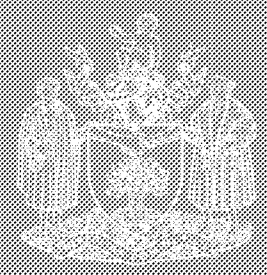


An investigation into
the nature and impact
of complaints made
against paediatricians
involved in child
protection procedures

January 2007



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**Dr Jackie Turton
Linda Haines**



Royal College of Paediatrics and Child Health
www.rcpch.ac.uk

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Foreword

This report is an effective and sobering review of the experiences of many paediatricians in relation to complaints arising from child protection work. A survey carried out by the RCPCH demonstrated that many paediatricians had experienced complaints which had been handled through the hospital system and some of which had been made directly to the General Medical Council (GMC). Only a tiny proportion had been taken forward by the GMC, or indeed been upheld in any other way. This is not to say that the complaints were completely unjustified or unfounded and we must recognise that they arose from real concerns of the parents and in some cases were a reaction to the difficult situation in which they found themselves. The aim of this document is not to question the validity of the complaints, but an attempt to describe how paediatricians felt on receiving such a complaint and how they dealt with this. This report contains some powerful and evocative real-life case vignettes. The recommendations in this report are aimed to offer some strategies in minimising the risk of complaints and handling better those complaints that are inevitable.

There are many issues that underlie such complaints, some of which are common to all medical complaints, and some which are specific to issues around working in child protection in general. We have tried to draw lessons from the experiences described here. Paediatricians need support and the College has been criticised in the past for not providing this. We must accept that we previously appeared less than supportive of colleagues and we need to correct this. Nevertheless, a great deal has previously been done, both behind the scenes and overtly, and we will continue this trend.

This report has been the results of qualitative research conducted by our Research Division under the leadership of Professor Neil McIntosh and Linda Haines. Dr Jackie Turton was commissioned to do the work and we owe her a great debt of gratitude. We also owe a debt of gratitude to those who have read the report and made contributions in developing the final draft.

The recommendations are based on the College's response to the findings of the research and have been produced by Senior Officers and Council of the College. One of the recommendations to which we must give priority, is further involvement of parents in this ongoing work. Our initial attempts to involve parents in the first phase of the work were unsuccessful. We need to revisit this and clearly will involve their views in the next phase. Working with parents, both who are satisfied and those who are aggrieved, is an important part of the College's strategy in trying to resolve some of these difficult issues.

Any clinician working with children will inevitably encounter cases that may present an element of child protection. This is not just a report for those who specialise in safeguarding children, but all paediatricians, wherever they may work.

Dr Patricia Hamilton, President

November 2006

Acknowledgments

We are most grateful to the paediatricians who gave up their time to share their experiences of child protection complaints for the benefit of the research. Many of those interviewed continue to work to protect children despite the knowledge that this makes them vulnerable to an often distressing complaint about their practice. Thanks are also due to the lawyers, nurses and NHS trust complaints managers whose professional expertise enabled us to set the findings into the context of the complaints process, court procedures, multi-disciplinary and inter-agency working.

Members of the project steering committee provided support and direction throughout the project, ably assisted by the project administrator Dr Kay Chong Wan, who also helped to co-ordinate the fieldwork interviews. Thanks are also due to the transcribers, Amanda Leighton and Marion Haberhauer.

This project was funded by the Royal College of Paediatrics and Child Health (RCPCH) as part of on-going initiatives to support doctors working in child protection.

The quotes used in this report express the views of the respondents and are not necessarily views held by the College nor do they necessarily reflect Government guidelines or policy.

Dr Jackie Turton
Linda Haines

November 2006

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Executive Summary

Child protection is a complex and emotive area for any professional. A Royal College of Paediatrics and Child Health (RCPCH) survey (2004)ⁱ demonstrated that paediatricians in the field are often the targets of unfounded complaints and that the number of such complaints was rising. Although over 97% of complaints were subsequently unproven, the survey identified that complaints had a profound impact on the professional and private lives of some paediatricians and had influenced their willingness to undertake future child protection work.

The findings of this survey prompted a more detailed qualitative study to explore the nature and impact of complaints made against paediatricians in relation to child protection. The research undertaken was commissioned by the RCPCH as part of an ongoing programme of activity to support doctors working in child protection.

Semi-structured interviews with a representative sample of 72 paediatricians drawn from the 2004 survey were conducted during mid-2005. Interviews were recorded and transcribed and the transcripts thematically analysed with NVIVO software. The sampling method used enabled the inclusion of a broad spectrum of paediatric experiences and the complaints discussed varied both in relation to the nature of the complaint and how far they progressed through the system. It is acknowledged that a limitation of the study was that the views of complainants were not sought, mainly because of ethical and practical difficulties of identifying complainants within the project time frame. The College Research Division has recently received funding for a project involving parents that will be used to complement the findings from this study.

The study identified common themes in relation to complaints and considered strategies that might minimise complaints. It also highlighted the more general concerns expressed by paediatricians about their roles in safeguarding children, including educational and training needs.

Safeguarding children – the paediatric role

- Child protection is just part of safeguarding and promoting the welfare of children. While effective child protection is essential, the primary focus for *all agencies and individuals should aim to proactively safeguard and promote the welfare of children so that the need for action to protect from harm is reduced*ⁱⁱ. However, where there is evident harm or the risk of suffering significant harm then there may be a need for professionals to act in order to protect the child.
- Child protection work is very different from other areas of paediatrics. Respondents suggested that those not directly involved with child protection issues do not fully appreciate the difficulties and complexities.

- Safeguarding children can be a challenging and emotive area of work for paediatricians. The consequences of not recognising abuse can be devastating, so it is understandable that some may balance their decision on the side of caution when considering whether or not to make a referral to social services. However, the impact on families of an inappropriate referral can be equally devastating and this tension sets child protection work apart from other clinical assessments.

Understanding complaints

- Many paediatricians interviewed accept that complaints are a recognised risk of the job when child protection issues arise.
- When a child with suspected non-accidental injury presents directly to the paediatrician, it is the paediatrician who initiates the referral to social services. Paediatricians are aware that this responsibility brings the risk of complaints.
- Paediatricians are aware that the evidence-base behind many physical signs of abuse is weak, and that this places them in a particularly vulnerable position. They sometimes feel under pressure from other agencies to be able to make a definitive decision about non-accidental injury.
- Paediatricians highlighted the particular difficulties of safeguarding children where there were concerns relating to emotional abuse, neglect or fabricated or induced illness.
- Many complaints were triggered by the process of making, or excluding, decisions about possible non-accidental injury. Some parents clearly feel aggrieved when a non-accidental cause is considered even if subsequently ruled out, particularly when a second opinion did not agree with the original diagnosis.
- A small number of complaints may have occurred because of failure to follow good practice. Following the best practice outlined in Government guidelinesⁱⁱ as well as the Child Protection Companion (RCPCH, 2006) could help to minimise these complaints.
- The research highlighted the personal toll complaints can take. Paediatricians have been threatened, received threatening and unpleasant letters, been attacked, stalked, spat on, and accused of child abuse and even child murder.
- The complaints process, particularly that of the GMC, causes considerable concern for some paediatricians. The process can take too long to resolve, with little or poor communication from the investigating authority on the progress of the complaint.

Communication

- Communicating concerns of abuse to parents changes the normal collaborative partnership between doctors and parents, and paediatricians reported finding this a difficult area.

Communicating child protection concerns to parents or to members of the multi-disciplinary team often resulted in a complaint.

- Multi-agency working clearly still presents some challenges. Multi-agency and multi-disciplinary working is extremely important. It is the most effective way to safeguard children; it facilitates clear lines of responsibility; it offers parents and families more appropriate support and can lessen the burden of individual accountability. The Children Act 2004 and the updated guidance for all agencies offered in *Working Together to Safeguard Children 2006*ⁱⁱ should encourage the development of more effective and accountable multi-disciplinary teamwork.

Training

- Paediatricians feel very strongly that appropriate training and practical experience for doctors at all levels are vital components to enable children to be better protected.
- While the new RCPCH child protection training packages for SHOs are welcomed there are concerns about how this initiative could be encompassed and developed within the reduced working hours.
- Appropriate training for more senior members of staff including those already working in child protection is urgently required.

Resources

- A shortage of resources to undertake child protection work is a common problem. In some cases this indirectly resulted in complaints such as when there was no private space to talk with parents or examine children or when a lack of availability of specialist staff out-of-hours required families to stay longer in hospital than was otherwise necessary.
- Effective child protection takes time and yet insufficient time to do the job properly was often cited as one of the main causes of problems. Despite the recommendations in the RCPCH job descriptions for named and designated doctors^{iii, iv} there is still considerable variation between NHS trusts in terms of time allocated for child protection roles.

Support

- Paediatricians working in child protection need more support. Support needs identified include personal support and mentoring from colleagues, support from trusts when a complaint has been made as well as general support from the College and other national bodies.
- Good local support networks and forums for discussing difficult cases may encourage good practice. Using such resources should be seen as a normal part of child protection work and not a sign of professional weakness.

College role

- Paediatricians see an important role for the College in raising the profile of child protection work with the public. Increasing knowledge and understanding about child protection and the role of paediatricians could help to alleviate fears and misconceptions within the general public. Furthermore, encouraging a dialogue between paediatricians and families could work towards effective partnerships for safeguarding children.
- There is extreme concern about the media reporting of recent cases against paediatricians and the vilification of colleagues. It is seen as essential for the College to take a more proactive stance in relation to specific cases ensuring that both paediatricians and the media have accurate information about any high profile child protection complaint.

Conclusion

This research has identified elements required to reduce the number of unfounded complaints while ensuring that children are safeguarded and that both paediatricians and families feel fairly treated. Some of these elements would appear to be easily put into place, others less so.

However the important message is that while paediatricians accept safeguarding children can make them vulnerable to complaints, unless some of the issues highlighted in this research are addressed there will continue to be a reluctance to take on essential child protection roles.

Recommendations from the College

Training and education

- There is an urgent need for ongoing child protection training for consultants and others already working in child protection. Although training materials for career grade doctors are currently in development, interim training courses should be put into place during this development phase to fast-track child protection training for those already working in the area.
- The child protection training packages should include components to enable doctors to understand the boundaries and limitations of other professionals involved with the child protection process as well as modules and role-plays in relation to court appearances.
- There is an urgent need to increase the training for those working in child protection on effective communication with families. This training should be informed by an understanding of the parents' perspective when there are potential child protection concerns.

- Attendance at multi-disciplinary and multi-agency training courses at local level should be mandatory to enhance the effectiveness of child protection teams. Where these are already in place the College could facilitate the sharing of locally developed training materials via its website.

Time pressures

- An audit of designated and named doctors would identify workload pressures and evaluate job descriptions in relation to RCPCH recommendations. The findings of such an audit would be of use to individual members in their negotiations with trusts in ensuring an appropriate time allocation for child protection work.

Support

- The RCPCH leaflet^v on sources of support and advice should be updated and disseminated more widely.
- The RCPCH should consider developing a list of members with experience in child protection who can provide mentoring and support for individuals.
- Child protection networks should be developed to allow advice to be given in the management of all cases and consideration should be given to the need to have two doctors involved in decisions to make formal referrals to social services.

Information and media

- The College should work with other organisations such as the NSPCC and Children First to develop good quality information for the public on the role of paediatricians in child protection.
- The College should exploit any opportunity to raise the profile of child protection work and the role of paediatricians in the media.
- The College should provide accurate information to its members in relation to legal rulings on court findings.

Complaints Process

- The College should continue to engage with the GMC, National Clinical Assessment Service, the Ombudsman's office, and NHS trusts to improve the handling of complaints against paediatricians and to ensure fair service standards are set in relation to communication with the paediatrician and timely resolution of the complaint.

- The College should explore the feasibility of implementing the recommendations of the Working Party on Fabricated or Induced Illness ^{vi} in relation to complaints. The recommendation that complaints from the family in relation to a child protection case should be first investigated as a complaint against the employing health or social service department is particularly important.

Evidence-base and primary research

- The College should continue funding both primary and secondary research to improve the evidence-base for the physical signs of abuse.
- There is an urgent need to undertake more research that considers the families' perspective to the child protection process and develop ways to communicate concerns more effectively with parents. The College intends to undertake research in this area.

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1. Introduction

This research project forms part of the on-going strategy of the Royal College of Paediatrics and Child Health (RCPCH) to find ways of supporting paediatricians in their role of safeguarding children. The focus of this work was on the paediatric role and as such only offers this perspective. Further research has been funded to investigate the views, frustrations and fears of parents and families who become involved with the child protection process. It is hoped that future work will consider the views of children and a more multi-disciplinary perspective in order to develop a broader framework of reference for practice¹.

It is important to understand that child protection is part of safeguarding and promoting the welfare of children. While effective child protection is essential, the primary focus for *all agencies and individuals should aim to proactively safeguard and promote the welfare of children so that the need for action to protect from harm is reduced*². However, where there is evident harm or the risk of suffering significant harm then there may be a need for professionals to act in order to protect the child.

Child protection is a complex and emotive field of work for any professional but has particular difficulties for paediatricians. Generally the paediatric role involves a close relationship with parents, working together to ensure the welfare of the child. However, paediatricians along with other professionals, have a legal duty to ensure the safety of children within their care and it is this area of paediatric work that can create tensions between paediatricians and parents and sometimes between paediatricians and other professionals. Part of the problem lies with the assessment of risk that may be based upon medical opinion even though any physical signs can be ambiguous.

Any paediatrician suspecting that a child's injury or illness has not been caused accidentally has a responsibility to make a referral to social services². As the consequences of not recognising abuse can be devastating, it is understandable that some may balance their decision on the side of caution when making such a referral. However, the impact of inappropriate child protection proceedings on families can be equally devastating and if abuse is subsequently disproved parents often feel justifiably aggrieved. It is this tension that sets child protection work apart from other medical decisions and imposes a particular burden on professionals in the field. A recent Canadian study of stress within multidisciplinary child protection teams found that while job satisfaction was high, over a third of staff exhibited burnout and 13.5% had psychological morbidity³.

1.1 Background to the research

There were a number of events that influenced this project:

- In 2004 a survey conducted by the RCPCH (Appendix 1) of over 6000 members found

that the number of complaints against doctors involved in child protection had increased five-fold between 1998 and 2003⁴. Although over 97% of complaints were subsequently not upheld, the survey identified that complaints had a profound impact on the professional and private lives of some paediatricians and had influenced their willingness to undertake future child protection work. The survey also highlighted that some felt unsupported by the College and their trusts in relation to child protection work and that there was a lack of confidence in the General Medical Council's (GMC) handling of complaints. More recently it has been shown that anxiety about child protection work is also felt by paediatric trainees, 60% of whom said they would not consider a job with specified child protection responsibilities⁵.

- There have been numerous enquiries into child deaths caused by non-accidental injury. The Victoria Climbié enquiry conducted by Lord Laming is of particular significance for paediatricians and its recommendations were taken into consideration in this study. Furthermore the difficulty of filling specialist posts was highlighted as Lord Laming noted with concern that named and designated doctor roles in some NHS trusts were vacant.

. . .one might have expected that the scale of the problem would act as an inducement to those doctors who wished to make a significant impact on the health and well-being of the child population to enter the field⁶.

- General anxieties about child protection work and the risks of “getting it wrong” have also been exacerbated by recent successful appeal cases and the considerable public attention for a small number of paediatricians. The impact of such cases and other issues threatening child protection has triggered a debate about the future of the service and how public and professional confidence may be restored⁷. As one paediatrician suggested,

... I feel very strongly that society needs to tell us – as a multi-agency professional group - ...what they want, how do they want their children to be safeguarded.

It is therefore clear, that for a variety of reasons, paediatricians working to protect children have begun to feel demoralised and vulnerable. The College response has been to initiate a broad programme of work to support doctors in this area in an attempt to address these issues. As part of this programme the Research Division was commissioned to undertake qualitative research to explore the circumstances in which complaints are made against paediatricians and to identify strategies to reduce the number and impact of complaints. This report presents the findings from this research and identifies the key issues arising from the experiences of paediatricians who have had a complaint made against them. These experiences have been used by the RCPCH to formulate a series of recommendations to further support paediatricians working to protect vulnerable children.

2 Research Methodology

The research was a qualitative study comprising in-depth, semi-structured interviews, investigating the experiences of paediatricians in connection with child protection complaints.

The research was funded by the RCPCH and undertaken within the Research Division of the RCPCH. The work was overseen by a project steering committee that met regularly throughout the 12-month project (see page 9 for committee membership). The RCPCH Principal Research Officer and the Director of the Research Division provided research supervision and support for the researcher, Dr Jackie Turton (Appendix 2).

2.1 Research Aims

The aims of the research project were:

- to build on the RCPCH 2004 survey and analyse issues and concerns expressed by paediatricians in more detail
- to investigate whether the nature of the complaints highlighted any common themes
- to identify areas of concern for paediatricians in relation to child protection
- to identify practice or strategies that might minimise unjustified complaints
- to highlight any educational needs identified by paediatricians
- to consider ways in which paediatricians could be better supported in child protection work
- to identify some of the problems of working with other agencies when child abuse is suspected and/or where the child protection processes fail
- to identify problems that arise when dealing with families when child abuse is suspected.

2.2 Research Methods

The semi-structured interviews were based on a series of primary questions or themes to define the boundaries of discussion. Unlike quantitative research,

. . . qualitative research begins by accepting that there is a range of different ways of making sense of the world and is concerned with discovering the meanings seen by those who are being researched and with understanding their view of the world⁸

Taking such an approach to the methodology is particularly important when dealing with a sensitive topic and when there is not always a clear indication of all the questions that need

asking. Furthermore by adopting this method we enable respondents to participate in, rather than be objects of, the research process⁹. This is an important element in the case of this project, as any findings that challenge practice or processes require the involvement of the research participants to effect change.

The interview themes (Appendix 3) were developed from a review of the literature and free text comments from the 2004 RCPCH survey. They were also informed by the 'subjective adequacy'¹⁰ of the researcher in her knowledge of the child protection system and the role of paediatricians within it. The themes were initially tested for validity and sensitivity with a small pilot study of nine paediatricians experienced in child protection.

While the interviews focussed on specific child protection complaints they also covered the more general concerns that paediatricians have about safeguarding children such as:

- support needed and received, both professional and emotional
- training needs
- multi-disciplinary and multi-agency working
- local child protection procedures and practices
- ethical concerns such as confidentiality and consent.

2.2.1 Research Sample

The research sample was drawn from the consultant paediatricians in the RCPCH survey (2004) who had indicated a willingness to participate in further research (329/532). Complaints dated prior to 1999 and unresolved complaints were excluded from the data. The chosen sample of 80 paediatricians was purposive and the following factors were considered to enable a broad spectrum of responses:

- geographic location - both urban and rural workplace
- child protection role to include designated and named doctors and those with general clinical role
- NHS trust employer - primary care trusts, acute trusts, district general hospitals and tertiary centres
- number of complaints received
- complainant - suspected abusers, grandparents, the police, social services, MPs, health colleagues and journalists
- level the complaint reached - informal, NHS trust, independent review, GMC
- level of media involvement.

The 80 paediatricians selected were invited by letter to participate in the project. Those not selected were invited to submit in writing any particular concerns although in the event this

produced no additional data for the research. Eventually 72 paediatricians were interviewed by the researcher between March and July 2005; 47 interviews were face-to-face and 25 conducted by telephone. If consent was given interviews were recorded and transcribed for analysis otherwise contemporaneous notes were taken.

2.2.2 Other interviews

In order to set the paediatricians' experiences in context, interviews were also held with:

- four complaints managers from NHS trusts employing paediatricians in the sample
- two designated nurses with management responsibility for developing multi-disciplinary, multi-agency links, training and competencies in child protection
- two lawyers experienced in family law and child protection.

2.2.3 Parental involvement

From the outset it was recognised that a full understanding of why complaints arise in child protection cases would be difficult without the perspective of the complainant, usually the child's parents. It is well documented that parents may adopt differing perspectives to health professionals when considering the needs of their children^{11,12} and gaining a better understanding of this in relation to complaints would be of considerable value for both practitioners and families.

Consequently, 40 NHS trusts were contacted, via the clinical director or the chief executive, and asked if they would be willing to contact parents who had been involved with the complaints process and pass on information and an invitation to participate. Replies were received from 16 trusts but none were able to help us recruit parents who had complained about a paediatrician. This could have been due to the fact that insufficient time had been built in for recruitment in such a sensitive area and further research is needed to develop a full picture of the difficulties encountered within the child protection process.

2.2.4 Ethical considerations

Oxfordshire REC granted ethical approval for this study (reference 05/Q1604/8). All information provided by participants was made anonymous at the data analysis stage and no individuals, specific cases or children were identified at any time. It was made clear that participants could terminate the interview at any time or decline to discuss any issues they felt unsure or uncomfortable about. Signed consent was obtained for all interviews. Tapes were erased after analysis and transcripts were further anonymised as necessary. After transcription the quotations from the case studies and comments in the report were returned to the paediatricians involved to verify content and to obtain consent for inclusion in the report.

2.2.5 Study Limitations

The research was conducted during a period of rapid change concerning the service provision to children and young people and any findings need to be considered within the context of recent inquiries reports, changes in legislation and Government initiatives and guidelines, especially the Victoria Climbié Enquiry and recommendations. During the fieldwork period three important documents were still in draft, Working Together to Safeguard Children 2006, the RCPCH's Child Protection Companion and the Cross-Government Guidance on Sharing Information on Children and Young People. Furthermore the Children Act 2004 only became law in October 2005 and its full effect is yet to be realised.

It is also important to note that although the paediatricians interviewed had been the subject of complaints in relation to different types of suspected abuse, the research did not set out to investigate which cases were more likely to trigger a complaint, nor did the researcher set out to decide whether the complaint was justified or not. The findings offer an insight into the nature of complaints made against paediatricians and their concerns about child protection at the time of the research. While the findings do not make any universal claims, the data collected offers an experiential perspective of the paediatricians interviewed, reinforcing some of the earlier survey findings as well as identifying new areas for consideration.

2.3 Analysis

The transcripts and interview notes were anonymised, numbered and analysed using qualitative analysis software NVIVO (QSR NUD*IST Vivo, Scolari Software Inc.). The interviews with the NHS trust managers, designated nurses and lawyers were not formally analysed but the transcripts were used to aid the interpretation and to contextualise paediatrician interviews. The analysis was data led and took a reflexive, grounded theory approach¹³. This is an inductive process of identifying analytical categories as they emerge from the data - developing hypotheses from the ground upwards rather than defining them *a priori*. Therefore, while there was a discrete analysis phase after the completion of the fieldwork, grounded theory enables the enquiry phase to grow and adapt according to early results.

For the interviews with the 72 paediatricians the following analyses were undertaken:

- Demographic characteristics of participants in relation to gender, length of service, child protection role, type of employing authority and number of complaints.
- The transcripts were read in conjunction with the tapes and passages describing a complaint identified and coded as a unique case. Cases were then re-read and any specific

incidents or behaviours that could be considered *triggers* for the complaints were identified and coded. Some cases could not be coded for triggers because of the fragmented nature of the discourse. The cases were then grouped according to the trigger themes and for each theme a number of illustrative cases were selected.

- Interview transcripts were also read for common concerns in relation to child protection complaints in particular and safeguarding children in general. These concerns were coded as *nodes* and clustered in a systematic structure of *families* of ideas. A second reading of the transcripts enabled more individual issues to emerge.

2.4 Demographic characteristics of research participants

Of the 72 paediatricians interviewed, four had not actually had a complaint made against them but were included in the research because of their insight and experience in child protection. Of the others 34% had had a single complaint, 49% two or three and 18% four or more. Just under half (49%) were designated and/or named doctors while 33% had no official child protection role. Two-thirds of the designated and/or named doctors had had two or more complaints compared to 52% of those with no official CP role. Overall 35% of those interviewed had been referred to the GMC and for 25% the complaint had been reported in the media, within either local or national press reports or on national websites.

3. Child Protection Complaints

3.1 Nature of complaints

The complaints against paediatricians discussed in the study were diverse both in relation to the nature of the complaint and how far it progressed through the system. Although the NHS complaints system has recently been reviewed¹⁴, the complaints in the study all arose between 1999 and 2003 when the system involved an initial consideration at trust level with referral to an independent ombudsman for complaints not resolved locally. As with the current system, doctors could be referred to the GMC at any stage by complainants, with or without the initiation of the NHS complaints process. Although the majority of complaints had been made by members of the child's family, complaints had also been made by police, social services, nurses and other doctors.

In nearly all the cases considered, the complaint could be generally described as having arisen from the management of the case in its broadest sense. Included in this category are some cases where it would appear that a complaint was inevitable whatever action the paediatrician had taken. Although it is less easy to identify the lessons that can be learned from these, it is nevertheless important to include them as they highlight the areas in which rigorously followed good practice guidelines could help in the defence against the complaint.

Occasionally the type of complaint was different and this was where the paediatrician was accused of being an abuser. There were two cases in this sample where sexual abuse was alleged. These cases were extremely distressing particularly because both, seemingly easily defensible, took a considerable time to resolve. The complaints were made when the paediatricians were investigating the children for possible abuse so may have been counter-allegations. These cases highlight some of the risks paediatricians run when dealing with potentially abusing families and again emphasise how crucial it is to ensure that best practice is being followed, particularly when examining children.

One of the research aims of this study was to investigate any common themes in relation to the nature of the complaint. Although the experiences of the paediatricians interviewed were, to a great extent, unique, the analysis did identify a number of key factors as potential 'trigger' points for complaints. These are discussed below using specific complaints from the research to illustrate the main points.

3.2 Causes of complaints

3.2.1 Making decisions about possible non-accidental injury

The research revealed that one of the most common areas where complaints arose was associated with the process of making the ‘diagnosis’. In some cases it was the difficulty of making these medical decisions and the particular steps the paediatrician took to safeguard the child, which led, either directly or indirectly, to the complaint. A trust complaints manager interviewed also acknowledged the diagnostic difficulties paediatricians face.

‘...the only job more difficult than a complaints manager must be a clinician looking at an infant who is either unwell or who has an injury and trying to make a judgement about the extent to which child protection procedures are necessary. Clearly that’s a dreadfully difficult decision. I think it’s fair to say that most paediatricians, and certainly the paediatricians I know well here, will err on the side of caution. If there is even a potential concern about child protection issues they will . . . invoke the process. So what that must mean is that there will be parents who are very upset...’

Diagnostic difficulties occur in all types of suspected abuse. The issues associated with the physical signs of abuse are discussed separately from the cases of suspected emotional abuse, neglect or fabricated or induced illness (FII).

3.2.2 Ambiguous signs of physical and sexual abuse

It is becoming clear from recent reviews of research evidence,^{15,16} and from the challenges of professional opinion in the courts, that the physical signs of abuse can sometimes be ambiguous or even non-existent. Paediatricians interviewed were acutely aware of how the knowledge base is constantly changing.

‘I’m very aware of ‘the facts’ changing ... I’m keenly aware that what I thought was true some time ago, may not be quite so true now...’

‘...we thought we knew about bruises and now we realise that really you can tell rather little from a bruise as regards to timing... we’re in difficulties about retinal haemorrhages... the science has not been very good... I’m very worried about the dogmatism in this field...’

One case in particular highlighted the difficulties that can arise for the paediatrician when new research evidence emerges.

Case one

A toddler was referred to the paediatrician with a perianal abscess infected with Chlamydia. The paediatrician made a number of inquiries as to whether this could be anything other than sexually transmitted and in the end concluded that it was.

I had to call the parents in, and say ...I've got to refer ... this child to Social Services. They were shocked and horrified ...I worried about the case all afternoon, trying to cope with a busy outpatients... and eventually got on to the adult sexually transmitted diseases people, where ... the top chap said...he thought this was all quite kosher. But then one of his assistants, hearing him, said, - there's just been a paper showing that in the presence of staphylococcal pus, you can get cross contamination activity with Chlamydia, so... it may all be spurious, as it turned out to be. But the grandparents, quite correctly, I think, were very upset about this, and felt that the system had let them down... somehow, I got in the situation of taking the flak.'

Another paediatrician received a complaint after a young child initially diagnosed with pneumonia on the basis of a chest X-ray and sent home was re-called after the named doctor had re-evaluated the X-ray and raised the possibility of rib fractures.

Case two

The family were contacted and the child returned to hospital for a skeletal survey after which it was decided that the "rib fractures" were pockets of infection overlying the ribs.

'But they looked very much like fractures. And I still feel we did the right thing for the sake of the child, in terms of getting the child back and investigating it, even though within...within 24 hours, it was proven not to be. And there followed the written complaint!'

Given the ambiguous nature of some physical signs, paediatricians may seek a second opinion to confirm or refute the diagnosis and this can lead to complaints as in the case below.

Case three

A named doctor saw and discharged an infant with a viral infection who was admitted two weeks later with a bulging fontanelle. Another consultant requested an MRI scan which showed bilateral subdurals and social services took the child into care. However a subsequent report on the MRI scan by an expert came back as normal and the parents tried to sue the paediatrician for wrongful diagnosis.

'... the consultant who'd been on-call informed me that he wanted me to discuss that MRI scan with the parents as I had seen the child previously...So I went in and explained to parents what we'd found and it did imply some kind of more serious injury and we needed to do a skeletal survey ... and we would have to think of child protection. They got extremely upset at this point ... and we were as sympathetic as we could be...'

In other complaints described in the study, it was social services or parents rather than the paediatrician who sought the second opinion. When the paediatrician is not aware that a second opinion has been sought, any resulting complaint can come as a complete surprise.

Case four

A child presented at a DGH with a limp arm and abnormality in the wrist. An opinion was sought from a specialist doctor at a nearby acute unit.

'I said, - I think there's an old fracture on the wrist, and a recent fracture on the other side - they ... got another opinion from somebody else who disagreed with my opinion, and ... I didn't actually hear any more about it, I didn't know somebody else had done an opinion, . . . and it went to court, and the Local Authority climbed down, and . . . there was no further action taken, which I thought was actually wrong, but that's due process. And about six months later, I get a letter from the solicitors saying the parents are suing me for negligence!. . . So it was a variation of opinion, and . . I still happen to think I'm right.'

The paediatrician in one case questioned the expertise of the individual who social services approached for a second opinion.

Case five

This paediatrician referred a young infant with a chronic subdural haemorrhage to social services who requested a second opinion before taking the case further.

'...Social services went for a second opinion to a ... paediatrician, who might see a subdural every other year, and has good training in child protection, I will acknowledge, but has no particular knowledge or experience in subdurals, as far as I'm aware, and I'm not aware that he's doing any expert witness work independently. His view was this could all be due to a birth injury. . . And it was much easier for Social Services to accept . . . that guy's opinion. So they did. . the parents complained that I'd been wrong.'

Some paediatricians suggested that at times social services appeared to accept the medical opinion that resulted in the least work for them, leaving the initial doctor vulnerable to a complaint. A study of cases of serious injury where there was discrepant parental explanation found that some parents and members of the legal profession might shop around until a doctor is found to give credence to the parental explanation¹⁷.

The interpretation of ambiguous physical signs places the paediatrician in a vulnerable position. If abuse is not considered as a differential diagnosis, the welfare of the child can be at risk, as in the case of Victoria Climbié on whose body cigarette burns were so profuse that they were initially diagnosed as scabies. However the initiation of child protection procedures has a profound effect on parents and carers, particularly when injuries are found to have an innocent explanation¹². It is not surprising that the study identified a number of complaints linked to diagnostic uncertainties.

3.2.3 Assessing complicated cases

Emotional abuse and neglect can be chronic, it is often insidious and therefore more difficult to assess in terms of child protection. A number of complaints were associated with the particular difficulties of recognising FII.

'... it is very difficult and I think there's quite a spectrum, from people who worry unnecessarily about their children's illnesses, through to people who subconsciously almost collude with it, ... through to somebody who sticks potassium in the IV line and stuff like that...the further you go up the line, the more . . . straight forward it is, but the ones in the middle, very difficult.'

Identifying FII is made more complicated when an accurate history is unavailable. One paediatrician cited a case where a parent sought medical advice in the USA, mainland Europe and across the UK. Children in such cases can become involved in unnecessary medical investigations and the cumulative concerns¹⁸ about neglect or FII may be missed¹⁹. However some of the complaints that arose when FII was suspected appear to have been almost inevitable regardless of good practice.

Case six

This was a young child whose unsubstantiated on-going medical problems suggested the possibility of fabricated illness. Following a number of strategy meetings with various professionals the team felt sufficiently concerned to refer this case to social services.

'... the fictitious illness story is extremely difficult to ... very easy to read all the stuff and then say, - oh yes, yes, but the next step, - what are you going to do about it, is extremely difficult. So we got to a stage where we said, - right, look, enough meetings... And, and we decided we would move it on... I would make a formal child protection referral. So I knew when that happened, and it was all open and above board, and Mum realised what was happening, there would be a bit of a calamity. So I was expecting it.'

In one case of suspected fabricated illness the complaint had more serious consequences for the paediatrician as it was made directly to the GMC and the allegations were aired in the public domain on web sites.

Case seven

'She actually sent a complaint to the GMC, saying that ...that we'd made allegations about her that were untrue, that we had managed the child in a way that was to the detriment of the child...there was very little specific in terms of the allegations that she made. But she complained about me to the GMC, who, of course, had to launch a formal investigation. it was very unpleasant being investigated by the GMC.'

Cases of FII are clearly very complex and require particular skills and expertise to ensure the welfare of the child and avoid provoking complaints. In one case discussed, early recognition that a particular approach or management style was not working may have

prevented the complaint.

Case eight

'...we had been weaning down on medication, trying to sort it all out. Mum refused to believe it, so sent in a complaint, stating that this child was really sick, and the doctor didn't believe it. Before the complaint came in, I'd already suggested to Mum that a second opinion might help her, and so had organised for her to have a second opinion by a consultant who is the complete opposite to me . . . she listened to him in a completely different way . . . The different approach suited her although we were both saying the same things; it was the approach that was different... although the complaint went through, and nothing came of it... she has got on with this consultant, and has proceeded to take his advice. So that was a good outcome for that child.'

Other paediatricians in the study had been the targets of a "multiple-complainant" being one of a number of professionals complained about. These situations can further complicate the decision-making process as paediatricians are often aware that they risk complaints if child abuse is considered as a differential diagnosis. One paediatrician in such a situation expressed concern about having to make a choice between making the diagnosis and risking a complaint or keeping quiet.

Case nine

Following a referral this child with Asperger's Syndrome was admitted for medical investigations.

'... and it became very clear that his symptoms were related to the presence of his mother, and her story didn't fit with what we were seeing when the child was on the ward. . . And from then on, we pursued it as a fabricated illness, and we had a strategy meeting, . . . which was very angrily responded to by ... by mother, particularly. And the complaint was ... to the GMC, but there's been a lot of different complaints from this lady, (she) ... has pursued me, and the community paediatrician, and the GP, and the health visitor, so multiple complaints about all the people, and social services. . . And I still am uneasy that (this child) won't be presented again. I think they've moved on.'

For some paediatricians interviewed, the knowledge that a complaint was likely made it less stressful because it facilitated early discussions and planning with the trust.

'And I think, in fact, that we handled that one fairly reasonably, because the consultant paediatrician tried to smooth things over, and explained, you know, what it was, and explained how we had to act for the sake of the child and things. But we still got a written complaint. But that, I think that was fair.'

However for others, even the knowledge that they could not have acted any differently did not prevent significant stress.

'... when I heard it was going to Independent Review, it was quite distressing ... But underneath I knew I couldn't have done anything else ... even with all of that support and feeling that I had done (everything possible) ... I was still stressed.'

3.2.4 Decisions that are challenged

Decisions may be challenged by a variety of individuals including medical acquaintances of the parents and these may act as precursors to complaints.

Case ten

A four-month old child of professional parents presented with unexplained physical injuries giving cause for concern. After explaining the child protection process to the parents the paediatrician on-call requested further investigations on the child, including a skeletal survey and a more in-depth interview with the parents. Subsequently the parents complained to their medical acquaintances.

'It was infuriating when I had another consultant from a non-paediatric background telephone and say – how dare you. . . And the GP rang me up as well to ask why was I taking this up as a child protection issue? It is difficult and annoying when within the medical profession your judgement regarding child protection is questioned and you are not supported...'

In another example, a paediatrician wrote a report on a case of a fracture in a baby where the medical consensus was that the cause was non-accidental. In the report the paediatrician stated that she could not say who had caused the injury and this resulted in pressure from the parents' legal representatives to change the emphasis of the report to remove suspicion from the child's parents. Refusal to do so triggered the complaint.

Case eleven

'...the consensus from the radiologist, and the paediatricians, was that this was NAI, in other words, somebody had flexed this baby's leg very severely. . . I couldn't say who'd done it, but I agreed with everyone else that this was NAI...I said - I can't change my view. . . I'm not pointing a finger at them, I'm simply stating the evidence. . . the next thing is, a report . . . went to the GMC, alleging that I lacked the expertise to come to the opinion that I'd come to. And I've no idea what's happened since.'

Making medical decisions about suspected child abuse is not an exact science and paediatricians in the study were aware of the paradoxical nature of child protection that makes decisions vulnerable to challenge.

3.3 Communicating decisions

Although making medical decisions about possible abuse can be a challenge, paediatricians also face the difficult situation of explaining their concerns to the child's parents. In most areas of paediatric practice, the child's parents and doctors form a collaborative partnership working together for the good of the child. However, when abuse is suspected, the child's best interests may not be aligned with those of the parents and this changes the normal relationship between doctor and parents.

Several paediatricians expressed anxiety about having to tell parents that they suspected abuse and recognised the need for sensitivity, as each case is very different.

'It's that awful moment where you reach a point where you have to sort of turn from being friend to foe, and it's extremely difficult to do in a way that is acceptable.'

'You play it on the hoof really. Medically there's no rocket science about child protection at all; it's not really hi-tech super-duper exciting medicine. But I think, emotionally and communication-wise, it is real rocket science. You can screw it up so easily.'

It was also acknowledged that decisions about when, how and even whether to initiate this discussion are inevitably influenced by external factors such as the paediatrician's own perceptions of the family or the circumstances at the time.

'If you sit in a room with an apparently loving mother, who's got a baby in her arms,

and then tell them you think they have injured their baby, and you say that's easy, then you don't know what you are talking about. So what a lot of us used to do was to sort of try and check it out and reassure ourselves that there's nothing going on. And if our tests were negative and we thought the mother was nice, and she looks after the baby, then maybe we wouldn't do anything. I now realise that is completely hopeless.'

'I did gloss over it once with a year old baby who had a fractured humerus, who I thought had been sexually abused ...I had present with me at the time, in the middle of the night, a very fierce mother, a very large man, and a very tiny social worker. And so I said I'm very worried about his bottom and ...I really want to take some pictures and do some tests, but I didn't say sexual abuse, I only approached that later ...it's a good policy to be open and honest with parents but at the same time have to protect yourself and indeed the nurses working on the ward.'

Communicating something as difficult as concerns about non-accidental injury to families requires time, expertise and perhaps most importantly an appropriate environment. This is not a discussion to have in a busy hospital ward or in a cramped outpatient clinic and yet some paediatricians found themselves in just such circumstances. Community paediatricians felt particularly vulnerable to a complaint if child protection cases occur in their clinics because they often work alone in places with limited facilities. But problems can also occur within the hospital environment.

Case twelve

This child was admitted to the ward before the consultant realised that it was possibly a child protection issue. The ward was very busy and there were no spare rooms to discuss the concerns with parents. Although later that day the child was moved to a side cubicle where staff were able to talk with the family, the way that the case had initially been handled lead to a complaint.

'So it was very difficult and I was trying to stop the parents and say, look I'm sorry but I don't want to go on with this here, and they wouldn't stop. And then in the middle of all this, two sets of grandparents arrived, who started shouting and swearing and physically threatening ...it was all extremely difficult and unpleasant...'

The study also confirmed the findings of other research¹⁷, that there are particular concerns about confronting the more articulate professional and middle class parents.

'They (professional parents) can be very difficult because they threaten legal action, or ...can almost kind of talk you round.'

Although a significant number of complaints resulted from the paediatricians' communication with parents, sharing the diagnosis with other members of the professional team also resulted in complaints. Lord Laming's recommendations in the Victoria Climbié enquiry⁶ make it very clear that where there are concerns about deliberate harm these must be shared and recorded in the child's medical records. But where there is little physical evidence it can be difficult to know at what stage perceived risks to the child's welfare should be recorded, particularly if these concerns are not discussed with parents or carers. In one case described in the interviews, an unsubstantiated comment about possible child abuse understandably came as a shock to parents and led to a complaint.

Case thirteen

The child in this case was severely disabled. He had been a patient of various consultants as his mother sought opinions for a variety of reported symptoms and was frequently admitted to hospital with copious medical notes. As the parent was dissatisfied with the treatment a second opinion was requested.

'... I wrote to the consultant who'd agreed to take the referral saying that I was concerned that the child would be put through unnecessary further investigations ... I said there might be an element of what was then termed 'Munchausen's by proxy' ... somehow the label of MBP rather stuck, even though it was only a suggestion, and it was used in further correspondence between other clinicians. Eventually the mother gained access to these letters and made a formal complaint.'

Perhaps it was not surprising the study found that issues surrounding communicating the diagnosis resulted in a significant number of complaints. In some cases simply initiating a referral to social services led to the complaint. In others it was communicating the possible diagnosis within the multi-agency setting. This particular area of multi-agency communication is further complicated by knowing when, and how much information, to share. The devastating results when things go wrong have been highlighted in all too many child death enquiries.

3.4 Consent issues

Several complaints discussed in the study had arisen around the issue of consent. Although it is good practice to seek parental consent for examination or information sharing, when the welfare of the child is considered at risk, current guidance^{20,21} indicates that provided the child is

assessed as competent he or she may give consent. This is supported by the Laming report⁶ that recommends the rationale and circumstances in each case should be clearly recorded and the competence of the child assessed according to Fraser (Gillick) rules. However the study found that even in situations where guidance is followed complaints may still arise.

Case fourteen

The police brought a young girl into casualty with a very large, nasty slap mark on her face. She revealed that her father had hit her. A male paediatrician who was chaperoned by a junior female colleague examined her.

'I asked the girl's consent every step of the way, which I always do ...I found some bruising around the pelvis, which leads one to think there might have been some sexual abuse as well ... I can't remember the words I used but I conveyed to her that I wished to do a genital examination ...would she consent?'

Both the young girl and her mother refused consent. Subsequently the mother made a complaint to the police concerned that the paediatrician had even suggested a genital examination. The police reported this concern to the trust.

In a similar case the complaint led to a change to local policies and procedures to prevent future problems.

Case fifteen

Having disclosed sexual abuse, a girl of fifteen was referred for a medical examination. She was in foster care as there were concerns that she would remain at risk in her home environment. She did not want her foster mother present at the examination. The paediatrician assessed for Gillick competence and took consent from her both for the examination and in order to share the information with the police and social services afterwards.

'The mother subsequently made a complaint against me, that I'd seen the child without the mother giving consent to the examination ...we've now changed our paperwork so that we formally say who's giving consent and if it's the child that we have assessed, just so you are mentally making people go through the thought process.'

3.4.1 Initiating referrals

Although many cases where child abuse is suspected are referred to paediatricians by other agencies, some cases present directly through casualty or a clinic and under these circumstances referrals have to be made to social services. Paediatricians interviewed were well aware that this responsibility brings the risk of a complaint.

'I think the person who initiates the inquiry of ... of abuse, it doesn't matter what sort of abuse, gets an awful lot of criticism'

In several specific cases it was the action of making this referral that triggered the complaint against the paediatrician.

Case sixteen

The consultant on-call, a paediatric specialist with no specific child protection role, was asked to see an infant who had presented in casualty with an unexplained spiral fracture of the femur. This doctor was very careful to ensure everything was witnessed and documented carefully and transferred the child to the orthopaedic specialists

'...as I'm obliged, I had to inform the parents that ...we had to take the matter one step further and investigate things ...but also an obligation to inform social service and start a child protection process ...at the time the parents were obviously a bit disgruntled but didn't voice any particular complaints. I came back from holiday. . . to find a letter from the GMC on the doorstep. . . I think the parents focussed on me as being . . . the baddie. . . I initiated the child protection process so I think they obviously saw me as the baddie.'

Paediatricians also acknowledged finding it easier when another agency initiates the referral as parents have been informed about child protection concerns and the paediatrician can take more of an independent role.

'It's very easy, when I get somebody sent in by a GP or the social worker, because I'm then actually ... introduced as an independent person, but I'm not breaking the news that ... so I find I get into a lot of arguments on the ones I initiate.'

Most paediatricians found the early involvement of other agencies facilitates a collaborative approach to information gathering, discussion and decision making supportive. However,

sometimes the involvement of other agencies can result in lack of clarity about who takes ultimate responsibility for the child's safety as the case below suggests.

Case seventeen

This six year old was referred by social services and attended clinic with her social worker and foster mother. She had a number of bruises and a history of failure to thrive and urinary tract infections. The foster mother explained that the bruising was a result of bullying at school and the child, while quiet, appeared to agree. An arrangement was made between the paediatrician and the social worker that the social worker would check with the school to substantiate this. When five days later both foster parents came to the clinic with the child, the bruising had gone and the family appeared to have a good relationship.

'I was therefore inclined to think that it was playground bullying, but nobody actually went back to the school (to check the story). That was it. And the next thing we knew, the child was dead. I was criticised very heavily for not phoning the school myself, and also for believing the story.'

There are important issues to consider here. Multi-agency collaboration may facilitate joint decision-making. However, working together is not easy and involves not just information sharing but understanding roles and responsibilities across professional boundaries²² and developing trust between individual child protection practitioners.

4 Safeguarding children – general concerns

The concerns that emerged within this research covered a wide range of topics highlighting the challenging nature of child protection work. The main concerns have been grouped together under a number of themes that are illustrated by quotations from the interviews.

4.1 Understanding Child Abuse

A recurring theme from many of the interviews was how different child protection work is from other areas of paediatrics. As a result some feel that those not directly involved in child protection work failed to grasp its complexities.

'I think it can be difficult when one is balancing. . . needs and rights of children with needs and rights of parents. . . unless you're working within the field of Child Protection, then you do not fully understand the complexities'

There was a feeling that this lack of understanding extended to professional organisations and disciplinary bodies.

'There is a strong feeling amongst paediatricians that the GMC don't understand child protection issues. They have no designated advisor, and they should have. There is a lot of criticism around the GMC. They don't seem to be working for the professionals but they are veering towards the parents and complainants. Not that this is wrong, we want a robust control mechanism for the profession but we need representation.'

Paediatricians also voiced concerns about the lack of public understanding about the child protection process.

'Let's not forget that people are still killing their children and it is our job to do something about it, and I think if the Royal College said that very clearly, then the public's perception would change...'

Addressing this lack of understanding by giving the public accurate information about the child protection process and why it is so important, and to counteract the effects of misleading media reporting was seen to be essential. In situations where the public perceive paediatricians as over-zealous some children may not get the medical help they need.

'I think some parents are very worried they're coming to a paediatric clinic because (doctors) are thinking the child's being harmed by them.'

4.2 Resources

Lack of resources to undertake effective child protection was another common concern and in some cases indirectly resulted in complaints. Resource issues discussed included a lack of appropriate space to talk with parents and examine children, lack of availability of skilled health and social services staff especially out-of-hours and the lack of dedicated time to do the job properly. Equipment was cited as a problem less often although one paediatrician was challenged in court for not using a colposcope to examine a child where sexual abuse was suspected, when there had not been one available. Complaints arising from a lack of space have been discussed earlier but the resource issue raised most often was the lack of time available for effective child protection. This lack of time was cited as a possible deterrent to those who might otherwise take on a child protection role and others felt that it was this that was a major cause of problems in child protection cases.

'... that's the biggest thing Laming never looked at, was why were the services not so brilliant? And part of the reason was they were all rushed off their feet, and trying to do ten jobs in one day. . . Whenever I've had child protection problems, it's always been that I haven't had enough time to do it properly.'

Previous research has identified that some named doctors had no obvious time allocation for their child protection role, despite a demanding job description²³ and the present study confirmed this. There was considerable variation between NHS trusts in terms of specified time allocated for child protection despite the RCPCH recommended job descriptions for named and designated doctors^{24,25}.

'I was very ambivalent about taking the job because I felt that one session was not enough and ...I'm already doing quite a lot ... on the other hand, there was no-one else to do it.'

Attending court adds an extra burden for paediatricians and the time required for this was a concern for some interviewees. The increase in the child protection workload was also cited as adding to the time pressures.

'... we're having far more referrals, and picking up far more injured babies and children than we ever have before. It's hugely time-consuming and, if anything, we

have less time to do it, rather than more time, and I think every paediatrician in the country would say that.'

Some paediatricians commented that although training and support for new consultants may overcome a lack of experience, this cannot compensate for insufficient time. Clearly this lack of time for child protection work is a very important issue that needs to be addressed. Other research has shown it does affect outcomes for children in terms of protection and welfare²⁶ as well as making paediatricians more vulnerable to complaints as this study shows.

4.3 Training and experience

While many of the paediatricians interviewed were aware of and welcomed the new RCPCH child protection training packages for SHOs there remains a genuine concern about how any such initiative could be encompassed within the reduced working hours.

'... my experiences are quite different to the newer paediatricians coming into the game. They haven't seen it before as registrars. The duration of their (practical) training has been reduced so it makes it difficult.'

'... I think there's a big issue for me about experience. ... How do you gain experience in child protection within the present training structure? It's simply not enough just to fit it in.'

Paediatricians highlighted the need for child protection training targeted at all levels of doctors including consultants, a plea which echoes one of Lord Laming's recommendations²⁷ that there should be readily available expert advice and regular training updates for all grades of doctors.

Other suggestions made by those interviewed included a more supportive and mentoring style of management for new consultant paediatricians to compensate for the lack of experience.

'... I'm retiring in a year's time, and one of the jobs I'm negotiating ... is supporting new consultants, because with new consultants, who come off the end of the production line, they're going to have two years less experience. ...'

'We're not good in clinical work about mentoring and yet in the management world it happens all the time. But we should do it and we shouldn't expect a new consultant to be thrown in without a great deal of support.'

Although better training and more support for those working in the area might encourage

paediatricians to take on child protection roles, the importance of practical experience was expressed.

' . . . the parents complained about me, because I raised the possibility of non-accidental injury, in view of the history of injury and the fracture. There was no action taken against me, but, of course, it caused a lot of anxiety. This was in my first few years as a consultant paediatrician, and then I realised that one should not be appointed as a consultant paediatrician with lead responsibility for Child Protection, in the first few years. . . '

' . . . part of the stress always comes from thinking, you know, - I don't do this very often. I wonder if somebody more experienced could be doing a better job at this? '

Appropriate training and practical experience for doctors at all levels are vital components to enable better safeguarding of children.

4.4 Support

Most of the paediatricians in this study recognised how important it was to have support when undertaking child protection work. Comments in this area focussed mostly on support needs when a complaint was made but it is also clear how important it is that paediatricians working in child protection feel well supported in their day-to-day work.

'I think we're very privileged in this city, in terms of the amount of support we get, compared to most other places that we hear about.'

Support needed when a complaint occurs ranged from personal support by colleagues to support from the College and other national bodies. For some, talking through the circumstances of the complaint with a colleague would have helped.

'The GMC said I couldn't discuss it with anyone, and I talked to a senior colleague about it really for mentoring. I didn't ask them to help me with the mechanics of ... because I had the Medical Defence Union doing it, but I just really wanted somebody's shoulder to lean on really, to talk to.'

Other paediatricians had felt unsupported by their trust when the complaint was made and this lack of managerial support at Trust level led to a feeling of isolation.

' . . . I felt very unsupported by the trust. I felt the trust were only out to save

themselves, they'd wanted to minimise any complaints against them. . .'

'...I thought, well if the trust isn't going to support me, who is? ...the trust was so obviously prepared to dump me in it if they could ...that's the first time I felt I worked for a trust that didn't support me.'

Where a trust had given support over a complaint or more generally, paediatricians acknowledged how helpful this had been.

'They (trust) have been very supportive...mainly from the point of view of listening to what I've said, reading my written reports. . . there has been genuine understanding.'

'I have that (support) from my Chief Executive, I know I can phone her if I know that there are issues she needs to know. . .'

Some paediatricians found local multi-agency networks helpful and reported using nursing, paediatric and social work colleagues to discuss cases. The need to formalise these local support arrangements was highlighted.

'I should think it (support) probably should be formalised at this point, . . . particularly for consultants it should be formalised, because they won't get it otherwise, they won't say they need it and they just won't do the job. . . I think support is within agency and between agencies. . .'

On a national level, although it was acknowledged that the RCPCH had made attempts to support paediatricians in child protection, there was also dissatisfaction about the way that the College had responded to some complaints.

' . . . the individual feels that they need to be supported, and there certainly has been, you know, correspondence where there was a feeling that the College were taking a back seat.'

' . . . paediatricians see very senior colleagues being left to be pecked at by the crows, without the support, directly, of the College. . .'

Perhaps not surprisingly the media reporting of recent cases against paediatricians and the vilification of colleagues on campaigners' websites was expressed as a major concern. Some felt that the College had been too complacent in this area and that a more proactive stance was

required both in relation to specific cases and in raising the profile of child protection work. This is seen as an essential role for the College in supporting paediatricians.

'I have a colleague in the States ... and she said to me – why doesn't your College have some sort of press office to try and nip these things in the bud, so it doesn't run out of control and you can actually present a united cohesive voice to the media?'

'... our relationship with the press is absolutely disgraceful, and it ain't the press's fault, it's ours ... I think the way we deal with the press is absolutely crucial and needs to change.'

The “apparent silence” from the College in relation to recent high profile cases was also noted by the two lawyers interviewed who considered it to be the responsibility of the College to keep its members informed about cases.

'There should be a process of informing professionals about the reality of cases. So for instance, do members understand why and how decisions are made or do they rely on anecdotal accounts?'

Communication and support are essential elements if doctors are to be encouraged to take on child protection roles and good local support networks, as well as forums for discussing difficult cases, may prevent some complaints arising. Using experienced colleagues or local networks for discussing concerns should be seen as a normal part of child protection work and not a sign of professional weakness.

Paediatricians working in child protection should also have the security of knowing that if a complaint is made they have appropriate support from their trust and their colleagues. The College also has an important role in raising the profile of child protection work with the public. Increasing knowledge and understanding about child protection services and the role of paediatricians will benefit vulnerable children and those working to protect them and alleviate fear and misconceptions within the general public. Such moves will work towards developing more successful relationships between paediatricians and parents when child abuse is suspected.

4.5 Over- and under-reporting of possible child abuse

The recent failures of high-profile child protection cases resulted in individual paediatricians being portrayed in the media as zealots looking for child abuse where none exist²⁸. This research suggests on occasions paediatricians also perceive some colleagues in the same way.

'... it's like they get the thing about child protection, it's almost like they've got to save all the children, and they become almost... obsessed by it.'

'... there is certainly one person around here, if you wanted it to definitely be child abuse, that's who you'd get to come and see it.'

It is worrying that some paediatricians reported that colleagues shy away from non-accidental injury to avoid a complaint by refusing to take on child protection work or by choosing to ignore the possibility of abuse.

'If you diagnose abuse, of course, then you're a sitting target ... so we've got lots of consultants who never diagnose a case, have never been to court, and I'm sure that's the pattern throughout the country.'

'I think it can be worse in that some of our colleagues just don't want to know... They can't wait to get rid of the cases, and they just wash their hands of the whole thing, and write very bland reports ... they don't see child protection if it's under their nose. So they don't do it.'

Perhaps one of the most powerful weapons of any abuser is silence²⁹ and this silence can extend beyond that of the abuser or the child victim. Silence can take a number of forms such as *defensive practice*³⁰ when doctors may be concerned about taking risks for fear of litigation or complaints³¹. This silence is of great concern for child welfare. Child protection professionals were fully involved in the Victoria Climbié case but that did not make Victoria safe. *They saw and did not see. They knew what they had to do, yet they failed to act*³².

4.6 Multi-agency working

Research has already shown that effective multi-agency working is difficult to achieve³³ by means of laws, procedures or guidelines. This study found that, where collaboration really means working together, bonds of trust and mutual respect have emerged.

'I think our relationship on a one-to-one basis with both the police and social services is superb. There are very few occasions when I have ever doubted the professionalism.'

But invariably these good working relationships are forged between individuals and working together may mean different things to different people.

'Multi-disciplinary working. . . I don't find this a personal problem because I've been in this work for so long. But some paediatricians working in the acute area think that involving others means 'that's the end' and so don't take CP action.'

Some paediatricians reported that making referrals and discussing cases has become more difficult in recent years because of changes and recruitment problems within social service department child protection teams. Others reported the difficulties of working with different social services departments in the same hospital.

'You can have three children in the ward with subdurals, and you've got one social services department saying, - We're taking out immediate Care Orders for removing the two year old, and we want all contact by parents supervised. And you've got (another) social services department who says, - well, yes, that's all right, we'll go a softly, softly investigation, and you've got these two parents with babies in adjacent beds!'

Staffing pressures in social services and different agency priorities may explain the reports of referrals not being picked up by social services.

'If you get a finding without a disclosure, in my view, it goes nowhere. And, for example, lots of colleagues ring me up and say they've got somebody with genital warts, what should they do? And my answer is, - well, if you haven't got a history, or anything else that concerns you, referring to the social services is going to get nowhere.'

Other difficulties reported in relation to multi-agency working focussed on the undue weight other agencies put on the medical opinion. When police and social services look to doctors to provide firm evidence, any suggestions of uncertainty can give rise to dissatisfaction.

'I was under huge pressure to try and put an exact date on that injury, you know, when did it happen? . . . You cannot date these things like that. . . basically I was piggy in the middle between this very, very outraged social services team and very, very angry parents...'

'I had the CID on my coattail saying - well, is there anything suspicious there? I said, - well, as far as I can see . . . there isn't anything that causes me . . . But you're always on your guard. Well ... are you going to get criticised? Are you going to be hauled up because you missed something? That's effectively what the CID Officer said in this case. - okay, then, we'll have to let him go then. And it's based on what you've said'

A closer working relationship with other agencies, especially social services and the police, could enable a better understanding of the restrictions and limitations of the different professional and organisational roles. But this is just part of the solution; trust and confidence needs fostering between organisations and individuals³². Where interagency communication works effectively child protection becomes a shared task and both professionals and children benefit. As one family lawyer pointed out,

'..accountability in child protection does not stop with the paediatrician but is a multi-disciplinary/multi-agency process. Child protection is not to do with one injury but it is to do with a whole life-style.'

4.7 Complaints process, the courts and the judiciary

The complaints process was highlighted as a concern for paediatricians, particularly for those referred to the GMC. Common concerns were that lack of information from the GMC about the progress of the complaint and the media being informed about a case before the individual concerned.

'...the GMC didn't even contact me about it, but I know it went to the GMC because father copied the letter to our ... chief executive and the children's lead at regional level and they both told me.'

'The GMC seems ambivalent and statements can fan the flame of publicity. . . when a reporter rings up to enquire whether the GMC is taking up a case, the GMC may reply on the 'phone before doctor concerned has been notified. No chance to defend yourself at all in these instances.'

Several of those interviewed discussed their experiences in the courts. Many research respondents found the courts alien environments where the adversarial process is the antithesis of normal paediatric practice. It is clear that giving evidence in court, whether as a witness to the fact or as an expert, does not come naturally to many paediatricians. A lack of awareness about the legal process of child protection can leave doctors vulnerable and lead to unpleasant or demeaning experiences in court. More importantly the safeguarding of children is not promoted by poor or inadequate advocacy and can leave children at risk of harm. Many paediatricians recognised that information about court work and the legal process should be included in training where appropriate.

'I've been to various training courses, which ... were not particularly good,

because they were done by people who didn't know much more than I did...

'... I try and make sure the SpRs come along to court when I go ... I normally ask the judge if they can sit in ... I've always found the magistrates and judges very amenable.'

Paediatricians with court experience highlighted the importance of clear, contemporaneous hand-written notes. These can not only help in court but can sometimes help prevent the need to attend judicial proceedings.

'... good original hand written notes, which you can then refer to in court, are very powerful evidence, because you wrote them down at the time and whatever the mother seems to think she can remember afterwards, is not half as strong as what you wrote down at the time.'

'... we don't actually go to court very often ... and we're told it is because our reports are in a language that makes sense to everybody and they are appropriate... if you write a reasonable report it will help you stay out of court.'

Most doctors agreed that attending court as a witness required some preparation as well as an accurate understanding of the limitations of medical knowledge and skills.

'the whole thing about going to court is being absolutely clear on what you can and cannot say. If you stick to the facts and research, you're fine and anything beyond that, you can quite legitimately say, I'm sorry, I cannot comment because there's no research or there are no facts and then they can't question you on that.'

Experienced paediatricians emphasised the need to maintain a child focus and were concerned that they were sometimes asked in court about the parents rather than the child.

'...you're there for the child is the key thing, that's the only thing that's got me through every single court case, just thinking, I'm not here for the barrister, the jury or the parents, I'm here for the child. Maintaining that kind of perspective helps.'

There is a distinct difference between civil courts, where the evidence required is in the balance of probabilities, and criminal courts, where evidence needs to be beyond reasonable doubt. Some paediatricians suggested that the differences go beyond these definitions.

'you actually get the feeling ... in a civil court that everybody there, especially the

judge, actually wants to find out the truth. ... whereas in a criminal court, they don't want to find the truth ... neither side wants to find the truth!

Given that the civil and criminal courts can both be adversarial, finding ways to deal with aggressive cross-questioning is sometimes difficult. One paediatrician coped by physically changing his position in the stand.

'you actually listen to the lawyer and then you physically turn your feet to the judge, because you are answering the judge, so you turn your whole body to the judge... and then you turn back to the lawyer ... it's a superb technique ... when you're being harassed.'

The lack of feedback about the outcome of court cases was a concern. A debriefing after witness work could improve court practice and increase self-confidence in court situations.

'There's no-one to talk to ... it's just you never hear the end or the outcome ... if there's no feedback then I don't think one can necessarily ... better the service.'

Most paediatricians, while not enjoying court work felt more competent to give evidence as a witness to the fact, as long as it was made clear to the court their level of ability and training in the area.

'I think the key is to know what you're there for ... I've learned that I'm there to... describe the facts as I saw them and to give an opinion up to a level where I feel I'm qualified.'

A few paediatricians interviewed actually enjoyed the challenge of the adversarial court system.

'I enjoy it ... I know that I am going to get a respectful hearing ... it's absurd to do expert witness work if you're afraid of a bit of gunfire. You should do something else.'

Appearing in the witness box was not the only concern about court work. Anxiety was expressed about personal security and protection against complaints resulting from court work. Some paediatricians found themselves face-to-face with parents while waiting to be called as witnesses and there were a number of concerns raised about the isolation and vulnerability of paediatricians appearing as witnesses in court.

'it's bizarre that you turn up, there's really very low level security ...I was giving evidence ... in a civil court ... essentially saying that this father had done some

terrible things and half an hour later, I find myself ... standing beside this same man in the gents.'

There was considerable anxiety expressed about the GMC's handling of complaints against medical witnesses. At the time of writing this report the GMC was appealing against the judgement made by Mr Justice Collins³⁴. However, this is not in order to reinstate the original decision to remove Sir Roy Meadow's name from the medical register but to consider points of law and how the judgement would significantly affect the scope and authority of its role in protecting the public interest.

The lack of support for paediatricians undertaking court work was raised as an issue. The level of support fluctuated between NHS trusts and was in some cases dependent upon whether the doctor was appearing as a witness to the fact (as a trust employee) or an expert witness (usually private work). In the latter case doctors may not have support from their employing authority or their unions if complaints arise.

'... there's no support for you. It's there for all the other people, but you can have your professional reputation shredded to bits, but there's no-one there to support you.'

Diagnostic uncertainty does not always sit well within the legal process and differences between two experts can be used to discredit a professional's opinion.

'... I deal with the most probable diagnosis ... I choose the option that is the most likely ... But of course, that sort of woolliness ... sits all right in the Family Division, it doesn't sit in the Criminal Court.'

'What solicitors usually manage to make a great thing of (is) to try and discredit one or both opinions, depending on which one suits them ... they will spend a lot of time picking out, not what we agree on, but ... where we disagree.'

Differences of medical opinion are clearly difficult for the courts but setting one 'expert' against another with the aim of discrediting one is unlikely to encourage paediatricians to act as expert witnesses. A number interviewed stated that they would never do expert witness work or have given up doing it. Regardless of the difficulties that can arise for paediatricians involved as court witnesses, this is a process that endeavours to work in the best interest of children and does consider their welfare as paramount. And there were sometimes added advantages to the court process as one paediatrician suggested.

'... if the case goes through the courts, it's very rare you get a complaint.'

So, despite the few high profile cases, allowing the family and experts to be heard in courts could help avoid some unfounded complaints against paediatricians.

5. The impact and consequences of complaints

So far this research has considered the complaints made against paediatricians in some detail highlighting areas that may give rise to ‘trigger’ points and also some of the major concerns identified by doctors when child abuse is suspected. This section focuses on the effect of complaints on the paediatricians themselves.

Any complaint can be harrowing and the nature of the complaint, how it was handled and the level it reached, all had a bearing on how stressful the experience was. Stressful factors included delays in the resolution of the complaint, not knowing how far the complaint would go and, for some, the fear of losing their job and livelihood. Some comments highlighted the emotive nature of child protection work and how complaints had affected their working lives.

‘Absolutely horrendous! That was the one thing that’s ever happened to me in my whole career. Horrendous!. . .the whole thing, from start to finish, was just a total nightmare. Total nightmare.’

‘I have to say from a personal point of view I was absolutely devastated.’

Several paediatricians interviewed had become the target of co-ordinated campaigns, with homes and families put under siege, violent threats made against them and their families, and property damaged. The research found that these threats were not restricted to high-profile cases. Other paediatricians have been threatened, some with murder or have received threatening and unpleasant letters, been attacked, stalked, spat on, and accused of child abuse and even child murder.

The way in which the complaint is handled can have more effect than the complaint itself, especially where the resolution of the complaint was delayed, as suggested below.

‘. . .they (the trust) were arranging for an external review of my handling of a particular case, and I felt extremely threatened by that . . . because I didn’t know who they would invite to that panel, and . . . and what experience they would have, and what they would. . . I really felt extremely threatened.’

As with many emotional events some complaints were met by a mixture of anger and sadness, often with a resigned recognition that complaints are an inevitable consequence of this field of medicine. Interestingly much of the anger expressed by the paediatricians was not focused on the complainants but on the complaints system.

'my wife said that I was unbearable at the time of the complaint. . . we'd just had a baby and she just said that I really didn't bond with the baby for the first couple of months and I think that's really sad when I look back at that, and that makes me even more resentful of it and although I feel angry about the complainant, I feel even more angry about the GMC.'

Once complaints have been made, sharing and discussing cases is not always possible or legally advisable, resulting in feelings of isolation, shame and in some cases fear, which were expressed.

'The constant wearing down of resistance by hounding 'phone calls, phone tapping, anonymous letters, media misinformation and complaints to the GMC. The letters say things like – how bad do you feel now. Haven't you committed suicide yet?'

'...I kept it fairly quiet. I don't know if there was a touch of shame associated with this ... because someone's ... trying to haul me up in front of the GMC. So I think, even to this day, only a handful of close colleagues were aware of it. It's not something you want people to be aware of ... you almost have the feeling that you are guilty until you've proven yourself innocent.'

For some paediatricians, the emotional consequences of unfounded complaints were considerable. Many of the stresses identified arose from the concerns highlighted in the previous chapter such as lack of support and lack of information. Addressing these concerns could not only minimise the likelihood of a complaint by enabling closer partnership working with parents, but robust support networks could reduce the impact of the complaint on paediatricians.

6. Conclusions

The NHS complaints process provides patients and their families with a mechanism to ensure complaints about health-related issues can be fairly and objectively addressed. Although in recent years the number of complaints made against doctors working in child protection has increased substantially⁴ it is unclear if this is a general symptom of a more litigious, complaining society or whether child protection attracts more complaints than other areas of medicine. Whatever the cause, the impact of the complaints, and the high-profile media interest they have generated, have lowered morale in child protection services.

The problems facing doctors working in child protection have previously been acknowledged but this was the first qualitative study to explore the experiences of paediatricians who have had a complaint. The sampling method used enabled the inclusion of paediatricians with a broad spectrum of experiences, not just those with a particular motivation for participating. The complaints discussed ranged from relatively minor issues resolved locally to those referred to the GMC and involved paediatricians who had been targeted by co-ordinated media campaigns. Given the wide range of experiences and expertise, it was not the intention to draw specific conclusions but to identify common themes and problems. These themes have been used to identify new ways in which the RCPCH can support child protection work and to highlight possible pathways and practical steps to avoid or minimise complaints.

The study illustrates how stressful complaints can be, both for those experienced in child protection and those less frequently involved. For some participants, the research was their first opportunity to reflect on the impact and the circumstances of the complaint. Interestingly, most paediatricians interviewed appeared to accept complaints against them as a recognised risk of the job. However they were less able to accept the threats to themselves and their families that sometimes accompanied the complaint. Being an advocate for a child under these circumstances is not an easy job.

Analysis of the complaints identified that a small number had occurred because the paediatrician had not followed what would now be considered to be good practice, although sometimes for reasons outside of their control. While it is accepted that some complaints occurred before the publication of relevant good practice guidance, such as the Responsibilities of Doctors in Child Protection cases with regard to confidentiality,²⁰ paediatricians should be familiar with and follow the national and local government guidelines produced for all professionals involved with child protection². The Child Protection Companion (RCPCH, 2006) provides further good practice guidance in relation to doctors' roles and responsibilities. Following guidelines and promoting inter-agency cooperation should work towards supporting families and act as a proactive response to safeguarding children.

While this was a qualitative study, which did not attempt to quantify the types of abuse, cases of suspected fabricated or induced illness frequently featured. Some of these complaints may have been

inevitable. The particular difficulties faced by paediatricians in this area have already been recognised in Government enquiries and professional guidelines have been produced³⁵; the RCPCH working party report³⁶ also contains valuable practical guidance. This research has identified that in cases where a complaint seemed inevitable, those doctors who were confident that they had followed best practice in relation to record keeping and who had good communication with NHS trust managers, found complaints less stressful.

The analysis identified that complaints were often triggered at or around the time of diagnosis and when communicating concerns to parents and other professionals. Paediatricians clearly feel under pressure from other agencies to establish with certainty, from the physical signs, whether a child has been abused and yet it is the ambiguity of the physical signs that can indirectly lead to a complaint. It was understandable that some parents felt aggrieved that a non-accidental cause was being considered even if it was subsequently ruled out, particularly when a second opinion failed to agree with the initial diagnosis. Systematic reviews of evidence such as by the Welsh Child Protection Systematic Review Group¹⁶ and the RCPCH may help doctors in making medical decisions. However it seems likely that for some types of abuse, an accurate diagnosis will not be possible without more empirical studies although such research is fraught with ethical difficulties and challenges. It seems inevitable that some diagnostic uncertainty will continue with the corresponding potential for complaints. The focus should therefore be on providing better information for parents and for the public in general, about paediatricians' roles and responsibilities and by understanding the parent's perspective in these difficult situations.

Differences of opinion between doctors also left paediatricians open to a complaint. In a court setting it has been suggested that meetings between experts beforehand are helpful³⁷ and encouraging a dialogue between doctors giving opinions about ambiguous signs might also help to avoid complaints. Acting as an expert witness and appearing in court were areas of concern for some paediatricians. The Academy of Royal Colleges has produced guidance for doctors undertaking expert witness work³⁸ and the report of the Kennedy Inquiry³⁹ also provides some useful information on the role of expert witness as well as making recommendations for training.

Communicating a diagnosis of possible abuse and getting consent for specific examinations left some paediatricians vulnerable to complaints. Although clinical assessments are part of the multi-agency information-gathering process, the paediatrician often has the initial face-to-face encounter with parents. Good communication both between the members of multi-agency teams and between professionals and parents is clearly a vital component of effective child protection. But both Laming⁶ and Nicholls⁴⁰ recognised that while communicating with parents and obtaining their consent is preferable, this was not always desirable in cases of suspected abuse. Paediatricians' responsibilities in relation to confidentiality and child protection cases have recently been clarified²¹ emphasising that any decision not to seek parental consent to examine a child or disclose patient information should be clearly

documented, giving reasons for the decision. Adherence to these guidelines might help to prevent some complaints and the ruling by Lord Nicholls should ensure that any complaints about such decisions are easily dealt with at a local level.

Paediatricians working in child protection identified a need for better and more, training, support and time to do the job properly. Some of these training needs are already being addressed by the RCPCH with the recent launch of the child protection training materials for junior doctors and new work on the development of a similar package for SpRs. Although these training materials will eventually include modules for consultants, there is an urgent need for targeted training and courses to support consultants already working in child protection, a point emphasised in the new *Working Together to Safeguard Children (2006)* document.

All paediatricians need to maintain their skills in the recognition of abuse, and be familiar with the procedures to be followed if abuse and neglect is suspected. Consultant paediatricians in particular may be involved in difficult diagnostic situations, differentiating those where abnormalities may have been caused by abuse from those which have a medical cause. In their contacts with children and families they should be sensitive to clues suggesting the need for additional support or inquiries

The lack of resources, especially time, is a significant problem for doctors with specific child protection responsibility. Socolar & Reives²⁶ have also noted that time constraints were the major barrier for physician involvement in medical evaluations for potentially maltreated children. The RCPCH's model job descriptions for named and designated doctors^{24,25} specify the number of programmed activities that consultants need for this work, which is clearly an area where doctors could be supported when negotiating with NHS trusts.

The requirement for more support from colleagues, trusts and professional organisations, especially the College, for doctors working in child protection work was identified. Although the College cannot always provide support for individual members, there is a leaflet signposting a range of organisations⁴¹, which should be updated and made more widely available. The study showed that the practice of using local colleagues for support and advice is more active in some trusts than others. Where it happens, it is not only used by junior consultants but also by senior clinicians, some of whom cited this as one of the most important strategies for dealing with child protection cases. Good and supportive local networks can protect doctors against complaints and, in the event of a complaint, can provide support. It is these local networks that while promoting the welfare of children can provide effective safeguarding mechanisms and help to develop and maintain communication links and partnerships with parents and families. Support networks need to be representative of all professionals involved in safeguarding children. This way they can also help to build trust between disciplines and agencies and lead to more effective child protection.

However, this research found that in general, unsatisfactory multi-disciplinary working is still a cause for concern in some areas. Informal multi-disciplinary arrangements that involve the accountability and responsibility of the agencies involved with child protection have been given statutory significance in the new Children Act 2004. This is important if the burden of child protection work is to be shared and the new act should encourage the development of a more accountable, multi-disciplinary team, who regularly work together and are capable of assessing risk from a variety of professional and social perspectives. Importantly for the paediatricians this could lessen the burden of individual accountability and responsibility.

The complaints procedures, locally and nationally, were also highlighted as an area of concern. Poor communication between the paediatrician and the investigating authority about the initiation and progress of a complaint and, importantly the outcome is unacceptable and causes additional stress. This is clearly an area that needs to be addressed urgently by trusts and the GMC. Standards should be set (and monitored) around the communication flow with doctors when a complaint is made, in line with those set for complainants.

Finally there is a need to build a better understanding about the child protection process within NHS trusts, the GMC and the general public. Finding ways to build a dialogue with the public about child protection issues, and particularly with parents who find themselves suspected of abuse, is a necessary element for avoiding and minimising unfounded complaints. The College has an important role to play in raising the understanding and profile of paediatrician's role in protecting children. While it was not possible to include any parents' views on complaints in this work, it is essential to gain better understanding of communication process from their perspective.

This research has identified elements required to reduce the number of unfounded complaints while ensuring that children are safeguarded and that both paediatricians and families feel fairly treated. Some of these elements would appear to be easily put into place, others less so. The important message from this research is that while paediatricians accept safeguarding children can make them vulnerable to complaints, unless some of the issues highlighted in this report are addressed there will continue to be a reluctance to take on essential child protection roles.

7 Recommendations from the research with the College response

This research study formed part of a broad programme of work within the College to support doctors working in child protection. The recommendations arising from the research are presented here in the context of other College initiatives, and are for the College to take forward in collaboration with members, trusts, and other agencies.

Training and education

Recommendations for future work

- There is an urgent need for ongoing child protection training for consultants and others already working in child protection. Although training materials for career grade doctors are currently in development, interim training courses should be put into place during this development phase to fast-track child protection training for those already working in the area.
- The child protection training packages should include components to enable doctors to understand the boundaries and limitations of other professionals involved with the child protection process as well as modules and role-plays in relation to court appearances.
- There is an urgent need to increase the training for those working in child protection on effective communication with families. This training should be informed by an understanding of the parents' perspective when there are potential child protection concerns.
- Attendance at multi-disciplinary and multi-agency training courses at local level should be mandatory to enhance the effectiveness of child protection teams. Where these are already in place the College could facilitate the sharing of locally developed training materials via its website.

College response

- The basic course in child protection (Safeguarding 1) is mainly aimed at SHOs but it is applicable to any paediatrician who feels in need of such training, much as the resuscitation courses are open to all. Nevertheless the College recognises the constraint of places in these courses and the need to tailor courses to the needs of senior doctors and especially consultants.
- The course for SpRs is being developed on a modular basis and is taking advantage of existing distance based and local materials already developed.
- The family justice training scheme is being developed and there will be mini-pupilage experience where the paediatrician is attached to a barrister or solicitor for a time. There is also a 2-day course that is mixture of didactic teaching by lawyers and a practical mock court experience.

Time pressures

Recommendations for future work

- An audit of designated and named doctors would identify workload pressures and evaluate job descriptions in relation to RCPCH recommendations. The findings of such an audit would be of use to individual members in their negotiations with trusts in ensuring an appropriate time allocation for child protection work.

College response

- The College Census 2005 has revealed a vacancy rate of 10% in Community Paediatric posts compared to 2.5% in acute posts. Some of this is attributed to reluctance to adopt child protection roles and attention has been drawn to this in meetings with ministers and the Department of Health.

Support

Recommendations for future work

- The RCPCH leaflet ⁴¹ on sources of support and advice should be updated and disseminated more widely.
- The RCPCH should consider developing a list of members with experience in child protection who can provide mentoring and support for individuals.
- Child protection networks should be developed to allow advice to be given in the management of all cases and consideration should be given to the need to have two doctors involved in decisions to make formal referrals to social services.

College response

- Although the College cannot provide support to individual members, much work with them goes on behind the scenes.

Information and media

Recommendations for future work

- The College should work with other organisations such as the NSPCC and Children First to develop good quality information for the public on the role of paediatricians in child protection.
- The College should exploit any opportunity to raise the profile of child protection work and the role of paediatricians in the media.
- The College should provide accurate information to its members in relation to legal rulings on court findings.

College response

- The College is working hard to raise the profile of paediatricians' role in child protection using media opportunities when offered. The College's press office also corrects inaccuracies in press reports although these are not always taken up.

Complaints Process

Recommendations for future work

- The College should continue to engage with the GMC, National Clinical Assessment Service, the Ombudsman's office, and NHS trusts to improve the handling of complaints against paediatricians and to ensure fair service standards are set in relation to communication with the paediatrician and timely resolution of the complaint.
- The College should explore the feasibility of implementing the recommendations of the Working Party on Fabricated or Induced Illness³⁶ in relation to complaints. The recommendation that complaints from the family in relation to a child protection case should be first investigated as a complaint against the employing health or social service department is particularly important.

College response

- The College agrees that there needs to be improvements in the handling of some complaints and has initiated ongoing discussions at high level with the GMC over the handling of CP complaints.

Evidence-base and primary research

Recommendations for future work

- The College should continue funding both primary and secondary research to improve the evidence-base for the physical signs of abuse.
- There is an urgent need to undertake more research that considers the families' perspective to the child protection process and develop ways to communicate concerns more effectively with parents. The College intends to undertake research in this area.

College response

- College is currently funding evidence reviews in two areas, oronasal bleeding and non-accidental head injuries, to help define the evidence base behind the often ambiguous signs of non-accidental injury.
- The College Research Division has been awarded a grant from the DfES to undertake some qualitative research with parents in relation to information needs when non-accidental injury is suspected but subsequently disproven.

Appendix 1

2004 RCPCH Child Protection (CP) Survey

Executive summary

1. Of the 3879 practicing or recently retired paediatricians that have been involved in child protection, 13.8% (536) reported that they had been subject to complaints related to child protection. 533 of these 536 paediatricians reported a total of 786 child protection complaints of which 765 were detailed.
2. 79% of complaints were dealt with exclusively locally; 8% went for independent review and 11% were referred to GMC.
3. 406 doctors (605 complaints) were dealt with locally by trust.
 - a. Of those complaints where the outcome was known, 76% were dropped. Official enquiry found 21% complaints unproven, and only 3% complaints upheld. 8% of complaints are ongoing.
 - b. In 44 cases the complaints then went further to independent review or to the GMC.
 - c. Of the complaints dealt with locally by the trust, 9% (57/605) received publicity.
4. 59 doctors (59 complaints) were dealt with by independent review.
 - a. Of those complaints where the outcome was known, 29% were dropped. Official enquiry found 58% complaints unproven, and only 13% complaints were upheld. 18% complaints are ongoing.
 - b. In 7 cases the complaints then progressed to the GMC.
 - c. Of the complaints dealt with independently, 26% (15 out of 59) received publicity.
5. 71 doctors (86 complaints) were referred to the GMC.
 - a. Of those complaints where the outcome was known, 41% were dropped. 59% complaints were found unproven and none was upheld by an official enquiry. 20% of complaints are ongoing.
 - b. Of those complaints referred to the GMC, 51% (44/86) received publicity.
6. The number of complaints per year has increased dramatically; from less than 20 in 1995 to over 100 in 2003.
7. The majority of ongoing complaints, 61% (49/80), have only been ongoing since 2003.

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11% (9/80) have been ongoing since 2002, and 18% (14/80) have been ongoing since before 2002.

8. 84% of complaints received no publicity. Of those that did however, the local press (9%) was the commonest form of publicity and local radio or TV was (3%) was the least common.
9. Whether or not a complaint receives publicity seems independent of the outcome. Ten percent of complaints receiving adverse publicity were later dropped by the complainant. In nearly a quarter of those cases where the complaint was found unproven, the doctor had previously received adverse publicity.
10. 47% of complaints were made about paediatricians whose involvement in child protection was infrequent or when they were not a member of a CP team. 50% of complaints were made when the paediatrician was a member of a CP team or when they were the named or designated CP doctor.
11. 29% doctors were affected in terms of their willingness to become involved in potential CP cases subsequently. Unwillingness to continue with child protection work was not related to
 - a. The level at which the complaint was investigated or
 - b. The outcome of the investigation
12. 62% doctors are willing to participate in a detailed structured telephone interview about their experience.

For a copy of the full report of the RCPCH Child Protection (CP) Survey, contact Linda Haines (email linda.haines@rcpch.ac.uk or telephone 020 7323 7903). Alternatively, you can download and view this report at: http://www.rcpch.ac.uk/publications/recent_publications/Latest%20news/CP%20report.pdf

Appendix 2

Dr Jackie Turton – brief biography

Jackie started at Essex University as an undergraduate in sociology in 1992 after a career in the health service as a nurse, midwife and health visitor. Most of her NHS career was served in the community including 2 years working with a multi-agency child protection training team. Jackie has been teaching criminology and sociology at Essex University since 1996 and has also worked as an associate lecturer for the Open University in the faculty of Health and Social Welfare. She completed her PhD, *Child sexual abuse: understanding female offenders* in the sociology department of Essex University in June 2003.

Jackie is an experienced qualitative researcher. Her research activities have included child protection, drug misuse, social and health needs of older people, pathways to employment for refugees and women as offenders. More recently her qualitative research projects have included a study of interpretation services in the NHS for the Department of Health (2002); a project for the Home Office mapping interpretation and translation services across the public sector (2003) and research leading to strategic planning frameworks for the health and social care of asylum seekers and refugees for the Eastern Region DH (2004). She was employed by the College (2004/5) to investigate complaints made against paediatricians relating to child protection.

Jackie is currently completing her book *Child Abuse, Gender and Society* and is a full-time teaching fellow in the sociology department at Essex University.

Appendix 3

Themes and questions for paediatricians

The quantitative questions will consider some of the generic information to be gathered concerning child protection complaints such as:

- standards of training,
- quality of and access to professional and emotional support,
- practical concerns and implications of information gathering, recording, sharing and retrieval,
- concerns about consent, particularly when parents/carers are under suspicion

Themes for interviews with paediatricians

Working with suspected cases of child abuse - case studies

- can you say more about the circumstances of the case/s you were involved in that led to a complaint
- did the procedures work?
- if not, why not?
- what were the problems or barriers?
- what do you do?
- how would you act now?
- when dealing with child protection issues, what works for you and why?
- what would make these experiences less harrowing?

Working with suspected cases of child abuse - general

Practical issues

- examining the child
- dealing with parents or carers
- communicating concerns
- record keeping

Support issues

- second opinions
- support from named & designated doctor
- multi-disciplinary support
- accessing support

Child protection procedures

- trust guidance & policy
- differences between what should and does happen
- barriers & problems
- when & whom to call for advice or to inform
- access to Child Protection Register

Ethical issues

- what information
- when
- consent concerns

Emotional issues

- anxiety
- uncertainty
- anger - parents & others
- trust - whom to trust with what

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