or less numerous examples that in scattered cases the facts have varied as the hypothesis demands.41

Only two cases were available and accessible. Consideration of confidentiality have made it necessary to comply with requests by the agencies to disguise the sources to the extent of withholding the name or location of the agencies involved, the names of the key informants, the principal witnesses and the dates. A list of case sources is on file with the University of British Columbia, School of Social Work. Permission, in writing, to study the respective files was received from the directors of each agency. Excellent co-operation was afforded the researcher and every effort was made to assure access to all pertinent case material.

Agency child and family files, including all correspondence, in both cases were studied. Both the prosecuting attorneys were interviewed at length. At least one social worker involved with each case was interviewed. The official transcript

was made available in one case. The Clerk of the Court involved with one case was interviewed.

In reporting or discussing the case examples the writer will attempt to base any statements or arguments on facts, as they appear to him, readily traceable to the sources in the respective cases. Through the examination of these two examples, using an idiographic method, we hope to give an intimate, accurate portrayal of the uniqueness of the subject rather than seek to make any statistical inferences or to suggest any general law.

Our hypothesis was that the medical, legal and social work machinery for dealing with the Battered Child Syndrome is adequate. This study is being made in an objective attempt to increase knowledge and understanding. The observations are made with this in mind.

Case Example #1

The Family Constellation

At the time of the first diagnosis, the child, a four month old girl, apparently clean, healthy and well cared for, was brought to a doctor for examination at the insistence of the maternal grandmother because the child "looked ill". On admission the doctor reported the baby as being pale with convulsive twitching of the right arm and leg, bulging anterior frontanelle, disrupted optic discs, hard swelling of the lower femur, hyperactive reflexes and some coma. X-ray revealed a fracture of the lower end of the right femur with large calcifying hematoma in area extending up the shaft of
femur and fractures of the lower end of each tibia. The frac-
tured femur was judged to be three weeks old, and the tibia
breaks about ten days old. The left subdural hematoma affect-
ing the optic cups was judged to be seven to ten days old. The
child was born with rudimentary thumbs which the family found
disturbing.

The father was described as a pale, thin, "small
holdings" farmer, aged thirty-six, married four years. He had
been a mechanic before marriage. He was seen as stubbornly
determined to be independent, immaturity set in his ways, overly
sensitive to noise, noticeably unresponsive in his contacts
with people, and believing that all people should have to work
as hard in life as he has. He claimed he had to do his wife's
bidding. Little information about his early life or extended
family was available.

The mother was described as an attractive intelligent
thirty year old employed person who resented having to support
the family because of farm crop failures. To be able to afford
to have the baby's thumbs operated on she felt she should go
back to work. (Medical estimate of the thumb removal was
approximately $25.00.) She resented her husband's unwilling-
ness to give up the farm. The only description of her emotional
pattern of behavior was that of an efficient, slightly
"narcissistic", almost too well controlled person. There was
little information about her earlier life. The point was made
several times that she wanted and planned for her baby. The
mother, and more particularly, the maternal grandmother were
The maternal grandmother seemed to play a prominent part. There is a brief reference to her emotional immaturity in that she was a compulsive talker with a very short temper, subject to tantrums. She was separated from her husband. Her story regarding the circumstances of the original admission of the child changed. At times in the case history she is held up as the person capable of taking the special child care training but at other times suspicion is cast on her as possibly being responsible for the trauma.

The Defense Attorney was related to the mother. He became very closely identified with, in his own words, "these poor innocent people being picked on by big business". However there were times, from direct recorded admissions, when he questioned why he had ever become involved in the case.

**Sequence of Events**

About a month before a general practitioner made the Battered Child Syndrome diagnosis, the child was seen by the family doctor because of haemorrhaging in the optic cups. A week later the child was seen again by the same doctor, or he was consulted by phone (the record is contradictory) because of a swelling of the right leg. No X-rays were taken and there is no record of the prescribed treatment. About this time the child started convulsions and became irritable and listless. The parents claimed they were reluctant to consult the doctor again but the maternal grandmother arranged an appointment with her own doctor. It was this doctor who made the Battered
Child Syndrome diagnosis because there was no adequate explanation of the child's condition or emotional response from the parents. When pressed for explanations the parents suggested the child might have been hit by an apple or jolted by a sudden stop of their car. The doctor recommended immediate hospitalization of the child.

From the first contact with the child medical authorities were convinced they had a typical Battered Child Syndrome on their hands. As such, the case was used as an example in many medical conferences and consultations. The medical evidence was reviewed time and time again.

While in the hospital the child "thrived". It was established that she was blind, the etiology of blindness dating from the time of the first medical consultation, and looked suspiciously like the result of trauma! The child was kept in the hospital for two months before officials felt they had enough evidence to apply to the courts for temporary guardianship while a hearing was prepared under Section "K" of the Protection of Children Act -- "no parent capable". Gathering information was complicated by the distance between the respondents. There was the suggestion that a Criminal Code charge might be made and this tended to further delay proceedings. Shortly before the first Family Court hearing the parents realized that they might have to surrender their child to the Superintendent of Child Welfare. They then engaged their lawyer.

42 Protection of Children Act, op. cit., Section 7, subsection K.
Preparation for the Family Court hearings took on many dimensions. The mother's lawyer tried to persuade the authorities to drop the case. He had three medical experts see the parents and the child. One wrote a treatise on the possibility of scurvy, another ascribed the X-ray symptoms to some rare and as yet undiagnosed blood disease. The third ignored any reference to or questions about the X-ray interpretation and set out to defend these "fine people" (his opinion based on a two hour interview). By the record, it was only after the lawyer was engaged that new suggestions of possible causes of trauma were "remembered" such as another slight car accident, a visit from a twenty-eight month old nephew and five days under the care of the maternal grandmother. At this stage of the case it was stated that it had been the natural mother who had made the final doctor's appointment, not the maternal grandmother as originally reported.

Many pressures were brought to bear to have the case dropped. The suggestion was made that the chief radiologists should amend the X-ray report in that it was claimed it improperly suggested trauma. Members of the British Columbia Medical Association became uneasy due to internal pressures. Officials of the union to which the mother belonged applied pressure. Hints were made that the court would be purposely confused by the medical evidence.

Under such pressures, the prosecuting attorney representing the child protecting agency had difficulty gaining and holding consensus of interpretation among his prosecution
witnesses, as well as in gaining access to pertinent records of some co-operating disciplines until their boards met to dictate conditions of access. The pressure changed the impending court hearing from "just another protection case" to one in which the Superintendent of Child Welfare became involved as a matter of "principle". It was recognized that costs would be high with so many expert witnesses necessary.

In the records at this stage little reference is made to the child except to report that it was definitely blind, had had its rudimentary thumbs removed, was making satisfactory progress in its locomotion and was thriving under the care of a devoted foster mother with the capable help of a specialist in blindness.

The Hearing

This was held in the Family Court with a judge pre­ siding, two months after the first identification by the court and four months after the first apprehension. Complaints against the parents were filed under the Protection of Children Act, section seven, sub-section "K" (no parent capable...) "L" (who is subject to blindness ...), and "O" (in peril in respect to life...). Six subpoenas were prepared for the prosecution's expert witnesses, however most witnesses were so deeply involved in the case they attended without the subpoenas being served. The admitting doctor who first suggested the Battered Child diagnosis, besides elaborating on the original symptoms,

43 Protection of Children Act, op. cit., Section 7.
gave evidence that he had ruled out meningitis, scurvy and neoplasm. He felt that trauma could explain the whole clinical picture but that it was difficult to make a diagnosis without a history of trauma.

The radiologist interpreting the X-ray evidence attempted to establish the existence and the sequence of the several fractures and haemorrhages suggesting trauma. Several other expert witnesses for the prosecution substantiated the evidence and theory of trauma.

The three defense medical witnesses testified as suggested earlier by introducing theories of scurvy, unidentified blood disease and impeachable character references. The defense attorney "confused" the court by introducing this conflicting medical evidence and by persistent cross-examination so that the court finally agreed there was no evidence as to who or what might have caused the trauma and therefore ruled out the existence of trauma. The defense applied to have section "O" (in peril in respect of life ...) dropped from the complaint as it was claimed that there was no evidence supporting this complaint. This was granted and it was decided to proceed as "best they could" with sections "K" and "L". Then the defense had section "L" dropped from the complaint. The record reports that the

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44 Re the scurvy -- the child had been receiving additional calcium support from birth.

45 Protection of Children Act, op. cit., Section 7.

46 Ibid.
court was further "confused", however substantiating legal argu-
ment was omitted.

Without consultation with his retainer or the court, the
Prosecuting Attorney proposed an implied guarantee to the parents
that if they would undertake a training course on the handling and
training of a blind child a subsequent re-application for the
child's custody would be successful. This compromise was supported
by the defense. The court therefore ruled that the child be com-
mited to Care until the parents could establish that they had
undertaken the suggested special course and were then "parents
capable".

Commentary, Case Example #1

Evidence: This case was studied and discussed by the
medical profession as a typical Battered Child Syndrome. There
was ample opportunity to verify and thoroughly establish opinions.
There were pages of social record but little reference was made
during the hearings to the parents' background or "normal" emo-
tional state. A psychiatrist prepared a lengthy report on the lack
of evidence of any disturbing mental disorder. Records of the case
indicate that a good percentage of basic supportive case history
evidence was gathered even though there was a good percentage of
subjective opinions all through. It was impossible to learn from
the records whether or not the child's environment was considered
dangerous and if so whether or not it was possible to make it safe.
One of the biggest difficulties in preparing and presenting this
case was the multiplicity of expert witnesses necessary, all of
whom were scattered throughout a large geographical area. Con-
sultation by correspondence added to the distortions and
confusions of the social and medical evidence.

Evidence Pro the Battered Child Syndrome

1. The first medical evidence indicates a series of unexplained trauma.

2. The parents' explanation of the possible cause was far from convincing or appropriate according to the admitting doctor.

3. The parents seemed unaffected by events, even the possibility of losing their child to the authorities. Their infrequent visits to the child while in hospital and their behavior on those occasions prompted many professionals to comment on their inappropriate reactions.

4. The parents were unprepared to modify their lives to accommodate the child. The mother continued to work while the father continued his farm chores giving minimal attention to the child. The mother was unwilling to give up her job to take the treatment course necessary to caring for a blind child.

5. There were hints of dissatisfaction from the parents over their respective roles. The father resented but had to accept the financial contribution to family resources made by his wife. The wife openly disliked living on a farm.

6. The effect of the child's deformity is just mentioned. The maternal grandmother however claimed that the mother was "not the same" since discovering the extent of the child's deformity.

7. The parents did not appear to be sufficiently concerned about the child's first seizures. This condition had to be revealed by subsequent questioning by the doctor.
8. Normal mothering would certainly reveal that a baby of this age was blind and ill.

The main emphasis of the court case seemed to be on proving the parents guiltless. These parents appeared to become aware of the child's welfare only as the case gathered momentum. This awareness seemed to be independent of the case process.  

**Evidence Negative to Battered Child Syndrome Diagnosis**

1. The child was the result of a planned and desired pregnancy.

2. The child is reported by both attending doctors to have been clean and well cared for.

3. The explanation of the possible causes of the trauma are so inappropriate that they might in fact be the desperate attempts of innocent parents to co-operate with authority.

4. This was their first child. Past medical advice had told them on two occasions not to worry so much about childish difficulties. They apparently took this advice literally, for the maternal grandmother had to insist on a doctor's examination.

5. They were able to enlist a great many character references and support from relatives, employers and professionals.

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47 Visits to see the child were forced and mechanical. The father handled the baby as little as possible. The demands of the parents regarding visits were for their own convenience with little thought of the child's schedules. As the case proceeded the mother seemed to become more concerned about the child's schedules, its maturational progress and the necessity for specialized training for rearing a blind child. The father allowed himself to become involved and interested in the child's progress.
Procedures

The prosecuting attorney had to prepare a legal case using the limited knowledge regarding the Battered Child Syndrome available in a few articles in medical journals as well as to make an intensive study of medical terms likely to be encountered. The only case law he could draw on was "Sv's infant" discussed by Harvey. Before the case was presented to the court for initial identification it was repeatedly remanded (over a period of two months). The formal hearing was delayed a further two months due to pressure of other court business.

Before the child was presented in court the medical profession thought of the case as a typical Battered Child Syndrome. The prosecuting attorney attempted to present unanimous testimony by the witnesses for the prosecution. Under cross examination these witnesses admitted that some accidents might cause similar fractures. Even the existence of fractures was questioned. The court interpreted the confusion as to who might have caused the trauma to rule out the possibility of trauma.

Even if anything in the evidence of Mr. C. or Dr. G. points to present incapacity or deficiency, and I do not think it does, the testimony of these experts should not be permitted to outweigh the testimony of eye-witnesses based upon the evidence of their senses . . . If however, I should have regard to the potential danger to the child when it reaches the age of six months, as described by Dr. G. I find

48 C. C. J. Harvey, op. cit., p. 374.

49 Protection of Children Act, op. cit., Section 8, Paragraph 1 -- specifies that a child must be brought before a judge for examination within seven days of apprehension.
that I have not been satisfied beyond a reasonable doubt, or by a high preponderance of probability, that such danger does or will exist. 50

Social evidence for supporting the medical evidence was not used. When the medical evidence was questioned and a Criminal Court standard of proof was demanded, social arguments were not presented to support the charges beyond a "reasonable doubt". Much of the documented, supported evidence was not used, such as the delayed "remembering" that appeared after the parents retained counsel; the changing story of the original admission; and the earlier inadequate handling of the child's ill health. No mention was made of the parents' behavior, feelings, reactions or interpreted emotional state. The early part of the record made many references to their immaturity as revealed by their behavior.

Results

Very little medical evidence was heard as relevant evidence. The final disposition of the case was resolved around the need for special training of the blind child and parents. This accomplished some measure of control of the child's future environment. In this manner each side claimed to have won. The prosecution had the child committed to care until certain conditions were met. The defense claimed that as wilful injury had not been proven their clients were innocent and when the good of the child was the main consideration they willingly agreed to placing the child under special

50 C. C. J. Harvey, op. cit., p. 381.
care for a limited period of time.

In this example the legal "machinery" seemed adequate, however the ways in which it was used or modified were enlightening. That the end result was in the best interest of the child seems almost fortuitous.

Case Example #2

The Family Constellation

At the time of apprehension the child was described as a ten month old boy whose body, clothes and eating utensils were very dirty. He had red welts on his "bottom" and was apparently terrified of his father. He suffered nightmares later in the foster home. He was obviously behind in his locomotive skills which "suggested he had been left alone a great deal".

The records reveal the father, at the time of the apprehension, as a twenty year old contractor, steadily employed, aggressive in manner. He is the oldest in a large rural family of thirteen, with a father described as mean, cruel and openly promiscuous. There is a report of mental illness in the father's extended family. The marriage which produced the child in the case, was one of necessity and was opposed by the father's maternal grandmother. A magistrate's order was therefore necessary. The father stoutly defended his right, as master in his own home, to discipline his child as he saw fit, and by his standards physical discipline was the only way to teach the child.

The mother was described as an immature, spoiled nineteen year old, totally unprepared for matrimonial responsibilities.
Her father refused permission for the marriage but a premarital pregnancy forced both parents into finally accepting the situation although she too had to obtain a magistrate's order before the wedding could take place. As an only child she was very dependent on her parents for emotional support and at the time of the apprehension of the child kept running to them for sympathy. She neglected her personal appearance as well as her child and her home.

The maternal grandparents recently moved from the Interior to be near their only daughter. They had lived with, then next door to, the parents for about a week prior to the apprehension. They continued their solicitous attention towards their daughter, and attempted to counsel the young couple but seemed unable to protect their grandchild.

The paternal great-grandparents were the only relatives of the father mentioned in the reports. Their chief concern was for their grandson to regain custody of the child, their first and only great-grandchild.

Sequence of Events Prior to the Hearings

Six months prior to the apprehension of the child a Public Health nurse attended the baby, then aged four months, because of torn mouth and throat muscles, caused by the father having forced a soother into his mouth to quiet his crying. Two months after this incident and again two months prior to the apprehension, a neighbor complained to the child protection agency about the parents' ill treatment of the child. At the second complaint the child (then eight months old) had a broken arm. X-rays were taken of the left side only. No X-rays of
the skull or detailed interpretation of the X-rays was made. The explanation given by the parents for the break was that the child had caught his arm in the crib railing, and bruises on its body had been caused by his falling off a pillow.

On the day of the apprehension the maternal grandmother called the police to investigate a child beating. Child protection officers, police and health nurse arrived at the home. The red welts were still visible on the baby's buttocks and lower limbs. The child was still terrified. The father, breaking down and weeping, admitted he had slapped the child because it would not stop crying. The nurse who took the child into custody could not find clean clothes or diapers for the child. The bottle of baby food given to tide the baby over was dirty and the milk rancid. The attending officers reported that the home, the mother and the baby were "filthy". Regarding the home, it was reported that the plumbing had been plugged for several days and garbage was piled about indiscriminately.

First Court Hearing

The first court hearing was held seventeen days after apprehension. This Family Court was presided over by a lay magistrate. The parents were represented by the attorney whom the child protection agency had planned to retain. The agency therefore had to bring in another attorney. The agency's prosecuting attorney was assisted in his handling of the case by a social worker. Good co-operation and understanding for the child's protection was evidenced between the opposing attorneys and the court. Minimal evidence was
presented -- a statement by the maternal grandmother as to why the police were called. A two months adjournment was requested so that additional information about the parents might be obtained and the father receive a psychiatric assessment. 51 The defending attorney made a request for the child's protecting officers to consider the maternal grandparents as suitable foster parents.

The Second Court Hearing

Prosecution proceeded under a complaint under Section "K" (no parent capable) 52 The father had had one psychiatric consultation without any follow up program being planned. No severe dishabiliating emotional conditions were discovered. The child protection agency had not been successful in gaining a very complete insight into the parents' background other than what appears in the brief personality profiles above. The child was thriving under foster home care. The maternal grandparents were found to be unsatisfactory as foster parents (they had been unable to protect the child previously and placing the child with them would stir up extended family animosities). The mother was reported to be pregnant again.

Results

Considering the factors above, the court ruled that the child remain in Care without a re-application for return to parents' control being made until: 1. the new baby had

51 Protection of Children Act, op. cit., Section 4, Para. 1.

52 Protection of Children Act, op. cit., Section 7, subsection "k".
arrived and the parents demonstrated their capabilities in regard to its care; 2. the father showed some evidence of learning to control his temper; 3. the family living arrangements proved suitable to the rearing of an additional child. The magistrate instructed the father in part:

... you work on this and get a little counselling and definitely make up your mind to control your emotions that might lead to any further outbursts that could cause further harm to anyone...53

Case Example Commentary

Evidence: This case had competent witnesses and an admission of abuse from the father. With these witnesses there apparently was no need for medical evidence. The only persons involved were the maternal grandparents, the parents and the apprehending officials. There seemed to be considerable undeveloped evidence. However this case, held in this court with this combination of personnel, had no need for more elaborate evidence.

Again considering the Battered Child Syndrome many typical symptoms were in evidence. The premarital pregnancy; the first reports of an inappropriate attack by the father on the child at four months; the inappropriate story of the etiology of the broken arm; the obvious neglect of the child evident in its filth, its food supply, its retarded socialization; the apparent misdirected aggression and frustrations of the father against the child and only occasionally against his wife. X-rays were not complete nor were they interpreted to suggest

53 Court transcript of second hearing, Case #2, p. 12.
trauma. There seems to be no evidence that anybody in the family role network or the family doctor was concerned with the child's malnutrition, physical filth or the dirt of the home. The physician was concerned that the mother not allow her child to be removed from her.

**Procedure:** This case followed a more normal course. Feelings were not too intense nor were there too many people involved. The social case history seemed to be adequate and supportive. The two lawyers involved appeared to have the best interest of the child as their paramount consideration. The expert witnesses had the respect of the court.

**Results:** This case accomplished its task of protecting the child in an efficient, straightforward manner. Parental duties to the child were spelled out in such a manner that all could see the connection with the rights that were temporarily forfeited. The prosecuting and defense counsels and the court itself inspired confidence that justice was in fact being meted out, that both the child's and the parents' rights were being upheld, and that the dignity of all coming before it was respected.

**Summary of the Current Situation**

**Focus of Court Action**

There is such a diversity of religious and social opinion, intellectual development, social standing and moral responses in society at large that courts seek to exercise great charity and forbearance of the opinions, methods and practices of all different classes of society. Therefore,
of necessity, cases have to be sufficiently unique, grievous and shameful to meet the condemnation of law-abiding people regardless of religious beliefs or social standing before a parent may be deprived of the custody and comfort of his child.

In considering any action the courts tend first to think in terms of physical care for they: 1. Can readily understand these needs; 2. Are able to impose control devices over the family and its domestic relationships; 3. Recognize that the court cannot command one person to love another; 4. Find it difficult to understand ideas of emotional neglect as a violation of a duty when there does not seem to be a defined duty; 5. Will not command that which it cannot enforce. 54

In examining the medical definition of the Battered Child Syndrome one point in assisting the interpretation of this medical syndrome in terms acceptable to and understood by the court is that there should be evidence of "persistence of maltreatment ... showing in various stages of healing," 55 and the origins of this evidence inadequately explained by the parents or guardians. Each case must be viewed in total as presenting a constellation of symptoms which, viewed together, unerringly point to a medical diagnosis of a physically abused child. At this point in time it appears that the courts tend to focus on establishing validity of physically observable


55 P. V. Woolley, et al., op. cit., p. 539.
fragments of the evidence and appear reluctant to take an over­
all view of the total evidence such as the observable evidence
of trauma, the documented sequence of events, the established
patterns of parental behavior, the emotional maturity of the
parents, the history of mental illness in the extended family
and the inter-relation of all of this evidence.

Traditionally, the courts are concerned with establish­
ing the guilt or innocence of those who appear before them,
based on objective evidence that supports their decisions beyond
a reasonable doubt. To change this prevalent attitude (which is
not the concern of the act under which Battered Child Cases
are heard) and to influence the court and all participating in
such cases, to focus their concern on establishing the safety
or lack of safety of the child's environment, is the major
task, for it must be remembered that in cases of the Battered
Child Syndrome we are concerned with repeated abuse.

1. The chief concern of the medical witnesses would
then be concentrated on establishing the existence of a series
of traumatic occurrences. If evidence can be expertly inter­
preted and substantiated to indicate wilful as against accidental
etiology so much the better. This evidence of trauma then sets
the stage. Any additional evidence they provide concerning the
parents' explanations or reactions simply adds to the overall
picture.

2. If it is an accident the parents should be able to
give a reasonable explanation. If they fail to do so they must

56 Protection of Children Act, op. cit.
then satisfy the court that their explanation is acceptable and that they can guarantee that the child's environment will be safe in the future.

3. Social investigation should proceed to establish the safety or otherwise of the continued custody of the child by its parents and attempt to establish the validity of their explanations. Conducting the social investigation with this focus, based on questioning in the areas suggested by Morris, et al., sufficient acceptable evidence should be established to assist the court in deciding on the safety of the child's environment.

To maintain this focus of the hearing a well informed attorney will be necessary to persistently direct the attention of the court, the witnesses and the defending attorney. Well informed questioning will be required to bring out evidence from equally well informed and prepared social and medical witnesses which will add to the picture of the child's safety. With this emphasis the matter of the conflicting rights of parents and children would not become such an issue. With well informed counsel able to maintain this focus the broad latitude for good judgment in the present legal machinery becomes an asset to the benefit of any particular case. Variations in interpretation by judges and magistrates would not then influence the outcome so unpredictably. Under such circumstances feelings and emotional build up would not constitute the hazard it does at present, for attention in the court would be continually directed away from the establishment or

suggestion of guilt or innocence and from the parents' self-concern, to a continual all-pervading court concern for the welfare of the child.

The three disciplines are at least united on a common focus in this area. Each competency is relied on to play its allotted role. Communication problems would be lessened and each discipline might gain in respect for the others instead of the open distrust and suspicion that shows itself on too many occasions.58

For example, social workers are prone to condemn the notion of police participation in the problems because police are traditionally thought 'too harsh'. Physicians tend to be impatient with social workers whom they consider 'too dreamy and optimistic' about the families' motivation and capacity for change. And the police become distressed when doctors hesitate to report these situations.59

It is apparent that in many instances the medical profession fails to recognize the Battered Child Syndrome. They do not or cannot agree on a diagnosis. They are easily led by an expert attorney's questioning to give answers of "perhaps" or "maybe" thus destroying their own cases in court. It was suggested by one court observer that medical evidence would be less confusing to the court if the doctors would summarize or have some legal definitions of what they were proceeding to prove.60

The comment has been made that social workers generally know even less about the syndrome than do medical witnesses

58 Health Council of the Community Chest and Council of the Greater Vancouver Area, February 2, 1965, op. cit. A special council was called to decide whether sufficient evidence existed to diagnose the Battered Child Syndrome.


60 Mr. B. Howie, personal communication.
and are generally entirely "out of their depth".\textsuperscript{61} They have been accused of over-zealous investigations, attempting to prove preconceived theories.\textsuperscript{62}

Questions Raised about the Adequacy of the Legal Machinery

1. In British Columbia there is no provision for permanent ward-ship for children. A parent may delay permission for adoption indefinitely. Any child removed from the custody of its parents moves only into foster care, a system social workers report as grossly overcrowded, with results far from satisfactory or reliable for the child. The courts are therefore, very reluctant to remove a child from its natural parents. Depriving parents of their rights of custody:

\textldots{} carries with it the obligation of providing for the child what the parents cannot provide and individual communities may not be prepared to accept their obligation.\textsuperscript{63}

2. Our modern ideas of individual freedom do not coincide with the increasing delinération of that freedom by statute. What freedoms we have, modern man tends to exploit. He still has freedom of movement which he is using to an unprecedented degree. The breakup of the extended family and community life creates a state of "anomie" where neighbors are unaware of each other, and if they are aware, they are very reluctant to interfere. It has to be flagrant abuse of a neighbor's rights or duties before a modern citizen will involve

\textsuperscript{61} Mr. S. Clyne, personal communication.

\textsuperscript{62} Health Committee, Community Chest, Feb. 2, 1965, \textit{op. cit.}

himself. In this situation a child may be beaten to death with the neighbor refusing to recognize what is going on and refusing to become involved. If the situation becomes too noticeable or uncomfortable the family moves. Another doctor is chosen to repair any damages and the parent remains secure. A central reporting registry might tend to keep track of these families.

3. Before hospital staffs, doctors and social workers in the U.S.A. could be induced to cooperate with mandatory reporting of Battered Children they had to be protected from any possibility of a civil suit for malpractice or defamation of character. Under Canadian law this protection does not seem to be as necessary. As long as the person reporting a Battered Child Syndrome does so in the light of objective, witnessed fact as he sees and interprets facts, and acts in good faith, he has little to fear from that source at present. 64, 65 Rather than following the American lead in advocating the introduction of legislation to the separate jurisdictions that would make reporting of Battered Children mandatory and the reporting official immune to civil suits, Canadian officials in the professions of medicine and social work are attempting

64 S. Clyne, G. McLean, N. Christie, personal communication.

65 The medical profession is currently attempting to have this point in law guaranteed either under the existing statutes or under proposed new ones that will so guarantee. Competent legal opinion (borne out by all legal opinions obtained by the writer) assured the medical profession that chances of a malpractice suit is remote under present legal practice in Canada. It is the opinion of the legal profession that the doctors are asking for something that is virtually impossible even if immunity legislation were introduced, for all citizens are liable to civil suits even though the action may be illegal.
to educate all those who might come in contact with the syndrome so that they will be able to recognize the syndrome and accept responsibility for reporting such cases. Because of the small number of cases handled and the apparent novelty of these, all disciplines who treat or safeguard the child victim tend to do so with poor understanding of the competence of other disciplines. The Battered Child Syndrome is forcing the social work, medical and legal professions to take a serious look at their existing "machinery" to see where it is expected to mesh.

4. In the operation of the physical facets of the legal machinery, facilities in the larger centers at least should be provided for basic care of the many babies brought to court and subjected to interminable waiting. The baby has to be presented in court for identification only, yet may be away from its sheltered routine for many hours. Why could affidavits not be accepted or the judge travel to the foster home to identify the child?

5. Few parents know where to turn for legal help. It was felt by some court officials that if legal help and counsel were more readily accessible fewer families would become involved in court.

6. Court proceedings are often ponderous, requiring attendance and expenditure of time out of proportion to actual testifying time. The question therefore arises of providing


67 G. McLean, B. Howie, personal communications.
alternative means by which professionals may give evidence so that they will be freer in accepting involvement in a court action. Less use of the subpoena might then occur although many doctors feel they are not prepared to violate patient confidentiality without the subpoena.

Questions Raised about Family Courts Hearing Battered Child Cases

1. This court was not set up to be a hospital for the improvement of the sick, nor a school for the education of the ignorant, but rather to help families avoid the use of open court. More freedom of action is allowed with a view to helping parents help themselves.

2. This freedom and relaxed atmosphere may well obscure the seriousness of the child's plight.

3. This freedom permits laymen, such as social workers, to attempt to perform as counsel for the prosecution and the defense, as parental advisers, as well as instructors of the court with the risk of unduly influencing all parties with subjective evidence.

4. One of the biggest drawbacks and criticisms of hearing Battered Child cases in the Family Court is that such cases are not recorded in a manner in which Case Law can be built for the guidance of future hearings. Interpretations and case law based on experience is desperately needed to guide courts, judges, magistrates, lawyers or anyone called on to prepare cases for hearings.

5. Because Family Court is often presided over by a layman an unofficial hierarchy of expert witnesses may unduly influence the manner in which cases are run, even their outcome.
Attorneys and police officials seem to be at the top of this hierarchy, followed by medical witnesses, social work witnesses, and finally other professional witnesses. As suggested by Harvey this hierarchy can be superseded by evidence of the non-professional's "own senses". 68

Recommendations

The writer would generally agree with the recommendations of the Health Committee of the Community Chest and Council 69 but would add:

1. That judges and magistrates be required to give the reasons for their findings in writing. Suitable coding to safeguard the confidential nature of the Family Court could be worked out. These written decisions would not only tend to make the judges or magistrates scrutinize the basis of their decisions more closely but also would build a body of case law to guide future courts.

2. The possibility of dealing with parents using legal restraints other than removal of their children should be

68 C. C. J. Harvey, op. cit., p. 381.

69 Health Committee, Vancouver Chest, op. cit. The following measures were recommended as possible solutions to the problem:

1. Mandatory reporting.
2. Increased doctor education will be necessary for success in a treatment program directed towards "abused children."
3. Mandatory protection for children under certain clearly prescribed circumstances, e.g., on recommendation of Board consisting of pediatricians, psychiatrists, general practitioners, orthopedic surgeons, social workers.
4. In cases reporting suspected "abuse" there should be mandatory psychiatric, social service and pediatric consultant reports within a prescribed period of time.
5. Under certain clearly prescribed circumstances there should be mandatory psychiatric care of parents.
thoroughly investigated. There is a growing conviction that authority can be used constructively in correcting more and more kinds of deviation.  

3. The three intimately concerned disciplines - medicine, law and social work - should: a) recognize their inter-dependency; b) allocate and delineate areas of competency; c) clarify points of overlapping of concerns; d) attempt to agree on some common vehicle of communication through a mutually understood vocabulary; and e) learn to respect the idiosyncratic competency of the other disciplines.

4. Police can be a valuable adjunct with their usually well trained staff of investigators. Areas where they can be used should be examined.

Conclusion

This chapter of the thesis has attempted to examine the adequacy of present legal machinery in dealing with the Battered Child Syndrome. All legal consultants have emphatically assured the writer that the legal machinery is adequate and sound; it is the tremendous range of interpretation and implementation by the different disciplines and individuals within these disciplines that need critical appraisal. The writer is prepared to agree. Suggestions regarding modifications of this machinery made above are not calling for fundamental changes. However, until this wide range of interpretation and implementation can be narrowed and some

70 Child Protection in Canada, op. cit., p. 25.
standardization introduced, the shortcomings of the legal machinery will generally be obscured.

Confusion will continue to exist until the:

... community faces a critical decision. What does it see its major responsibility to be? Should the destructive behavior on the part of parents be viewed primarily in terms of the criminal nature of the act so that arrest, prosecution and punishment are the major objectives, or, should community concern be over the need for social planning for the child victim of abuse?71

71 Child Abuse, Children's Division, the American Humane Association, p. 14.
Table A. Structural Characteristics of Family

<table>
<thead>
<tr>
<th>Case No.</th>
<th>No. of Children</th>
<th>Age of Patient (0-3 mos.)</th>
<th>No. of Children Abused</th>
<th>Age of Mother</th>
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(a) H. W: Housewife  (b) Emp: Employed  Unemp: Unemployed  (c) Pres: Present
Table B. Hospital Care

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(a) Priv. Dr: Private Doctor
Table C. Stability Factors Relating to Abuse

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(a) M: Male  F: Female

(b) Evidence of long term neglect includes malnutrition, failure to thrive, diaper rash, and display of emotional disorder in the child.
Table E. Socio-Economic Status of Families as Indicated by Occupation.

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Table F.  **Patterning of Abuse in Family.**

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</tr>
<tr>
<td>107</td>
<td>2</td>
<td>2</td>
<td>4 mon</td>
<td>4 mo- 2</td>
<td>#</td>
</tr>
<tr>
<td>101</td>
<td>2</td>
<td>2</td>
<td>3 1/2 mon</td>
<td>3 1/2 mo- 2</td>
<td>#</td>
</tr>
</tbody>
</table>

* There are 5 other children who were not in the home at the time of this apprehension due to marriage, adoption, prior apprehensions.
Table G. Parental Attitudes in Relation to Abuse.

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Abuser</th>
<th>Personal Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Suspect</td>
<td>Confirmed</td>
</tr>
<tr>
<td>101</td>
<td>Step-father</td>
<td></td>
</tr>
<tr>
<td>102</td>
<td>Mother or Father</td>
<td></td>
</tr>
<tr>
<td>103</td>
<td>Father</td>
<td></td>
</tr>
<tr>
<td>104</td>
<td>Mother</td>
<td></td>
</tr>
<tr>
<td>105</td>
<td>Step- * father</td>
<td></td>
</tr>
<tr>
<td>107</td>
<td>Mother</td>
<td></td>
</tr>
<tr>
<td>108</td>
<td>Mother</td>
<td></td>
</tr>
<tr>
<td>109</td>
<td>Mother (Father dead)</td>
<td></td>
</tr>
<tr>
<td>110</td>
<td>Mother</td>
<td></td>
</tr>
<tr>
<td>111</td>
<td>Mother</td>
<td></td>
</tr>
</tbody>
</table>

* Charge was dismissed although it was recognized that step father had beaten child. Magistrate's decision was that there was no proof step-father used any more force than that which might come under normal parental discipline. This was in spite of boy's broken rib, black eye, bruises, and state of shock.
Table H. Community Involvement in Laying a Complaint on Behalf of Child.

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Age at Apprehension</th>
<th>Origin of Complaint</th>
</tr>
</thead>
<tbody>
<tr>
<td>103</td>
<td>12</td>
<td>Child went to police for protection police call CAS</td>
</tr>
<tr>
<td>105</td>
<td>10</td>
<td>Child went to police for protection police call CAS</td>
</tr>
<tr>
<td>109</td>
<td>9</td>
<td>neighbor calls CAS</td>
</tr>
<tr>
<td>104</td>
<td>7</td>
<td>police received complaint, investigated, contacted CAS</td>
</tr>
<tr>
<td>110</td>
<td>7</td>
<td>2 or 3 anonymous complaints to CAS over 2 year period</td>
</tr>
<tr>
<td>111</td>
<td>5</td>
<td>maternal g.m. phoned CAS after child admitted to hospital</td>
</tr>
<tr>
<td>108</td>
<td>1½</td>
<td>Hosp. authorities contacted CAS same day</td>
</tr>
<tr>
<td>102</td>
<td>1</td>
<td>maternal g.m. insists child should see doctor</td>
</tr>
<tr>
<td>107</td>
<td>4 mon</td>
<td>VGH Health Center for Children contacted CAS</td>
</tr>
<tr>
<td>101</td>
<td>3½ mon</td>
<td>doctor refers child to CAS via VGH Health Center for Children</td>
</tr>
<tr>
<td></td>
<td>4 mon</td>
<td>police contact CAS after child admitted to hospital- sequence unclear</td>
</tr>
<tr>
<td></td>
<td>3½ mon</td>
<td>parents request care from CAS after child placed in hospital</td>
</tr>
</tbody>
</table>
Table I. Placement of Child after Abuse.

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Age at Apprehension</th>
<th>Charges</th>
<th>Placement of Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>103</td>
<td>12</td>
<td>Assault with intent to cause bodily harm; given 2 years protection</td>
<td>Returned home 1½ months after incident</td>
</tr>
<tr>
<td>105</td>
<td>10</td>
<td>Assault with Intent to cause Bodily Harm - charge dismissed</td>
<td>Moved frequently. Placed in foster home, then in resettlement homes</td>
</tr>
<tr>
<td>109</td>
<td>9</td>
<td>none</td>
<td>Placed with married sister--- later in a receiving home</td>
</tr>
<tr>
<td>104</td>
<td>7</td>
<td>none</td>
<td>Placed in a church boarding home</td>
</tr>
<tr>
<td>110</td>
<td>7</td>
<td>none</td>
<td>Placed in a foster home</td>
</tr>
<tr>
<td>111</td>
<td>5</td>
<td>none</td>
<td>Placed in foster home</td>
</tr>
<tr>
<td>108</td>
<td>1½</td>
<td>none</td>
<td>Placed in foster home</td>
</tr>
<tr>
<td>102</td>
<td>1</td>
<td>none</td>
<td>Parents regain custody</td>
</tr>
<tr>
<td>107</td>
<td>4 mon.</td>
<td>none</td>
<td>Returned home under 6 months supervision at age 1½</td>
</tr>
<tr>
<td>101</td>
<td>3½ mon.</td>
<td>none</td>
<td>Placed in foster home then placed for adoption</td>
</tr>
</tbody>
</table>
SOCIAL WORK RESEARCH
FACE SHEET

1. Agency:
2. Date:
3. Researcher:
4. Assigned number:
5. Open or closed file:
6. Person/s writing file:
7. Family constellation:
   Member
   Birthdate
Relationship to child: ________________

1. Age:
2. Education:
3. Race:
4. Income:
5. Religion:
6. Occupation:

7. All known agency contacts:

8. Marital status and history:

9. Mental health and behavior:

10. Childhood experience:
1. Age:

2. School:

3. Legal status:

4. Siblings:

5. Injuries sustained:

6. Parental statement about child's condition:

7. Description of child:

8. Parent-child interaction:
   Abused child:
   Siblings:
1. Sequence of prior agency contact:

2. Referral to this agency:

3. Diagnosis: (pre and post referral)

4. Inter-agency contact and sequence:

5. Legal action taken:

6. Disposition of case:
   - Abused child:

   Siblings:

   Parents:

   Agency:
ARTICLES: Newspapers and popular magazines, listed according to publication.

**The Atlantic Monthly**

A frank discussion of the increasing difficulties in finding adopting homes for the increasing numbers of children being placed for adoption.

**Chicago Daily News**

**Cosmopolitan Magazine**

A dramatic story, vividly illustrated, of the price children pay for parental rejection and the efforts some agencies and individuals are making in an attempt to alleviate some of the suffering.

**Good Housekeeping Magazine**

A popularly written article describing the incidence of the Battered Child Syndrome, introduced by a dramatic case.

**Medical World News** 2, No. 22:30 27 October, 1961

**The National Observer**

**Newsweek**

A new syndrome of child abuse - result of oversolicitude after or from suspected illness.

**New York Times**
Kalpan, Morris. "Deaths of Young Studied by City." 5 May 1962.

**New York Times Magazine**
LeShan, E. "When Parents Convict Themselves." 12 July 1964, p. 32.

Psychiatrist's review of problems modern parents have and make for themselves raising a family.
Parents Magazine
"Tragedy of the Unwanted Child."

Philadelphia Evening Bulletin

P.T.A. Magazine
A general discussion of the Battered Child Syndrome.

Paulsen, M. G. "Do Children Have Rights?" 58:7-9, February 1964.
A look at the rights of children (up to fourteen) in Juvenile Court.

Saturday Evening Post
The shock treatment for the general public. A frank expose, with pictures, of the B. C. S. They raised many issues that will have to be faced by the public in improving treatment for child abuse.

Time
General introductory story of the Battered Child Syndrome. Review of changing laws re mandatory reporting. Question: have agencies manpower enough to implement reports.

The Vancouver Sun
The paper calls for stiffer penalties.

29 January 1964. Toronto Date line.
Dr. Harold B. Cotnam, Ontario's supervising Coroner.
The first publicity in Canada for the Battered Child Syndrome.

Points out that the Society for the Prevention of Cruelty to Animals was formed fifty years before a similar one for children.

30 January 1965. Richmond date line.
Father jailed for whipping girl with split belt and chair arm.

**BOOKS**


An excellent book tracing the emerging concept of children as human individuals.


Descriptions of legal procedures that minimize the impact of emotional reactions and strive for calm and rational disposition.


A differentiation between characteristics of neglecting parents and abusing parents.

**JOURNALS**

**MEDICAL JOURNALS**

1. *Journal of the American Medical Association*


Fatal abuse of children by acts of omission. Discrepancy between history given by parents and obvious physical evidence.

Describes factors of childhood abuse common to convicted murderers.


Report of several case histories and some of the results of court appearances.


Brief comment supporting article in same issue by Kemp and others.

Editorial. 8 June 1964.

Capsules of news re mandatory reporting advice offered to M. D. if called as expert in B.C.S. cases.


Supports and expands upon problem outlined in same issue by Guinn and others.


Differential diagnosis between traumatic Periostitis and skeletal lesions of a more serious nature.


Urges early medical diagnosis and characterizes problem as of medical, social and legal importance.


Diagnostic signposts in the child plus psychiatric aspects of parents. Recommends doctors reporting cases to authorities.


Discussion of the advantages and disadvantages of the mandatory reporting law proposals.

Points out possible frequency of abuse in cases where child has skeletal damage.

A.M.A. News. 17 February 1964, p. 11.


States X-rays are irrefutable proof that babies have been cruelly treated.


Suggests doctors should always be on the alert for the battered baby syndrome in cases of infant subdural haematoma.


Doctor suggesting front page treatment by the press plus exemplary sentence of many years in prison as deterrent to potential baby beaters.


Suggests the problem of physical cruelty to children is an iceberg in which the "battered" baby syndrome represents only the part we can see.

West, S. "Acute Periosteal Swelling in Several Young Infants of Same Family." Vol. 1, p. 856.


Letter from Vancouver doctor cautioning reporting of suspected battered children unless evidence justifies police charge.

Claims irrefutable clinical and radiological evidence of trauma in B.C.S. almost unique.

Other British Publications


A tentative look at the Battered Child Syndrome by a psychiatrist, popularly phrased.


Review of statistics re deaths of all babies in Great Britain with a plea for better services.


3. Canadian Journals.

Canadian Health and Welfare.

Canadian Medical Association Journal.


M.D. of Canada.

Sound the alarm in Canada re the Battered Child Syndrome.


Claims irrefutable medical evidence of abuse can be proved.

Fractures caused at play or in motor accidents are more common than those caused by parental assault. Continued to outline physician's care of fractures.


Description of syndrome plus the resulting laws passed in Minnesota in 1963.


Outlines the difficulty in rescuing the battered child before homicide or irreparable damage is the result.


Cautions Social Workers re unwarranted break up of families.


270:960-1, 30 April 1964.


Reviews this "medical and social emergency" to date. Promotes mandatory reporting.


Outlines the reasons why not enough help is being given the battered child.


Caffey, J. "Infantile Cortical Hyperostosis." 29: 541-559, November 1946.

Coleman, R. W., Provence, S. "Environmental Retardation (Hospitalism) in Infants Living in Families." February 1957.


Places the responsibility of the protection of the child on the physician who may, however, delegate part of his task to a social worker, community agency or psychiatrist. Also outlines characteristics of the battered child syndrome.


Points out that doctors have a duty to report suspected cases where there have been a series of injuries not accounted for in parents' explanations, because the child is the patient, not the parents.


Clinical description of an infant with both conditions, etiology not established.


Follow study on fifty suspected battered children admitted to the Children's Hospital, Pittsburg, from 1951-1960, plus some social factors of the battering families.


Commentary on the necessity of removing the battered child from his environment and the difficulty of doing so.

33:1003, June 1964.

Newsletter (American Academy of Pediatrics)


American Academy of Pediatrics

Silver, P. H. "Round Table on New Diseases and Syndromes." October 1962.

7. Miscellaneous Medical Journals.


Rezza, Emilio and De Caro, B. "Fratture ossee multiple in lattante associate a distrofia, anemia e ritardo mentale." (with numerous references to European articles).

American Journal of Diseases of Children, Chicago, Ill. 98, No. 4, p. 528, October 1959.


American Journal of Nursing, New York, Vol. 64, No. 6.


Cites reasons battered children usually brought to hospital as well as other legitimate reasons for displacement of the epiphysis.


Some suggestions to nurses for recognizing the battered and nutritionally battered child in hospital and also precautions as to family investigation before release.

California Medicine, San Francisco; 99:98-103, August 1963.  

Implications of diagnosing the battered child syndrome as such in California.

Schroten, S. R. "Responsibilities of Physicians in Suspected Cases of Brutality."

Barta, R. A. "Wilful Trauma to Young Children - A Challenge to the Physician."

Giornale di Psichiatria o di Neuropatologie, Ferrara, 80:  
No. 3; 311-317, 1952.  
Schachter, M. "Contribution to the Clinical and Psychological Study of Mistreated Children; Physical and Moral Cruelty."

Andrew, J. P. "The Battered Baby Syndrome."

Journal of the Arkansas Medical Society, Fort Smith, 59:  
Potts, W. E. and Forbise, O. L. "Wilful Injuring in Children - a Distinct Syndrome."


Journal of Iowa Medical Society, Des Moines.  

Journal of Kansas Medical Society, Topeka.  

The Attorney-general's opinion regarding the reporting of such occurrences.


Journal of the Louisiana Medical Society, New Orleans,  
"The Battered Child Syndrome."

Journal of Newark Beth Israel Hospital, Newark, N. J., 3:17, 1952.  
Bakwin, R. "Roentegenologic Changes in the Bones Following Trauma in Infants."

Erwin, D. T. "The Battered Child Syndrome."

Monat schrift fur Kinderheilkunde, 105:10:393-394, October 1957.
Schleyer, F. and Pioch, W. "Fatal Outcome by Crush Syndrome After Continuous Beatings of a Child."

New York State Journal of Medicine, New York, 64:2140, 1 September 1964.

Post Grad Medicine, Minneapolis, Minn.

Rhode Island Medical Journal.

Surgery; Gynaecology; Obstetrics, Chicago, Ill.

Fisher, S. H. "Skeletal Manifestations of Parent Induced Trauma in Infants and Children."

Comments on the seriousness of the abused-child problem particularly as it is difficult for physicians themselves to believe that parents "do" beat their children.

Jones, Henry R., and Davis, Joseph H. "Multiple Traumatic Lesions of the Infant Skeleton."

Texas Journal of Medicine, Austin, Texas, 60:107-8, February 1964.


Parent and child vs state rights to take custody of a child in need of medical care.


Discussion of one parent giving evidence against his or her spouse.


A sketchy review of a new bill in England re children and young persons.


Statistics of prenatal mortality.


Swanson, Lynn D. "Role of the Police in the Protection of Children from Neglect and Abuse."

Suggests police must handle emergency complaints re neglect and abuse of children. Chronic or nonemergency complaints should be referred to a social agency.


Parents accused of child beating may not claim the doctor-patient privilege to prevent medical testimony.


National Probation and Parole Association Journal.


National Probation and Parole News.


Title LX: Chap. II, Section 273A. P. 61. Unjustifiable Punishment Causing Child to Suffer.
Section 273D, p. 61. Corporal Injury to Wife or Child.
Part IV, Title I.
Sections 11160-11162. Reports of Injuries to Hospitals. Jurisdiction of the Juvenile Court.

Simmons, E. B. "Forseeability in Negligence to Children." Re negligence, duty and trespass from standpoint of English law decisions re children; responsibility for probable consequences of act.

Division 2, Part 1, Chapter 2. Article 5. Section 600A. (new Juvenile Court Law 1961.)

Harvey, C. C. J. "Sv's Infant." Discussion of legal standard of proof required for child custody cases in court.


PSYCHIATRIC JOURNALS

American Journal of Psychiatry, Hanover, N. H.

Postulates that battered children are prone to react with violence, sometimes to the point of murder, in later stressful life situations.

Examines psychopathological and biological characteristics of mothers so involved.
Kiernan, Irene R. and Porter, Margaret H. "A Study of Behavior Disorders: Correlation between Parents and Children."

Researchers proof that behavior disorders are repeated in the next generation.

Weidman, Dr. Hazel. "Family Patterns and Paranoidal Personality Structure in Boston and Burma."

J. A. C. Psychiatry.


Rosen, L. V. "Personality Factor in the Reaction of Child Care Workers to Emotionally Disturbed Children."

RADIOLOGY JOURNALS


American Journal of Roentgenology, Radium Therapy and Nuclear Medicine, 33, No. 3:413-427, March 1953.
Silverman, F. N. "The Roentgen Manifestations of Unrecognized Skeletal Trauma in Infants."

Astley, R. "Multiple Metaphyseal Fractures in Small Children (Metaphyseal Fragility of Bone)." 26:577-583, November 1953.

SOCIAL WORK JOURNALS


Discusses children's developing rights. Problems of identification of cases and treatment - new areas for study.


Outline of personality characteristics of battering parents.


Discusses legal rights and duties; definition of neglect; difficulties in taking child abuse and neglect cases to court. Calls for better definitions which will be understood by the courts. Hints on preparing cases of neglect.


Examines some of the legal questions involved in dealing with neglectful and abusive parents. Makes a plea for workers to become acquainted with the relevant laws and become reconciled and proficient with the use of Authority.

Hospital Research Project - follow up of battered children.

Dramatic description of consequences to children allowed to return home and also permanent con­sequences to the children.


Typical reactions and attitudes of neglecting, battering parents compared with typical reactions of normal protective parents, as seen in a hospital setting.

Ferreira, Antonio J. "Rejection and Expectancy of Rejection in Families."


Problems involved in charging parents with child abuse. Asks some perplexing questions about children's rights, problems of placing guilt and insuring the child's protection.


Letter commenting on distortion of a professional article by TV "script hunters" for sensationalism.


Comments on the possibility of unconscious feel­ings and attitudes of medical and social work personnel as a reason for their reluctance to accept the cause of the Battered Child Syndrome. Also relates history of child rearing practices.


Nurse, Shirley. "Familial Patterns of Parents Who Abuse Their Children."

A very thoughtful and informative paper. This study made use of a sample group from probation case loads.
Discusses mandatory reporting and penalties.

MONOGRAPHS AND PAMPHLETS

Wilful injuries to children.

Hennepin County Welfare Board, Minneapolis, Minnesota.
"Protection Services and Emotional Neglect," Protection Unit, Child Services Division, Max Wald, Supervisor.

Statistics of hospitalization of children.


S. R. C. Bulletin.
Allport, G. W., "The Use of Personal Documents in Psychological Science." Bulletin No. 49, 142.

A project in community planning for improvement in service to neglected children.

Prugh, D. C.; Harlow, R.G.; Masked deprivation in infants and young children. In Deprivation of maternal care -- a reassessment of its effects.

OFFICIAL REPORTS AND STUDIES

Canadian Welfare Council, Ottawa, Ontario.
Annual Report, Family and Children Welfare Division, 1963-64.
Discusses the mandatory reporting legislation in reference to the Canadian scene.

Short history of child neglect laws in Canada. Cautions against removing too many parental rights. Makes a plea for legally considering emotional neglect.
The Battered Child syndrome must be considered when bruises are present and a diagnosis of coagulation defect cannot be considered. Important to interview parents separately when the syndrome is suspected.

Outlines the characteristics by which the doctor can recognize the battered child syndrome and urges him to take a direct approach with the parents as it is felt that most parents want help but are afraid to ask.

Fresno County General Hospital, Fresno, California.
"Routing Procedure for Management of Suspect Pediatric Patients Suffering Inflicted Trauma or Abuse," April 1963.


Henry Ford Hospital Medical Bulletin, Detroit, Michigan.

New York Academy of Science, Annals.

Public Health Reports.

Children's Division, AMERICAN HUMANE ASSOCIATION, P. O. Box 1266, Denver, Colo.

A look at legal safeguards in termination legislation.

Review of ways and recipients of abuse cases; types of action and charges taken and made; some recommendations.

De Francis, Vincent.

A statement of the co-operation needed between community institutions, social agencies and the public at large in recognizing and referring neglectful families.

"Interpreting Child Protective Services to Your Community."

Good references for Child Welfare personnel engaged in speaking to the public.


A statement of a Children's Bill of Rights and four facets of Child Protecting marking it as a specialized field.


Excellent orientation for a beginning Child Welfare worker.

"The Court and Protective Services, Their Respective Roles." 1960, p. 19.

Clarification of roles and responsibilities plus the co-operation needed between the court and protection agency.


Suggestions to the medical profession for the identification and future protection of battered children.

"Guidelines for Legislators to Protect the Battered Child." 1962, 10 pp.

Basic principles and concepts. Position statement on proposals for mandatory reporting of suspected inflicted injuries on children.


Psychiatric characteristics of parents who batter children plus behavior patterns of children which predispose abusive parental discipline.


Concerns for social workers in the Battered Child Syndrome.


How to employ authority in casework with neglectful parents.


Suggestions on legal procedure to the social work and medical professions.


"Principles and Suggested Language for Legislation on Public Child Welfare and Youth Services."


An Act for the mandatory reporting by Physicians and Institutions of certain Physical Abuse of Children.

Standard Family Court Act, 1959.

The Standard Juvenile Court Act, Sixth Ed. 1959.


CHILD WELFARE LEAGUE OF AMERICA INC., 345 East 64 St., New York 10, N. Y.


Suggests interviewing techniques to be used with battering parents for most truthful results.


Instructs Social Workers how to prepare cases for court.