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CASE SERIES

Did Child Neglect Cause Severe Injuries in Nine Children?

Case series from a regional hospital in Oman

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abstract: Child abuse and neglect (CAN) is a global phenomenon that takes many forms, with child neglect being the most common. CAN comprises serious incidents with medicolegal implications for the caregivers. The recognition of CAN is still in its early stages in Middle Eastern cultures, including in Oman, where parental authority over children is traditionally sacrosanct. This case series presents nine serious incidents from a regional hospital in Oman from 2020–2021 that appear to fulfil the definition of child neglect. All cases were diagnosed by the Suspected Child Abuse and Neglect (SCAN) team. This article provides evidence that child neglect exists in Oman and has resulted in the death of some children while causing significant physical, psychological and social sequelae in others. It also addresses risk factors and provides recommendations for management. Furthermore, the experience of the SCAN team and limitations of the current Child Protection Services in Oman are highlighted.

Keywords: Child; Child Abuse; Child Protection; Case Series; Oman.

Child abuse and neglect (CAN), also known as child maltreatment, is a global problem.[1] As per World Health Organization, 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 type of CAN, can occur in physical and emotional forms.[3] The prevalence of child neglect is estimated at 163/1,000 for physical neglect and 184/1,000 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 a scarcity of studies reporting CAN in the Arab Peninsula, which is sometimes attributed to a 'culture of silence'.[5] Thus, medically reported cases in this region may only represent the tip of the iceberg.[6] In Oman, the limited available data suggest the prevalence of all known forms of CAN.[7]

Oman ratified the Convention on the Rights of the Child in 1996, and the country's Ministry of Health has sought to implement international norms for the management of CAN as laid out in its Clinical Guidelines on Child Abuse and Neglect.[8,9] 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 well-being of their offspring. Understandably, there is some resistance from these communities regarding medicolegal interference in child welfare.[5] Thus, legal action for CAN cases often tend to be avoided, as demonstrated by the cases presented in this article.

This article aimed to contribute to the body of emerging evidence that indicates that child neglect exists in Oman and is associated with significant trauma in children and even occasional child deaths. The nine cases reported here were evaluated by the Suspected Child Abuse and Neglect (SCAN) team at a regional secondary hospital in Oman during 2020–2021 and are proposed as examples of child neglect. The fact that all the nine cases emerged from a small region over a period of just nine months indicates the need to study this much-ignored problem and take necessary actions.

This paper provides a brief account of the nine cases of child neglect and details how the hospital SCAN team managed the individual cases. It highlights the risk factors, provides recommendations for management and lists the practical limitations of the current Child Protection Services in Oman. Ethical permission was obtained from the Research and Ethics Review Approval Committee at the Regional Health Directorate, Rustaq, Oman. Verbal consent for the publication of each case was obtained from the guardians.

The SCAN team at the regional hospital was constituted in 2020 and is led by the author of this paper (a paediatrician specialised in CAN). The medical evaluation of the identified cases was conducted by the

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SCAN team according to international standards.[10–12] Since the hospital does not have a qualified social worker, a nurse with a bachelor's degree in community health is assigned to the team. Physicians from different wards in the hospital, including the emergency room (ER), are assigned to notify the SCAN team of suspected cases. A radiologist and an ophthalmologist are also included in the team when such evaluations are required.

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

Case One

A two-year-old boy presented with a 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 had been in the care of an aunt since birth. On the day the child sustained the injury, his aunt had a job interview and left the child in the care of the mother at the latter's house. The father had left a bottle of highly corrosive acid (sewage opener) open for two days in the toilet used by the child and the child consumed it. The mother later admitted to being aware that the bottle was in the toilet while the child used it. The father admitted that the care of three other siblings of the child was also being neglected due to maternal mental illness and his work commitments. More information was secured from the child's primary caregiver (his aunt), which were found to be consistent with the physical examination of the child and with the 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 aunt also admitted to being stressed due to her own social and financial troubles. They were both referred for psychological support in a specialised centre. The team was able to procure psychological and financial assistance for them. The mother was encouraged to attend the psychiatric sessions she had missed. However, efforts to bring the child's three siblings for medical examination were unsuccessful and the child protection system in Oman failed to take further intervention measures.

Case Two

A baby boy diagnosed with trisomy 21 at birth was lost to follow-up and then seen at the age of six months when he was brought to the ER by his grandmother after having suffered from a fever and breathing difficulty for one week. He was diagnosed with heart failure (HF). Before treatment could be commenced, the grandmother took the child away against medical advice, claiming that his primary caregivers (parents) were refusing admission and that they would take him to another hospital. The SCAN team tried to call the parents to enquire about the child but received no response. The child protection delegate was involved, but they too failed to bring the child back to hospital. The child was brought back at the age of eight months with HF, only to be similarly taken away against medical advice. The SCAN team was not involved at that time. The child was brought back at the age of nine months again 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 the ER in critical condition, which required immediate ventilation and PICU admission. The child had sustained severe traumatic brain injury, grade IV liver injury, grade V kidney injury, multiple fractures and lung contusion. He stayed in the PICU for two months and underwent multiple operations. He had seizures and was on multiple anticonvulsants. On discharge, the child was in a vegetative state.

The SCAN team interviewed the mother, stepfather, older brothers and uncles. The child was living with his maternal grandparents as his father had died and his mother, having married an older man, was living in a very small accommodation. He used to visit his mother frequently. On the day of injury, the child had been 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, beside the bedrooms and the 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 concerns about the safety of the children at the mother's home. A multidisciplinary team meeting was conducted to plan social assistance for childcare after the child's discharge. The SCAN team has been following-up on 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 two-year-old girl was found drowsy, excessively sweating and very warm to the 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 became busy with cooking. Even though the mother was notified that the child was not around, she assumed that her child was playing.

On presentation to the hospital, the child had abnormal movements, features of heat stroke as well as deranged liver and renal functions. She was managed in the PICU and recovered within 48 hours with no neurological or behavioural sequelae. The liver and renal functions were normalised. The SCAN team provided extensive counselling to the parents and discussed the case with the child protection delegate, who interviewed the family by phone.

Case Five

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

Case Six

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

Case Seven

A four-year-old boy presented with burns involving 20% of the body surface area. He was intubated in the ER due to perioral burn and swelling of the lips. On the day of injury, his uncle had taken him and four other children, all below 12 years of age, to watch him burn dry grass in a small, closed room to exterminate insects that had been infesting the goats he kept there. As the children huddled near the entrance to watch, the uncle doused the grass with petrol and set it alight. The fire got out of control, severely burning this child and causing milder burns to two other children. After hospitalisation of the child, the uncle was counselled by the SCAN team and the child protection delegate was informed. No further actions were taken.

Case Eight

A 15-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 of time. The event happened when the mother was busy in the kitchen. The pool was unfenced and allowed easy access to small children. The child survived after 20 minutes of resuscitation but remained ventilator-dependent with severe neurological sequelae and died after three months. The event was witnessed by four older siblings, all aged below 12 years, who developed symptoms of PTSD. The SCAN team organised a management plan; however, the children did not attend as the parents did not consider the intervention necessary.

Case Nine

A four-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 as follows: haemoglobin = 0.5 g/dL (normal range: 11.5–15.5 g/dL), platelets

= 10 × 10^9/L (normal range: 150–450 × 10^9/L), reticulocytes = 5% (normal range: 0.2–2%), urea = 13 mmol/L (normal range: 3.5–5.5 mmol/L), C-reactive protein: 243 mg/L (normal range: <5 mg/L) and bilirubin = 117.5 µmol/L (normal range: <20 µmol/L). The child died despite resuscitation attempts. The SCAN team interviewed the parents, who explained that the child had had pain in her 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 the child was moaning. The mother went to sleep, leaving the child and her siblings in the living room, while the father left for work. When he returned, he found the child unconsciousness and brought her to the ER.

The 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 a deep laceration near her 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.[15,16]

This article features nine serious cases attributable to child neglect that presented to the ER of a secondary regional hospital in Oman, over a period of nine months. All cases required PICU admission except for one child (case nine) who died in the ER. Eight out of the nine cases were children below the age of five years. Preventable factors and warning signs were observed in at least six cases. If these signs had been heeded and timely action had been taken, injuries might have been avoided.

Case one illustrates a likely case of chronic neglect of several children in a family. Leaving an 'unwanted' child with his mentally ill mother, even for a short time, seems prima facie an instance of neglect by the caregivers—the aunt and the father. Furthermore, leaving a dangerous chemical open and accessible in a child's toilet represents significant neglect of home safety. 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.

Cases two and nine represent a severe professional challenge for any dedicated paediatrician. Here, the caregivers not only neglected their child's serious symptoms but also refused medical care after presentation. This phenomenon has been studied in Oman and remedial procedural changes have been made in hospitals.[17–19] The difficulty lies in the implementation, especially since the Omani Arab culture 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 three is an example of a suboptimal environment in the home of a non-custodial parent. The child was exposed to physical neglect which resulted in a vegetative state due to the explosion of a gas cylinder placed in a narrow kitchen. On the other hand, factors beyond the parent's control, such as economic deprivation, might explain the lower safety levels. Therefore, various factors need to be considered before attributing cases to child neglect.

Table 1: Types of neglect[15,16]

Type of Neglect	Definition
Physical	Inadequate food, clothing, shelter and/or 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, failure to provide necessary psychological support, allowing children to use drugs and/or alcohol.
Educational	Failure to enrol 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.

Adapted from references 15 and 16.

Economic deprivation may be less relevant in cases 4–8. These cases illustrate a lack of attention by the caregiver to the child and perhaps a lack of awareness on child safety among caregivers. In case eight, absence of physical safety provisions in a home swimming pool and lack of supervision took the life of a toddler. In case four, even after being reminded, a mother failed to check whether her infant had been left in the car. Similar cases of heat stroke and lack of supervision have been reported in the Omani medical literature.[17,21]

Deciding whether a caregiver's behaviour was neglectful is often difficult. Each case is unique and may have many causative factors. Therefore, it is important to ensure attention and sensitivity while working with the family and the child protection team. The team should aim to identify signs of harm and explore the factors that led to neglect but with the objective of preventing similar occurrences, rather than presuming any intentionality from the side of the parents, as most seek the child's welfare.[22]

Several factors usually interact and result in neglect; for instance, parental factors such as mental health issues, as in case one, 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 case one, for example, the injury could have been prevented if there were alternative supportive resources such as an accessible nursery. Economic deprivation, as in case three, might explain some unsafe home environments. Additionally, the traditional status of the father as having the ultimate say on matters regarding the child makes medical non-compliance more likely,[5] as in cases two and nine.

It is apparent from the cases discussed in this article that CAN is afforded only suboptimal management. Legal action was not taken in any of these cases and neither were home visits made. Randomised 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 four, five, six and eight give sufficient grounds for investigating the home environment of the caregivers. Insufficient monitoring of home environments was also observed in cases 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 among the Omani Arab population for revealing family matters to 'outsiders' may also play a role. Such attitudes can be modified over time through public education. Health professionals need to be trained to change such potentially harmful attitudes and be more alert to abusive practices and behaviours of parents and other caregivers.[28] They must also be trained 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 in other parts of the world, but it is less visible due to cultural factors and inadequate social monitoring systems. The nine cases discussed in this article, emerging from a small region in Oman during a short period, add to the evidence on the occurrence of serious incidents that sometimes result in death as well as medical and psychological sequelae 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 urgent 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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