SUBMITTED 5 SEP 21
REVISIONS REQ. 24 OCT 21 & 4 JAN 22; REVISIONS RECD. 23 NOV 21 & 18 JAN 22
ACCEPTED 2 MAR 22
ONLINE-FIRST: MARCH 2022
DOI: https://doi.org/10.18295/squmj.3.2022.026

Severe Injuries in 9 Children: Is it due to child neglect?

Case series from a regional hospital in Oman

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Abstract

Child Abuse and Neglect (CAN) is a global phenomenon and has many forms. Child neglect is the most common form observed. CAN are serious incidents with medicolegal implications for the caregivers. The recognition of CAN is still in its early stages in the Middle Eastern cultures such as in Oman where parental authority over children is traditionally sacrosanct. This case series presents nine serious incidents from a regional hospital in Oman that appears to fulfil the definition of child neglect. All cases presented were diagnosed by Suspected Child Abuse and Neglect (SCAN) team. This paper provides evidence that child neglect exists in Oman and had resulted in death of some children and led to significant physical, psychological and social sequelae in others. It also addresses risk factors and management recommendations. The article also highlights SCAN team experience along with the limitations of the current Child Protection Services (CPS) in Oman.

Keywords: Child Abuse; Child Neglect; Child Protection Services; Case Series; Oman

Introduction

Child Abuse and Neglect (CAN), also known as *Child Maltreatment*, is a global problem.[1] As per World Health Organization (WHO), it includes all forms of physical and/or psychological ill-treatment, neglect or negligent treatment, sexual abuse and commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.[2] Child neglect, the most common form of CAN, can occur in physical and emotional forms.[3] The prevalence of child neglect is estimated at 163/1000 for physical neglect and 184/1000 for emotional neglect.[1] In 2008, one-third of CAN investigations in Canada involved neglect.[4]

Though well-studied and socially accepted in the Euro-American populations, the concept is still relatively new in the Arabian Gulf region. There is scarcity of studies reporting CAN in the Arab Peninsula, which is sometimes attributed to a 'culture of silence.'[5] Medically reported cases thus may represent the tip of the iceberg.[6] In Oman, the available limited data suggest that all known forms of CAN are prevalent.[7]

The Sultanate of Oman ratified the Convention on the Rights of the Child (CRC) in 1996[8] and the country's Ministry of Health has sought to implement international norms for management of CAN as laid out in its *Clinical Guidelines on Child Abuse and Neglect*.[9] However, the traditional Omani Arab society (like its Middle Eastern peers) has a culture that consider parents—especially the father—as the final authority for the wellbeing of their offspring. Understandably, there is some resistance from the community regarding medico-legal interference in child welfare.[5] Thus, legal action for CAN cases often tend to be avoided as demonstrated by the cases discussed below. This paper aims to add to the emerging evidence that child neglect exists in Oman and is associated with significant trauma in children and even occasional deaths. The nine cases reported here have been evaluated by the team that monitors Suspected Child Abuse and Neglect (SCAN) at Rustaq Hospital (a regional hospital in Oman) in 2020–21 and are proposed as examples of child neglect. The fact that all the nine cases have emerge from a small region over just 9 months indicates the necessity to study and act on this much-ignored problem.

This paper briefly recounts the nine cases of child neglect and how the hospital SCAN team experienced and managed each. It brings out the risk factors, management recommendations, as well as the practical limitations of the current Child Protection Services (CPS) in Oman. Ethical permission was obtained from Research and Ethics Review Approval Committee at the Regional Health Directorate, Rustaq. Verbal consent for the publication of each case was obtained from the guardians.

The SCAN Team: Constitution and Management

The SCAN team at the Rustaq Hospital (a regional secondary hospital) was constituted in 2020, led by a pediatrician specialized in child abuse and neglect (the author of this paper). The medical evaluation of the identified cases by SCAN team was conducted according to the international standards.[10-12] As there is no qualified social worker in the hospital, the team has appointed a nurse with a bachelor's degree in community health. There are physicians assigned from different wards

in the hospital including the ER to notify the SCAN team of suspected cases. A radiologist and an ophthalmologist are also part of the team when such evaluation is required.

In the cases described below, the history was obtained in a non-leading manner by interviewing the caregivers, and where possible, the child. The SCAN team also interviewed other family members where required to triangulate the data. The family's perceptions and concerns were acknowledged and the team avoided the common pitfall of blaming the caregivers, rather engaged them in the management plan. All children were medically examined for signs of other types of abuse or neglect and to rule out other medical diagnoses. Where CAN was suspected, there was continuous liaison with the police, general prosecution, and the child protection delegate (social worker assigned by Ministry of Social Development (MOSD).

Case Reports

Case one

A 2-year-old toddler presented with chemical burn involving 20% body surface including eyes, face, chest, and limbs. He required intubation and admission in the paediatric intensive care unit (PICU). His mother had an untreated mental disorder. Born 'unwanted,' the child was in the care of an aunt since birth. On the day of injury, this aunt had a job interview, and she left the child in the care of the mother at the latter's house. In the toilet used by the child, the father had left an opened bottle of highly corrosive acid (sewage opener) for two days, and the child consumed it. The mother later admitted of being aware of the bottle while the child was in toilet. The father of the child admitted that the care of three other siblings of the child were also being neglected due to maternal mental illness and his work commitments. The information provided in the case were mainly taken from his primary caregiver (his aunt) which are consistent with the physical examination of the child and with information given later by both parents.

The child remained hospitalised for two months and underwent multiple operations. He developed significant disfigurement of his face in addition to vision and breathing problems. He also showed symptoms of post-traumatic stress disorder (PTSD). Meanwhile his caregiver (aunt) also admitted being stressed with her own social and financial pressures. They were both referred for psychological support in a specialised centre. The team was able to procure psychological and financial assistance to them. The mother was encouraged to attend her missed psychiatric sessions. However, efforts to bring the child's three siblings for medical examination were unsuccessful and the current child protection system in Oman failed to take further intervention.

Case two

A baby boy, diagnosed with trisomy 21 at birth, was lost to follow up and then seen at age of 6 months when he was brought to the Emergency Room (ER) by his grandmother with fever and breathing difficulty for one week. He was diagnosed with heart failure (HF). Before starting treatment, the grandmother took away the child against medical advice claiming that his primary caregiver (parents) were refusing admission and that they would take him to another hospital. SCAN team tried to call the parents to ask about the child but received no response. Child protection delegate was involved but failed to bring the child back to hospital. The child was brought again at age of 8 months with HF but again taken away against medical advice. SCAN team was not involved this time. The child was brought back at age of 9 months for a routine appointment and was found to have severe pulmonary hypertension and huge tamponade which required pericardiocentesis. No home visit or legal escalation for child neglect was conducted.

Case three

A 10-year-old boy was brought to ER in critical condition which required immediate ventilation and PICU admission. The child sustained severe traumatic brain injury, grade IV liver injury, grade V kidney injury, multiple fractures and lung contusion. He stayed for two months in PICU and underwent multiple operations. He had seizures and was on multiple anticonvulsants. On discharge, the child was in a vegetative state.

SCAN team interviewed the mother, step-father, older brothers and uncles. The child was living with his maternal grandparents as his father had died and his mother had married an old man and was living in a very small accommodation. He was visiting his mother frequently. On the day of injury, child was visiting his mother at her home when a cooking gas cylinder burst severely injuring him and three others. The cylinder was kept in the narrow kitchen, just beside the bedrooms and living room even though there was space for it outside the kitchen. The mother and her husband had underestimated the safety risk. The child's uncles and older brothers raised their concerns on the safety of the children at their mother's home. Multidisciplinary team meeting was conducted to plan social assistance for childcare after discharge. SCAN team has been following up the child and his family situation. Though the child protection delegate was involved, no home visit was conducted by him and no legal action was taken.

Case four

A 2-year-old girl was found drowsy, excessively sweating and very warm to touch after being entrapped in a car for two hours. Her mother had been driving with five children. When they arrived home, she locked the car assuming everybody was out and then got busy with cooking. Even though the mother was notified that the child was not around, she assumed that she was playing. On presentation to the hospital, the child had abnormal movements and features of heat stroke with deranged liver and renal functions. She was managed in PICU and recovered within 48 hours with no neurological or behavioural sequelae. The liver and renal functions were normalised. The SCAN team extensively counselled the parents and discussed the case with the child protection delegate who interviewed the family by phone.

Case five

A 13-month-old girl developed severe upper airway obstructive symptoms which required ventilation and PICU admission after ingesting hot water. Her father had boiled water to prepare formula, poured it into an open container which he left on the floor. Though her parents were in the same room they were not actively supervising her, and were alerted by her screams. With burns involving anterior neck and upper anterior chest area, the child was ventilated for two days due to severe airway obstruction. On follow up, she had no breathing or feeding issues. The SCAN team gave extensive counselling to the parents.

Case six

An 18-month-old boy sustained skull-fracture, intracranial and lung contusion and liver hematoma that required PICU admission after a fall from staircase at home. The balustrade had holes that enabled the child to climb onto the guard-rail and ride down. He did this repeatedly. One week prior to the injury a fall was prevented as his clothes became stuck. Despite that incident, no effective preventive measures were taken by the caregivers. In this case the child's injuries healed with no sequelae. SCAN team counselled both parents. The child protection delegate was involved, but did not engage in communication with the family.

Case seven

A 4-year-old boy presented with burns involving 20% of the body surface area. He was intubated in ER due to peri-oral burn and lips swelling. At the day of injury, his uncle had taken him and other four children, all below 12 years of age, to watch him burn dry grass in a small, closed room to get rid of insects that infested the goats he had been keeping there. As the children huddled at the entrance to watch, the uncle doused the grass with petrol and set light to it. Fire went out-of-control, severely burning this child and causing milder burns in other two children. After hospitalisation, the

uncle was counselled by SCAN team and the child protection delegate was informed. No further actions were taken.

Case eight

A15-month-old toddler was brought to the ER with no breathing and no pulse after drowning in a home swimming pool for an unknown period. The event happened when the mother was busy in the kitchen. The pool was unfenced with easy access to small children. Child survived after 20 minutes of resuscitation however remained ventilator-dependent with severe neurological sequelae and died after 3 months. The event was witnessed by four older siblings aged below 12 years. They developed symptoms of PTSD, and SCAN arranged a management plan. However, the children did not show up as the parents did not consider the intervention necessary.

Case nine

A 4-year-old girl diagnosed with sickle cell disease (SCD) was brought to the ER in a state of cardio-respiratory arrest with deep jaundice and severe pallor. The investigation results were: Hb: 0.5 g/dL (N:11.5-15.5), platelets: 10x9/L (N:150-450), reticulocytes: 5% (N:0.2-2), urea 13mmol/L (N:3.5-5.5), C-reactive protein: 243 (N<5), bilirubin: 117.5 umol/L (N<20). The child died despite resuscitation attempts. SCAN team interviewed the parents who explained that the child had pain in limbs, lethargy, and loss of appetite for two days, which was managed at home with pain medications. On the morning of the day of presentation, the lethargy increased and child was moaning. Mother went to sleep and left the child and her siblings in the living room, and the father left for work. When he returned, he found the child unconsciousness and brought her to the ER. Parents have another child with SCD and they acknowledged that they had been counselled about the disease, but that this child's disease was mild. Medical records indicated that her SCD was not being followed up, nor was she on any treatment, which the parents confirmed during the interview. One year earlier the same child had been brought to the ER with deep laceration near the eye after falling from the staircase. The mother developed prolonged grief disorder and was referred for treatment. The delegate called the caregiver by phone. No further action was taken in this case.

Discussion

Child neglect is the most common form of CAN.[3] At its core, neglect is a situation where the child's normal development and safety is impeded by the failure of the caregiver to meet the child's basic needs.[13,14] There are various types of child neglect as shown in Table 1.

This paper features nine serious cases attributable to child neglect that were presented at the ER of Rustaq Hospital, a secondary regional hospital in Oman, during a period of nine months. All cases required PICU admission except for one child (case 9) who died in ER. Eight out of the nine cases were below the age of 5 years. At least in six cases there were preventable factors and warning signs. If these signs had been heeded and timely action taken, the injuries might have been avoided. A likely case of chronic neglect of several children in a family is illustrated by case-1. Leaving an "unwanted" child even for a short time with his mentally ill mother seems prima facie an instance of neglect by the caregivers, the aunt, and the father. It also represents significant neglect of home safety by leaving open a dangerous chemical in a child's toilet. The fact that the father did not present the remaining children for counselling despite invitation from the SCAN team is yet another indication of ongoing chronic child neglect.

Case-2 and case-9 represent severe professional challenge for any dedicated pediatrician. Here the caregivers not only neglected their child's serious symptoms, but after presentation refused medical care. Such phenomenon has been studied in Oman and remedial procedural changes have been made in hospitals.[17-19] The difficulty lies in the implementation, as the Omani-Arab tradition gives primacy to parental authority over external intervention. However, over the years the state has been increasingly able to intervene in clear cases of child neglect.[20]

Case 3 is an example of suboptimal home environment in the home of a non-custodial parent. The child was exposed to physical neglect and ended up in a vegetative state due to explosion of gas cylinder placed in a narrow kitchen. On the other hand, factors beyond parent's control such as economic deprivation might explain the lower safety levels. Therefore, various factors need be considered before attributing cases to child neglect.

The economic deprivation argument may be less relevant in cases 4-8. These cases illustrate the lack of caregiver attention to toddlers and perhaps a lack of awareness on child safety among caregivers. In case 8, absence of physical safety provisions in a home swimming pool and absence of supervision took the life of a toddler. In case 4, a mother fails to check for her infant left in the car even after being reminded. Similar cases with heat stroke and lack of supervision have been reported in Omani literature.[17,21]

Challenges faced and Management Recommendation

Deciding whether a caregiver's behaviour was neglectful is often difficult. Each case is unique with many causative factors. Therefore, attention and sensitivity while working with the family and the

child protection team is important. The team should aim to identify harm and to explore the factors that led to neglect and with the intention to prevent similar occurrences, rather than presuming any intentionality from the side of the parents because most seek the child's welfare.[22]

Several factors usually interact and result in neglect.[23] Parental factors such as mental health issues as in case 1 and child-related factors such as younger age.[23-26] Lack of community centres and other supportive resources are also associated with higher prevalence of neglect.[23] In case1, for example, if there were alternative supportive resources such as a nearby nursery, the injury could have been prevented. Economic deprivation, as in case 3, might explain some unsafe home environments. Additionally, the traditional status of the father as having the ultimate say on the child makes medical non-compliance more likely, as in cases 2 and 9.

It is apparent from the discussed cases that there is suboptimal management of CAN cases. In any of these cases no legal action was taken, or home visits made. Randomized controlled trials have demonstrated that home visits are effective in reducing CAN in a society.[27] In addition, requests for bringing siblings of the injured child for medical examination were not complied with. In fact, cases 4, 5, 6 and 8 give sufficient grounds for investigating the home environment of the caregivers. There is also insufficient monitoring of home environments where children visit their non-custodial parents and relatives. Possible causes for such deficiency may include the underestimation of the importance of the situation among professionals working with children.[28] Traditional reticence in the Arab Omani population against revealing family matters to outsiders may also play a role. These can be modified over time through public education. Health professionals need to be trained to change false attitudes and to be more alert to abusive practices and behaviours of parents and other caregivers [28] and to intervene (in a culturally appropriate manner) not only in one's own family but also in one's neighbourhood.

Conclusion

Child neglect does exist in Oman as it does elsewhere but is less visible here due to cultural factors and inadequate social monitoring systems. The nine cases discussed in this paper, emerging from a small region from Oman during a short period, add to the evidence for occurrence of serious incidents that sometimes result in death, as well as the medical and psychological sequalae in the survivors and their families. This report highlights the need to upgrade and implement effective community-based services and provide proper social support to victims and their families. There is an absolute need for culturally adapted community awareness campaigns to help prevent child neglect and minimise its significant adverse short- and long-term impacts.

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354 **Table 1:** Types of neglect

Type of neglect	Defention
Physical	Inadequate food, clothing, shelter, hygiene
Medical	Failure to provide prescribed medical care or treatment or failure to seek appropriate medical care in a timely manner
Dental	Failure to provide adequate dental care or treatment
Supervisional	Failure to provide age-appropriate supervision
Emotional	Failure to provide adequate nurturance or affection, failing to provide necessary psychological support, or allowing children to use drugs and/or alcohol
Educational	Failure to enroll a child in school or failure to provide adequate home schooling, failure to comply with recommended special education, allowing chronic truancy
Other	Includes exposing children to domestic violence, or engaging or encouraging children to participate in illegal activities such as shoplifting or drug dealing

355 *Adapted from Reference 15&16.*