Child Abuse: A Critical Analysis of Health Professionals’ Roles

Summary

Child abuse is a significant problem, clinically and legally. Clinically it is important to be aware of the symptoms and signs of how children suffering from child abuse may present—this is not discussed here. Legally it is important that doctors and other healthcare professionals know what their responsibilities are and what actions to take in order to meet them. Health professionals who suspect or know of a case of child abuse should report it to the authorities as part of their professional duties. The role of health professionals in any investigations and legal proceedings following a child protection referral are varied and complex. Case law dictates that the time-consuming nature of such investigation and legal proceedings is not an excuse for health professionals not co-operating in the sharing and exchange of information. In particular, it is now part of one’s professional responsibilities to report any suspicions of suspected child abuse and/or neglect to your superior, and to follow this up to ensure that the concerns have been acted upon. If the reporting professional has any worries that their concerns are not being listened to they have a duty to report their concerns about the child to another more senior professional and to keep doing this until they are sure that their actions are being listened to and acted upon.

Introduction

Child abuse is considered a growing problem. Most recently, this has been highlighted by the recent public and media outcry over the death of Victoria Climbie, killed by her aunt and uncle, the tell-tale signs of child abuse ignored by numerous professionals 1. At the same time, government statistics show that unlawful deaths of children—most killed by their parents—rose by fifty percent in the UK in 2001 compared to 2000 1.

This essay seeks to: explain what action health professionals should take if they suspect that a child is being abused or at risk of abuse; to critically analyse the role of health professionals in any investigations, and legal proceedings, which follow a child protection referral; and, considers whether there are any particular difficulties in relation to the exchange and sharing of information between health professionals and other agencies.2

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1 This essay borrows heavily from the following papers Working Together to Safeguard Children (1999) and Cobléy, C. (2002) 19, 20.
2 This essay was written in 2002 and as such some of the responsibilities may have been superseded: the conclusion has been re-written to reflect the major change.
Child Abuse

Abuse is defined as making bad use of, maltreating, verbal or physical attack(s), reviling, the misuse of, or the effects of unjust or corrupt practice on an object, person or being\(^2\). Actions fitting these descriptions, directed towards a child, could be termed “Child Abuse”. The type of abusive action, the personality of the child, and the environment the action occurs in, all contribute to how the abuse may affect the child, both at the time of the abuse and later.

Child abuse is a not a simple concept, but it is the duty of the child’s guardians to make their child safe from harm. Normally the child’s guardians will be one, or both of, the child’s biological parents, but not always. Irrespective of who the guardian(s) is (are) the duty to protect the child from harm remains the same.

There are different forms of child abuse: physical, emotional and sexual. In the public conscious neglect is also often considered a form of abuse\(^3\), although the Government appears to consider neglect a related but distinct issue. Since neglect can be both a form of positive or negative action, hereafter neglect and abuse will be considered effectively as one.

Prior to the Victoria Climbie case there was no specific legal duty in the UK on a person to have report a case of suspected or known child abuse to the authorities. This included persons involved with the child in a professional capacity: for example, health professionals.\(^3\) Health professionals include any healthcare worker who is involved with providing care for the health needs of a person. The definition covers a diverse range of health professions. In the area of childcare, the main health professions include GPs, specialist doctors, nurses, midwives, health visitors and school nurses. All of these health professionals are in contact with children. And, health professionals are often some of the persons best able to identify children who are being abused or who are at risk of abuse\(^4\).

Irrespective of the lack of a specific legal duty, health professionals’ professional bodies place a responsibility on health professionals to report cases where they suspect that a child is being abused or at risk of abuse to the appropriate authorities\(^5\). The appropriate authorities include Social Services, the police, and any person authorised by the Secretary

\(^3\) The exception to this involves persons who are involved with the custody, charge or care of an abused child who know that the child has been abused and that there is likely to be further instances of abuse. Under these circumstances failing to report the child abuse may lay the person open to specific criminal liability under section 1 of the Children & Young Persons Act 1933.
of State for Health. Unless a health professional considers (and can justify) that it is not in their patient’s (namely the child’s) best interests, a health professional should report a child whom the professional believes may be being abused or at risk of abuse to the authorities.

Assessing Risk of ‘Significant Harm’

When an allegation or suspicion of child abuse has been brought to the attention of the authorities, the respective Local Authority (LA) is under a duty to investigate. This duty is imposed by either (or both) section 47 or section 37 of The Children Act 1989. Government guidance makes it clear that the aim of an enquiry is not to assess whether the child should be permanently removed from his/her family. Rather enquiries seek to assess what course of action is best for the child, with the intention of keeping/reuniting the child with his/her family whenever possible.

The Children Act 1989 requires that the authorities take action to protect the child when the child is suffering, or at risk of, ‘significant harm’. In deciding whether to take action or not, the LA has first to decide whether or not the alleged ‘harm’ is of a ‘significant’ nature. Then, the LA has to determine whether the ‘harm’ is continuing or is likely to occur in the future. Finally, the ‘significant harm’, or its likelihood, must be attributable to inadequate parental care or control.

The Children Act defines ‘harm’ as the “ill-treatment or the impairment of health or development” 8. In this context, ‘development’ covers a child’s physical, intellectual, emotional, social and behavioural development. ‘Health’ includes both physical and mental well-being 8. ‘Ill-health’ is described as pertaining to sexual abuse and non-physical forms of ill-treatment 8.

Whether the child is suffering ‘significant’ harm is a question that is specific to the child and his/her individual circumstances. The Act states that evaluation of whether the harm is ‘significant’ should be decided by comparing the child’s health and development “with that which could reasonably be expected of a similar child” 9. Government guidance recognises that to achieve an objective comparison it is necessary to understand the child and the environment the child is living in. As such, LAs are required to assess the child’s family context, the child’s development within this context and the child’s wider environment, any special needs of the child, the nature of the alleged harm, the harm’s

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4 Which duty of the Act applies depends on how the allegation or suspicion has been brought to the attention of the local authority

5 Abuse that merely occurred in the past, but which does not pose a present threat of harm now or in the future, does not provide a valid reason for the LA to take action: although the police are likely to be informed.
impact on the child’s health and development, and the adequacy of the parental care provided to the child.

Best-practice dictates that the investigating LA works in partnership with other agencies in order to adequately assess the child’s needs and the type and level of harm the child is experiencing. This need for joined-up working has been recognised in such influential reports as the Cleveland Report and the courts 10. The need’s relevance is reflected in section 47 of the Children Act. Section 47 places a statutory duty on a number of agencies to aid a LA with its child abuse enquiries 11. This list of agencies includes inter-agency cooperation health authorities, Special Health Authorities and the NHS.

In practice, the Social Services of the investigating LA is the body responsible for conducting child abuse enquiries.6 The local health authority (HA) is responsible for taking the overall strategic lead in the area of health. The HA has to co-ordinate local inter-agency working between the health and social services. This involves ensuring that vulnerable children’s health care needs are met, that local health agencies and professionals contribute in a full and effective manner, and that health professionals act in the best-interests of the children’s welfare.

Following a referral, social services decide whether the referral should be investigated. If a decision to investigate is made then an initial assessment of the child is made 7. For a child in need, but who is not judged to be at risk of significant harm, a core assessment of the child’s needs is made. For a child in need and judged to be at risk, a strategy discussion takes place where the case so far is reviewed with one of the following outcomes occurring. If the decision is made that the assessment was correct, a section 47 enquiry, and possibly a criminal investigation, are started.

A section 47 enquiry is an inquiry carried-out by the LA to investigate whether action is required to safeguard the child’s welfare. The inquiry assesses whether the child is at risk of significant harm by building an understanding of the child and the environment the child is living in. This requires the social service to carry-out an objective assessment, as described previously. If the section 47 enquiry, and any criminal investigation, decide that the child has been the subject of significant harm an initial child protection conference

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6 Where there are suspicions of criminal wrong-doing, the enquiry is conducted jointly by the police and social services.

7 This has to be completed within a maximum of seven days from the date of the referral- although because of circumstances pertaining to the referrals, the time taken is often shorter.
(CPC) is convened. When criminal wrong-doing by the abuser is suspected, the police will pursue criminal charges.

CPCs involve inter-agency partnerships. Government guidance requests that professionals from those agencies with the most contact with the child be asked to attend the CPC. Often this will include health professionals, such as the child’s GP, or the midwife (for the unborn child). Evidence indicates that health professionals are generally some of best-placed professionals to determine whether the child is at significant risk of future harm and what ‘effective’ action to recommend.

The initial CPC decides whether the respective child(ren) should be registered or not as at continuing risk of significant harm. For a child registered as at continuing risk, the child is given inter-agency help. The intervention is delivered through a formal child protection plan, with the outline of the plan being formulated by the CPC. The CPC also identifies a core group of professionals and family members who will develop the plan in detail and help implement it in the best interest of the child: often the quorum will include health professionals such as the child’s GP. The CPC is also required to agree a date for further meetings to review progress, including whether the child should remain on the register.

The Role of Health Professionals

Since April 2002, the effects of the 1997 Health Reform’s mean that primary care is now organised into Primary Care Trusts (PCTs). The creation of PCTs mean that all of the major health professions involved in working with children are now clearly under the jurisdiction of section 47 of the Children Act; as such, all health professionals have a statutory duty to aid the LA’s Social Services department in its child abuse enquiries.

Under this role general practitioners (GPs), and other health professionals in primary care, are required to share information when enquiries are being made about a child. Members of the primary care health team are also required to make relevant information concerning

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8 Child protection conferences have to take place within 15 days of the strategy discussion.

9 Before the creation of the PCTs fund-holding GPs were not part of any health authority, the result of the 1990 Internal Market Reforms. Although the NHS had a statutory duty to work with the investigating LA 11, the role of GPs as independent contractors, especially fund-holders, may have provided a legal anomaly whereby GPs were not covered by section 47 of the Act, and thus under no legal requirement to assist with the investigating LA. This may be especially true for those health professionals fund-holding GP's sub-contracted to help them in the provision of the primary-care service; these sub-contracted professionals were often working outwith the NHS in a private capacity.
the child and the child’s family to the CPC. The GP, or a member of the GP’s team, is often expected to attend the CPC. The same person is likely to be requested to attend the core group meetings. GPs should also have in place a means of identifying to themselves, and other health professionals working with their patients, which children on the GPs’ patient lists are listed on the child protection register. When cases of child abuse reach the courts, GPs and their team may be requested to provide this same information in testimony to the courts.

In general, secondary care professionals do not have the same degree of on-going contact with their patients. For these health professionals, their role is most likely to be limited to noticing possible cases of child abuse and reporting them to the authorities. However, some secondary care specialists may be involved in making assessments of the child’s health, for example paediatricians and psychiatrists. Paediatricians may be required to determine whether the child is ‘failing to thrive’, the health needs of the child, or whether the child has been sexually abused. Whilst, psychiatrists may be required to determine the child’s mental state of development, educational and emotional needs. The results of such assessments are used by the CPC to guide their decisions on whether to register the child, formulate the child protection plan, and/or de-register the child from the child protection register.

The nature of the referral and registration process means that the health professionals’ role is often a long-term involvement with a given case once a child protection referral has been made. Assessment reports may also be requested by the courts, and thus require the relevant specialist to testify to his/her assessment in court. Because of this, the time demands of child protection enquiries are often large. These demands have to compete with the other numerous demands on a health professionals’ time. They are a potential cause of frustration and distrust with other CPC members, especially if health professionals feel their time is being wasted or the pressures of their other duties appear to be ignored by other professionals of the inter-agency group. Potentially this could lead to break-downs in communication- if allowed to fester by LA and HA management.

**Particular Difficulties in the Exchange & Sharing of Information**

Inter-agency working is difficult. Different professions often have different interpretations of a given issue, and hence whether it is of ‘significant’ concern. This is often a result of the different backgrounds, both in training and experience, of the respective professions. To accurately identify cases of child abuse, different professions need to work together—experience shows that the differing backgrounds is an asset.
Communication may break-down because of personal feelings, values, prejudices and beliefs creating distrust between the different professions. Alternatively, a court-order may prevent disclosure of information between the different professions. In such instances, this could prevent cases of child abuse either being detected or acted upon. This principle has been recognised by the courts, for example Butler Sloss’s ratio decidendi in Re G (a minor).

In contrast, the Cleveland Inquiry showed that beliefs, whereby a profession is held in too high an esteem by another, can have just as serious consequences as distrust of a profession. The high esteem of doctors, and their medical knowledge, held by Cleveland social services during the spring and summer of 1987 led to health professionals’ professional power being too forcefully exercised. The result was an excessive number of child referrals turning on the basis of medical evidence alone—evidence that was later shown to be unreliable. Whilst, ineffective management allowed the problems of distrust to fester. Overall this resulted in the best-interests of children and their families being abused by the very agencies meant to have been protecting them.

Similarly, distrust or lack of knowledge about the legal framework by health professionals, and/or lack of effective management of the health services by the HA may lead to health professionals failing to exchange information or act on information which is shared. The issue of confidentiality, and health professionals concerns about breaking patient confidentiality, may mean that health professionals do not pass-on information to social services about issues of child abuse. The legal position is unclear, especially as the majority of doctors’ knowledge of the specifics of the law is limited. Although the GMC and Government guidance require the doctor to break patient confidentiality under these type of circumstances the guidance from at least one of the medical defence unions appears to contradict this. This is likely to lead to difficulties in the exchange and sharing of info.

Lord Laming points out in the Climbie Report, that different backgrounds of the collaborating professions may also mean that different professions interpret the information differently. Information may be shared between the different agencies, but this may still not prevent cases of significant child abuse being missed, or failed to be acted upon. As Sinclair & Bullock (2002) found in their review of 40 serious case reviews, “… different interpretations of assessments or accumulating evidence on low level need [exacerbated] ambiguities about what information should be appropriately shared … [leading to agencies failing to act on cases of child abuse]”.
Conclusion

Past experience would suggest that the system for protecting children from abuse will never be foolproof. Despite this, health professionals who suspect or know of a case of child abuse should report it to the authorities as part of their professional duties. Often the nature of child assessment means that the role of health professionals in any investigations and legal proceedings following a child protection referral are varied and complex. The fact that they are time-consuming should not be an excuse for health professionals not cooperating in the sharing and exchange of information. This viewpoint is reflected in the Victoria Climbie report. The result of the report means that it is now part of one’s professional responsibilities to report any suspicions of suspected child abuse and/or neglect to your superior, and to follow this up to ensure that the concerns have been acted upon. If the reporting professional has any worries that their concerns are not being listened to they have a duty to report their concerns about the child to another more senior professional and to keep doing this until they are sure that their actions are being listened to and acted upon.

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