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Child protection procedures in emergency departments

P Sidebotham, T Biu, L Goldsworthy


Background: Emergency departments (EDs) may be the first point at which children who have been subject to abuse or neglect come into contact with professionals who are able to act for their protection. In order to ascertain current procedures for identifying and managing child abuse, we conducted a survey of EDs in England and Northern Ireland.

Methods: Questionnaires were sent to the lead professionals in a random sample of 81 EDs in England and 20 in Northern Ireland. Departments were asked to provide copies of their procedures for child protection. These were analysed qualitatively using a structured template.

Results: A total of 74 questionnaires were returned. 91.3% of departments had written protocols for child protection. Of these, 27 provided copies of their protocols for analysis. Factors judged to improve the practical usefulness of protocols included: those that were brief; were specific to the department; incorporated both medical and nursing management; included relevant contact details; included a single page flow chart which could be accessed separately. 25/71 (35.2%) departments reported that they used a checklist to highlight concerns. The most common factors on the checklists included an inconsistent history or one which did not match the examination; frequent attendances; delay in presentation; or concerns about the child’s appearance or behaviour, or the parent–child interaction.

Conclusions: There is a lack of consistency in the approach to identifying and responding to child abuse in EDs. Drawing on the results of this survey, we are able to suggest good practice guidelines for the management of suspected child abuse in EDs. Minimum standards could improve management and facilitate clinical audit and relevant training.

Field each year around 3.5 million children pass through emergency departments and other ambulatory care settings such as walk in centres. Some of these children may present with non-accidental injuries, or with non-intentional injuries or illnesses that have nevertheless occurred within an abusive or neglectful context for the child. Emergency departments may be the first point at which such children come into contact with professionals who are able to act for their protection. Child maltreatment encompasses a spectrum both in terms of types and severity of abuse experienced. It is recognised, however, that many children who go on to experience more serious forms of abuse, including the small numbers experiencing fatal maltreatment, will have had previous contact with health services. The government document, Working Together, places a responsibility on health professionals to identify and respond appropriately to suspected abuse and neglect. Distinguishing those children whose circumstances may require further investigation from the majority with genuine accidental injuries can be a difficult task that is compounded further by the stresses and constraints inherent in a busy department striving to meet national targets for care.

Although there is a large body of research on risk factors for child abuse and on primary prediction and prevention, there is less published research on early indicators of abuse or procedures for detecting and responding to abuse in emergency care settings. Some previous attempts have been made to combine these indicators into screening tools that can be used in accident and emergency (A&E) departments to improve the recognition of child abuse. Some audits have shown that clear protocols with a simple flowchart, backed up by training and liaison, can lead to increased awareness, consideration and documentation of intentional injury and improved effective social service referral. However, other audits have failed to show any significant improvement. A recent national survey of A&E departments showed that over 90% of departments do have written protocols for child protection. However, our perception, based on discussions with colleagues in child health and emergency medicine, is that there remains a great deal of uncertainty around their use and the guidelines in use are not based on empirical evidence.

The aims of the research were to document the range of information available to guide current practice in the management of child protection in emergency departments; to identify models of good practice; and to suggest ways in which departments can improve and clarify guidance given to staff.

METHODS

Questionnaires (appendix 1) were sent out addressed to the lead nurse/consultant in a sample of 81 emergency departments in England, selected randomly from a list provided by the British Association of Emergency Medicine, to provide a 20% sample of all departments. Questionnaires were also sent to all 20 emergency departments in Northern Ireland. Respondents were asked to return an anonymous completed copy of the questionnaire, along with a copy of their protocol if available. The returned protocols were scrutinised by all three authors using a structured proforma (appendix 2) looking for emerging themes, consistent threads, examples of good practice and any discrepancies within the key areas outlined below. Nine randomly selected protocols were read by a second reviewer to check for internal consistency; these indicated that the three reviewers were identifying the same themes and conclusions from their reviews. All three researchers compared notes to highlight the key features in the protocols along with both good and areas for improvement.

This research was supported by the National Society for the Prevention of Cruelty to Children (NSPCC) in Northern Ireland, who wanted to undertake a more thorough review of child protection procedures in Northern Ireland. Resource constraints meant we were unable to include all departments in England, or to access departments in Scotland or Wales.
and bad points arising from them. From these reviews, a series of recommendations were developed by consensus among the authors.

**RESULTS**

A total of 74 questionnaires were returned, 17 from Northern Ireland and 57 from England. Forty-five questionnaires were from general emergency departments, six from children’s emergency departments and 20 from minor injuries units. Three questionnaires were incomplete and have been excluded from the analysis.

**Procedures**

Sixty-three of 71 departments (88.7%) had written protocols for child protection, although only 27 of these supplied a copy, some of which consisted simply of pages copied from the Area Child Protection Committee (ACPC) procedures. The protocols returned showed a large variation in size (from 1 to 93 pages), format and content, and this significantly affected the ease of accessing relevant information. The most helpful were those that focused more on direct management, with only small amounts of background information, presented in short, numbered paragraphs and with an index, subheadings or other system of pointers. Seven protocols incorporated a single page flowchart, most of which were helpful, although some were too complicated to be of practical use. The majority of protocols were intended for both medical and nursing staff and this was considered to be helpful. Very few included quality measures such as date, author or sources of information.

**Roles and responsibilities**

Few protocols clearly outlined the roles and responsibilities of different staff groups. A common theme in many was the hierarchical approach with nurses being expected to refer their concerns to doctors, junior doctors to consultants, and emergency staff to paediatricians. Very few emphasised that each individual has a responsibility for the welfare of children. Several protocols included contact details, most commonly for the named or designated professionals; paediatricians or community paediatricians; the child protection register and social work departments. Forty-nine of 71 departments (69%) were able to identify lead professionals for child protection, of which 12 listed a lead doctor, 23 a lead nurse, and 14 both. Fifty-five departments (77.5%) reported that there were opportunities for regular liaison on child protection matters, but these varied in both frequency and in the personnel involved. Forty-one departments provided details of frequency, 12 having at least weekly liaison, 24 having liaison less than once a month or only on an ad hoc basis, and the remainder between weekly and monthly. The most common professional to provide liaison was a nurse practitioner or specialist nurse (13/51, 25.5%).

**Identification of children at risk**

Overall there was a lack of clarity about the purpose and appropriate use of indicators of concern. Twenty-five of 71 (35.2%) departments reported that they used a checklist to highlight concerns. Only nine respondents reported the factors they would use to highlight concerns (table 1). The median number of items listed was 7 (range 5–14). A large number of the protocols returned included long lists of signs and symptoms of abuse (up to 68 separate factors in one protocol), with no guidance on how to use these. Those felt to be of more practical value included a short (up to 8 items) checklist, with clear guidelines on what to do if concerns were identified. Some indicators were very specific (for example, “children under 1 year with a fracture, burn or scald”), while others were more descriptive (for example, “the parents’ behaviour gives rise to concern”). One included recognised risk factors (for example, teenage parents, low income, or prematurity) as well as signs and symptoms, but gave no indication on how these were to be interpreted. The majority of departments (47/71, 66.2%) checked the child protection register if there were suspicions for a particular child, and 38 specified reasons for doing so (table 1). Sixteen departments (22.5%) checked the register for all children and eight (11.3%) did not check it at all. Twenty-five departments checked a database or list kept in the department, while 30 used a telephone check, and nine a combination of these. In the protocols supplied, there was often some confusion about how and when to check the child protection register, or on what to do following a positive result.

**Referral process**

This was the strongest element of most protocols, though surprisingly totally lacking from four and unclear in a further five. Those protocols supplied by walk in centres or minor injuries units limited their referral pathway to sending the child to the main emergency department. A few emphasised the importance of backing up referrals in writing, but few included any subsequent check of management. Some protocols incorporated safeguards—for example, action to take if a child is taken from the department; informing the locality manager or child protection nurse of all attendances; or information on contacting the social worker or police urgently if the child is perceived to be at immediate risk. A number of protocols specified different pathways according to the level of concern (for example, child in need/possible child abuse/definite child abuse) either in the body of the protocol or in a flowchart.

**Subsequent management**

The most common aspects of subsequent management incorporated in the protocols were guidelines on documentation, details on informing primary care, and action around discharge. However, most protocols provided very little detail beyond initial recognition and referral. Very few included any mention of dealing with the child’s presenting complaint, or assessing their medical needs first. One protocol inappropriately commented that nurses should not undertake treatment of any injuries. None gave any details on management in cases requiring admission and very few on closing the case if concerns are not verified.

**Interagency working**

This did not always feature highly and was not always clear. Some protocols made no mention of social services at all. Some

<table>
<thead>
<tr>
<th>Item</th>
<th>Number (%) listing as a reason for checking the child protection register (n = 38)</th>
</tr>
</thead>
<tbody>
<tr>
<td>On child protection register</td>
<td>9 (100)</td>
</tr>
<tr>
<td>Inconsistent history</td>
<td>7 (77.8)</td>
</tr>
<tr>
<td>Delay in attendance</td>
<td>7 (77.8)</td>
</tr>
<tr>
<td>Parent-child interaction</td>
<td>6 (66.7)</td>
</tr>
<tr>
<td>Child’s appearance/behaviour</td>
<td>5 (55.6)</td>
</tr>
<tr>
<td>History and examination do not match</td>
<td>4 (44.4)</td>
</tr>
<tr>
<td>Direct allegation</td>
<td>4 (44.4)</td>
</tr>
<tr>
<td>Injuries of different ages</td>
<td>3 (33.3)</td>
</tr>
<tr>
<td>Frequent attendance</td>
<td>3 (33.3)</td>
</tr>
<tr>
<td>Other features in history</td>
<td>6 (66.7)</td>
</tr>
<tr>
<td>Other features in examination</td>
<td>7 (77.8)</td>
</tr>
</tbody>
</table>

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Table 1: Items on checklists

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gave helpful advice on early liaison with social services, the
importance of joint planning and ongoing information sharing.
One protocol repeatedly emphasised that staff should not share
information with other agencies until this had been approved
by senior managers or professionals. Some of the protocols
provided helpful details on how to prepare a report for a case
conference or statements for the police.

**Information sharing, consent and confidentiality**
No protocols clearly set out guidelines on information sharing,
very few gave any details on consent, and none mentioned confidentiality. The few that did give details limited this to
reminding staff of the importance of explaining concerns and
action to the accompanying adult, but also did not give
guidance on when it is not appropriate to do so. One protocol
specifically stated that “The parents should not usually be told
that [child abuse] is the reason for admission”. One protocol
gave helpful guidance on what to do if consent to examination
is not given.

**Evidence of a child centred approach**
There were few protocols that retained an emphasis on the
welfare of the child and none that gave any specific guidelines
on listening to the child. The inclusion of a clear statement early
on in a few of the protocols did, however, convey a child
centred approach. These included statements emphasising that
“the welfare of the child is paramount” or that “children are
vulnerable”. Other helpful points were consideration of the
environment, providing a quiet private room with toys
available. Only two mentioned the importance of abuse in
disabled children, and none referred to cultural, ethnic or
gender issues.

**Other features**
Some protocols had information on the management of specific
issues, including alleged sexual abuse and the taking of forensic
samples; possible fabricated or induced illness (Munchausen
syndrome by proxy); unaccompanied children; domestic
violence; and parental mental illness. These were most helpful
when they were included in separate, and therefore identifi-
able, headed sections.

**DISCUSSION**
Maximising the recognition of children at risk and optimising
any subsequent response within emergency department set-
tings is a priority that can be enhanced by promoting
recognition and development of clear, standardised, accessible
procedures. Such procedures should accord with both national
and local guidelines, allowing for consistency in standards,
while remaining locally relevant. This representative survey of
procedures in emergency departments has enabled identifica-
tion of good practice around the country, provides pointers
towards developing robust local protocols, and suggests some
quality standards for the development of such protocols
table 2). These quality standards have been developed by
consensus among the authors and reflect our opinions based on
the review of supplied procedures. We have not been able to
identify any clear evidence base to support these recommenda-
tions, and further research is needed to evaluate their validity
and usefulness.

For any child attending an emergency department, the first
responsibility of the staff is to attend to that child’s needs.
Medical treatment, including treatment of injuries and admin-
istration of analgesia, should not be delayed because of
concerns about possible child abuse or neglect.

Where concerns about possible abuse or neglect are
identified, the lead agency for investigation is social services;¹

There should be clear lines of referral and responsibility in
place, emphasising that all staff members have a responsibility
to protect children. Consideration should be given to different
responses according to the level of concern including clear
procedures for responding to situations where a child, other
family member, staff member or member of the public is
potentially at immediate risk of harm. There should be clear
procedures to be followed in the case of admission to a ward,
which include full handover and transfer of responsibilities;
and also for children who are discharged from the department,
including arrangements for follow up and for notifying the
primary care team and other relevant professionals. For minor
injuries units and other small units, procedures need to be in
place to facilitate good liaison between the small unit and any
larger referral unit providing support and secondary care. While
the larger units may follow through on concerns, the referring
unit must take responsibility for ensuring that information is
passed on and received, and that concerns are acted on. This
may require safeguards to ensure that a child has attended the
main department, or for contacting social services directly in
cases of concern.

There is currently no scientific evidence to support the use of
screening tools or checklists in identifying children at risk of
abuse or neglect and no evidence from this or other studies to
inform which procedures are effective at identifying children at
risk. However, some early indicators are perceived by profes-
sionals to be suggestive (though not diagnostic) of abuse or
neglect.² If a checklist is incorporated, it should be simple and
specific, and staff should be reminded that they serve as an aide
memoire and not as a screening tool. Staff should also be
reminded of the importance of listening to the child.³ This may
involve both verbal and non-verbal forms of communication,
and consideration should be given to the age, developmental
stage and ethnicity of the child, along with any disability.

The presence of a child’s name on the child protection
register, or any other database, should not be used as an
indicator of risk, nor should it be used as the sole basis for
decision making in relation to possible concern, but is a
relevant additional piece of information and an important part
of understanding the full context of the child’s presentation.
Each child should receive an evaluation of the risks and
concerns identified through the presentation, and any action
should be based on such an evaluation. Nevertheless, for any
child in whom there are pre-existing concerns, an emergency
department attendance is a significant event (this may be
positive, indicating appropriate care on the part of the parents/
carers). In order to facilitate the flow of information to those
professionals working with the child and family, all emergency
department attendances should be notified to the child’s
primary care team. Recent government guidance recommends
that local authorities should no longer hold separate child
protection registers.⁴ Children about whom there are concerns
will still be subject to child protection conferences at which a
child protection plan will be put in place, but their names will
no longer be held on a separate register. Emergency depart-
ments will therefore need to work with their Local
Safeguarding Children Boards (LSCBs, formerly ACPCs) and
named professionals to put in place appropriate systems for
accessing and sharing information.

Effective child protection requires joint working of profes-
sionals from different agencies. Information sharing is essential
in order to fully evaluate and appropriately respond to possible
concerns. Staff should be encouraged to share concerns with
other agencies, to respond to requests for information in
relation to child protection, and to question other professionals
where there are differences in opinion.⁵ ¹⁸ ¹⁹ Advising staff not
to share information with other agencies is inappropriate and
must be approached in the same systematic and rigorous way. Lord Laming emphasised that “the investigation and management of a case of possible deliberate harm to a child”. In his report on the death of Victoria Climbie, Lord Laming made numerous recommendations on the appropriate investigation and management of suspected child abuse, many of which is being implemented within the health service.

CONCLUSIONS
This representative survey of child protection procedures in emergency departments has confirmed that most departments have operational protocols, but has highlighted a wide variation in the quality and appropriateness of those protocols. Some examples of good practice have been identified and the process of evaluating local protocols has informed some recommendations on good practice. In his report on the death of Victoria Climbie, Lord Laming emphasised that “the investigation and management of a case of possible deliberate harm to a child must be approached in the same systematic and rigorous manner as would be appropriate to the investigation and management of any other potentially fatal disease”.

Concerns about possible child abuse or neglect should normally be shared openly with the parents or carers unless to do so might further increase the risk to the child, or could compromise any criminal investigation. Consent to examination or any investigations should normally be obtained from a person with parental responsibility and from the child, providing he/she is competent to give such consent.

Table 2 Quality standards and recommendations

<table>
<thead>
<tr>
<th>Domain</th>
<th>Quality standards/recommendations for good practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of guidelines</td>
<td>All local protocols must concur with Local Safeguarding Children Board (LSCB) guidelines and with national guidelines (Working together to safeguard children; what to do if you’re worried a child is being abused). All protocols should indicate clearly the author(s); Trust and Local Safeguarding Board endorsement; date of publication; date for review; and any evidence base used. Protocols should be clearly laid out with appropriate subheadings and a contents or index to enable staff to identify information quickly. References and sources of further information should be clearly signposted. Protocols should be brief, ideally no more than 4 pages in length, with a single page flowchart summarising the procedure to be followed.</td>
</tr>
<tr>
<td>Child centeredness</td>
<td>The welfare of the child must be the prime consideration throughout any departmental protocol. For any child attending an emergency department, the first responsibility of the staff is to attend to that child’s needs. Medical treatment, including treatment of injuries and administration of analgesia, should not be delayed because of concerns about possible child abuse or neglect. Each department should have opportunities for regular liaison with an experienced child protection practitioner.</td>
</tr>
<tr>
<td>Roles and responsibilities</td>
<td>Protocols should incorporate both nursing and medical management. Child protection is everyone’s responsibility. All staff must be able to act on their concerns. There should be a clear description of different professionals’ additional responsibilities in relation to child protection. Staff should know who to contact if they have concerns about possible abuse or neglect.</td>
</tr>
<tr>
<td>Identification</td>
<td>There is currently no evidence that any screening tools help in the identification or management of child abuse. If a checklist is used to aid recognition of possible child abuse, it should be brief (no more than 8 items), specific and clear in its use. Staff should be reminded that a checklist may act as an aide-memoire, and should not exclude the use of clinical acumen. The presence of a child’s name on the child protection register, or any other database, should not be used as an indicator of risk, nor should it be used as the sole basis for decision making in relation to possible concern. It is nevertheless an important piece of information that may or may not be directly relevant to the presentation.</td>
</tr>
<tr>
<td>Referral process</td>
<td>If a member of staff has concerns about a child’s welfare, they should discuss these concerns with a senior colleague. If, following discussion with a senior colleague, concerns persist, the practitioner should refer the child to social services, following this up in writing within 48 h. There should be clear plans for emergency management if there are immediate concerns about the safety of a child, or if a child is removed from the department inappropriately.</td>
</tr>
<tr>
<td>Subsequent management</td>
<td>If a child needs admission to a ward, there should be clear procedures which include full handover and transfer of responsibilities. Do not assume that the initial concerns will be followed up by the inpatient team. No child for whom there are concerns about possible maltreatment should be discharged from the department without a clear plan of management, including appropriate follow up. For minor injuries units and other small units, procedures need to be in place to facilitate good liaison between the small unit and any larger referral unit providing support and secondary care; small units should be able to evaluate and act on child protection concerns in accordance with local LSCB guidelines.</td>
</tr>
<tr>
<td>Interagency working, information sharing, consent and confidentiality</td>
<td>Staff should be encouraged to share concerns with other agencies, to respond to requests for information in relation to child protection, and to question other professionals where there are differences in opinion. Concerns about possible child abuse or neglect should normally be shared openly with the parents or carers unless to do so might further increase the risk to the child, or could compromise any criminal investigation. Consent to examination or any investigations should normally be obtained from a person with parental responsibility and from the child, providing he/she is competent to give such consent.</td>
</tr>
</tbody>
</table>

Authors’ affiliations
P Sidebotham, Health Sciences Research Institute, University of Warwick, Coventry, UK
T Biu, Community Child Health, North Bristol NHS Trust, Bristol, UK
L Goldsworthy, Children’s Emergency Department, United Bristol Healthcare NHS Trust, Bristol, UK

Competing interest: None declared.
REFERENCES


APPENDIXES

Appendix 2: Qualitative analysis proforma

1. Procedures

Length and how long it takes to read the protocol. How easy is it to understand and to find relevant information? Is there a flowchart incorporated? Balance of information and management. Authors, dates and plans for review. Evidence base used. Sources of further information.

2. Roles and responsibilities

Are different staff roles identified? Does the protocol contain contact details? Is it clear who takes responsibility for decisions and actions?

3. Identification of children at risk

Approaches taken to identifying concerns; use of the child protection register; use of checklists.

4. Referral process

Is the referral process clear? Who is responsible? Any safeguards in place.

5. Subsequent management

Any guidelines on subsequent management, including admission and discharge, action plans, liaison with social services and primary care. Documentation. Supervision, training, audit.

6. Interagency working

Guidelines on working with other agencies, particularly social services and police.

7. Information sharing, consent and confidentiality

Any guidance on approaches to information sharing, consent and confidentiality. Who is responsible for any of these aspects.

8. Child centeredness

Is the welfare of the child clearly central to the protocol? Guidelines on listening to the child.

9. Other features

Are any other issues addressed? For example, fabricated and induced illness, sexual abuse, other specific forms of abuse.

10. Concordance with national and local guidelines

Is reference made to local and national guidelines? Does the protocol contain guidelines on subsequent management, including admission and discharge, action plans, liaison with social services and primary care? Documentation. Supervision, training, audit.

Appendix 1 Questionnaire sent to emergency department leads

1. Does your department have a written protocol for management of suspected child abuse? Please forward a copy

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

3. Do you check the child protection register for children attending the department?

4. If so, is this:

   A list kept in A&E

   A database accessible from A&E

   By telephoning the register

5. Do you have a check list of concerning presentations?

6. If yes, could you please list or forward the items on your check list.

7. Do you have a lead professional for child protection within the A&E department?

8. Do you know how to contact the trust named doctor and named nurse for child protection?

9. Who do you contact first if a staff member has a concern of a child protection matter?

   A designated named professional

   A designated named professional

10. Do you have any regular liaison on child protection issues?

11. If so, please describe who with and how frequently

12. Do you have a training programme in child protection?

   Yes, regular

   Yes, ad hoc

13. If so, who participates?

   Medical staff

   Nursing staff

14. Do new staff receive child protection training as part of their induction?

   Yes, medical staff

   Yes, non-clinical staff

15. Please complete your title and grade

16. How many years have you been in post?

17. Is your department...