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Complaints in child protection

Linda Haines,[1] Jacqueline Turton[2]

The current difficulties facing paediatricians working in child protection have already been well documented.[1–3] Studies have shown that as well as causing significant stress and psychological morbidity,[4] complaints against UK paediatricians in relation to a child protection issue are becoming increasingly common.[5] A survey of members of the Royal College of Paediatrics and Child Health (RCPCH) found that 13.8% of over 4500 respondents had been subject to a total of 786 complaints about child protection and that the number of complaints per year had increased from less than 20 in 1995 to over 100 in 2003.[6]

Although worrying, the finding that the number of child protection complaints rose fivefold in 4 years needs to be set in context. Over this same period there were still almost twice as many paediatricians with a non-child protection complaint against them, and information from the Medical Defence Union shows that complaints to the General Medical Council increased almost 15-fold between 1990 and 2003, an annual rise of 33%.[7]

If we are now more likely as a society to complain about any aspect of our medical care than we were a decade ago, why are child protection complaints of particular importance? The answer we believe is threefold. Firstly, the rising level of complaints is clearly making the paediatricians that society relies upon to protect vulnerable children feel demoralised and disengaged. The evidence is clear: 29% of paediatricians who have experienced a complaint are reluctant to take a future lead role in child protection,[7] there are continuing recruitment difficulties in community paediatrics,[8 9] and paediatric trainees are reluctant to consider a job with specified child protection responsibilities.[10] However, the impact of complaints is not just felt by those who "specialise" in child protection. Protecting children is part of every paediatrician's work and nearly half of the reported complaints involved paediatricians who were not actively involved with child protection teams or were not named or designated doctors.

Secondly, complaints are hugely time intensive for both practitioners and managers, time that could be more effectively spent on delivering services to patients. In some cases complaints can take years to resolve; 23 complaints reported in the survey were still unresolved a year after being made and eight were still unresolved after 3 years. And yet most complaints are shown to be unfounded; where the outcome of the complaint was known, 59% were dropped, 24% were found unproven after an official enquiry and in only 3% of cases was the complaint upheld.

Finally, and very importantly, the rise in the number of complaints suggests that families do not believe that they are being treated fairly within current systems and this needs addressing. As 16% of reported complaints attracted some level of media attention, there is the risk that adverse media coverage could further undermine the confidence of the public in the child protection system and paediatricians more generally.

Understanding how and why child protection complaints arise can surely only help to improve systems and processes for all involved. In 2005 the RCPCH commissioned its research division to undertake some qualitative research to explore child protection complaints in more detail. This paper summarises the findings of this research and other RCPCH child protection activities. A more detailed report of the findings is available.[11]

METHODS

Qualitative interviews were held with 72 consultant paediatricians who had been the subject of a child protection complaint between 1999 and 2003. The purposive sample was drawn from consultant paediatricians responding to the RCPCH survey[6] and took into account geographical location, child protection role, number of complaints and media involvement in order to capture a range of experiences and roles. Ethical approval was obtained from Oxfordshire Research Ethics Committee (ref 05/Q1604/8).

The interviews were based on a series of questions and themes drawn from a literature review and free-text comments from the earlier survey.[6] They were taped and transcribed and the transcriptions analysed using NVIVO software to identify "trigger" points for complaints as well as the problems and concerns for paediatricians undertaking child protection work. To put the data in context, a number of interviews were held with Trust complaints managers, designated nurses and legal experts. It was recognised from the outset that an understanding of why complaints arise would not be possible without including parents. However, although 40 Trusts were contacted, in the event none were able to help contact parents.

RESULTS

The interviews sent the overwhelming message that paediatricians are well aware of the risk of a complaint, particularly when they initiate a referral to social

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services. To a large extent doctors understand and accept the risk of complaints when undertaking child protection responsibilities.

However, for a small number of individuals, the complaint was accompanied by threats, personal attacks, threatening mail, accusations of child abuse and even child murder. These clearly had a considerable impact on the individual and their family. Even when complaints did not attract such extreme reactions, delays in resolution, lack of information about the progress of the complaint, the fear of job loss and feelings of guilt or shame added significant stress.

Triggers for complaints

Although the circumstances around the complaint were varied and often unique to the individual situation, analysis of the interviews identified three main dilemmas facing paediatricians which appear to trigger complaints, either directly or indirectly. The first dilemma is in relation to the clinical uncertainty that can exist when making a diagnosis of non-accidental injury, given the often ambiguous signs and limited evidence base. The second is how to communicate initial child protection concerns to families and the third dilemma is the insufficient time most paediatricians have for effective child protection work. There were a very small number of complaints which might have been avoided if best practice guidance recently outlined in the RCPCH *Child protection companion* had been followed.[12]

Limited evidence base

Paediatricians clearly feel under pressure from other agencies to make a firm decision about the cause of an injury, whilst being acutely aware that the evidence base behind any particular signs and symptoms may be weak. For instance, the challenges of aging bruises[13] and the controversy regarding retinal haemorrhages in "shaken baby" syndrome[14] have made professionals more vulnerable to complaints. The ambiguity of signs leads paediatricians to seek further tests, advice or second opinions and complaints can arise when the initial suspicion is not confirmed, with innocent parents clearly aggrieved that non-accidental injury (NAI) was even considered. A difference in opinion between clinicians can also lead to the complaint that the paediatrician lacked the expertise in making a diagnosis of NAI.

Communicating concerns

When NAI is suspected, the relationship between paediatrician and parent changes from the usual collaborative relationship, shifting the balance between the parents' and the child's rights. The Children Act 2004, the Laming enquiry[15] and government advice[16] all reinforce the rights of the child and the position of the paediatrician in these cases by emphasising that the welfare of the child is paramount. This has been recently tested within the courts (that the paediatrician's duty of care is to the child and there is no competing duty of care owed to the child's parents or carers) which should reassure frontline professionals.[17]

However, paediatricians acknowledged how difficult it can be to know how and when to communicate concerns to parents:

> … it's that awful moment where you reach a point where you have to … turn from being friend to foe.

Some paediatricians found themselves having this difficult conversation in cramped out-patient departments, busy hospital wards with few facilities or alone in rural clinics with limited resources and insufficient privacy or time. Such situations can lead to complaints.

Regardless of the type of suspected abuse, it was the action of making the initial referral to social services that in several cases triggered a complaint against the paediatrician. It was considered easier to deal with cases referred by other agencies when the doctor could take a more independent role:

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

Most paediatricians welcomed an early collaborative approach to information gathering, discussion and decision making. But it was recognised that working together is not always easy and there needs to be a clearer understanding of roles and responsibilities across professional boundaries as well as a development of trust between individual child protection practitioners.

Insufficient time

A shortage of resources for effective child protection work emerged as a major concern. In several cases this had indirectly resulted in a complaint, such as when a family were inconvenienced by an extended stay in hospital because a skeletal survey could not be undertaken over a weekend. In particular, insufficient time to conduct child protection work, which may require extensive report writing, multi-agency meetings and court appearances, was cited as a cause of problems:

> … whenever I've had child protection problems, it's always been that I haven't had enough time to do it properly.

Despite the recommendations in the RCPCH model job descriptions,[18,19] it is clear that many paediatricians feel they do not have enough time for effective child protection.

General concerns

The interviews identified a number of general child protection issues not directly related to the specific complaint. These were principally focussed around the levels of training and support for child protection professionals and the complaints process.

It was clear that many of those interviewed feel that child protection training has been a neglected area. Although the new RCPCH training packages were welcomed, there are concerns about how these can be incorporated into the shortened training period available for junior staff and it was felt there is an urgent need to offer training to more senior staff already working in child protection.

Many paediatricians feel unsupported in their child protection work. Personal support and mentoring from colleagues, support from Trusts as well as general support from the RCPCH were all highlighted as needs. The practice of using local colleagues for support and advice is more active in some NHS Trusts than others, but where it was available, it was considered to be extremely valuable. Local multi-agency networks not only build trust between disciplines and agencies, but they can also protect doctors against unfounded complaints by sharing the responsibility for decision making. These networks can also offer both formal and informal support to individuals if complaints arise.

Another area of concern was the complaints procedure, both locally and nationally. Poor communication between the investigating authority and the paediatrician about the progress of a complaint and

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Table 1 RCPCH child protection activities

Working parties and publications
Responsibilities of doctors in child protection cases with regard to confidentiality (2004)
Sudden unexpected death in infancy. A multi-agency protocol for care and investigation (2004)
Procedures to be adopted by the dental professional who suspects child abuse
Model job description: designated doctor for child protection (2005)
Model job description: named doctor for child protection (2005)
Child protection companion (2006)
Child protection and duties of the anaesthetist (2007)
Standards for radiological investigations of suspected non-accidental injury (2007)
Child protection reader (2007) (training manual)
Research
Child protection complaints survey (2003)
Qualitative study into the nature and impact of complaints made against paediatricians involved in child protection procedures (2006)
Evidence based guidance on the physical signs of sexual abuse in children (due 2007)
Guideline on diagnosis of salt-poisoning leading to hypernatraemia in children (due 2008)
Research to explore parents information needs and experiences when professional concerns regarding non-accidental injury were not substantiated (2007)
Funding for a systematic review of non-accidental head injury
A review of the evidence in relation to oronasal bleeding
Training and education
Safeguarding children – recognition and response in child protection for doctors in training
Family justice training scheme with mini-pupillages
Courses on court skills in child protection
Safeguarding children and young people – roles and competencies for health care staff (2006)
Child protection competencies defined for all health service staff (2006)
Collaboration
Regular meetings and discussions on joint working with the Department for Education and Skills, the Department of Health and the General Medical Council

the outcome, and the length of time it can take for complaints to be resolved, can cause unnecessary stress. It has already been suggested that it might be more appropriate for child protection complaints to be handled initially as a complaint against the employing Trust and only considered to be against an individual when negligence has been proven.[20] In the meantime, however, there is considerable discrepancy in the support offered by Trusts to paediatricians who find themselves subject to a complaint.

THE WAY FORWARD

Child protection decisions, if wrong, can have devastating consequences for individual children, for families, for the professionals with a responsibility to protect vulnerable children and for society as a whole. Because the consequences of "getting it wrong" are so huge, all sectors of the public need to have confidence in the child protection system. The recent rise in child protection complaints, adverse media coverage and the difficulty of recruiting to child protection posts suggests that this confidence may be lacking.

Although the increasing number of complaints in relation to child protection could simply be a reflection of a more "complaining" public, they should nevertheless prompt a reflection as to why some families feel they are unfairly treated. There is also a need to work in partnership with other organisations and the public to ensure a better understanding of the paediatrician's role in protecting children and the difficult decisions that have to be made.

As complaints can also be stressful, time consuming and undermining for paediatricians, the fact that they are becoming more common also suggests an urgent need for professional support and decision making informed by the best research evidence. Over the last few years, the RCPCH has established a wide-ranging programme of work to support those involved in child protection (see table 1) which will be further strengthened by the recent appointment of a College Officer for Child Protection. It is hoped that the increased training, support, primary research guidance for paediatricians and developing partnerships with families which will emerge from this programme over the next few years will minimise the number of complaints and restore public and professional confidence.

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