Working together to protect children: who should be working with whom?

Alan Craft

Paediatricians and others involved in the area of child protection must work together with other professionals

Children have always been subjected to abuse and it is possible to read about the dreadful, by today's standards, things which befell them throughout history. Western society changed its attitude during the 19th century partly prompted by the graphic descriptions of Charles Dickens and other great writers of the day. Yet little was done about abuse of children until the famous case of Mary Ellen Wilson in New York in the 1860s. Mary Ellen was persistently beaten and abused by her adoptive parents. Although the abuse was widely known about amongst the local community, it was impossible to get the police to prosecute the parents, as the rights of parents to chastise their child were sacrosanct. There were no laws to protect children from such abuse but eventually the Society for the Prevention of Cruelty to Animals were persuaded to use the animal protection laws on the grounds that Mary Ellen Wilson was a member of the animal kingdom and, therefore, should be protected. Mary Ellen was removed from her parents and very soon afterwards in 1871 the Society for the Prevention of Cruelty to Children was formed in New York, followed soon afterwards by the National Society for the Prevention of Cruelty to Children (NSPCC) in the UK. Yet it was not until Henry Kempe in 1962¹ described "the battered child syndrome" that child protection really gained momentum.

Throughout the latter part of the 20th century there were many high profile cases of deaths of children following mistreatment, including that of Maria Colwell. There were a lot of official enquiries and most highlighted the fact that opportunities to intervene had been missed, very often because of poor communication between professionals. The recognition that children could also be sexually abused led to the enquiry into how child sexual abuse was handled in Cleveland, which led on to the Children Act of 1989² and to the Department of Health's guidance on the practical aspects of investigating and managing suspected child abuse and its prevention. *Working*

together to protect children was published in 1989³ with the hope that high profile tragedies such as that of Maria Colwell⁴ would never occur again, but of course they did. The enquiry by Lord Laming found numerous opportunities during Victoria Climbié's short life where intervention could have made a difference. The report made many recommendations and many of these were to do with professionals working together.⁵ Once again the government responded with a revision of the Children Act and the Department for Education and Skills published a new guide for interagency working to safeguard and promote the welfare of children, *Working together to safeguard children*.⁶ This has been accompanied by the replacement of Area Child Protection Committees (ACPCs) with Local Safeguarding Boards. Similar updates to child protection procedures have been made in Scotland, Wales and Northern Ireland.

It is clear that professionals must work together and in particular health professionals must work with each other and with social workers. But there are many other interactions between professional groups, and of course parents and the public, which are essential if we really are going to make Victoria Climbié England's last great child protection scandal. A recent survey of the implementation of the healthcare recommendations in the Laming report has shown some improvement, but many acute Trusts in England are still not fully complying with the new standards.⁷ So what else can be done to help protect children?

In spite of the fact that child protection is an essential part of all paediatricians' everyday work, it has not been systematically well taught to our trainees. The Royal College of Paediatrics and Child Health (RCPCH) is beginning to rectify this situation and is producing a series of training packages. These will be aimed at various different levels, but the most important point is to ensure that the correct steps are taken in the first contact with a possible abused child. It is equally

important to ensure that the wrong thing is not done. The course is based around the principles and methodology of the Acute Life Support package of training and provides essential first steps.⁸ It is currently being implemented across the UK and is being well received. However, it is very labour intensive as it requires large numbers of trainers all of whom have themselves to be trained. Time in busy schedules has to be allocated for this to happen. It is too early yet to know what difference this will make, but early signs are very favourable. The programme is attracting considerable interest from overseas and the RCPCH is now working with the Indian Academy of Paediatrics to develop a similar programme for that country's vast population of children. If trainees are basically competent, then they should have the confidence to do what is correct for vulnerable children. Higher level training programmes are also being developed.

The recent publication of *Working together to safeguard children* has provided the overall strategic framework but day to day guidance on how to manage suspected abuse has been developed by the RCPCH Child Protection Committee. The *Child protection companion*⁹ is a handbook giving guidance which, if followed, should protect both children and professionals. When things have gone wrong in the past, it has often been because basic procedures have not been followed. The handbook has been written by leading experts in the field and extensively reviewed from both the medical and legal standpoint.

One of the real issues in child protection is a lack of an evidence base both for diagnosis of abuse and for management. The former is being addressed by the excellent evidence based reviews being undertaken by the Department of Child Health in Cardiff led by Professor Jo Sibert and Dr Alison Kemp with the financial backing of the NSPCC. Dating of bruises and fractures, much needed by police and the courts, has been found to be a much less precise "science" than previously thought.¹⁰

Sharing information about vulnerable children is an area which can lead to huge problems. Again this was highlighted by Lord Laming and is a core theme running through many child protection enquiries. In 2004 the RCPCH produced guidance on the *Responsibilities of doctors in child protection cases with regard to confidentiality*.¹¹ Patient confidentiality is one of the key factors of all medical practice, but in the area of child protection it seems even more complex than in other areas. The fundamental principle around information sharing is that the child's needs are

paramount and this approach together with a knowledge of legislation should help to bring some clarity to this difficult area. In England there is a huge investment in information technology for the NHS – Connecting for Health.¹² As part of this there is to be a central “spine” on which basic information about the entire population will be available. Safeguards are being put in place to ensure that access is only given to appropriate individuals. Potentially this ought to be a very powerful tool in tracking vulnerable children through their various professional contacts and would be even more powerful if it could be linked to education and social services records using a single identifier. However, there is much public debate about whether people need to opt in or can opt out of having their personal information on this spine. The current thoughts seem to be that an opt out would be most workable. But where children are concerned there are very few reasons why parents or carers should be allowed to opt out on behalf of their children. This is a very emotive area, but paediatricians must become involved in the debate with the IT professionals and the public about how to best use this enormously powerful tool to protect children.

The recent history of child protection has been greatly influenced by several high profile cases of families who had two or more sudden infant deaths and where there was concern that these were homicides. One of the real underlying issues that has emerged is the inadequacy of investigation of apparent sudden infant death in many cases. Once a second baby has died in a family, a detailed post mortem is usually undertaken and if suspicious features are seen then the first death is reviewed. If the investigation on the first death was not detailed, then it may be impossible to correctly interpret what is going on in the family. This was recognised by the RCPCH and the Royal College of Pathologists and they commissioned Baroness Helena Kennedy to undertake a review of the investigation of sudden unexplained death in infancy (SUDI). The main conclusion¹³ was that every apparent SUDI must be properly investigated at the time with a full investigation of all of the circumstances and a post mortem carried out by a paediatric pathologist or a forensic pathologist, both working to a standard protocol. The investigations which need to be done are all specified and if this system had been in place earlier, many of the cases which hit the headlines could have been correctly resolved at an earlier stage. At least 90% of all SUDIs have no explanation and are not homicides. It is

the right of all parents to have their baby's death properly investigated. They need to know why it happened and whether or not there are genetic factors which might affect future offspring. For the few cases where homicide is the reason, other children in the family need to be protected. Working together with pathologists and other health care professionals is a vital part of the management of SUDI. As a part of the setting up of Local Safeguarding Boards there are to be reviews of all deaths, not only those in babies.

The recent high profile cases of mothers accused of murdering their babies has also highlighted the need to review the laws on infanticide. There has been a strong feeling in some quarters that the killing of a baby by the parent, usually the mother, should not be classed as first degree murder for which there is a mandatory life sentence. The experiences of two of the mothers recently jailed and then released have been chronicled in books and they graphically describe the treatment which they received from other prisoners.^{14 15} A major review of the homicide laws is currently being undertaken in England and after a lengthy period of consultation, to which paediatricians and others contributed, the Law Commission have recommended minimal change to the infanticide laws. In order to plead this defence a mother will have to admit that she killed her baby whilst suffering a mental illness as a result of the birth of the baby. If successful she would receive a non-custodial sentence and perhaps get the psychiatric help and support which she probably needs. However, many mothers protest their innocence, perhaps because they are genuinely unaware of what they have done. The proposed changes to the law would allow a judge to use their powers to allow an immediate appeal against a verdict of murder, before sentencing, where they thought there was compelling evidence that the mother was mentally ill.¹⁶ This could be a major step forward and once again is an example of different professionals working together to improve the law.

Awareness of the importance of working with judges and other members of the legal profession has developed over the last few years. A system of “mini pupillages” has been instituted where paediatricians and psychiatrists can sit with judges during child protection cases to try and better understand both sides. This is proving to be very beneficial, giving doctors more confidence to appear before a judge, which can be very intimidating for those who have little experience of this essential aspect of their professional lives.

Finally, working with politicians is important. When a family has been accused, rightly or wrongly, of abusing their children, then one of the avenues which they pursue to obtain redress is by contacting their local member of parliament. In the last few years this has been a particular issue around fabricated and induced illness (FII). There is still concern that this is not a real diagnosis and that parents are being falsely accused. Indeed questions are asked in parliament and debates reported in Hansard.¹⁷ It is important, therefore, for health care professionals to work with politicians to help them understand what parents can, and do, do to their children. We are currently going through a phase of denial similar to that originally encountered when Kempe first described the battered baby and that which occurred following the events in Cleveland which brought to the attention of all that sexual abuse of children does occur.

However, the final message for paediatricians and others involved in this difficult area of child protection is not only that you must work together with other professionals. It is even more important that you must not work alone. If you are a trainee then your consultant should always be consulted. But what if you are the consultant and you are uncertain? In the words of a current popular TV programme, “phone a friend”. No doctor, however senior, should be above consulting a colleague when they are not sure. Indeed the recently published consultation document on expert witnesses in child protection cases suggests that joint opinions should be the norm.¹⁸

Child protection is not something that should be a burden to paediatricians. It should be a satisfying area of clinical practice with a good measurable outcome with the child either restored to their own family or in alternative care arrangements. There can be few greater achievements than to see a child restored to an environment where they can grow and develop safely.

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The Working Time Directive

The implications of the Working Time Directive: how can paediatrics survive?

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The changes necessitated by the Working Time Directive are likely to be painful but can be ameliorated by careful planning

In August 2004 the Working Time Directive (WTD) came into force for doctors in training, imposing a maximum of 58 working hours per week with minimum rest requirements. The next challenge will be WTD 2009, which takes the maximum working hours down to 48.¹ For many of us trying to cope with service and training demands and achieve a reasonable work-life balance this may seem a step too far.

The WTD limit already applies to nurses and other National Health Service (NHS) staff including consultants and staff grade doctors. Doctors in training will no longer be exempted from the original WTD, now enacted in the UK as part of health and safety law as the Working Time Regulations (WTR).² The WTR specify maximum hours of work and minimum rest periods based on the SIMAP³ and Jaeger⁴ judgements in the European Court of Justice. All time spent resident in the hospital, even if sleeping, is to count as working time for the purposes of the directive. Taken in conjunction with the New Deal,⁵ working time is limited to 13 h in any 24 with at least an 11 h rest between shifts. These constraints are of particular importance in rota design when providing 24 h emergency cover. An absolute minimum of eight practitioners is currently required to run a basic full shift system. A rota "cell" model⁶ using at least 10 doctors has been proposed to give extra cover for periods of peak activity and facilitate

greatly improved handover. When the 48 h week is implemented, a rota cell of even 10 doctors will be under considerable pressure, further limiting time for experience in clinics and other non-acute work.

There are several radical changes taking place simultaneously within the NHS, even more than envisaged in the RCPCH report by Professor Sir David Hall in 2002.⁷ The most significant in relation to the WTR are the Changing Workforce agenda¹ and Modernising Medical Careers (MMC).⁸ MMC implementation will strictly limit the number of training places in each specialty with the intention of supplying estimated future workforce needs. Training will be more structured and focussed to include specific assessments of competence. These must be verified and documented.^{8,9} Most training and assessment will be done within the workplace and all within working hours in the context of reduced contact time between consultants and trainees. Consultants are also increasingly expected to deliver service personally and to meet increasingly challenging service targets.

NEONATAL SERVICES

An additional pressure for paediatrics is the Department of Health review of newborn services.¹⁰ This defines three different levels of newborn care and staffing requirement. Level 3 (full intensive care) requires two tiers of cover separate from

general paediatrics; level 2 (high dependency and short-term intensive care) requires one separate basic tier but allows sharing of the middle tier with general paediatrics. Level 1 (special care and emergency resuscitation) is essentially nurse led and does not require any separate medical cover from general paediatrics. Whether level 1 is generally viable when separated from paediatrics as in the Ashington model is still open to debate.¹¹

The following scenario is typical of the current and emerging difficulties in the neonates and obstetrics services.

Take three hospitals (A, B and C) within a radius of 10 miles, serving a combined population of 800 000 and with a combined delivery rate of 11 500 per annum. Each of the three hospitals currently has acute in-patient paediatrics. High-risk obstetrics is practiced on all three sites. A level 3 neonatal unit is justified in one of the hospitals (A) and a level 2 neonatal unit is required on each of the remaining two sites (B and C) to provide cover for the maternity services.

To cover general paediatrics and neonates, hospital A will require two basic and two middle grade tiers for 24 h cover. Hospitals B and C will each require two basic and one middle grade tier. For legal rotas, each tier currently requires a minimum of eight doctors. Therefore, together the three hospitals require a minimum of 48 basic level practitioners (advanced nurse practitioners (ANPs) or paediatric trainees) and 32 middle level practitioners to run all three hospitals. In 2009 the numbers will increase to 60 at the basic level and 40 at the middle level.

This level of staffing is unlikely to be practical or affordable. Numbers of specialty trainees and trained nurse practitioners will be limited. The population could not realistically provide enough experience for all those doctors in training.

Abbreviations: ANP, advanced nurse practitioners; MMC, Modernising Medical Careers; NHS, National Health Service; WTD, Working Time Directive; WTR, Working Time Regulations