Lessons from the past, learning for the future:
safeguarding children in primary care

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INTRODUCTION

Pat Byrne gave the first William Pickles Lecture in 1968,[1] a year before Pickles, famous for *Epidemiology in Country Practice*'[2] and the first president of the Royal College of General Practitioners (RCGP), died. The lecture was initially funded by the Education Foundation Board, and Annis Gillie who was President at the time suggested that 'we have an annual lecture, which might be called the William Pickles Lecture, preferably on an educational theme, to be given ... out of London at the May meeting'.[3] Pickles personally demonstrated key elements of being a leader in public health; with well-developed communication in both his listening skills and written notes; a systematic interest in health, disease and its determinants; and an aptitude for partnership working with schools and local communities.[4] It is my great pleasure to deliver the 2006 lecture and I hope you will agree that the theme of safeguarding children in primary care is a particularly relevant topic for the occasion, as it represents a significant international public health problem with high prevalence and unacceptable levels of morbidity and mortality. Throughout this lecture, I will be drawing on my own journey in child protection over the last 20 years: from my first experiences of working as a junior doctor during my vocational training scheme in the accident and emergency department of Alder Hey Children's Hospital in Liverpool,[5] to my current role as Dean of a newly established medical school at Warwick. I developed an early research interest in the vulnerability of children and the difficulties that doctors face in forming a decision about 'the category of intent' when an injured child is being assessed. This interest in child protection has resulted in a number of academic papers including the RCGP's 2002 Position Statement[6] and a textbook on the subject.[7]

The lecture is designed to appeal to the straightforward factual evidence base, covering the history of the topic, size of the problem, diagnostic categories, impact of policy, importance of education and training and, importantly, the role of the College. I will focus on the opportunities that GPs and their teams have to become engaged, and I will also highlight the emotional burden of personal involvement. In summary, I hope to leave you with an appetite to learn more about the subject and be inspired to continue this valuable role in general practice and primary care.

HISTORY

Charles Dickens (1812–1870) is rightly acknowledged as an advocate for the underprivileged. Throughout his novels he provides a vivid account of the social injustices of his era. Brennan, a consultant paediatrician at Sheffield, who having read Dickens' *Oliver Twist*,[8] recently made the observation that the author demonstrated a remarkable insight into child abuse and domestic violence. In her essay *Oliver Twist: A Textbook of Child Abuse* she states that Dickens describes institutional abuse in its varied forms: emotional cruelty, neglect, and extreme physical maltreatment.[9] What is even more remarkable is that Dickens identifies several at-risk

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factors now known to be associated with adults who abuse children: alcoholism, domestic violence, cruelty to animals and mental health problems. The character Bill Sykes is an example of an abusive adult who demonstrates violent behaviour towards his partner and his dog.

The 19th century was a time of social deprivation with resulting adversity. The Revered George Staite in a letter to the Liverpool Mercury in 1881 observed: '… whilst we have a Society for the Prevention of Cruelty to Animals, can we not do something to prevent cruelty to children?'.[10] The London Society for the Prevention of Cruelty to Children was formed in 1884. Lord Shaftesbury was the first President and Reverends Benjamin Waugh and Edward Rudolph were joint secretaries.[11] Five years later, the Society changed its name to the National Society for the Prevention of Cruelty to Children (NSPCC), with Queen Victoria as patron. Waugh became the Society's director. Also in 1889, the Children's Charter was passed, allowing the police to arrest an adult who was suspected of maltreating a child.

While Dickens and other writers have described child abuse, the issue did not attract serious attention from the medical profession until the middle of the last century. Since then, several landmark papers and events have shaped our attitudes towards and understanding of child maltreatment. It has been accepted that children have been abused and neglected by their carers for many centuries. However, until relatively recently, child abuse was considered to represent a social evil. It received little attention from doctors, as it was not considered amenable to medical intervention. All this changed when Kempe *et al* published their article 'The battered child syndrome' in 1962.[12] This crucial paper was responsible for stimulating medical interest in the topic. Caffey's paper followed describing the whiplash shaken infant syndrome.[13] The continuum of child abuse was extended further by the publication of Meadow's paper on Munchausen syndrome by proxy.[14] In the UK public attention was focused on sexual abuse as a result of the Cleveland Inquiry.[15] Using covert video surveillance, Southall and his team in North Staffordshire published a further influential and disturbing paper in 1997.[16]

FACTS AND FIGURES

There are many definitions of child abuse in current use. One definition that has the advantage of being comprehensive and simple is that written by Meadow in his classic text *The ABC of Child Abuse*.[17] Child abuse refers to any treatment of a child which is unacceptable in a given culture at a given time. Four main categories are recognised: physical, emotional, neglect, and sexual abuse, and the categories are not mutually exclusive. NSPCC research shows that a significant minority of children suffer serious abuse or neglect.[18] Statistics confirm that 16% of children experienced serious maltreatment by parents, of whom one-third experienced more than one type of maltreatment.[19] There were 32 700 children on child protection registers in the UK on 31 March 2003.[20] Data maintained by the US Department of Health and Human Services confirm the high prevalence of child maltreatment in the US. Three children die daily in the US as a result of child abuse and nearly 1 million cases of child abuse were substantiated in 1998.[20] The adverse effects of abuse and neglect on child welfare, future adult wellbeing, and on society as a whole are now well acknowledged.

BARRIERS TO PARTICIPATION IN PRIMARY CARE

GPs and health visitors now undertake the majority of child health surveillance. Moreover, GPs rather than paediatricians are usually the first point of contact for parents regarding child health problems. GPs provide continuing care and support for children with chronic illness and disability. Child abuse may present to primary care in a number of ways: during a routine medical examination or appointment for child health surveillance; as a result of an allegation or disclosure; when an injured child is brought to the surgery; and as a result of general welfare concerns. However, GPs have an apparent low profile in the child protection process. I was aware of a perception that GPs were considered to undertake a relatively peripheral role in the protection of children. This limited role was not in keeping with the enhanced role that GPs undertake in the provision of health services to children.

Hallett[21] summed up a commonly-held viewpoint when she stated in 1995:

> *'It seems clear the mandate to work together is not widely accepted by GPs, who may have the status and independence to ignore it. It may be that … they have, in fact little to contribute and the system can and does function in the main without their active participation.'*

A number of inter-related factors may help to explain this. Child protection issues represent a source of considerable anxiety and uncertainty for many clinicians. Concerns have been expressed about the legal implications of involvement; confidentiality and the sharing of information with other agencies; and the distasteful nature of the subject. Some GPs also fear the personal consequences of challenging parents in terms of damage to the long-term and inclusive relationship they enjoy with families. The RCGP Position Statement explores these issues and

emphasises the enhanced role of the GP, the importance of inter-professional collaboration, and the continuing need for education and training.[6] A survey of Canadian hospital-based child protection professionals also confirmed the stressful nature of child protection work in acute secondary care settings.[22]

Research evidence on prevention and treatment is important but has prompted little attention from lawyers. Chadwick emphasises that it is the work which underpins the definitions of different kinds of abuse that has generated the political and personal attacks on expert witnesses such as Southall and Meadow.[23] In his editorial in the *Lancet*, Horton describes how:

> *'The real danger of the judgment against Meadow is that, by worsening the professional conditions in which child protection services are provided, children will be put at greater risk of abuse and murder.'*[24]

Focus group discussions undertaken with five primary healthcare teams in the West Midlands found that GPs were uncertain of what was required of them in the child protection process. The lead role in healthcare teams was often delegated by default to health visitors who then represented the GPs' views at case conferences.[25] GPs acknowledged their unmet training needs and expressed a preference for practice-based, multidisciplinary, clinically-oriented seminars.

Some doctors feel that child protection work is the prime responsibility of other professionals such as social workers and specialist paediatricians. Possibly, the most relevant issue is the lack of awareness of child protection issues as a result of inadequate training. The largest survey to date, conducted among 1000 GPs working in England, confirmed that GP principals had specific and unmet child protection training needs including detection of maltreatment and recognition of clinical indicators, legal aspects, intervention protocols, interagency liaison, and knowledge of procedures at child protection case conferences.[26] A more recent and positive training needs analysis conducted among GP registrars in North London concluded that, overall, registrars had received some training on more general aspects of child abuse and neglect, including predisposing factors and presenting features.[27]

THE VICTORIA CLIMBIÉ INQUIRY AND BEYOND

In November 1998, 7-year-old Victoria Climbié left the Ivory Coast to live with her aunt and her aunt's boyfriend in North London. By the following year she had had significant contact with no less than six public services comprising two hospitals, three local authorities, and the police.[28] Others, such as health visitors and GPs, should have had contact with Victoria but the referral was neither logged nor acted on. By July 1999 her hospital records noted the presence of cuts and bruises. She had been seen by a consultant paediatrician who considered her injuries to be self-inflicted, and a social worker had cancelled a home visit. Victoria spent much of the last weeks of her life wrapped in a bin liner, lying in a bath with her faeces and urine, with her hands and legs tied. She was regularly beaten, with the post mortem recording 128 separate physical injuries. The failure to conclusively detect abuse and protect Victoria by many agencies over a period of 10 months contributed to Victoria's death on 25 February 2000. Victoria's aunt and her aunt's partner were subsequently convicted of murder.

In the 2003 report into her death,[29] Lord Laming wrote of evidence that showed maltreatment 'to be the single biggest cause of morbidity in children.' He stated:

> *'It seems clear that when considering the issue of deliberate harm to children, one must keep in mind that one is dealing not simply with the extreme cases which occasionally prompt public inquiries such as this one, but an enormous number of instances in which the health and development of children is impaired by maltreatment.'*

The logic of Laming's report is straightforward but deeply troubling for society. The Inquiry made 108 recommendations, almost all of which have been accepted in full or in principle by the Government. Some of the recommendations are reflected in the RCGP Position Statement published the previous year.[6] There were 27 recommendations made about health services, four of these were specific to general practice (recommendations 86–89) and again focused on awareness raising of local policies and procedures, as well as emphasising the ongoing need for education and training for primary care staff.[30] Laming concluded that:

> *'The extent of the failure to protect Victoria was lamentable. Tragically, it required nothing more than basic good practice being put into operation. This never happened … doing the basic things well saves lives … Victoria died because those responsible for her care adopted poor practice standards.'*

Lord Laming found that the standard of work done by those with direct contact with Victoria was generally

of very poor quality. However, the strongest criticism was reserved for the managers and senior members of the authorities whose task it was to ensure that services for vulnerable children were properly financed, staffed, and able to deliver good quality support to children and families. The report highlights a story of failures of effective inter-professional and inter-agency collaboration. There are key lessons from primary care that may be learned. Failure to protect children from serious abuse and neglect will result in serious implications for all involved: the child, carers, perpetrators, and involved professionals.

Since 1945, there have been at least 70 public inquiries into serious cases of child abuse in the UK.[31] These have highlighted similar themes including inadequate communication between professionals; poor documentation; over reliance on the actions of others; ineffective action once abuse is suspected; and inadequate professional awareness of child protection issues. The last 3 years have seen great changes in our thinking about children and in particular, how we respond to children in need of protection. Following publication of the Inquiry there have been a considerable number of publications focusing on the need to prioritise services for children.[32–35]

ROLE OF MEDICAL ROYAL COLLEGES AND THE ONGOING NEED FOR TRAINING

> *'Child protection training is essential for all health professionals engaged in services for children. It is not an optional extra.'*[36]

The previous statement was made by Barry Capon, Chair of the Independent Inquiry into the death of Lauren Wright. The RCGP has published position statements on both domestic violence and child protection.[6,37] Following the publication of Lord Laming's report the RCGP has been engaged in a number of initiatives to support its members in relation to child protection. These include a joint conference with the UK Centre for the Advancement of Interprofessional Learning (CAIPE) in November 2003, a workshop to review the implications for general practice following Laming's recommendations, and, more recently, the development of the 'Keep Me Safe' strategy.[38, 39]

Current evidence from a systematic review of training and procedural interventions to improve child protection supports the use of procedural interventions, such as the use of check lists and structured forms, improving the documentation of suspected child maltreatment, and enhancing awareness. While a variety of innovative training programmes were identified, there was an absence of rigorous evaluation of their impact. It is recommended that future studies attempt to evaluate a variety of training methods (didactic, interactive, and computer-assisted) and that, in addition to self-reported changes in attitudes and confidence, objective evaluation of knowledge and clinical behaviour is needed.[40]

Effective participation in child protection work requires a range of clinical competencies in terms of history taking, clinical examination, documentation, communication skills, and decision-making ability. These are attributes demonstrated by Pickles and highlighted at the start of this lecture. I propose that the following principles should be applied to child protection training:[41]

- Equal importance to advanced life support training.
- Delivery to all doctors who have contact with families.
- Content and scope must be relevant to role and seniority and should be available at different levels (basic, standard, advanced, and expert).
- Content should be standardised similar to the implementation of the advanced paediatric life support course.
- Scope of training should be broadened to include domestic violence, cultural diversity, and evidence-based practice.
- Input of educationalists should be sought with respect to curriculum and modes of delivery.

The RCGP Curriculum Statement focusing on the future of vocational training: 'Care of Children and Young People', has now been accepted as the final version by the Postgraduate Medical Education and Training Board in 2006.[42] Importantly for the RCGP, there are also other bodies developing competencies for health professionals. The launch of an intercollegiate document involving the Royal College of Paediatrics and Child Health (RCPCH), the Royal College of Nursing, the RCGP and other Colleges in April 2006 is particularly welcomed. The RCPCH document defines six levels of competency that apply to all members of the health workforce, from expert witnesses to those who have little contact with children.[43] Much more needs to be done. I perceive three major challenges over the coming years. Firstly, there is an urgent need to improve the evidence base for child protection decision making. For example, at present there is a dearth of consensus on the precise ageing of bruises. Secondly, we must restore public and professional confidence in child protection work. Finally, we must all work together to ensure that the protection of children is recognised as a key responsibility for health professionals. My final quotation is from Sir David Hall, Professor of community paediatrics and past president of the

RCPCH. In his paper 'The future of child protection', he asserts:[44]

> *'Our hope is that protecting children will once again be seen as a core part of paediatric practice and that health professionals can continue clinical work and research with skill, compassion and humility, recognising the difficulties, but aware of their duty to protect children from cruelty, abuse and neglect.'*

In a similar vein to David Hall's expression of hope that protecting children should be seen as a core part of paediatrics, the main message of this lecture is that child protection should be seen as an important and integral part of general practice.

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