Paediatrics and accident & emergency: learning from case reviews

Summary of risk factors and learning for improved practice for the health sector

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Introduction

Professionals in paediatric and accident and emergency (A&E) teams have a vital role to play in spotting and responding to some of the most severe forms of child abuse and neglect. Medical staff need to be able to recognise signs of child abuse and neglect and be clear about what action they should take if they are worried.

Reasons case reviews were commissioned

This briefing is based on case reviews published since 2013 which have highlighted lessons for paediatric and A&E teams in hospitals to improve safeguarding practice.

In these case reviews, children died or suffered serious harm in a number of different ways:

- non-accidental injuries
- child sexual exploitation
- physical and emotional neglect.
Key issues

The case reviews highlighted examples of good practice. They praised examples of effective inter-agency working and appropriate escalation of concerns to children's services. They also highlighted professionals' awareness of cultural sensitivities when treating children and families from different ethnic backgrounds.

However, the case reviews also highlighted a number of issues for learning:

**Dealing with each incident in isolation**

Dealing with incidents in isolation is particularly true in A&E where there is a high turnover of patients and medical teams may only focus on the immediate issue. Considering previous hospital admissions as well as the child and family's history and background can help professionals distinguish non-accidental injuries (NAI) from other medical conditions. It can also be vital in spotting patterns which indicate child neglect.

**Following up on missed appointments**

Missed medical appointments may indicate that parents and carers are struggling to provide adequate care to their child. It is particularly important that health professionals follow up missed appointments for vulnerable children who are the subject of child protection plans.

These case reviews flagged the issue of health professionals not having common policies or systems of patient recording. Without this shared view, it is impossible to identify patterns of missed appointments, inconsistencies and risk.

**Effective working with colleagues and other agencies**

Health professionals can have doubts about the approach of children’s social services, but they do not always challenge them due to the assumption that the social workers know best.

Within medical teams there can also be poor communication and escalation of concerns. Some reviews uncovered evidence of doctors over-estimating how well they had briefed doctors coming on duty.

In some hospitals only senior consultants can inform police of a child’s death in suspicious circumstances. Out-of-hours, this can lead to considerable delays in initiating investigations.
Focusing exclusively on the child’s physical health needs
Sometimes health professionals focus primarily on children’s physical health needs whilst ignoring the impact of emotional stress on some medical conditions. This is particularly true if the child is living with domestic abuse or a parent’s drug or alcohol dependency.

Being heavily influenced by assertive parents
Sometimes parents invent or exaggerate their children’s symptoms; their views should never replace a thorough examination of the child. If one parent has very strong opinions, there is also a risk that professionals are not listening to the child and other family members. Their views are critical in providing an holistic picture.

Assessing risks to children when treating parents/carers and siblings
Parents and carers can present in A&E with mental health difficulties, self-inflicted injuries or drug and alcohol-related problems. It is very difficult for A&E staff to make an on-the-spot assessment of risks to children if they are not present, they have limited contact with other professionals dealing with the family and there are no records available.

When treating a child who may have sustained non-accidental injuries, medical teams do not always make enquiries about other children at home who may need protection.

Considering child protection issues when treating teenagers
Not considering child protection and safeguarding issues when treating teenagers under the age of 18 was flagged as an issue, particularly in A&E. There was specific evidence of a lack of understanding of child sexual exploitation.

Access to medical records
A lack of key medical diagnostic services can lead to failure to quickly identify and respond to significant injuries suffered by the child. There can also be delays in taking photographs of injuries which can hamper child protection investigations.

Learning for improving practice

Being aware of and responding to safeguarding concerns
• Establish a system for flagging children subject to child protection plans to A&E staff.
• Develop documentation which prompts an assessment of the social history and background of the child and their family. Train staff in how to ask these questions.
• Make sure that GP lists are available to medical staff.
• Professionals should document they have read and understood the nature of safeguarding concerns about the child they are treating.
• Record discussions which take place during a medical supervision meeting where safeguarding concerns are identified.
• If there are safeguarding concerns about the child receiving treatment, consider any risks to their siblings.
• Use peer review to ensure medical staff are responding appropriately to safeguarding concerns.
• All staff should be prepared to act promptly if there are child protection concerns and not delay by deferring to senior/named colleagues, particularly out-of-hours.
• Be aware of safeguarding responsibilities for 16 and 17-year-olds.

Identifying non-accidental injuries (NAI)
• Be aware of the significance of bruising on non-mobile babies and the importance of referring such cases to children’s social care with full and accurate information.
• Be aware of correct procedures in the event of a GP (or other) referral of suspected non-life threatening NAI.
• Take clinical photos as near to the time of injury as possible to record the greatest detail – include the photos in all formal child protection reports.
• Make all necessary diagnostic tools available to children whenever required, including out-of-hours.
• It is not always good practice to have separate paediatric and child protection examinations – it can be distressing for an older child to be examined more than is necessary.

Challenging other agencies about child protection concerns
• Train medical staff in how to recognise when it is necessary to challenge other agencies about child protection concerns.
• Ensure there are policies and procedures for challenging other agencies and that everyone is aware of what these are.

Discharging children and following up missed appointments
• Liaise with health, police and social care about arrangements for discharge and after-care of vulnerable children. Involve parents in these discussions.
• Consider the impact of a discharge made late in the evening on a very young child.
• Assess and interpret parental avoidance and always follow up missed appointments if the child is subject to a child protection plan.

Responding to the death of a child

• If there is a suspicion a child has died in unlawful circumstances, contact children’s social care and take action to safeguard any remaining siblings immediately.
• A thorough examination of the body by a senior doctor must take place with the examination findings recorded on a body chart (including any post mortem changes).
• Always take a detailed history of the circumstances leading up to the death from parents when police officers are present.

More ways to help you protect children

Take our Level 4 safeguarding training for names health professionals.

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Read more learning from case review briefings.