



# Child Protection Is No Accident

Views on current practice in Northern Ireland from senior medical and nursing staff in A&E

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**GIVING CHILDREN BACK THEIR FUTURE**

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# Acknowledgements

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# Introduction

Accident & Emergency departments<sup>1</sup> (A&E) may be the first point at which children who have been abused and suffer an injury have contact with the Health and Personal Social Services (HPSS) system in Northern Ireland.

In the UK in 1998/9 there were 14 million new A&E attendees of all ages at casualty departments<sup>2</sup>; this gives a conservative estimated national figure of 3.5 million children per annum having contact with hospitals through these units<sup>3</sup>. Research completed for the Department of Health, Social Services and Public Safety (DHSSPS)<sup>4</sup> indicated that there were approximately 175,000 new accidental injuries necessitating attendance at A&E departments each year and a third of these injuries (55,000) concern children under the age of 16. The survey also found over-representation of this group attending A&E in comparison with other age groups in the general population. Equally figures obtained from the Eastern Health and Social Services Board (EHSSB)<sup>5</sup> indicate that in years 1999-2001 there were over 30,000 attendances annually of children at the Royal Belfast Hospital for Sick Children A&E Department. Additional research has also suggested a relationship between attendance at A&E and patients from more deprived areas (Beattie et al<sup>6</sup>) which may be significant given the relationship between some forms of abuse and deprivation. This is supported by recent findings that injury rates to children in the North and West Belfast Health and Social Services Trust are double in areas categorised as having the most social deprivation, in comparison to areas with the least<sup>7</sup>.

Often it is junior hospital doctors who are in the forefront of dealing with injuries and who have to consider whether these might be the result of child abuse or neglect (CAN). These deliberations/assessments frequently take place in busy casualty departments and while each of the Boards have clear child protection procedures for the onward reporting and management of suspected abuse cases, the issue may not arise if it is not detected nor recognised in the first place.

The difficulties around the diagnosis of child abuse and neglect in this context (and hence a failure to respond) have been widely documented in the literature and it was a issue that was to have tragic consequences for Victoria Climbié<sup>8</sup> where injuries were subsequently incorrectly diagnosed in hospital. Bengier and McCabe<sup>9</sup> in an audit of burns and scalds in

- 1 The term A&E is due to change to Emergency Department. For consistency they will be referred to as A&E departments throughout this study, the prevailing term at the time of the survey.
- 2 British Association for Accident & Emergency Medicine's directory 1998/9 cited in Accident and Emergency Services for Children Report of a Multidisciplinary Working Party Royal College of Paediatrics 1999.
- 3 Accident and Emergency Services for Children Report of a Multidisciplinary Working Party Royal College of Paediatrics 1999.
- 4 Department of Health, Social Services and Public Safety 2002 Accident and Emergency Survey Summary Report Price Waterhouse Coopers.
- 5 Personal communication with NSPCC specific attendances were 1999/2000 30,414 2000/1 30,165.
- 6 Beattie, T.F., Gorman, D. R. and Walker, J.J. (2001) The association between deprivation levels, attendance rate and triage category of children attending a children's accident and emergency department. *Emergency Medicine Journal*. 18 (2); 110-1, 2001.
- 7 Glasgow J. Personal communication, research to be published.
- 8 The Victoria Climbié Inquiry [www.victoria-climbie-inquiry.org.uk](http://www.victoria-climbie-inquiry.org.uk).
- 9 Bengier, J.R. and McCabe, S.E. (2001) Burns and scalds in pre-school children attending accident and emergency: accident or abuse? *Emerg Med J*;18:172-174.

pre-school children attending A&E departments, found that the prevailing awareness and documentation regarding the possibility of non-accidental injury (NAI) was poor.

Jayawant et al<sup>10</sup>, in a retrospective sample of young children who had suffered subdural haemorrhage, reported that child abuse was confirmed in 21 cases (61%); they concluded, however, that a further 6 cases or 20% of the sample contained findings that were highly suggestive of abuse. In 14 cases a clear history of shaking was obtained although this was never reported as being the first explanation put forward and the study found clear associations between injuries and a previous history of child abuse in the family. Carty and Ratcliffe<sup>11</sup> commented that the clinical presentation of a shaking injury may not suggest abuse and that the history may be confusing if inter alia, information is withheld.

Examination of the literature on the diagnosis of child abuse and neglect in the context of A&E departments shows that a number of areas have come in for particular attention and focus:

1. the use of checklists incorporating clinical signs and social circumstances that are widely predictive of abuse;
2. developments around the use of stickers as a memory aide in case notes (Benger, R.P., and Pearce, A. P.<sup>12</sup>; Benger J.R. and McCabe. S.E.<sup>13</sup>)
3. the role of the Child Protection Register (Quin and Evans<sup>14</sup>); and
4. training programmes in child protection for A&E staff (Sidebotham and Pearce<sup>15</sup>, Flanagan et al<sup>16</sup>).

These areas will be discussed in more detail later; suffice to point out that there are a number of factors which have been consistently found to produce better diagnosis, detection and subsequent reporting of child abuse and neglect.

10 Jayawant, S., Rawlinson, A., Gibbon, F., Price, J., Sharples, P., Sibert, J. R. and Kemp, A.M. (1998) Subdural haemorrhages in infants: population based study *BMJ* 1998; 317: 1558-1561.

11 Carty, H. and Ratcliffe, J. (1995) The shaken infant syndrome *BMJ* 1995; 310:344-355.

12 Benger, J.R., and Pearce, A.V. (2002) Simple intervention to improve detection of child abuse in emergency departments *BMJ* 2002; 324:780-782.

13 Benger, J.R. and McCabe S.E. (2001) Burns and scalds in pre-school child attending accident and emergency: accident or abuse? *Emergency Med J* 2001; 18: 172-174.

14 Quin, G. and Evans, R. Accident and emergency department access to the Child Protection Register: a questionnaire survey *Emerg Med J* 2002; 19:136-137.

15 Sidebotham, P.D. and Pearce, A.V. (1997) Audit of child protection procedures in accident and emergency department to identify children at risk of abuse *BMJ* 1997;315:855-856.

16 Flanagan, N.M., Macleod, C., Jenkins, M.G. and Wylie, R. The Child Protection Register: A tool in the accident and emergency department?

# Background to this study into A&E and child protection in Northern Ireland

In 2001 Barnardo's, NSPCC and Child Poverty Action Group published the Children's Manifesto '*Our children their future*<sup>17</sup>'. It was subsequently customised for Northern Ireland and republished to suit a devolved context. The document contained a range of local and national policy statements and on the issue of better child protection procedures in A&E departments called for:

"Regionally agreed guidelines to ensure consistent procedures in casualty departments to detect non-accidental injuries as soon as they occur. This should include full multi-disciplinary investigations of all cases where babies have been shaken<sup>18</sup>".

Interest in exploring the issue further was simultaneously expressed by the Child Care Unit at the DHSSPS and Dr John Glasgow Royal Belfast Hospital for Sick Children (through the Intercollegiate Advisory Committee on A&E services at the RCPCH). Subsequently a small steering group was established comprising Barnardo's, NSPCC, the Child Care Unit of the DHSSPS, SSI and Dr Glasgow (for membership see Appendix 1). A literature search was initiated, as was an examination of current research in the UK. It was through this process that we contacted Dr Peter Sidebotham, a Consultant Community Paediatrician in Bristol who had previously researched this area. Dr Sidebotham was at that point preparing to carry out a questionnaire survey of casualty departments in England and Wales and kindly agreed to extend his study to Northern Ireland. The results of this wider study will be examined elsewhere, but it was felt that the result of the survey in Northern Ireland could produce some local information that may have particular implications for policy developments and practice in this jurisdiction.

Dr Sidebotham's questionnaire (see Appendix 2) was adapted slightly to reflect the different structures that exist in Northern Ireland. More specific details are contained in the Methods section.

17 Our Children their future A manifesto for children in Northern Ireland published by Barnardo's [Northern Ireland], NSPCC [NI] and CPAG May 2001.

18 Page 15.

# Methods

In April 2002 40 questionnaires were disseminated to 20 hospitals in Northern Ireland with an A&E department. Names of all lead A&E consultants/nurses were obtained by telephone and where there was more than one named individual within each profession, the survey was addressed to multiple recipients. The documentation included a questionnaire and enclosed a joint letter from the Northern Ireland Director of Barnardo's and the Divisional Director of NSPCC. A letter from Dr Peter Sidebotham explaining the background to his survey in England was also included (Appendix 3 and 4).

The questionnaire was anonymous, although some details about location of the hospital in a Board area were sought, and recipients were invited to complete details of their address for follow-up information.

# Results

## NUMBERS OF QUESTIONNAIRES AND RETURNS

In total 40 questionnaires were sent to 20 hospitals in Northern Ireland with a casualty unit. 19 replies were returned with two not being completed as they ceased to operate an A&E department or had a children's unit on site. One response was completed jointly by medical and nursing staff and as such treated as two returns. There were therefore 18 out of the 38 questionnaires completed, representing a response rate of 47%<sup>19</sup>.

## BREAKDOWN OF RESPONSES BY DISCIPLINE

With one exception, it was possible to ascertain professional background of those who responded with 11 being completed by doctors and 6 by nursing staff.

## THE GEOGRAPHICAL LOCATION OF THOSE WHO RESPONDED

Table 1: No Of Medical Personnel By Board Area

Board Area	No of Respondents (n = 18)
EHSSB	6
NHSSB	5
WHSSB	3
SHSSB	4

## RESPONSES TO SPECIFIC QUESTIONS

### QUESTION 1

**Does your department have a written protocol for the management of suspected child abuse? [please forward a copy]**

There were a variety of responses to this question: 14 respondents reported yes and 3, all consultants, reported no. Where a written protocol was forwarded [n=7] the documentation consisted in the main of excerpts from ACPC procedures. Two returns comprised of more specific internal guidance in relation to protocols in particular circumstances.

<sup>19</sup> Note not all questions were answered fully by all respondents. Conversely some questions may have had more than one answer. Numbers who responded to questions are therefore indicated in brackets where relevant.

## QUESTION 2

**Are local Area Child Protection Committee procedures available in the department?**

This question was completed by all 18 respondents.

Yes 14 No 4

## QUESTION 3

**Is the Child Protection Register (CPR) checked for all children attending the department?**

17 out of the 18 respondents reported that they would only check the Child Protection Register (CPR) when there were suspicions of abuse (Table 2).

**Table 2: Numbers Checking The Child Protection Register**

CPR Checked	No of Respondents
No	1
Yes all children	0
Yes where there are suspicions	17

For those who responded 'Yes' Q 3 went on to ask what would trigger a check of the Register. As expected, access to the Register was prompted by more than one factor and these are reported in Table 3.

**Table 3: Factors Which Trigger Medical Personnel To Access The Child Protection Register**

Factors Triggering Access to Register	No of Respondents*
Repeated attendance	6
Injury not in keeping with history	5
Delay in attendance	5
Inconsistent explanation	3
Suspicious clinical findings	3
Pattern to injuries	3
Child's relationship with the parent	2
Unusual injury	1
Appearance of injury	1
Reason for attendance was suspicious	1

\*The figures in this column are greater than total no. of respondents for this question (N = 17) as respondents were asked to select as many options as they thought appropriate.

#### QUESTIONS 4

In checking the Register is this:  
A list kept in A&E;  
A database accessible from A&E;  
By telephoning the Register.

Table 4: The Ways In Which Medical Personnel Access The Child Protection Register

How CPR is Accessed	No. of Respondents (n=18)
Through a list held in A&E	1
Through a database accessible in A&E	6
By telephoning the Register	12

#### QUESTION 5

**Who is responsible for checking the Child Protection Register in your department?  
Please specify.**

Most respondents indicated that they were able to check the Register either through a database accessible in A&E, by telephone contact or in some cases, a combination of both (see Table 4). One response indicated that access to the Register was gained via social services 'out of hours' system and that this was very time consuming.

Responses indicated that the CPR is checked by a range of personnel medical, nursing, and social work staff.

#### QUESTIONS 6 and 7

**Has the person had occasion to check the Child Protection Register from another Trust/Board area**

**If yes to above, did they experience any access problems? If yes, please specify**

Approximately half of those who responded reported never having to access the Register held in another Board/Trust area. Where this was required those who responded reported no access problems.

This response is interesting given the location of many A&E departments in catchment areas that cut across Trust and Board boundaries (such as in Belfast) and also in circumstances where children might be expected to attend away from their place of domicile (e.g. holiday areas such as the North Coast). Given that virtually all respondents appeared to be accessing the CPR, we might have expected to see greater numbers of occasions when staff accessed Registers for children domiciled outside the location of their Trust/Board.

## QUESTIONS 8 and 9

**Does your department have a checklist of concerning presentations?**

**If yes, could you please list or forward the items on your checklist**

As can be seen from Table 5 the majority of respondents reported that there were no checklists of concerning presentations available.

**Table 5: No Of Medical Personnel In A&E Departments Who Have Access To A Checklist Of Concerning Presentations.**

<b>Does department have a checklist for concerning presentations</b>	<b>No of Respondents (n = 18)</b>
Yes	7
No	10
Not answered	1

Remarkably in relation to question 9, there were very few responses or enclosures. One respondent referenced and enclosed ACPC procedures, which contain a list of concerning presentations. There was one example of specific medical guidance, taken from an internal Emergency Paediatric Life Support Manual, which contained quite detailed information in regard to clinical examination and skeletal X-Ray.

## QUESTIONS 10 and 11

**Does your department have a lead professional for child protection?**

**Are there clear procedures for contacting the Trust named doctor and nurse for child protection?**

In relation to question 10, there was a high degree of consensus that lead professionals in child protection, represented evenly by medical and nursing staff, do exist. 3 questionnaires indicated however; that there was no child protection lead in their department.

Eight respondents, over 40% of those questionnaires returned, indicated that there were **not** clear procedures for contacting lead child protection staff.

## QUESTIONS 13 and 14

**Are there arrangements in place which facilitate regular liaison on child protection issues?**

**If so, please specify who this is with and how frequently this occurs.**

There was a relatively positive response to Q13 (Yes 12, No 4) indicating that more often than not, there is regular liaison on child protection matters. Comments received in response to the question on the frequency of liaison arrangements indicated that there were a wide diversity of actual arrangements in place. Comments included:

- Child Protection nurse twice yearly and ad hoc
- Social services team in the hospital at any time we have concerns and at least weekly
- Nurse Practitioner
- This has recently been introduced
- Duty social worker from Child and Family Team contacts Department each morning for referrals. 1-2 monthly meeting with Family and Childcare Co-ordinator and child nurse specialist Liaison HV comes twice weekly to the Department
- Child Protection Nurse Specialist
- I am a member of the Trust Child Protection Panel and it meets quarterly
- Child Protection Nurse Specialist liased with on demand
- Child Protection Committee every 2-3 months
- Paediatric consultant twice a year
- Copy of children's notes sent out to health visitor

#### QUESTIONS 15 and 16

**Does your department have a training programme in child protection?**

**If so, who participates?**

The majority of those who responded to Q15 indicated that training programmes existed for staff although, as shown in Table 6, these are not always regarded as regular. In response to Q16, it would appear that all relevant groups of staff participate in unidisciplinary and multidisciplinary training programmes.

**Table 6: No Of Medical Personnel Who Have Access To Training Programmes In Child Protection.**

Training Programmes in Child Protection	No of Respondents (n = 18)
Yes Regular	9
Yes Ad-Hoc	6
No	3

#### QUESTION 17

**Do all staff receive child protection training as part of their induction?**

Most respondents indicated that there was child protection training available as part of induction. However, this was not universally completed and there was one indication to the contrary.

# Discussion

There are always difficulties in drawing hard and fast conclusions from questionnaires, particularly when we are dealing with such a relatively small population sample. The completed questionnaires that formed part of this study do, however, provide some information on broad themes and issues.

A response rate of 47% for postal surveys is good by social research standards and there was a spread of responses from Board areas and from medical and nursing staff. It was also felt to be a reasonable rate of return considering it was targeted at senior staff who work under considerable time constraints. Nonetheless, it might have been higher given the important role played by A&E staff who are at the forefront in dealing with injured children and who play an extremely important role in detecting non-accidental injury. With a number of recent tragic child deaths as a result of abuse in both Northern Ireland and Great Britain, and the prominence that child protection is receiving in the media, it was thought that this also might have promoted a better response. As a result, child protection arrangements in more than 50% of A&E Departments in Northern Ireland remain unknown. The returns from the questionnaires also raise a number of particular issues discussed below.

## THE IMPORTANCE OF ACPC PROCEDURES AND THE LACK OF SPECIFIC INTERNAL MEDICAL GUIDANCE ON DEALING WITH POSSIBLE CHILD ABUSE AND NEGLECT.

In response to Q1 most respondents clearly felt that guidance existed for the management of child abuse and neglect and material enclosed usually consisted of local ACPC procedures. This can be contrasted with Q9 where the majority of responses indicated that they had no checklists of concerning presentations and only one example of more detailed medical guidance was provided. In relation to Q2, 14 out of the 18 who responded indicated that ACPC procedures were available in the department and this, taken with the above, would tend to suggest that the only existing child protection guidance widely available to A&E staff is ACPC procedures. A number of questions arise from this:

- Do ACPC procedures deal adequately with the issue of actual 'identification' of child abuse for medical practitioners as opposed to the procedural steps that should be taken when abuse is suspected or confirmed? For example is there an argument that guidance for medical staff should include clinical signs, checklists and clinical photographs?
- With regular rotation of junior medical staff, is there potential confusion when they move between Board areas with different ACPC procedures which differ to a degree in layout and content?
- What is the practice in hospitals that did not return completed questionnaires?
- In response to Q1, 3 respondents, all consultants, said they did not have access to a written protocol on child protection. This is concerning when taken in conjunction with some respondents having no access to ACPC procedures (Q2) and the general lack of availability of checklists as indicated by the response to Q9. This questionnaire

was sent to senior staff who should be familiar with a locality and its personnel. If there is uncertainty among senior staff in relation to child protection procedures, this does not auger well for clarity among junior members of staff.

At the time the survey was conducted the over-arching guidance on child protection which sets out the responsibilities of A&E staff was contained in Volume 6 of the Children Order Guidance "*Co-operating to Protect Children*"<sup>20</sup>. This establishes some key principles for hospital staff and is complemented by more detailed guidance produced by each Area Child Protection Committee (ACPC).

Supplementary guidance for particular professionals and on particular topics (for example guidance for nurses<sup>21</sup>) has been published by the Department of Health in London and in Northern Ireland by the Central Nursing Advisory Committee of the then Department of Health and Social Services (DHSS).<sup>22</sup> There may well be a compelling argument for producing regional child protection guidance containing detailed medical information on the diagnosis and recognition of child abuse which is aimed specifically at staff working in A&E Departments. This may also have applicability to other settings such as minor injury units and GP out-of-hours services.

We therefore strongly suggest that:

**The DHSSPS in conjunction with ACPCs consider the development of standardised regional guidance (which include the provision of checklists) on the diagnosis and recognition of child abuse and this is provided to frontline medical staff in A&E.**

Related to the issue of specific guidance for A&E staff is literature and research which shows that there are beneficial outcomes from the use of flowchart stickers to prompt A&E staff to consider the possibility of NAI. Bengier and Pearce<sup>23</sup> carried out a two-stage audit of 1000 children aged under 6 years in a busy emergency department before and after the introduction of a five-factor flowchart sticker. The sticker required professionals to address their minds to a number of issues including, inter alia:

- the delay between the injury and seeking medical advice and whether there has been a satisfactory explanation;
- if there is a consistent history;
- any unexplained injuries on examination; and
- appropriateness of the child's behaviour and interaction.

Bengier and Pearce found that in a number of respects there was improved consideration of intentional injury among pre-school children attending A&E. Referral rates for NAI doubled from 0.6% to 1.4% and they concluded that the inclusion of a simple reminder flowchart in the notes of injured pre-school children attending A&E departments increased awareness, consideration and documentation of intentional injury.

20 *Co-operating to Protect Children* 1996 DHSS Revised by the DHSSPS and republished as *Co-operating to Safeguard Children* May 2003

21 *Guidance for Senior Nurses, Health Visitors and Midwives and their Managers* Report of the Standing Nursing and Midwifery Advisory Committee Department of Health London 1997

22 *Guidance on Professional Practice for Nurses, Midwives and Health Visitors* Central Nursing Advisory Committee April DHSS 1998.

23 Op cit

We would suggest that there is merit in piloting such a flow chart system in a hospital in Northern Ireland to assess the applicability and suitability of such a system regionally. While the benefit of such an approach may decline with time as staff become more familiar with it, the converse argument could be made that it would improve the profile and recognition of child abuse and would in addition help to standardise practice across hospitals in Northern Ireland. Linked to prospective A&E clinical audit, it would provide a means by which to attempt measurement of improvement.

## THE CHILD PROTECTION REGISTER

In Northern Ireland just over 30 per 10,000 children are on the Child Protection Register (CPR) at any one time.<sup>24</sup> In terms of children's presentation at A&E those on the CPR are probably very small relative to actual numbers, although in such hospitals as the RBHSC, they may be expected to see on average 2 children per week<sup>25</sup>. As can be seen from responses to Q3, the vast majority of those who checked the Child Protection Register did so only when there were concerns about a child and there was no evidence of automatic screening for all children attending A&E. Respondents also indicated that there were no access problems to the Register even where this crossed Board/Trust boundaries.

The Child Protection Register (or rather Registers as there are more than one) perform a number of functions outlined, for example, in the Southern Health and Social Services Board (SHSSB) ACPC<sup>26</sup> guidance:

- Providing a record of all children in the area for whom there are unresolved child protection issues, and who are currently the subject of an inter-agency child protection plan; and
- To provide a central point of enquiry for professional staff who are worried about a child.

The guidance<sup>27</sup> also goes on to state that:

"If the child is not registered but there is another child on the Register at the same address, the inquirer is informed of this and given the name of the Co-ordinator and the category of abuse for the other child. The appropriate Assistant Principal Social Worker will be advised as soon as possible in order to check the need for an investigation."

*"If a child's name is not registered and two enquiries are made about the same child, the appropriate Assistant Principal Social Worker should be informed as soon as possible following the second enquiry in order to check on the need for investigation"*

To provide a double check on enquires to the Child Protection Registers, a letter was sent to each of the 4 Boards asking for access information; in particular it asked for information on which 'professionals' were accessing the Register. Respondents to the questionnaire in Qs 4-7 appeared to indicate that medical and nursing staff accessed the Register and that there were no problems in doing so; this should then be reflected in the enquiries that were logged by each respective Register custodian.

24 32.2 per 10,000 in 1999/0 Key Indicators of Personal Social Services for Northern Ireland 2001 DHSSPS

25 30,000 children per annum attending RBHSC equates to 96 children (x32 per 10,000) or approx. 2 per week

26 Southern Area Child Protection Committee Child Protection Procedures

27 Section 9.4

Of the 2 Boards who responded particular information was provided from one Trust for 2 years and one Board area for one year. It was disappointing that more comprehensive data was not made available. The information provided by the Boards indicated that access to the Child Protection Register was relatively rare and the Board returns suggested that access was by social services staff only. There must be caution in drawing any conclusions as this was a very limited sample and there is a possibility that A&E staff are accessing Register information via the social services 'out-of-hours' co-ordinator (as was indicated in one questionnaire) or via social services directly during office hours. It may be the case that access requests are not recorded formally by social services when these occur.

The picture is also confused by the way in which the Registers are both held and accessed in each of the Boards and Trusts. There appear to be different arrangements and mechanisms between and within Boards and Trusts for both holding and accessing the information that is held on it. Some Trusts have consortium arrangements for holding and servicing the Register, whereas in others it is held by individual Trusts. Telephone access appears the norm although one hospital in the SHSSB area, until recently, had access to the Trusts' Registers through a social services SOSCARE computer terminal.

There is a debate about the role and importance of the CPR in relation to A&E departments and whether it is a useful tool to assist in the diagnosis and detection of child abuse. The CPR only provides information on child who are 'currently registered' (but **not** those previously de-registered), and there are many children who will suffer child abuse who are not known to social services. "It is neither sensitive nor specific" according to Quin and Evans.<sup>28</sup> However follow up studies have shown an appreciable re-injury rate of 6.9% in the year following registration (Creighton<sup>29</sup>) and the Register may have a role to play in safeguarding children. In addition it can be argued that children on the CPR will be more likely to suffer child abuse, the presentation of which will be mis-diagnosed because A&E doctors are unaware of their status.

Some of these issues have received recent attention in the literature. A Northern Ireland study in United Hospitals Trust published by Flanagan et al<sup>30</sup> examined the records of 91 children whose names had been on the Register in the NHSSB area between June 1994 and May 2000. This group of children was found to have attended A&E departments on 206 occasions and a retrospective examination was carried out on medical notes to ascertain the cause of presentation. The research concluded that the vast majority of children on the CPR attended hospital because of illness and trauma, not related to NAI, and access to the Register was considered less important than the need for properly trained A&E staff capable of recognising child abuse. However as outlined above, the CPR as well as acting as an alerting mechanism for staff in A&E also fulfils a number of other functions. Where there are concerns about a child, or a child in the same household and the Register is checked, this information may also be of significance and trigger further investigations by social services. It may be premature to dismiss the significance of the CPR in relation to valuable information it may provide to both A&E staff and social services.

28 Op cit.

29 Creighton. S., J. An epidemiological study of abused children and their families in the United Kingdom between 1977 and 1982. *Child Abuse and Negl*;9: 441-8.

30 Op cit.

Quin and Evans<sup>31</sup> recently published the results of a survey into how UK A&E departments accessed the Child Protection Register and found a variety of mechanisms were used. In the main access to the Register was through social services duty system (48%) with others using computer terminals (17%), a hard copy (17%) and a combination of methods (14%). There were much higher satisfaction rates recorded for the use of computer and paper based systems than through social services. The study also reported widely differing access and practice arrangements that related to the mode of access (e.g. routine screening of all children). No department who used social services to check the CPR screened all children attending A&E compared to 72% and 62% for those who had access to hard copy and computer terminals, respectively. Significantly it was concluded that the criteria used by A&E departments to access the CPR appears to be influenced by the mode of access; most departments who had hard copy or computer access to the Register tended to check it against all children who attend A&E.

While it is difficult to distil specific conclusions from the results of the survey in relation to the Register, its use and access to it by staff in A&E Departments, the questionnaire and published literature do raise a number of issues. We would strongly suggest that further research be carried out into the operation of the Child Protection Register by the 4 ACPCs and in particular: what information is stored and accessed; its location; and how access is recorded.

As regards A&E departments we would recommend that:

**There should be a consistent system for staff in A&E departments to check the Child Protection Register on children for whom they have concerns about possible abuse or neglect; and**

**When checks are made by A&E staff, irrespective of the children's status, these should be recorded by social services.**

## **INDUCTION AND CHILD PROTECTION TRAINING PROGRAMMES**

From the information provided in returns to the questionnaire, there appears to be a degree of child protection training for staff at induction and as part of on-going professional development. However, this was by no means universal. Again it is concerning that a number of respondents reported that there was no training or induction in child protection. Our fairly limited findings in this area would merit further research, and in hindsight more specific questions in relation to the content of induction and training programmes could have been asked to distinguish the difference between induction, awareness-raising and child protection training.

Flanagan et al in their study in United Hospitals Trust concluded that training for A&E staff in recognition of NAI was extremely important particularly as standard indicators of abuse were not always sought by A&E doctors. Consequently the Trust has introduced multi-disciplinary biannual child protection training for junior hospital staff. This also functions as an induction for A&E SHOs, and as an update for specialist registrars and other career grades. A similar model of child protection training has recently also been adopted at Altnagelvin Hospital in the WHSSB area with multi-agency training taking place in the A&E department every 6 months.

In parallel to our own study into child protection in A&E departments, McIlwee and Glasgow<sup>32</sup> conducted a questionnaire survey of 34 Senior House Officers working in A&E in 4 hospitals in Northern Ireland. This looked at a variety of issues including doctors' background, details of child protection induction/training and tested out a number of clinical case scenarios. Thirty one questionnaires were returned indicating that most of the junior doctors had undergone A&E induction. However a significant minority reported that this did not contain a child protection component (n=4/31) and for many this did not include an input from social services staff. There were 2 other very significant findings from this:

- Eight SHOs had attended a specific 2-day child protection course as part of their training (all in the Northern Health and Social Services Board (NHSSB)); and
- There was **little** awareness of ACPC policies and procedures and no staff reported that they had seen a copy of these in their A&E department.

The publication of the Climbié Inquiry Report has also highlighted again the important role of child protection training for staff in the NHS. Recommendations 85, 87 and 88 of the Report specifically deal with continuing education in both the hospital and primary care team settings.

In light of our findings, the literature and the unpublished McIlwee and Glasgow questionnaire, we would make the following recommendations:

**All A&E departments, in conjunction with ACPCs, should ensure that staff receive induction and mandatory training in relation to child protection and that this includes local child protection arrangements and procedures.**

**The DHSSPS in conjunction with Boards and ACPCs should examine existing child protection training arrangements for A&E staff with a view to ensuring a regional standard and consistency of approach for all newly qualified staff. This should include discussion with the NI Council for Postgraduate Medical and Dental Education, the Northern Ireland Practice and Education Council for Nursing and Midwifery and respective professional colleges.**

## PROFESSIONAL LIAISON ARRANGEMENTS

Twelve respondents reported regular liaison in child protection there appears to be a range of arrangements and ways in which this takes place. There was also evidence in responses of some good practice and proactive arrangements between family and child care teams and hospital units. Again it is hard to draw firm conclusions from this limited sample, suffice to note that 4 out of 16 respondents reported that there **were not** satisfactory liaison arrangements in place. Likewise a number of respondents indicated in response to Q11 that there were not clear procedures for contacting lead doctors and nurses for child protection. Again questions that arise from this include:

- are there a significant number of hospitals in Northern Ireland where child protection liaison arrangements are not satisfactory?
- do the differing local arrangements in casualty units cause confusion for staff and does a need exist for common and consistent child protection liaison arrangements in each hospital?

32 McIlwee, A. and Glasgow, J. Non-accidental Injury: Awareness Raising for Junior Staff in A&E Departments in Northern Ireland 2002 Unpublished.

The child protection guidance “*Co-operating to Protect Children*”<sup>33</sup> sets out child protection liaison arrangements for health professionals at the time the survey was conducted. One of the key components of this is the role of the designated doctor and nurse with expertise and a lead role on child protection. Specifically the guidance requires the appointment in each Trust of a senior doctor and senior nurse with a health visiting qualification to act as a ‘designated professional’ to provide advice and to co-ordinate child protection work within their discipline. The guidance states:

Each Trust should have access to the services of a least one senior doctor and senior nurse with a high degree of expertise in child protection to:

- identify the training needs of medical staff working with children in relation to child protection...;
- ensure the provision of a source of information and advice on child protection, including clinical aspects and procedures either personally or through well-defined delegation arrangements to *named posts*. **(our italics)**; and
- act as a reference point for other agencies so that advice is co-ordinated for these bodies.

This guidance is further developed on page 24 of the document, which deals with the responsibilities of hospital staff. Paragraph 4.37 states:

*‘Staff should know how to contact designated professionals for advice and assistance on procedural matters. When they need additional clinical advice in determining the exact significance of the history of injuries they should get help from the appropriate clinical specialist’*

However when examining this guidance which prevailed at the time this survey was carried out, it could be argued that existing systems for professional liaison arrangements were less than clear in the document and this was reflected in the operation of designated doctors and nurses, their roles and responsibilities.

The DoH Guidance “*Working Together to Safeguard Children*”<sup>34</sup>, revised in 1999, is somewhat more detailed on professional liaison arrangements than “*Co-operating to Protect Children*”. It establishes that each health authority should take the overall strategic lead for health services in local inter-agency working on child protection and requires the appointment of a senior paediatrician and a senior nurse with health visiting qualification to act as ‘designated senior professionals’. The guidance envisages that these staff will be based in Trusts but will have responsibilities across the health authority for a range of child protection issues. The guidance is developed further at paragraph 3.23, which recommends that each Trust identifies a ‘named’ doctor, nurse or midwife who will take a professional lead on child protection matters. Their role is to:

‘provide an important source of advice and expertise for fellow professionals and other agencies and also have an important role in promoting good professional practice within the Trust on safeguarding children’<sup>35</sup>

33 *Co-operating to Protect Children* op cit

34 *Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children* Department of Health 1999 London

35 Note this guidance has subsequently been revised to take account of the new structural arrangements brought about by *Shifting the Balance of Power within the NHS: Securing Delivery* Department of Health London 2002

The need to strengthen safeguarding arrangements for children in A&E is a feature of other reports in other jurisdictions. The Commission for Health Improvement (CHI) Clinical Governance Reviews of NHS Trusts<sup>36</sup> identified a number of shortfalls in the practice of individual hospitals. These included:

- insufficient awareness by all health care staff of the designated doctor role or who should be the most important person to hold that position; and
- lack of named doctors or paediatricians with child protection responsibilities, and inadequate time allocated to the role.

Likewise the recently published Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales '*The Carlile Review*<sup>37</sup>' endorsed and reaffirmed the designated and named professional role and made a series of recommendations to strengthen their role and responsibilities within the NHS structure.

It is also worth noting that only a small proportion of A&E departments in the UK have a consultant with specialist training in Paediatric Emergency Medicine. It is likely that this shortfall in consultants will remain. In light of this the Royal College of Paediatrics and Child Health have recommended the appointment of Designated Liaison Paediatricians, one of their tasks being to deliver enhanced expertise in a range of children's issues including child protection<sup>38</sup>.

Finally, but by no means least, it is important to point out that many of the Climbié Inquiry recommendations deal explicitly and implicitly with broad professional liaison arrangements both within and between professionals groups. Recommendations include:

- All designated and named doctors in child protection and all consultant paediatricians must be revalidated in the diagnosis and treatment of deliberate self harm and in the multi-disciplinary aspects of a child protection investigation. (recommendation 84)
- Liaison between hospitals and community health services plays an important role in protecting children from harm. The Department of Health must ensure that those working in such liaison roles receive child protection training. Compliance with child protection policies and procedures must be subject to regular audit by Primary Care Trusts. (recommendation 90)

As Lord Laming stated in the report:

"Improvements to the way information is exchanged within and between agencies are imperative if children are to be adequately safeguarded.....Effective action designed to safeguard the well-being of children and families depends upon the sharing of information on an inter-agency basis"

36 Reported in Safeguarding Children A Joint Chief Inspectors' Report on Arrangements to Safeguard Children DoH 2002 London

37 Too Serious a Thing The Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales The Carlile Review The National Assembly for Wales March 2002

38 Royal College of Paediatrics and Child Health Joint Inter-Collegiate Advisory Group on A&E Services for Children June 2001

DHSSPS has produced new guidance *Co-operating to Protect Children*. The guidance has been published subsequent to the Victoria Climbié Inquiry and has had the opportunity to take account of, and been influenced by Lord Laming's report, findings from this study and ongoing work led by Social Services Inspectorate. As a result the revised guidance paragraphs 3.17-3.22 makes more explicit the roles and responsibilities of designated and named doctors and nurses and where these posts should be located. In particular the guidance states that:

- All Boards should nominate a 'designated doctor' and designated nurse for child protection and these appointments should normally be from a Trust within the Board area;
- The role of the designated doctor should include inter alia, membership of ACPC and provision of a range of expert advice to the Board and liaison role with GPs and Trust named doctors and designated nurse;
- Each Health and Social Service Trust should appoint a named paediatrician, for child protection purposes and the guidance identifies in some detail the role and responsibility of such posts;
- Where hospital or community Trusts do not have sufficient medical expertise to fill such a role, they should nominate, by agreement, a doctor from another Trust to fulfil this role; and
- All Trusts, **including hospital Trusts**, should appoint a named nurse for child protection who should have a high level of skill and expertise in children's health and development, child abuse and arrangements for the safeguarding of children.

The new guidance is therefore clearer about the important role that designated doctors and nurses and named doctors and nurses have and sets this in a context of improved liaison arrangements, training and systems to ensure effective information exchange. This section of *Co-operating to Safeguard Children*, if properly implemented by Boards and Trusts and augmented by ACPC guidance, should result in better and clearer professional liaison arrangements and a higher profile for child protection within A&E and the NHS in general.

The only recommendation we would make is as follows:

**In line with the requirements in *Co-operating to Safeguard Children*, ACPCs should consider the periodic auditing of professional liaison arrangements for child protection in A&E departments to ensure compliance with the new guidance and to identify any issues arising.**

# Conclusion

A&E departments play a pivotal role in child protection and their importance as the first point of contact, for many injured children cannot be understated. Research has shown that the diagnosis of child abuse in the context of A&E departments is difficult and retrospective studies would tend to suggest that a proportion of cases are not recognised as being caused by abuse and hence not reported.

This study was a small postal survey responded to by senior nurses and doctors in A&E departments in Northern Ireland. The response rate of 47% was good by social research standards and while the results give some indication of child protection practice in local A&E, it leaves unanswered practice in the majority of departments.

The survey was adapted from one that was developed by Dr Peter Sidebotham for use in England and Wales and examined a number of key issues and questions around ACPC procedures, checklists, use and access to the Child Protection Register, induction and training and professional liaison arrangements. It did not seek to raise or answer all questions about child protection in A&E, but despite its focussed nature did generate some insights and significant further questions about safeguarding arrangements as well as a number of key recommendations. These may have applicability for other setting such as after-hours GP services and minor injury units. The survey was also timely in that its write-up co-incided with the publication by Lord Laming of his Inquiry Report into the tragic death of Victoria Climbié. There is considerable resonance and overlap between aspects of Lord Laming's Report and the findings of this study and it is our hope that the recommendations will produce a useful addition to work that will be ongoing in Northern Ireland aimed at improving child protection interfaces between health and social services.

**A summary of recommendations is as follows:**

## **GUIDANCE**

The DHSSPS in conjunction with ACPCs consider the development of standardised regional guidance (which include the provision of checklists) on the diagnosis and recognition of child abuse and this is provided to frontline medical staff in A&E.

## **CHILD PROTECTION REGISTER**

There should be a consistent system for staff in A & E departments to check the Child Protection Register on children for whom they have concerns about abuse or neglect; and

When checks are made by A&E staff, irrespective of the children's status, these should be recorded by social services.

## **INDUCTION AND TRAINING**

All A&E departments, in conjunction with ACPCs, should ensure that staff receive induction and mandatory training in relation to child protection and that this includes local child protection arrangements and procedures.

The DHSSPS in conjunction with Boards and ACPCs should examine existing child protection training arrangements for A&E staff with a view to ensuring a regional standard and consistency for all newly qualified staff. This should include discussion with the NI Council for Postgraduate Medical and Dental Education, the Northern Ireland Practice and Education Council for Nursing and Midwifery and respective professional colleges.

#### **PROFESSIONAL LIAISON ARRANGEMENTS**

In line with the requirements in Co-operating to Safeguard Children, ACPCs should consider the periodic auditing of professional liaison arrangements for child protection in A&E departments to ensure compliance with the new guidance and to identify any issues arising.

# Appendix I

## MEMBERSHIP OF PROJECT STEERING GROUP

Margaret Kelly	Assistant Director – Policy Barnardo's
Maurice Leeson	Assistant Director – Strategic Development Barnardo's
Dr John Glasgow	Consultant Emergency Paediatrician RBHSC/ Hon Reader, QUB
Julie Healey	Policy and Research Officer Barnardo's
Eilis McDaniel	Child Care Unit DHSSPS
Colin Reid	Policy Advisor NSPCC
Chris Walker	SSI to Feb 2002
Ken Wilson	SSI from Dec 2002

# Appendix 2

## A SURVEY OF CHILD PROTECTION IN A&E DEPARTMENTS

Thank you for taking a few minutes to complete the questionnaire. Please answer as much as you feel able to. All responses will be treated in the strictest confidence. Please return the questionnaire in the enclosed stamped, addressed envelope. If you would like a copy of the results, please complete your name and contact details below.

- 1 Does your department have a written protocol for management of suspected child abuse?**

Yes / No

Please forward a copy

- 2 Are local Area Child Protection Committee procedures available in the department?**

Yes / No

- 3 Is the Child Protection Register checked for children attending the department?**

\* .....

- No
- Yes – all children
- Yes – children in whom there are suspicions  
\*Please specify what would trigger this

- 4 If so, is this:**

- A list kept in A&E
- A database accessible from A&E
- By telephoning the register

- 5 Who is responsible for checking the Child Protection Register within your department?**

Please Specify.

.....

- 6 Has that person had occasion to check the Child Protection Register from another Trust/Board area?**

Yes/No

**7** If yes to the above, did they experience any access problems?

If yes, please specify.

.....

.....

.....

.....

.....

.....

**8** Does your department have a checklist of concerning presentations?

Yes / No

**9** If yes, could you please list or forward the items on your checklist.

.....

.....

.....

.....

.....

.....

**10** Does your department have a lead professional for child protection ?

- Yes – doctor
- Yes – nurse
- No

**11** Are there clear procedures for contacting the Trust named doctor and named nurse for child protection?

- Yes, named doctor
- Yes, named nurse
- Neither

**12** Who is the first point of contact if a staff member has a child protection concern

- Senior nurse A&E
- Senior doctor A&E
- Paediatrician
- Hospital social worker
- Other social worker
- Other please specify .....

**13 Are there arrangements in place which facilitate regular liaison on child protection issues?**

Yes / No

**14 If so, please specify who liaison is with and how frequently this occurs**

.....  
.....

**15 Does your department have a training programme in child protection?**

- Yes, regular
- Yes, ad hoc
- No

**16 If so, who participates?**

- Nursing staff
- Medical staff
- Non-clinical staff

**17 Do new staff receive child protection training as part of their induction?**

- Yes, nursing staff
- Yes, medical staff
- Yes – Non-clinical staff

**18 Please complete your title and grade**

.....

**19 How many years have you been in post? .....**

**20 Is your department**

- A general A&E
- A children's A&E

**Any other comments?**

.....  
.....  
.....

Please return in the enclosed envelope to:  
Caroline Weir; NSPCC, Jennymount Court, North Derby Street, BELFAST BT15 3HN.  
cweir@nspcc.org.uk

If you would like to be informed of the results of this survey, please complete your name and contact details below.

# Appendix 3

Date as Postmark

Dear

Last year Barnardo's and NSPCC jointly published the '*Children's Manifesto*' which consisted of a series of policy and legislative initiatives we believe would produce better outcomes for children in a whole range of ways. One section of the Manifesto dealt with child protection and we argued for the need for more sophisticated child protection procedures in A&E departments. This was around process and procedures prior to the actual diagnosis of possible non-accidental injury and included, for example, such issues as training for A & E staff, protocols and the use of checklists.

Earlier this year we approached Dr Peter Sidebotham, Consultant Paediatrician and Designated Doctor in Child Protection in Avon Health Authority, who was preparing to carry out research in this area in England and Wales. Dr Sidebotham has very kindly agreed to allow us to extend his study to Northern Ireland and to do an analysis of the results. This has a number of possible benefits, which include:-

- Facilitating benchmarking of current practices in Northern Ireland
- Identification of any suggested gaps or differences in practice
- A cross jurisdictional comparison

The survey is being sent to all lead A & E Consultants and Sisters in Casualty Departments in Northern Ireland. It is completely anonymous although we will be very happy to make the findings available to all those who wish to see them. Barnardo's and NSPCC have received assistance and endorsement in the development of this project from Doctor John Glasgow RBHSC, the DHSSPS and Social Service Inspectorate.

We have included a short questionnaire and letter of explanation from Dr Sidebotham and we would be very grateful if you could take a few moments to complete it in respect to the practice in your own hospital. If there are any questions you have about the questionnaire or you wish to discuss the matter further please feel free to contact either of us. We enclose a stamped addressed envelope for returns.

Thank you once again for your help and assistance.

Yours sincerely,

**Lynda Wilson**  
Director of Children's Services  
Barnardo's  
Northern Ireland  
542 Upper Newtownards Road  
Belfast BT4 3HE

**Ian Elliott**  
Acting Director  
NSPCC [NI]  
Jennymount Court  
North Derby Street  
Belfast BT15 3 HN

# Appendix 4

Dear Colleague

Survey of child protection procedures in A&E departments

With the Victoria Climbié inquiry currently in the news, child protection is very much in the public and media awareness. Health professionals working in A&E departments often find themselves in the front line with possible child abuse cases, and as such can feel professionally vulnerable. Since publishing the results of an audit of child protection procedures in an A&E department in 1997 (BMJ 1997; 315: 855-856), I have received numerous requests for information or advice from individuals trying to set up appropriate procedures in their own department. It seems that most departments face the same dilemmas of a lack of any evidence base, or examples of good practice.

I am sure that there is a lot to be gained by sharing information and examples of how different departments work. In order to facilitate this, we are undertaking a survey of accident and emergency departments throughout the UK, and would be very grateful if you could take a few minutes to complete and return the enclosed questionnaire. Once collated and analysed, we will aim to publish these results and to feed them back directly to all participating departments. The survey has been endorsed by the British Association for Accident and Emergency Medicine, the Child Protection Interest Group of the Royal College of Paediatrics and Child Health and the Inter-Collegiate Advisory group on A&E Services for Children.

Thank you very much for your help.

Yours faithfully

Dr Peter Sidebotham  
Consultant Paediatrician





**NSPCC** <sup>TM</sup>  
NORTHERN IRELAND  
**Cruelty to children must stop. FULL STOP.**

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