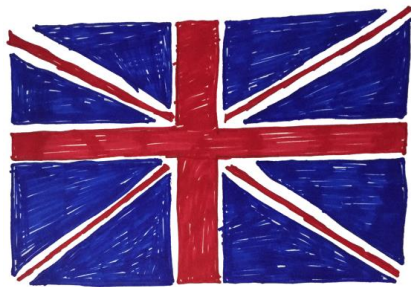


# Living on a railway line



Turning the tide of child abuse and exploitation in the UK and overseas:  
international lessons and evidence-based recommendations



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## Living on a Railway Line

Some children in the world are *physically* living on a railway line; others are *metaphorically* living on that same railway line at significant risk of harm from many different sources.



*Figure 1: Living on a Railway Line, Sihanoukville, Cambodia*

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## **2.0 Foreword**

### **2.1 Foreword by Professor Desmond K. Runyan and Professor Donald C. Bross**

**2.1.1** This Report by Churchill Fellow Dr Andrew Graeme Rowland has a number of virtues, among which are its potential for increasing needed visibility and recognizing the value of those within the United Kingdom (UK) who can agree to and support an improved response to child abuse and neglect.

**2.1.2** Child abuse and neglect are increasingly viewed as a health and public health issue of great importance – for countries at every stage of economic and political development. However, unlike the strategies developed for managing communicable diseases, safeguarding the quality of water and air, and bringing public health tools to bear on injury prevention, there is no model strategy anywhere for addressing human violence as a public health issue, and in particular with respect to child maltreatment.

**2.1.3** Dr Rowland's Report provides highlights of international experience and adaptation of evidence-based interventions for child abuse. His Report necessarily cannot provide a comprehensive review, based on one fellowship, of a field that has been widely accepted as a significant medical issue only in the past half century, yet has already created an extensive multidisciplinary research literature.

**2.1.4** As noted by the U.S. Centers for Disease Control and Prevention, violence is a highly significant issue that can benefit from and contribute to public health efforts to prevent disease and injury. Great costs to human health are associated quite particularly with child maltreatment. A CDC website is cited by Dr Rowland, with a link that is included in his report. The link is repeated here because of the importance of the problem this accumulating science of Adverse Childhood Experiences represents<sup>1</sup>:

<http://www.cdc.gov/violenceprevention/acestudy/>

**2.1.5** Studies of the treatment of children and parents affected by child maltreatment are becoming more numerous, sophisticated and scientific<sup>2</sup>. In particular, ‘trauma’ focused treatment, parent-infant interaction therapy, abuse-focused cognitive behavioral therapy, trauma-focused cognitive behavioral therapy and child-parent psychotherapy have been proved to achieve significant results. In the area of prevention, randomized trials have demonstrated the possibility of reducing child neglect<sup>3</sup> and child abuse<sup>4</sup> in specified circumstances, and, again under specified conditions, crime and delinquency<sup>5</sup>.

**2.1.6** Seemingly in a parallel to the hygienist movement of the early 1800’s, during the twentieth century public attention to maltreatment of children and spouses attracted public discourse that sometimes seemed to anticipate later research. Early in the twentieth century, even before proof of harm from excessive discipline was established, some countries changed their approach to learning and ‘discipline’ in schools. Eliminating corporal punishment in schools has proven to be an achievable, realistic policy over many decades in the Scandinavian countries, more recently in the United Kingdom, and in countries from six continents, societies of many types are demonstrating that learning and school discipline can be achieved absent corporal punishment without destroying education or undermining the host society<sup>6</sup>.

<http://www.endcorporalpunishment.org/pages/progress/global.html>

**2.1.7** Unlike public health law related to communicable diseases, progress has been uneven in the area of children’s rights. While children’s rights are often asserted to be a universal aspiration, children’s rights have not been given legitimacy by the ratifying of the UN Convention on the Rights of the Child by the U.S. or Somalia, and legitimacy for children’s rights has not received wide-spread enforcement and funding to address aspirations more prized in the abstract than obeyed in reality. As just one additional example of shortcomings among current efforts, all too rarely is there recognition of the importance of preventing violence to mothers as part of the prevention of child maltreatment.

**2.1.8** Because reliable data are essential in health and public health management of major societal ills, the epidemiology of child abuse is a central concern of child abuse remaining to be fully addressed. In a book to be published by Springer in early 2015 I wrote<sup>7</sup>:



*“While state-mandated reporting has a more than 40-year history in the United States, child maltreatment remains a serious public health problem. Because of the limitations in science, the impossibility of any clinical trials of mandatory reporting, and the constant evolution of intervention approaches, clearly establishing which children are better off for having been reported is virtually impossible. However, in contrast to available evidence from other countries, the US has seen a remarkable reduction in child abuse over 20 years.”<sup>8</sup>*

**2.1.9** Addressed in the same publication are discussions of such issues as the degree to which reporting and investigation might divert funds from treating and preventing child abuse, various other ‘myths’ of current child protection practices, and the economics of child maltreatment. It is worth noting that the treatment studies cited above are largely based on research with “involuntary populations” which means that the children or parents were either under a court order or risked a court order if they did not participate in treatment. The SafeCare® evidence-based research on prevention of neglect has been conducted until now with child protection services populations. There are reports that there is significant loss of enrollment by ‘eligible parents’ when a program such as the Nurse Family Partnership is offered only on a voluntary basis<sup>9</sup>. Still, decreases in child abuse and neglect on a population-wide basis have been shown to be achievable. Off-setting the gains, success is found largely in limited studies and replications. Only approximately 15% of 3,141 U.S. counties have adopted the Nurse Family Partnership model, the best researched prevention for child abuse.

**2.1.10** Measuring overall changes in child maltreatment rates in total populations does not depend on only one method. Continuing surveys offer another approach, and this has been established as valuable along with episodic international surveys<sup>10</sup>. As with any effort at public health measurements, there is a cost to such efforts that can be argued to draw resources away from prevention and intervention. There remains a philosophical and policy challenge with respect to the abuse and neglect of children: Any system that fails to reliably ‘find cases’ surrenders to the very long history of ‘gaze aversion’ in which professionals and the public, consciously or unconsciously, have repeatedly “discovered” a very long list of reasons for not seeing and responding to abused children.

**2.1.11** While no nation has developed, much more implemented, a model strategy for child abuse and neglect as a public health problem, there are important signposts of actual and possible progress. As represented by Dr Rowland's Report, to advance our response to preventable harms to children, as with any area of health, we need productive science, better and more available professional and public education, and a shared commitment to assuring children's health and well-being: a concern that must be prioritized among very many demands for attention by various adult interests. This commitment will most likely occur only in societies that recognize children's rights as current citizens, and which willingly provide continuing resources, visibility and evidence of progress for the work to reduce child abuse and neglect.

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# Executive Summary



***“The world is in greater peril from those who tolerate or encourage evil than from those who actually commit it”***

Albert Einstein, 1879-1955

## About this chapter

**This publication is not intended to be read cover-to-cover in one go as a book.** Instead, the report is grouped into different themes covering key areas of child protection work and is presented in chapters so professionals and community members interested in exploring different aspects of this challenging work can see the evidence base behind the conclusions and recommendations and can appreciate the international contribution to their creation.

This chapter summarises the main findings of this report and makes ten key recommendations that are applicable to the United Kingdom of Great Britain and Northern Ireland (UK).

This report makes recommendations for the UK and the international community. Whilst the nomenclature may differ between England, Northern Ireland, Scotland and Wales the intention behind the UK recommendations is that they are just that – recommendations to be applied on a UK basis. The intention behind the recommendations should be preserved and translated into whatever national or devolved terminology is necessary to implement the recommendations across all four nations of the UK.

## 3.0 Executive Summary

- 3.0.1** Some children in the world are *physically* living on a railway line; others are *metaphorically* living on that same railway line at significant risk of harm from many different sources.
- 3.0.2** *Living on a Railway Line* makes key recommendations to improve the safeguarding of vulnerable children in the United Kingdom and beyond. In light of recent events in Northern England, including the child sexual exploitation cases in Rochdale<sup>11</sup> and Rotherham<sup>12</sup>, this report is crucial to professionals working with children and families as well as to policy and law makers at a national level in the UK.
- 3.0.3** Child protective systems in the UK are *partially* broken. Not *completely* broken but they are certainly not functioning adequately in all cases. If they were then there would not be serious case review after serious case review highlighting inter-agency communication failures and failures to act upon information received which suggests that a child might be at risk of significant harm, as causative or associative factors leading to an adverse outcome for a child. That adverse outcome is, sadly, sometimes the death of a child who could and should have been protected.
- 3.0.4** Professor Alexis Jay's independent inquiry into Child Sexual Exploitation (CSE), published at the end of August 2014, estimated that approximately 1400 children were sexually exploited in Rotherham, UK between 1997 and 2013<sup>12</sup>. One thousand four hundred children in a town whose population is only around 250 000<sup>13</sup>.
- 3.0.5** In more than a third of Rotherham cases, children affected by sexual exploitation were previously known to services because of child protection and neglect. The abuse that these victims suffered was horrendous. Girls as young as 11 years old were raped by multiple perpetrators. Children were trafficked to other towns and cities in the North of England, abducted, beaten, and intimidated. Some children were doused in petrol and threatened with being set alight, threatened with guns, made to witness brutally violent rapes and threatened they would be next if they told anyone.

- 3.0.6** Professor Jay's inquiry concluded that over the first twelve years covered (1997 – 2009) the collective failures of political and officer leadership were blatant and that from the beginning there was growing evidence that child sexual exploitation was a serious problem in Rotherham. Within social care, the scale and seriousness of the problem was under-played by senior managers and at an operational level the police gave no priority to CSE, regarding many child victims with contempt and failing to act on their abuse as a crime.
- 3.0.7** Although there have been improvements over the last four years in Rotherham this does not detract from the horrendous abuse that over one thousand children and young people suffered over the course of more than a decade, without adequate inter-agency intervention and without effective investigation and support.
- 3.0.8** *Living on a Railway Line* has not been produced in response to the Rotherham report – the work underpinning this publication has been going on for over a year, well before publication of the Rotherham report. However, the timing of the release of information surrounding the appalling events in Rotherham over many years is such that there are recommendations contained within *Living on a Railway Line* that could, if implemented efficiently and correctly, go some way to reducing the likelihood of another “Rotherham” occurring in the future.
- 3.0.9** The fact that there continues to be the same lessons that still require learning in different regions of the country and in independent cases involving child protection, suggests that the system in place at the current time needs a further review and that a different approach is needed – potentially a more radical approach than has been tried before – to properly protect the most vulnerable members of our society.
- 3.0.10** As well as looking at good practice examples from the UK there is a real opportunity, provided people are willing to keep an open mind and to try new things, to see how experiences gained abroad in different settings could be modified or applied to the UK systems and processes and how they could be the different approach that is most definitely needed.



**3.0.11** When focussing on child protection issues it is right that special focus is given to those children who cannot speak up, or are prevented from speaking up, for themselves. However, the effects of child maltreatment on older children cannot be underestimated. It is crucial that professionals recognise the specific vulnerabilities that exist within the adolescent age group and that they are empowered to influence the community in which they live in a positive way, with the community advocating on their behalf and supporting them.

**3.0.12** The importance of protecting children who have to give evidence in Court cannot be underestimated and a recommendation is made to ensure that each region has access to a remote site where children can give evidence from outwith the Court building, without any possibility of meeting the alleged perpetrator. Mandatory training for all legal professionals involved in child abuse cases is vital.

**3.0.13** Throughout the whole report there are recommendations for further research surrounding child protection in the UK, including ascertaining the views of society and child protection professionals, as well as the continued development of international networks to respond to the global challenge of children's advocacy on a much larger scale.

**3.0.14** There are five major themes that are discussed throughout this report:

- **Mandatory reporting of child abuse occurring within certain organisations**
- **Better training to recognise and respond to cases of potential child sexual exploitation**
- **It takes a community to protect a child: protecting children is everyone's business including yours!**
- **Advocating for children**
- **Prohibition of physical punishment of children**

- 3.0.15** It is of the utmost importance that it is recognised that the majority of child abuse and neglect occurs within homes, families and communities not within organisations and institutions. Society must never lose sight of that or be distracted by a media frenzy of high-profile cases involving celebrities which, disturbing and disgraceful though they are, do not reflect the majority of abuse cases that do occur within our communities.
- 3.0.16** However, failing to take action to protect, and bring justice for, those vulnerable children who have suffered from abuse in a most heinous manner by people who occupy positions of trust, responsibility and power would be woefully egregious.
- 3.0.17** It is time for the UK to take an unequivocal stand against the child abuse cases that occur within organisations or institutions exercising care, supervision or authority over children. The law in the UK must be changed to introduce mandatory reporting of those cases.
- 3.0.18** Legislative change is required in some instances to properly protect children and for this reason there are specific changes recommended to both the Sexual Offences Act 2003 and the Children Act 2004.
- 3.0.19** Without better training for professionals to be alert to the possibility of child sexual exploitation cases and without a clear inter-agency commitment to thoroughly investigate those cases and to fully protect the children involved, it is highly likely that the circumstances leading up to the events in Rotherham<sup>12</sup>, and indeed those in Rochdale<sup>11</sup>, will occur again in the future.
- 3.0.20** The Academy Child Sexual Exploitation Working Group<sup>14</sup> has recently made a number of useful recommendations including that the medical Royal Colleges and Faculties should provide backing to individual members seeking to make contributions to tackling sexual exploitation. Following release of *Living on a Railway Line* it is hoped that the College of Emergency Medicine, the Royal College of Paediatrics and Child Health and other medical Royal Colleges and Faculties will be able to take advantage of this backing to move forwards with many of the recommendations contained within this report.

- 3.0.21** Although Multi-Agency Safeguarding Hubs (MASHs) have been set up to improve inter-agency working, if the UK is really serious about building strong and healthy communities with children at their heart, the proposal to launch a UK children's advocacy centre is something that should be tackled now to decide how this can be made a reality in the UK.
- 3.0.22** Education of professionals underpins safe services and enables them to support children and families in a better way – the standardisation of these child protection educational programmes will make services run more efficiently and will allow the community to be more confident that professionals in different areas of the country are more likely to have been trained, and assessed, to the same robust standards.
- 3.0.23** Finally, the position of a society where physical (corporal) punishment of children is permitted, yet efforts are being made to try and prevent all forms of child abuse in those same communities, is not a tenable one. Reducing the number of cases of child abuse must begin with a clear message from society that physical punishment of children, whatever the circumstances, is unacceptable. There should be legislative change in the UK to prohibit physical punishment of children in all settings and to remove the defence of 'reasonable punishment'.
- 3.0.24** There are communities around the world, including those visited in Cambodia during the preparation of this international report, that are, quite literally, Living on a Railway Line. In other areas, the UK included, there are children and families metaphorically living on that same railway line not in terms of physical location but in terms of living in a highly risky and dangerous situation, without adequate protection, never sure where the next harm is going to come from.
- 3.0.25** It is for that reason that although the inspiration for the name of this publication came from experiences abroad the themes highlighted and discussed in this report are as equally applicable to children and families living in the UK as they are to those living in the USA, Singapore, Malaysia, Cambodia and beyond.

**3.0.26** Whilst it was distressing to see the abject poverty or dysfunctional arrangements which blighted many of the communities that were visited during the Fellowship travels, the stories of resilience and recovery demonstrated clearly that no matter how severe the adversity facing people living in situations that none of us would choose to exist in, it is community spirit and a strong social network that is effectively able to protect children.

# Recommendations



***"Education is the most powerful weapon which you can use to change the world."***

Nelson Mandela, 1918-2013

## About this chapter

This chapter sets out all of the recommendations in this report dividing them into three groups:

- The top ten **key recommendations** for the UK
- Twenty-four associated and enabling recommendations for the UK
- Seven international recommendations

Throughout this report three different colours, and grey shading, have been used to categorise recommendations and personal practice learning points, particularly relevant to those professionals working in Emergency Medicine or directly with children and families in the community:

- **Key Recommendations:** the major and urgent recommendations in this report for policy makers, organisations and professionals working in the UK
- **Recommendations:** the associated and enabling recommendations for policy makers, organisations and professionals working in the UK
- **International Recommendations:** for policy makers, organisations and professionals working at an international level
- **Personal Practice Points:** (Continuing Professional Development - CPD) for professionals working directly with children and families



## **4.0 Recommendations**

### **4.1 Key recommendations for the UK**

#### **4.1.1 Mandatory reporting of child abuse and neglect**

##### **4.1.2 Key Recommendation ONE**

There should be a new law introduced in the UK to make it a legal (mandatory) requirement to report any reasonable suspicion of child abuse (of any type) occurring within any organisation or institution exercising care, supervision or authority over children, whether as part of its primary functions or otherwise. This new law should comply with the principles set out in Recommendation [THREE](#).

#### **4.1.3 Physical punishment of children**

##### **4.1.4 Key Recommendation TWO**

There should be legislative change in the UK to prohibit physical punishment of children in all settings and to remove the defence of 'reasonable punishment'.

#### **4.1.5 Legislative change required in the UK**

##### **4.1.6 Key Recommendation THREE**

Section 15(1)(a) of the Sexual Offences Act 2003 must be revised to change the number of times contact must be proven to have been made with a child, prior to meeting with that child with the intention of abusing him or her, from two to one. Consideration should also be given to raising the age in relation to sexual exploitation in section 15 from age 16 to age 18 to reflect that it is possible to treat someone in an exploitative manner who is above the age of legal consent to sexual intercourse but still a child aged under 18 years of age.

#### **4.1.7 Key Recommendation FOUR**

The Sexual Offences Act 2003 must be revised to remove the terms ‘child prostitute’ and ‘child prostitution’ and additional clauses should be inserted to better reflect the fact that children who were previously classed as being involved in ‘child prostitution’ are actually victims of serious child sexual abuse and child sexual exploitation.

#### **4.1.8 Key Recommendation FIVE**

Section 58 of the Children Act 2004 should be revised, and other legislation introduced as necessary, to make explicitly clear that in future there is no defence of ‘reasonable punishment’ and that any corporal or physical punishment of a child, aged under 18 years of age, is strictly prohibited in law.

#### **4.1.9 Paediatric Emergency Medicine Social Worker pilot**

#### **4.1.10 Key Recommendation SIX**

There should be a funded research evaluation of attaching a social worker to a UK paediatric emergency department to investigate the benefits of such provision, to children, families and the ED, and to contribute to setting standards for children in emergency care settings in the future.

#### **4.1.11 Child abuse and neglect education and training**

#### **4.1.12 Key Recommendation SEVEN**

A standardised, compulsory, multi-professional training programme, to complement the inter-collegiate competency levels, should be introduced in the UK for all professionals dealing with children and families. This must include specific training on the potential signs, features and vulnerabilities of children who are at risk of, or who are suffering from, exploitation including sexual exploitation. This coordinated educational programme would reduce inefficiencies of duplication of educational material preparation and would better quality assure the outcome of the educational programme.

#### **4.1.14 Society's views on child abuse**

#### **4.1.15 Key Recommendation EIGHT**

A research study should be conducted in the UK comparing professionals' and the public's views on the acceptability of various events which can occur to and around children and whether or not these are considered abusive. The results of this study should be used to inform organisations and groups working on primary prevention of child maltreatment in the community. To help facilitate achievement of this key recommendation there should be widespread support of The Academy of Medical Royal Colleges Child Sexual Exploitation Working Group recommendation (September 2014) that the Faculty of Public Health should consider how they can encourage their members to work closely with local safeguarding children boards to improve awareness in parents, communities, and schools of indicators of child sexual exploitation [and of other types of abuse] and of available help. This would also include a focus on primary prevention to help build awareness and resilience in children and young people to prevent them being exploited or abused in any way.

#### **4.1.16 Child abuse awareness event**

#### **4.1.17 Key Recommendation NINE**

The UK government should consult with key child protection stakeholders and prepare to launch a pilot Child Abuse Awareness Month as soon as is practicable after the 2015 General Election. This event should be evaluated and replicated in future years if it is found to be successful in either raising awareness of child abuse issues within society or decreasing the incidence of child maltreatment in different communities.

#### **4.1.18 Children's advocacy**

#### **4.1.19 Key Recommendation TEN**

A children's advocacy centre pilot should be launched in the North West of England with an initial evaluation after 12 months, an interim evaluation after 24 months and a full evaluation after 60 months of operation.

## **4.2 Associated and enabling recommendations for the UK**

### **4.2.1 Mandatory reporting of child abuse in the UK**

#### **4.2.2 Recommendation ONE**

Any introduction of mandatory reporting must be accompanied by a commensurate increase in resources to child welfare agencies to enable them to cope with the increased number of referrals that will be received and so that the safety of children who are in need of protection already is not compromised.

#### **4.2.3 Recommendation TWO**

Further research should be conducted in the UK to assess the training-reporting-outcomes relationship for children where suspicions of possible child abuse have arisen looking, in detail, at the outcomes for the child of a referral to child protective services.

#### 4.2.4 Recommendation THREE

Principles for the introduction of a new law on mandatory reporting of child abuse:

- All persons associated with an organisation or institution exercising care, supervision or authority over children, whether as part of its primary functions or otherwise, should be legally required to report suspicions of child abuse occurring within that organisation or by a person associated with that organisation, to a designated officer.
- All designated officers who are aware of suspicions of child abuse either from their own knowledge or as a result of a report from another person should be legally required to report this to the local authority and such a report should be treated as a referral falling within the auspices of Section 47 of the Children Act 1989.
- The local authority should be legally obliged to give feedback to the designated officer who, in turn, should be legally obliged to provide this feedback to the individual(s) who made the initial report(s). There should be mechanisms put into place within the legislation to ensure that if feedback is not received by persons entitled to receive it, this is both reported and acted upon.
- Timescales should be introduced within the new legislation covering the timescale for reporting, both by the person associated with the organisation and the designated officer, and the timescale for a response by the local authority.
- There must be introduction of a comprehensive, standardised, multi-disciplinary training package delivered to the necessary professionals in advance of the new legislation becoming law combined with a UK-wide community engagement programme relating to the new legal provisions.
- It should be an offence for any organisation, institution or individual to take action to prevent or discourage a person from making a report.
- There must be a full evaluation of the impact of the new mandatory reporting legislation before consideration is given to extending the scope of the legislation to other organisations, institutions, individuals or situations.



#### **4.2.5 UK legislative process**

#### **4.2.6 Recommendation FOUR**

The Modern Slavery Bill 2014 must ensure that children aged under 18 years of age are properly protected from trafficking, exploitation and modern slavery and that provision of guidance, education and training is mandatory.

#### **4.2.7 Child maltreatment screening tool**

#### **4.2.8 Recommendation FIVE**

An international, multi-centre research study should be carried out to investigate, and validate, the sensitivity, specificity, positive predictive value (PPV) and negative predictive value (NPV) of a new screening tool and appropriate clinical decision rules, which all require development, to assess the risk of child maltreatment in children attending urgent and emergency care facilities.

#### **4.2.9 Safeguarding vulnerable children professional educational programmes**

#### **4.2.10 Recommendation SIX**

Institutions training pre-qualification professionals who may in the future work with vulnerable children and families should ensure that their training courses incorporate the necessary training from the Intercollegiate Document on Safeguarding Children and Young People competencies, with an appropriate competency assessment at the end of the training programme to ensure that the skills and knowledge required have been obtained.

#### **4.2.11 Recommendation SEVEN**

Current educational programmes in child maltreatment ought to be formally validated including assessing the impact on the competence of the professional, both pre- and post-training, and, if possible, outcomes for children.

#### **4.2.12 Medical investigations in cases of suspected child maltreatment**

#### **4.2.13 Recommendation EIGHT**

Healthcare organisations involved in providing or requesting skeletal surveys in cases of suspected non-accidental injury should review their policies to ensure that they contain specific guidelines, based on the joint Royal College of Paediatrics and Child Health and The Royal College of Radiologists standards, relating to the repeating of skeletal surveys two weeks after the initial survey.

#### **4.2.14 Recommendation NINE**

Research should be undertaken in the UK to investigate the sensitivity and specificity of using elevated hepatic transaminase levels as a potential marker for occult intra-abdominal injury in children in whom there is concern for possible physical child abuse. The results of this research should be used to determine if there is a level at which definitive abdominal radiological investigation should take place in cases of suspected non-accidental injury in a UK population.

#### **4.2.15 Child protection peer review and multi-professional involvement**

#### **4.2.16 Recommendation TEN**

Child protection peer review meetings with clear terms of reference and involving representatives from the local authority (including, as an essential component, local authority, or Crown Prosecution (as appropriate) legal teams), the police and community health services, should be set up in all health organisations conducting child protection clinical work. Such peer review meetings should actively contribute to the case management of individual cases.

#### **4.2.17 Recommendation ELEVEN**

The role that advanced practitioners can play within child protection work should be further explored and promoted in the UK. Multi-disciplinary teams should seek out opportunities to develop an advanced practitioner service working as part of a pan-professional medical and non-medical team within the sphere of child protection work.

There should be an investigation of the benefits of this model of care for patients, families and health service effectiveness.

#### **4.2.18 Adverse childhood experiences (ACEs)**

#### **4.2.19 Recommendation TWELVE**

The concept of the importance of detecting and, where possible, eliminating Adverse Childhood Experiences (ACEs) in the UK, and beyond, ought to be included in undergraduate and postgraduate educational programmes for professionals working with children and families.

#### **4.2.20 Recommendation THIRTEEN**

Organisations working in the community on child abuse prevention programmes should incorporate material relating to Adverse Childhood Experiences (ACEs) and provide community education about the importance of minimising ACEs as well as recognising when they are present in the community and seeking appropriate community-based or professional assistance.

#### **4.2.21 World Health Organisation (WHO) Health Needs Assessment (HNA)**

#### **4.2.22 Recommendation FOURTEEN**

A formal Health Needs Assessment (HNA), from a secondary care point of view, should be conducted in a pilot community in the UK in relation to child maltreatment and its prevention. The result of this initial pilot should be used to conduct further HNAs in other regions of the country with the aim of building up a societal evidence base of the health needs of children who have suffered from, or who are at risk of, significant harm so that evidence-based preventative strategies can be appropriately designed and targeted.

#### **4.2.23 Children's advocacy**

#### **4.2.24 Recommendation FIFTEEN**

Children should be involved more in healthcare decisions and planning from the outset. A suitable version of the friends and family test, used to quality assure the service provided in healthcare facilities, should be developed for use by all children, including those with learning difficulties or who are pre-verbal. Children's councils should be created in departments or hospitals seeing children in the UK.

#### **4.2.25 Advocating for adolescents**

#### **4.2.26 Recommendation SIXTEEN**

All professionals dealing with adolescents need to recognise the specific vulnerabilities that exist within this age group and ensure that these are not overlooked. Professionals should ensure they use an appropriate history-taking framework, such as HEADSS, when talking to children of adolescent age and Emergency Departments should provide an adolescent area with age-appropriate information available.

#### **4.2.27 Paediatric Emergency Medicine Research**

#### **4.2.28 Recommendation SEVENTEEN**

Organisations involved in clinical research should promote this more widely with patients and the public. Those departments involved in paediatric emergency medicine research should consider the 'brand' that is used to promote this important work and should set up a local Paediatric Emergency Medicine Research Unit (PEMRU) to coordinate the research arm of the clinical work that is delivered. Such units should collaborate with PERUKI (Paediatric Emergency Research in the UK and Ireland).

#### **4.2.29 Child protection pro-bono work**

#### **4.2.30 Recommendation EIGHTEEN**

Organisations and individuals interested in strengthening international partnerships, either from an Emergency Medicine or Child Protection viewpoint, should seek out and foster lasting relationships with overseas individuals and organisations that will be of mutual benefit.

#### **4.2.31 Recommendation NINETEEN**

The Foreign and Commonwealth Office Medical Pro-bono Panel should be enhanced by creating a multi-disciplinary sub-panel focussing on child protection issues.

#### **4.2.32 Commonwealth Scholarship Commission Awards and Fellowships**

#### **4.2.33 Recommendation TWENTY**

Organisations in the UK interested in hosting Overseas Fellows should investigate the possibilities offered by The Commonwealth Scholarship Commission Awards.

#### **4.2.34 Child Sexual Exploitation**

#### **4.2.35 Recommendation TWENTY-ONE**

The ChildSafe initiative, and other similar schemes, should be promoted by the UK travel industry when products they sell, including flights, hotels and packages, involve travel to areas where child protection issues are abundant and children are at significant risk of harm from issues such as sexual abuse, sexual exploitation and child labour. A pilot region-specific ChildSafe initiative should be introduced, and evaluated, in the UK to contribute towards better protecting children who might be at risk of exploitation in that particular area.

#### **4.2.35 Children giving evidence in Court in the UK**

#### **4.2.36 Recommendation TWENTY-TWO**

Judges and lawyers involved in all child abuse cases should be required to undertake mandatory specialist training. The public, and professionals involved in child protection work, should support the NSPCC's campaign *Order in Court* to try to ensure that in every region there is at least one remote site for children to be able to give evidence from outwith the Court building.

#### **4.2.37 Locally provided health services**

#### **4.2.38 Recommendation TWENTY-THREE**

Economically viable services should be commissioned which allow patients who might have difficult accessing healthcare in a hospital setting to have their care provided more locally in the community.

#### **4.2.39 Domestic and inter-partner violence**

#### **4.2.40 Recommendation TWENTY-FOUR**

Domestic (inter-partner) violence interventions being undertaken in UK Emergency Departments should be subject to validation and a multi-centre research study should be undertaken looking at their short-term, medium-term and long-term benefits.

#### **4.2.41 International Network Development**

#### **4.2.42 Recommendation TWENTY-FIVE**

Further academic, clinical and other partnerships should be developed between UK organisations, professionals and NGOs who are providing essential child protective services in countries overseas where local statutory services are inadequate or absent.

### **4.3 International recommendations**

**4.3.1** It was never the original purpose of this project to make recommendations relating to any country other than the UK. However, as the project progressed it became clear that, whilst there were certainly significant areas of good practice identified overseas that could be useful to the UK, there were also certain aspects of international policy which appeared to sit either so far outside of that which would be permitted by International Human Rights policies, guidance and laws or which did not appear to be supported by the evidence gained in the preparation of this report, that to stay silent and not even refer to those policies or practices would be wholly wrong on many levels.

**4.3.2** Additionally, several requests were made by international hosts for this report to contain some recommendations for their own areas of work, in an earnest quest to learn from others and to improve the situation locally as well as international from their point of view. It is on that basis that this report incorporates some International Recommendations although the implementation of these, and the strategy so to do, falls outwith the control of the author of this report and they are something the International Community will need to grasp and handle if children are to be properly protected on a world-wide basis rather than just here in the UK.

#### **4.3.3 Ratification of the UN Convention on the Rights of the Child in the USA and Somalia**

##### **4.3.4 International Recommendation ONE**

The USA and Somalia should follow due process, commencing immediately, and ratify the United Nations Convention on the Rights of the Child (UN CRC) so that children living in these countries can be assured of the protection that the treaty quite rightly affords them.

#### **4.3.5 International prohibition of physical punishment of children aged under 18 years of age**

##### **4.3.6 International Recommendation TWO**

Countries that have not prohibited physical punishment of children aged under 18 years of age in all circumstances should do so as soon as possible.

#### **4.3.7 Children giving evidence in Court in the USA**

#### **4.3.8 International Recommendation THREE**

The USA should review legislation to facilitate the ability of children to be able to routinely give evidence in chief by pre-recorded video and to be able to be cross-examined by remote video link, preferably from outwith the Court building.

#### **4.3.9 Child protection strategy for Malaysia**

#### **4.3.10 International Recommendation FOUR**

An expert advisory panel, working in conjunction with the National Advisory and Consultative Council for Children, UNICEF and other partner organisations, should be created in Malaysia to guide future developments concerning safeguarding vulnerable people in Malaysia and to ensure that the other three recommendations relating specifically to Malaysia are completed effectively.

#### **4.3.11 International Recommendation FIVE**

There should be creation and launch of a publication, with statutory function, concerning protection of children in Malaysia including new guidance on when to suspect child maltreatment, the inter-agency investigation of suspected cases and the standardised management thereof within Malaysia.

#### **4.3.12 International Recommendation SIX**

There should be creation and evaluation of a pilot Multi-Agency Safeguarding Hub (MASH) or Children's Advocacy Centre of Malaysia.

#### **4.3.13 International Recommendation SEVEN**

There should be production and promotion of a coordinated standardised educational programme for all professionals working with families and children in Malaysia.



# Implementation Strategy



***"It is a mistake to look too far ahead. Only one link in the chain of destiny can be handled at a time."***

Sir Winston Churchill KG OM CH TD DL FRS RA, 1874-1965

## About this chapter

This chapter summarises the recommendations in this report, setting out those that are most important, those that can be most generalised and those that are most implementable. In addition, this chapter explains that some of the recommendations are able to be achieved locally, some will require national policy change and some will require the international community to work together to achieve results.

## **5.0 Implementation Strategy**

### **5.1 Important recommendations that can be implemented or generalised**

- 5.1.1** This report was launched to mark the 25<sup>th</sup> anniversary of the signing of the UN Convention on the Rights of the Child, which took place on 20 November 1989. Although there has been progress over the last quarter of a century there are still laws, policies and procedures in the UK and internationally which fall way short of properly protecting children as was agreed by the signatories to the convention twenty-five years ago.
- 5.1.2** Parliamentarians, professionals, communities and organisations in the UK and beyond that are interested in protecting the rights of children should find this report useful to assist them with their campaigns and aims to make our global society a better place for children to live in, now and in the future. It is vital that these individuals and organisations ensure the voices of children are heard and listened to and ensure that children's advocacy is at the forefront of people's minds when dealing with families and children.
- 5.1.3** There is no single short-term fix to the problems identified within this report but the recommendations that have been made should go some way to contributing to effective resolutions of the issues that were the springboard for the creation of this project. Many of these recommendations can be tackled locally without additional resources. Some will require regional co-operation between agencies and between units. Some can only be tackled at a national level and a minority will require international cooperation to be effective.
- 5.1.4** This report is just the start of the implementation process – what is required is for the agencies, organisations and individuals to whom this report is directed to grasp the challenge that has been set and put in place the recommendations contained herewith so that children, and young people, living in the UK and beyond can grow up in the safest possible environments, within supportive communities and realise their maximum potential.
- 5.1.5** That potential is something we would all surely wish them to achieve to create a strong and resistant society in the future, with healthy children at the heart of it.

**5.1.6** The following groups highlight those recommendations that are most important, those that are most implementable and those that can be most generalised. Whilst all of the recommendations in this report should be implemented to better protect and support children, it is recognised that some are easier to implement, and are of more urgency, than others and it is with these recommendations that work should start in earnest. Some of the recommendations are able to be generalised to other localities, individuals and groups, including those working outside of the UK.

## **5.2 Recommendations that are most important and urgent**

- Key Recommendation [ONE](#)
- Key Recommendation [TWO](#)
- Key Recommendation [THREE](#)
- Key Recommendation [FOUR](#)
- Key Recommendation [FIVE](#)
- Key Recommendation [SIX](#)
- Key Recommendation [SEVEN](#)
- Key Recommendation [EIGHT](#)
- Key Recommendation [NINE](#)
- Key Recommendation [TEN](#)
- Recommendation [ONE](#)
- Recommendation [THREE](#)
- Recommendation [TWENTY-ONE](#)

### 5.3 Recommendations that are most implementable

- Key Recommendation [ONE](#)
- Key Recommendation [THREE](#)
- Key Recommendation [FOUR](#)
- Key Recommendation [SIX](#)
- Key Recommendation [SEVEN](#)
- Key Recommendation [EIGHT](#)
- Key Recommendation [NINE](#)
- Recommendation [THREE](#)
- Recommendation [FOUR](#)
- Recommendation [SIX](#)
- Recommendation [SEVEN](#)
- Recommendation [EIGHT](#)
- Recommendation [NINE](#)
- Recommendation [TEN](#)
- Recommendation [TWELVE](#)
- Recommendation [FIFTEEN](#)
- Recommendation [SIXTEEN](#)
- Recommendation [SEVENTEEN](#)
- Recommendation [NINETEEN](#)
- Recommendation [TWENTY](#)
- Recommendation [TWENTY-FOUR](#)
- International Recommendation [FOUR](#)
- International Recommendation [FIVE](#)
- International Recommendation [SIX](#)
- International Recommendation [SEVEN](#)

## 5.4 Recommendations that can be most generalised

- Key Recommendation [TWO](#)
- Key Recommendation [EIGHT](#)
- Recommendation [TWO](#)
- Recommendation [FIVE](#)
- Recommendation [NINE](#)
- Recommendation [ELEVEN](#)
- Recommendation [TWELVE](#)
- Recommendation [THIRTEEN](#)
- Recommendation [FOURTEEN](#)
- Recommendation [SEVENTEEN](#)
- Recommendation [EIGHTEEN](#)
- Recommendation [TWENTY-ONE](#)
- Recommendation [TWENTY-THREE](#)
- Recommendation [TWENTY-FIVE](#)
- International Recommendation [ONE](#)
- International Recommendation [TWO](#)
- International Recommendation [FOUR](#)
- International Recommendation [FIVE](#)
- International Recommendation [SIX](#)
- International Recommendation [SEVEN](#)

# Purpose of this report



***"No matter what anybody tells you, words and ideas can change the world."***

Robin Williams, 1951-2014

## About this chapter

This chapter sets out the basis of *Living on a Railway Line* highlighting that a visit with a mobile health clinic to a community living, literally, on a railway line in Cambodia was the inspiration for the title of this report. The conclusions within it are evidence-based and use international experiences, together with published research work, to create a series of important and practical recommendations that can be generalised throughout the UK and to other countries.

These recommendations are designed to create strong and healthy communities in the UK, and internationally, with children at their hearts.



## 6.0 **Basis of *Living on a Railway Line***

### 6.1 **Purpose of this report**

#### 6.1.1 **Living on a Railway Line**

Thirty five thousand and forty three miles flown, 10 weeks away from home, eight different cities, five different mobile phone SIM cards, four different currencies, four different countries and one extra checked bag on the way back to the UK to carry books, research papers and gifts: *Living on a Railway Line* is a publication that uses international experiences to make recommendations designed to improve the safeguarding from child abuse of vulnerable children in the UK and beyond.

#### 6.1.2 **Definition**

In accordance with the United Nations Convention on the Rights of the Child ([UN CRC](#)), unless otherwise stated in this document the term “child” or “children” refers to a person or persons under the age of 18 years<sup>15</sup>. Throughout this report the terms “child maltreatment” and “child abuse and neglect” are used synonymously.

#### 6.1.3 **Purpose**

**This publication is not intended to be read cover-to-cover in one go as a book.** Instead, the report is grouped into different themes covering key areas of child protection work and is presented in chapters so professionals and community members interested in exploring different aspects of this challenging work can see the evidence base behind the conclusions and recommendations and can appreciate the international contribution to their creation.

#### 6.1.4 The purpose of this report is to present recommendations for the UK (although it does include some international recommendations) as well as to outline the evidence and experiential base upon which these recommendations are made; its purpose is not to describe the travel undertaken, or the visits in each location, in any detail. Those visits, the meetings that took place and the experiences gained have been invaluable in the creation of this report – without them it could not have been written. Absence of reference to any particular visit or project in this report should not, in any way, be taken as an adverse inference relating to the usefulness of that particular activity in question.

## **6.2 Disclaimer**

**6.2.1** The opinions and recommendations expressed in this work are entirely those of the author and do not necessarily reflect or represent the opinions or policies of any individual or organisation mentioned within this work unless explicitly stated. None of the organisations or individuals mentioned in this work, nor any person acting on their behalf, may be held responsible for any use made of the information contained herein.

**6.2.2** The Author is grateful to Professor Desmond K. Runyan and Professor Donald C. Bross for writing the joint foreword to this work.

**6.2.3** The right of Andrew Graeme Rowland to be identified as the Author of this work has been asserted by him in accordance with the Copyright, Designs and Patents Act 1988. All rights reserved.

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# Introduction



***"What is the use of living, if it be not to strive for noble causes and to make this muddled world a better place for those who will live in it after we are gone?"***

Sir Winston Churchill KG OM CH TD DL FRS RA, 1874-1965

## About this chapter

This chapter sets out the aims and objectives of this report and the project that led to it. It also describes the background to the problem that child abuse and neglect presents to society as it relates to the UK and the international community.

## **7.0 Introduction**

### **7.1 Aims**

- 7.1.1** The overall long-term aims of this report are to improve the safeguarding of vulnerable children in the UK, particularly those that come into contact with Emergency Medicine services, and to enhance the opportunities for children, who should be both seen and heard, to have a louder voice when engaging with welfare services. In the short term, the aims are to improve educational levels amongst professionals dealing with children and families and to make recommendations for legislative change to ensure that the laws underpinning the UK's child protective systems, in their widest sense, are optimum.

## **7.2 Objectives**

- 7.2.1** To ascertain what training is given to clinicians working in emergency medicine to help them to spot the more subtle cases of children who are at risk of, or who have suffered from, significant harm.
- 7.2.2** To investigate whether specific child protection training programmes are in place for other medical staff and what the format of these is if they do exist
- 7.2.3** To understand the impact of child abuse mandatory reporting legislation on referral rates to child protective services and how this operates in practice in various jurisdictions
- 7.2.4** To seek the views of professionals about mandatory reporting
- 7.2.5** To investigate whether outcomes measured for children who have been through child protective services, following an attendance at an emergency department or other health facility, and if so how these are measured
- 7.2.6** To investigate the interaction between paediatric emergency departments, child advocacy centres and child protective services
- 7.2.7** To compare overseas child protective services and child advocacy centres with our own local authority and police services to ascertain what can we learn from them which would improve things for children here in the UK
- 7.2.8** To form an opinion on whether or not the experiences of other jurisdictions would support legislative change in the UK to move towards a system based on mandatory reporting of child protection concerns and, if so, to what extent this should apply

## 7.3 Background

7.3.1 Child abuse and neglect are not simply modern occurrences.

7.3.2 Roman children occupied the status of chattels (items of personal property) because their fathers could sell, abandon or maltreat them.

7.3.3 In New York, USA in 1874 a young girl called Mary Ellen was systematically abused by her adoptive parent, Mary Connolly. The abuse was well known but complaints to the police brought no action as there was no specific law at that time to protect children. Henry Bergh, who had founded the American Society for the Prevention of Cruelty to Animals in 1866, intervened at the request of a local resident, Mrs Etta Wheeler, who wished to rescue Mary Ellen. With use of *habeas corpus* (a legal principle ensuring that a prisoner can be released from unlawful detention – that is detention lacking sufficient cause or evidence) Henry Bergh applied, via the Attorney of the American Society for the Prevention of Cruelty to Animals, to the Court and successfully secured the release of Mary Ellen. A prosecution ensued, which resulted in Mary Connolly being sentenced to one year's hard labour in the penitentiary. The pain and suffering behind Mary's statement to the Court in April 1874 requires no further comment:

*"My name is Mary Ellen. I don't know how old I am. My mother and father are both dead. I call Mrs C momma. I have never had but one pair of shoes, but can't recollect when that was. I have no shoes or stockings this winter. I have never been allowed to go out... except in the night time, and only in the yard [to use the outdoor privy]. My bed at night is only a piece of carpet stretched on the floor underneath a window and I*



Figure 2: Mary Ellen on rescuing in New York, 1874<sup>16</sup>

*sleep in my little undergarment with a quilt over me. I am never allowed to play with other children. Momma has been in the habit of whipping me almost everyday. She used to whip me with a twisted whip – a rawhide. The whip always left black and blue marks on my body. I have now on my head two black and blue marks which were made by momma with the whip, and a cut on the left side of my forehead which was made by a pair of scissors in momma's hand. She struck me with the scissors and cut me. I have no recollection of ever having been kissed and I have never been kissed by momma. I have never been taken on momma's lap or caressed or petted. I never dared speak to anybody, because if I did I would get whipped. I have never had... any more clothing than I have on at present... I have seen stockings and other clothes in our room, but I am not allowed to put them on. Whenever momma went out, I was locked up in the bedroom... I don't know for what I was whipped. Momma never said anything when she whipped me. I do not want to go back to live with momma because she beats me so".*

- 7.3.4** In 1874 the [Society for the Prevention of Cruelty to Children](#) was founded and the rights of children to be protected from such horrendous abuse became to be recognised in the USA. Mary Ellen was placed into a new home, married, raised a family of her own and died in 1956<sup>17</sup>.
- 7.3.5** It was not until 1962, following the publication of Dr C. Henry Kempe's seminal paper on child abuse<sup>18</sup>, that the public, in the USA at least, started to become aware of the impact of child abuse on a wide scale. Many decades later, child abuse is still a significant issue.
- 7.3.6** Here in the UK, Home Office figures show that in 2012/2013 there were 551 homicides (murder, manslaughter and infanticide) recorded in England and Wales (an increase of 4% on the 2011/2012 figures). This increase was driven by an increase among those aged under 16 years of age from 47 in 2011/2012 to 67 in 2012/2013 (60% of whom were killed by a parent or step-parent). In 2012/2013, as in previous years, children aged under one had the highest victimisation rate of 30 offences per million population<sup>19</sup>.

**7.3.7** The National Society for the Prevention of Cruelty to Children ([NSPCC](#)) has found that 18.6% of 11-17 year olds have been severely maltreated by a parent or guardian at some point in their lives and that one in 20 (4.8%) of children have experienced contact sexual abuse but most incidents are not reported to the police and only 3% of adults feel confident about spotting the signs of potential sexual abuse<sup>20</sup>.

**7.3.8** One in 14 (6.9%) children aged 11-17 years have experienced severe physical violence at the hands of an adult. Looking at findings from 18-24 year olds allows comparison with other research studies that have asked adults about their childhood experiences. The NSPCC found that 25.3% of young adults were severely maltreated during childhood and that 23.7% were exposed to domestic (inter-partner) violence in their homes during childhood<sup>20</sup>.

**7.3.9** The UK's four categories of abuse<sup>21</sup> that children may be at risk of, or may have suffered from, are:

- Neglect
- Sexual abuse
- Emotional abuse
- Physical abuse

**7.3.10** Each year in the UK, of those children physically abused<sup>22</sup>:

- 379000 are injured
- 70000 require medical attention
- 2800 are taken to Accident and Emergency Departments (EDs)

**7.3.11** Physical abuse can occur in any family, but it is more likely to happen in families that are vulnerable to certain risks, such as domestic (inter-partner) violence, substance misuse and adverse mental health.

**7.3.12** Safeguarding vulnerable children is not restricted to identification of children who might have suffered from the four main types of abuse but it is also the recognition of children who might have been trafficked into or within the country. Trafficking of children is a clandestine activity, which makes it difficult to identify victims and record their numbers but between 1 April 2009 and 31 March 2011, 390 potential child victims of trafficking were referred through the National Referral Mechanism in the UK<sup>23</sup>. In addition, evidence from successive reports from the Child Exploitation and Online Protection ([CEOP](#)) Centre indicate that there are approximately 300 child trafficking victims identified in the UK per annum<sup>24</sup>.

**7.3.13** Trafficked children may not only be deprived of their rights to health care and freedom from exploitation and abuse, but may also be denied access to education. The creation of a false identity and implied criminality of the children, together with the loss of family and community, may seriously undermine their sense of self-worth. At the time they are found, trafficked children may not show any obvious signs of distress or imminent harm, but they may be vulnerable to all types of abuse and may continue to experience the effects of their abuse in the future.

**7.3.14** Child maltreatment has severe and long-lasting impacts on children affecting all aspects of their lives.

**7.3.15** Effects on children who suffer from abuse and neglect include:

- accidental injuries
- lack of self-esteem
- physical changes to the developing brain and body as a result of trauma and stress
- mental health issues such as depression and anxiety
- poor emotional and physical development
- smoking, drinking alcohol or drug use
- disruption to education
- difficulties in forming and maintaining relationships.

- 7.3.16** The serious case review (SCR) into the tragic death of Keanu Williams in Birmingham in 2011 (presented to the Birmingham Safeguarding Children's Board in September 2013)<sup>25</sup> identified that Keanu experienced a number of presentations to hospital prior to his death which were all explained as simple childhood accidents, by the person later convicted of his murder, and the review identified that the child protection medical assessment was not undertaken in accordance with basic procedures and good practice standards.
- 7.3.17** Such a case is, sadly, not isolated. A number of the issues which arose in the review of Keanu Williams are familiar themes in other SCRs at a national level, including poor communications between and within agencies, a lack of analysis of information as well as a lack of professional curiosity in questioning the information, a lack of confidence amongst professionals in challenging care-givers and short-comings in recording systems and practice.
- 7.3.18** It is clear that inter-agency working and training of staff needs to be improved in order to safeguard children in the future.
- 7.3.19** Over 3.5 million children are seen in UK EDs each year<sup>26</sup> and clinicians working in those departments have a crucial role to play in identifying those children who may have suffered from, or who are at risk of, significant harm. Clinicians working in Emergency Medicine are ideally placed to recognise some of the early warning signs that a child may have been maltreated or may be at risk of maltreatment so that they can take steps to safeguard those children attending their EDs from further abuse and neglect. Furthermore, government guidance specifically relating to the identification and support of children who might have been trafficked makes clear that all practitioners who come into contact with children and young people in their everyday work need to be able to recognise children who have been trafficked<sup>27</sup> and be competent to act to support and protect these children from harm.



**7.3.20** This report focuses on the knowledge, skills and behaviours that professionals working with children and families need to have to be able to properly protect children; how child protective services in the UK could be improved to try and reduce the number of adverse incidents and what legislative change might be necessary to facilitate this; how children and families can be empowered to have a much louder voice when engaging with child protective services; and how communities as a whole, and the society in which they are placed, may need to change how they view the abuse of children to precipitate real progress towards a better and more supportive environment in which they can grow up in the future.

# Public policy transfer



**"Anything that is worth doing has been done frequently. Things hitherto undone should be given, I suspect, a wide berth"**

Sir Henry Maximilian Beerbohm, 1872-1956

## About this chapter

This chapter sets out how public policy research applies to *Living on a Railway Line* highlighting the challenge of fully analysing the lessons that have been learned from overseas and working out in what manner, at what time and in what place they can be useful to the UK.

## 8.0 Transfer of public policy from one jurisdiction to another

### 8.1 Who learns what from whom?

**8.1.1** Policy transfer analysis is a theory of policy development that seeks to make sense of a process or set of processes in which knowledge about institutions, policies or delivery systems at one sector or level of governance is used in the development of institutions, policies or delivery systems at another sector or level of governance<sup>28</sup>.



*Figure 3: It takes a team to protect a child: view from the Center for Child Protection, Austin, Texas*

**8.1.2** Understanding under what circumstances and to what extent a programme that is effective in one place could transfer to another is at the heart of a Winston Churchill Travelling Fellowship. The stimulus to search for programmes, institutions, policies or delivery systems comes from dissatisfaction with the status quo and a thirst to seek out alternative ways of working in the hope that one will be discovered which will improve efficiency and functioning of the primary organisation or circumstance.

**8.1.3** In any transfer of policy, lessons can be drawn which help understanding of the conditions that must be met for a programme to be effective as well as identifying under what circumstances a programme that works in one country will not work in another, thus avoiding a one-size-fits-all situational failure<sup>29 30</sup>.

**8.1.4** A lesson can be a warning about what to do as well as what not to do. Lessons can be sought by searching across time and/or space. The choice depends upon a subjective definition of proximity, epistemic communities linking experts together, functional interdependence between governments, and the authority of intergovernmental institutions<sup>29 30</sup>.

- 8.1.5** Every country has problems but seldom are these problems unique. Confronted with a common problem, policy makers in cities, regional governments and nations can learn from how their counterparts elsewhere responded. The process of lesson-drawing starts with scanning programmes in effect elsewhere and ends with the prospective evaluation of what would happen if a programme already in effect elsewhere were transferred here in the future. Lesson-drawing is part of a contested political process; there is no assurance that a lesson drawn will be both desirable and/or practical. The conclusion considers the uncertainty and instability of judgments about the practicality and desirability of transferring programmes<sup>30</sup>.
- 8.1.6** There are a range of options on how to incorporate lessons into different political and social systems including copying, emulation, hybridisation and inspiration<sup>31</sup>. Copying occurs when a country adopts a programme in use elsewhere without any changes, such as when legislation is transferred without any change in wording. Emulation occurs when a country rejects copying in every detail but accepts that a particular programme elsewhere provides the best standard for designing legislation in another jurisdiction. Hybridisation involves combining elements of programmes found in two or more localities to develop a policy best-suited to the emulator and inspiration involves studying problems in an unfamiliar setting to expand ideas and to inspire fresh thinking about what is possible in the originating community<sup>30 32</sup>.

## **8.2 The example of the introduction of the UK Child Support Agency**

**8.2.1** Not all transfers of policies are successful. Professors David Dolowitz and David Marsh, in a comprehensive review of the introduction of the British Child Support Agency (CSA)<sup>33</sup>, examine why some transfers are unsuccessful, to identify which factors are related to successful or unsuccessful transfer. First, the borrowing country may have insufficient information about the policy and how it operates in the country from which it is transferred (*uninformed transfer*). Second, although transfer has occurred, crucial elements of what made the policy a success in the originating country may not be transferred leading to failure (*incomplete transfer*). Third, insufficient attention may be paid to the differences between the economic, social, political and ideological context in the transferring and the borrowing country (*inappropriate transfer*).

**8.2.2** Professors Dolowitz and Marsh identify four key reasons why the British government decided to transfer the structure of the CSA from the USA:

- The USA and Britain were facing similar problems with their child support enforcement systems.
- The two administrations shared ideological values.
- The British government saw the agency as a means of reducing the public sector borrowing requirement (PSBR).
- The USA's Child Support Enforcement System (CSES) had a long history of success in operating child support enforcement agencies.

**8.2.3** The British government had no difficulty in introducing and passing the legislation establishing the CSA. However, following transfer, it soon became apparent that the agency was not operating as the government had originally hoped. There was widespread dissatisfaction with the operation of the agency. This was reflected in demonstrations, high-profile media coverage and many questions in Parliament, highlighting the widespread anger and dismay felt by many families whose lives were affected by the introduction of the CSA<sup>34</sup>, as can be seen, by way of example, in numerous *Hansard* records<sup>35 36 37</sup>.

#### **8.2.4 Uninformed transfer**

Although the British government consciously set out to draw lessons from the USA they did not conduct a detailed or thorough enough analysis of how the CSES system worked in multiple states, nor did they undertake a complete analysis of the Australian CSA. Had a more thorough analysis taken place the importance of the Court's involvement in the operation of the CSES in most states may have been more apparent.

#### **8.2.5 Incomplete transfer**

The CSA was imposed over the pre-existing system governing the granting and collection of child support maintenance, setting aside prior Court and Department of Social Security (DSS) maintenance arrangements for those families falling within the remit of the agency. The CSA also replaced the Courts and the DSS although this was not the case in the USA or Australia. In implementing the policy in this way there was a failure to recognise how important the Courts and the DSS were in serving as a pressure release valve for both the agency and the individuals involved. For example, the CSA had no discretion over the amount of child support an absent parent was required to pay. This problem was compounded by the fact that, initially at least, Britain, unlike in the USA or Australia, failed to take into account the actual circumstances of the individuals involved. Finally, in Britain the CSA was imposed immediately onto a pre-existing system, rather than being phased-in over time.

### **8.2.6 Inappropriate transfer**

In developing the CSA one of the main objectives was the reduction in benefit expenditure on single parents in an attempt to contribute to a reduction in Public Sector Borrowing Requirement (PSBR). By making this one of the main objectives, a significant change from one of the main objectives of the CSES (to address the growing problem of single parents and to help single mothers back into the workforce, not to reduce government expenditure) there was a failure to understand how the CSA's other objectives would be compromised leading to significant implementation problems.

**8.2.7** If governments are searching for policy solutions to new or changing problems then they are increasingly likely to look for 'solutions' abroad. It is not inevitable that transfer of such 'solutions' will be successful and, as such, whilst transfer may shape policy change, it may also lead to implementation failure. This means that, even if it is regarded that policy transfer is a key explanatory variable in the development of many other policies, it must be recognised that it is important to follow each policy through to see whether uninformed, incomplete or inappropriate transfer has led to policy failure<sup>33</sup>.

### **8.3 Applying public policy research to *Living on a Railway Line***

- 8.3.1** Reviewing public and social policy in other jurisdictions combines knowledge about what is happening in another country today with a specific proposal about actions that an institution, organisation or government in another location might take to inform and improve policy in the future. That process reinforces exactly the benefit of a Churchill Fellowship – to seek out knowledge and experiences from other countries and to use that information to help build recommendations for the UK to deal with a particular situation or a particular problem.
- 8.3.2** However, it is not simply a case of transplanting policies and processes to the UK and expecting them to work efficiently and effectively from the start. The cross-national transfer of agencification<sup>38 i</sup> between the UK and Japan is a further example of the inherent risks of subjectively reinterpreting policy to solve domestic problems, which were themselves socially constructed, rather than enabling policy to spread naturally based on objective merit<sup>39</sup>. This is particularly relevant to child protection work.
- 8.3.3** Once the basic human rights of children are accepted at a more advanced level the definition of some forms of child abuse depends on a particular culture, in a particular place and at a particular time – in effect a form of socially constructed phenomenon with some things being considered child abuse in one jurisdiction but not in another.
- 8.3.4** The CSA example, and in particular the failure associated with immediate imposition rather than phasing-in over time, perfectly highlights why any lessons learned in relation to child protection from overseas need to be interpreted cautiously in the UK. No matter what the benefits of social or public policies might be in overseas jurisdictions, this does not automatically mean that even if there are perceived benefits from policy transfer, those transfers should take place immediately. Nor does it mean that copying, emulating or hybridising those policies will automatically be successful in the UK. It is true inspirational transfer that is needed and that inspiration can come from visiting other organisations, other cultures and meeting new professional colleagues.

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<sup>i</sup> Agencification is the creation of semi-autonomous organisations that operate at an arm's length of the government, to carry out public tasks (such as regulation, service delivery, policy implementation) in a relatively autonomous way with less hierarchical and political influence on their daily operations and with more managerial freedoms.



**8.3.5** The real challenge, therefore, is to fully analyse the lessons that have been learned from overseas and to work out in what manner, at what time and in what place they can be useful to the UK. To do otherwise will almost certainly result in policy failure from the outset. The importance of keeping that key principle in mind when creating recommendations cannot be underestimated<sup>ii</sup>.

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<sup>ii</sup> Particular thanks to Susannah Nightingale for mentoring the creation of this chapter

# Mandatory reporting of child abuse



**"Our children's future and the world's future are one"**

Dr C. Henry Kempe, 1922-1984

## About this chapter

This detailed chapter describes one of the key recommendations. It sets out the scientific arguments for and against mandatory reporting of child abuse, balances these with public opinion and social justice themes and concludes that there should be a new law introduced in the UK to make it a legal (mandatory) requirement to report any reasonable suspicion of child abuse (of any type) occurring within any organisation or institution exercising care, supervision or authority over children.

There must be a full scientific evaluation of the impact of the new legislation before consideration is given to extending the scope to other areas.

## 9.0 Reporting of suspected child abuse

### 9.1 Overview

**9.1.1** Legislation that specifies who is required by law to report suspected child abuse or maltreatment is *Mandatory Reporting*. Many liberal democratic jurisdictions have enacted such mandatory reporting legislation requiring designated professionals, such as teachers, nurses, doctors and police to report suspected cases of child abuse and neglect<sup>103</sup>. These laws have been created on the basis that such cases would otherwise remain hidden because of the nature of the situation, the conduct and because the child victim usually cannot or will not seek help or is prevented from asking for assistance. It is a symbolic acknowledgement of the seriousness of child maltreatment in a community and implies that society will not tolerate it<sup>40</sup>.



**Figure 4:** *This is me... I'm OK:* drawing by a child from the Center for Child Protection, Austin, Texas

**9.1.2** Mandatory reporting laws reinforce the moral responsibility of individuals, either as permissive reporters (any person who knows or suspects a child is being maltreated can make a report to local child protective services) or mandated reporters (individuals who are required to report child abuse), to identify and report suspected cases of child abuse and neglect.



**Figure 5:** *Paws can heal: Pet Smart, Phoenix Children's Hospital, Arizona*<sup>iii 41</sup>

<sup>iii</sup> Phoenix Children's Hospital's provides an Animal-Assisted Therapy Program to patients and their families for therapeutic purposes. Scientific research has shown that a patient's interaction with an animal can provide positive physical and emotional benefits. It can reduce stress levels and invoke a sense of well-being. Animal-assisted therapy acts as a catalyst to motivate patients to help themselves.

Among the specific benefits of animal-assisted therapy are the ways it motivates children to:

- Get up, move, walk, leave their room and play
- Participate in therapy (physical, occupational and speech)
- Forget their discomfort or pain
- Interact more with others
- Improve their mood
- Improve their interactions with family and staff
- Do things that may be a struggle, such as eating, taking medication or waiting long times for things

- 9.1.3** Following publication of Dr C. Henry Kempe's paper in 1962<sup>18</sup>, California became the first US state to mandate the reporting of child abuse by statute. By 1967 all fifty states, the District of Columbia and the US Virgin Islands, had introduced some form of mandatory reporting legislation and in 1974 the US federal government enacted the Child Abuse Prevention and Treatment Act ([CAPTA](#)) which promoted state programmes for the identification, prevention and treatment of child abuse and neglect by providing federal financial assistance to those states willing to implement such programmes<sup>42</sup>.
- 9.1.4** Mandatory reporting laws have developed in several jurisdictions as a central part of governments' strategies to detect cases of abuse and neglect at an early stage, to protect children and to facilitate the provision of services to children and families. However, the terms of these laws differ in significant ways, both within and between different nations, with the differences tending to broaden or narrow the scope of cases required to be reported and by whom.
- 9.1.5** In England, Scotland and Wales there is no formal requirement in law to report child protection concerns to the statutory authorities. However, in Northern Ireland Section 5(1) of the Criminal Law Act 1967<sup>43</sup> provides for a criminal offence of failing to disclose an arrestable offence (which includes most offences against children) to the police. The extent to which this is enforced in Northern Ireland is unclear.
- 9.1.6** Although there may be no criminal offence of failing to report child abuse and neglect in England, Scotland and Wales, professionals who are bound by the requirements of regulatory bodies, including, for example, the General Medical Council ([GMC](#)) in the case of doctors, are often required to follow reporting guidance<sup>44</sup> issued by the regulator and persistent or serious failure to follow such guidance could place the individual's registration at risk.

## **9.2 Jurisdictions with Mandatory Reporting**

**9.2.1** There are generally two approaches to mandatory reporting in legislation. The first is to list designated professionals who, by the nature of their work, are likely to come into contact with families and children. These mandated reporters are usually required to report suspicions of child abuse which have arisen in connection with their work but some jurisdictions mandate reports regardless of the context in which the suspicions arose. The second is to impose reporting duties on all adult citizens in the area covered by the legislation.

### **9.2.2 Professionals required to report in the USA**

Forty-eight US states, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the US Virgin Islands all designate professions whose members are mandated by law to report child maltreatment<sup>45</sup>. Individuals designated as mandatory reporters typically have frequent contact with children. Such individuals may include:

- social workers
- teachers and other school personnel
- doctors, nurses and other healthcare workers
- counsellors, therapists and other mental health professionals
- child care providers
- medical examiners or coroners
- law enforcement officers.

### 9.2.3 Some other professionals frequently mandated across the USA include:

- commercial film or photographic processors<sup>iv</sup>
- computer technicians<sup>v</sup>
- substance abuse counsellors<sup>vi</sup>
- probation and parole officers<sup>vii</sup>
- directors, employees, and volunteers at entities that provide organised activities for children, such as camps<sup>viii</sup>
- domestic violence workers<sup>ix</sup>
- animal control or humane officers<sup>x</sup>
- Court-appointed special advocates<sup>xi</sup>
- members of the Clergy<sup>xii</sup>
- faculty, administrators, athletics staff at institutions of Higher Education<sup>xiii</sup>.

### 9.2.4 Reporting by other persons in the USA

In 18 states and Puerto Rico any person who suspects child abuse or neglect is required to report. Of these, 16 states and Puerto Rico specify certain professionals who must report but also require all persons to report suspected abuse or neglect, regardless of profession<sup>xiv</sup>. New Jersey and Wyoming require all persons to report without specifying

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<sup>iv</sup> Guam, Puerto Rico, Alaska, California, Colorado, Georgia, Illinois, Louisiana, Maine, Missouri, Oklahoma, South Carolina, West Virginia

<sup>v</sup> Alaska, California, Illinois, Missouri, Oklahoma, South Carolina

<sup>vi</sup> Alaska, California, Connecticut, Illinois, Iowa, Kansas, Massachusetts, Nevada, New York, North Dakota, Oregon, South Carolina, South Dakota, Wisconsin

<sup>vii</sup> Arkansas, California, Colorado, Connecticut, Hawaii, Illinois, Louisiana, Massachusetts, Minnesota, Missouri, Nevada, North Dakota, South Dakota, Texas, Vermont, Virginia, Washington

<sup>viii</sup> California, Hawaii, Illinois, Louisiana, Maine, Nevada, New York, Ohio, Oregon, Vermont, Virginia, West Virginia

<sup>ix</sup> District of Columbia, Alaska, Arizona, Arkansas, Connecticut, Illinois, Maine, South Dakota

<sup>x</sup> California, Colorado, Illinois, Maine, Ohio, Virginia, West Virginia

<sup>xi</sup> Arkansas, California, Louisiana, Maine, Montana, Oregon, South Carolina, Virginia, Washington, Wisconsin

<sup>xii</sup> Guam, Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Georgia, Illinois, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, Vermont, West Virginia, Wisconsin

<sup>xiii</sup> Alabama, Arkansas, California, Georgia, Illinois, Iowa (instructors at community colleges only), Louisiana, Oregon, Virginia, Washington

<sup>xiv</sup> Delaware, Florida, Idaho, Indiana, Kentucky, Maryland, Mississippi, Nebraska, New Hampshire, New Mexico, North Carolina, Oklahoma, Rhode Island, Tennessee, Texas, Utah

any professions. In all other states, territories, and the District of Columbia, any person is permitted to report.

### **9.2.5 Institutional responsibility to report in the USA**

Institutional reporting refers to situations where the mandated reporter is working, or volunteering, as a staff member of an institution, such as a school or a hospital, at the time she or he gains the knowledge that leads her or him to suspect that abuse has occurred. Many institutions have internal policies and procedures for handling reports of abuse and these usually require the person who suspects the abuse to notify a designated officer that abuse has been discovered or is suspected and that this needs to be reported to child protective services or other appropriate authorities. Statutes in 32 states, the District of Columbia and the US Virgin islands provide procedures that must be followed in those cases<sup>xv</sup>.

**9.2.6** In 18 states, the District of Columbia and the US Virgin Islands, any staff member who suspects abuse must notify the head of the institution when the staff member feels that the abuse or possible abuse should be reported to an appropriate authority<sup>xvi</sup>.

**9.2.7** In 10 states, the District of Columbia and the US Virgin Islands, the staff member who suspects abuse must notify the head of the institution first and then the head or his or her nominee makes the report<sup>xvii</sup>.

**9.2.8** In eight states the individual reporter must make the report to the appropriate authority first and then notify the institution that a report has been made<sup>xviii</sup>.

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<sup>xv</sup> Alaska, Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New York, North Dakota, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Vermont, Virginia, West Virginia, Wisconsin, Wyoming

<sup>xvi</sup> California, Connecticut, Georgia, Hawaii, Idaho, Illinois, Indiana, Maine, Maryland, Massachusetts, Michigan, New York, Pennsylvania, South Dakota, Tennessee, Virginia, West Virginia, Wyoming

<sup>xvii</sup> Georgia, Idaho, Indiana, Kentucky, Maine, Massachusetts, Pennsylvania, South Dakota, Virginia, Wyoming

<sup>xviii</sup> California, Connecticut (the Commissioner of Children and Families makes the notification), Hawaii, Illinois, Michigan, New York, Tennessee, West Virginia

**9.2.9** Laws in 14 states make clear that, regardless of any policies within the organisation, the mandated reporter is not relieved of his or her responsibility to report<sup>xix</sup>.

**9.2.10** In 15 states an employer is expressly prohibited from taking any action to prevent or discourage an employee from making a report<sup>xx</sup>.

#### **9.2.11 Criminal sanctions for failing to report child maltreatment in the USA**

Most states have provisions in their reporting statutes that make it a crime for a mandated reporter to knowingly fail to report suspected child abuse. Almost all of these statutes classify this offence as a misdemeanour<sup>xxi</sup> (a crime punishable with a maximum prison term of one year) and specify a maximum fine and/or jail sentence although Florida classifies it as a felony, with a maximum prison term of five years. Although criminal prosecutions for failure to report are rare, Courts have ruled that physicians may be subject to criminal penalty under the child abuse statute for failure to report suspected child abuse<sup>46</sup>.

#### **9.2.12 Australia**

It is not just in the USA that mandatory reporting laws exist. In Australia, for example, all states and territories have legislation, to varying extents, that requires medical practitioners to report cases of child abuse to the appropriate child protection authorities<sup>47</sup>.

**9.2.13** In the Australian Capital Territory<sup>xxii</sup> a report must be made, as soon as is practicable, if a person believes on reasonable grounds that a child or young person (aged under 18 years) has experienced or is experiencing sexual abuse or non-accidental injury<sup>48</sup>.

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<sup>xix</sup> Alaska, California, Florida, Indiana, Iowa, Kentucky, Michigan, Missouri, North Dakota, Oklahoma, Oregon, Tennessee, Texas, Wyoming

<sup>xx</sup> Arkansas, California, Connecticut, Georgia, Illinois, Iowa, Massachusetts, Michigan, Missouri, New York, North Dakota, Oklahoma, Tennessee, Vermont, Wisconsin

<sup>xxi</sup> 18 US Code §3559

<sup>xxii</sup> Children and Young People Act 2008



**9.2.14** In New South Wales<sup>xxiii</sup> a report must be made, as soon as is practicable, if a person has reasonable grounds to suspect that a child (aged under 16 years) is at risk of significant harm, and those grounds arise during the course of or from the person's work<sup>49</sup>.

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<sup>xxiii</sup> Children and Young Persons (Care and Protection) Act 1998

- 9.2.15** In the Northern Territory<sup>xxiv</sup> a report must be made, as soon as is practicable, if a person believes on reasonable grounds that a child (aged under 18 years) has suffered or is suffering harm or exploitation or a child (aged under 14 years) has been or is likely to be the victim of a sexual offence. A report must be made by a health practitioner if they believe on reasonable grounds that a child aged 14 or 15 years has been or is likely to be the victim of a sexual offence and the difference in age between the child and the alleged sexual offender is more than two years<sup>50</sup>.
- 9.2.16** In Queensland<sup>xxv</sup> a report must be made immediately (and within 7 days of the initial report – if it was made orally – the professional must provide a notice about the harm or likely harm, even if they no longer believe or suspect the child is at risk) if a professional becomes aware or reasonably suspects that a child (aged under 18 years) has suffered, or is likely to suffer, harm<sup>51</sup>.
- 9.2.17** In South Australia<sup>xxvi</sup> a report must be made, as soon as is practicable, if a person suspects on reasonable grounds that a child (aged under 18 years) has been or is being abused or neglected or that there is a reasonable likelihood of the child being killed, injured, abused or neglected by a person with whom the child resides<sup>52</sup>.
- 9.2.18** In Victoria<sup>xxvii</sup> a report must be made, as soon as is practicable, if a belief is formed, on reasonable grounds, that a child (aged under 17 years) is in need of protection from physical or sexual abuse<sup>53</sup>.

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<sup>xxiv</sup> Care and Protection of Children Act 2007

<sup>xxv</sup> Child Protection Act 1999 & Public Health Act 2005

<sup>xxvi</sup> Children's Protection Act 1993

<sup>xxvii</sup> Children, Youth and Families Act 2005

**9.2.19** In Tasmania<sup>xxviii</sup> a report must be made, as soon as is practicable, if a person believes or suspects on reasonable grounds, or knows:

- a) that a child (aged under 18 years) has been or is being abused or neglected or is an affected child<sup>xxix</sup>; or
- b) that there is a reasonable likelihood of a child being killed or abused or neglected by a person with whom the child resides; or
- c) while a woman is pregnant that there is a reasonable likelihood that after the birth of the child, the child will suffer from abuse or neglect or may be killed by a person with whom the child is likely to reside or that the child will require medical treatment or other interventions as a result of the behaviour of the woman or another person with whom the woman resides or is likely to reside, before the birth of the child<sup>54</sup>.

**9.2.20** In Western Australia<sup>xxx</sup> a report must be made, as soon as is practicable, if a person believes, on reasonable grounds, that a child (aged under 18 years) has experienced, or is experiencing sexual abuse<sup>55</sup>.

#### **9.2.21 Malaysia**

In Malaysia<sup>xxxi</sup> if a medical officer or registered medical practitioner believes on reasonable grounds that a child he is examining or treating is physically or emotionally injured as a result of being ill-treated, neglected, abandoned or exposed or is sexually abused, he shall immediately inform a Protector. Failure to comply with this legislation places the professional at risk of a fine of 5000 MYR (\$1550 USD) or a prison term of up to two years, or both<sup>56</sup>.

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<sup>xxviii</sup> Children, Young Persons and their Families Act 1997

<sup>xxix</sup> Family Violence Act 2004

<sup>xxx</sup> Children and Community Services Act 2004

<sup>xxxi</sup> Child Act 2001

### 9.2.22 Singapore

Singapore, like England, Wales and Scotland, does not have mandatory reporting for suspected cases of abuse and violence<sup>xxxii</sup>. The emphasis in Singapore has been to ensure that people with regular contact with children know how to detect and report child abuse rather than to make the reporting of it legally required<sup>57</sup>. The Singapore government provides [information](#) aimed at helping citizens to recognise risk factors for child abuse and to take action to mitigate these.

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<sup>xxxii</sup> Children and Young Persons Act 2001

## **9.3 Arguments surrounding mandatory reporting legislation**

### **9.3.1 Arguments against mandatory reporting**

The Royal College of Paediatrics and Child Health (RCPCH), in a position paper from December 2013, outlined at that time their lack of support for mandatory reporting of child protection concerns and recommended that the UK should not legislate on this issue stating that there is no credible or conclusive evidence that it better protects children at risk of harm, and its introduction would undermine the cultural approach of risk and responsibility sharing that has developed in the current system<sup>58</sup>.

**9.3.2** A number of arguments have been put forwards against mandatory reporting, as summarised by the NSPCC in their Strategy Unit Briefing paper on Mandatory Reporting, 12 June 2014<sup>59</sup>:

- perceived danger of over-reporting
- increases in unsubstantiated reports
- diversion of scarce resources from already deserving cases
- current law is adequate
- children fearing the implications of disclosure such as being forced into hostile legal proceedings
- diminished personal responsibility leading to a 'report it and forget it' culture
- research suggesting that despite mandatory reporting many professionals still fail to report abuse
- the structure of UK health and social care services and the inter-agency working that exists renders a mandatory system unnecessary due to the current channels of communication and professional accountability

- the introduction of external reporting mechanisms may slow down the process of dealing with allegations
- professional bodies take prompt action against registrants who persistently or seriously fail to follow their guidance.

**9.3.3** Some of the arguments explored in the NSPCC summary have been investigated scientifically including a belief that there is a lack of international evidence that mandatory reporting increases abuse detection rates<sup>60</sup> and that the introduction of mandatory reporting in the USA resulted in a tenfold increase in the number of children investigated for possible abuse and those shown to be ‘unfounded’ increased from 35% to 65% in one decade<sup>61</sup>.

**9.3.4** The majority of mandated reporters do not consistently report all suspected cases of maltreatment and therefore support for an alternative reporting policy among different groups, consideration of alternative strategies and policies that address the concerns of different types of professionals may be appropriate<sup>62</sup>.

**9.3.5** One reason given for not introducing a mandatory duty is that its enactment would be counter-productive and would increase the risk to children overall, first by weakening the professional’s personal sense of responsibility and, second, in casting the shadow of near-automatic reporting over their work which may raise barriers between clinicians and their patients or clients<sup>63</sup>.

**9.3.6** Several decades after implementing a mandatory child-reporting system in the USA many vulnerable children have been failed to be protected. The diagnosis may be missed, suspicions of abuse may be intentionally not reported, no intervention takes place or the intervention is inappropriate or inadequate<sup>64 65 66 67 68</sup>.

**9.3.7** Opponents believe that overloading of the child protection system is almost inevitable if mandatory reporting is introduced and that this would have potentially disastrous consequences. The number of unfounded (false positive) reports would increase and a huge resource would be required to effectively manage the filtering of referrals<sup>58</sup>.

**9.3.8** Without commensurate financial support, there would be a real risk that those children at the greatest risk and those with the greatest need would either be missed by the saturated system or, if they were identified, they would not be adequately supported by a system that has diverted a significant amount of resource to management and investigation rather than on-going planning, intervention, services and support<sup>58</sup>.

**9.3.9** There is a risk that mandatory reporting would have a negative effect on the existing, or planned, early intervention and prevention programmes, which have been widely advocated for the UK. Mandatory reporting would shift the emphasis to the hard end of child protection, with resources diverted accordingly, which may mean there is no capacity to develop preventative systems and services. This would not sit naturally with recent guidelines and recommendations, which have almost universally extolled the benefits of such upstream approaches<sup>58</sup>. By giving precedent to forensic and investigative activities, resources would be drained away from providing services to families most at risk.

**9.3.10 Recommendation ONE**

**Any introduction of mandatory reporting must be accompanied by a commensurate increase in resources to child welfare agencies to enable them to cope with the increased number of referrals that will be received and so that the safety of children who are already in need of protection is not compromised.**

**9.3.11** The issue of whether or not mandatory reporting should be introduced into New Zealand was considered in 2012 in a review by Professor Felicity Goodyear-Smith, Goodfellow Chair at The University of Auckland. The resounding conclusion of this review was that mandatory reporting by general practitioners of suspected abuse should not be introduced. Indeed, Professor Goodyear-Smith stated that 'extensive enquiries through a variety of avenues failed to find any paediatrician or other expert who would write in support of mandatory reporting' and that, in her view, the risks of the introduction of such a policy outweighed the gains<sup>69</sup>.

- 9.3.12** Professor Goodyear-Smith stated that whilst it is likely that most professionals would support sharing of information through the integration of services and inter-agency communication, this should not be confused with mandatory reporting of suspected child abuse<sup>69</sup>.
- 9.3.13** If general practitioners (GPs) are required to notify the authorities of abuse or neglect as part of their differential diagnosis, then Professor Goodyear-Smith believes that large numbers of unfounded cases may be reported and that too broad a definition of child abuse could lead to unnecessary and counterproductive reporting of minor problems that would be better dealt with by non-punitive agencies and interventions, such as assistance with parenting skills<sup>69</sup>.
- 9.3.14** In a retrospective study investigating all referrals received by child health, social services and police of suspected child sexual abuse in South Wales between 1986-1989 it was shown that of the 410 children referred, 197 (48%) were found to have been abused and of those cases where abuse was not proven (52%) only 63 (15% of the total cases referred) were judged to be due to false allegations, some of which were considered malicious. This pattern was found to be similar to that reported in the USA at the time where reporting was, and is, mandatory<sup>70</sup>. Armed with these figures, some opponents of mandatory reporting are bound to conclude that if detection rates are similar in two jurisdictions with completely different reporting laws – one with mandatory reporting and one without – changing to a system of mandatory reporting would do nothing to improve abuse detection rates.
- 9.3.15** In the USA one of the most vocal academic opponents of mandatory reporting is [Professor Gary Melton](#), Professor of Paediatrics in the University of Colorado School of Medicine. It is Professor Melton's belief that mandated reporting is a policy without reason and that there is overwhelming evidence that many of the catastrophic problems in contemporary child protection work in the USA are a direct product of the system's design with the assumptions that guided the enactment of mandated reporting laws to be largely erroneous<sup>71</sup>.



- 9.3.16** Professor Melton believes that the most fundamental mistake that the designers of modern child protection systems made was to grossly underestimate the scope of the problem of child abuse and neglect such that policymakers believed that an effective state response could be applied with existing resources<sup>71</sup>.
- 9.3.17** Professor Melton argues that calls to child protective services can be treated as allegations of wrong-doing rather than identifying families that are crying out for help and support. Relying on evidence showing that approximately one-eighth of referrals to child protective services in the USA are screened out without investigation and that approximately two-thirds of the reports of suspected child maltreatment that are investigated are never substantiated or found to be indicated<sup>72</sup>, Professor Melton believes that mandated reporting has transformed public child welfare agencies into investigatory bodies with diminished involvement in the provision of social services per se.
- 9.3.18** Professor Melton concludes that the mandatory reporting system has had paradoxical effects – and that some of those negative side effects probably adversely affect children’s safety. It is his belief that in aggregate there can be little question that jurisdictions with mandated reporting laws should be revising their systems to facilitate voluntary assistance to children and families – to create or sustain the norms of caring that prevent children from harm and that those countries without the USA-style child protection system should develop other models as both common sense and empirical research lead naturally to the conclusion that mandated reporting is bankrupt policy<sup>71</sup>.
- 9.3.19** If there were to be mandatory reporting in the UK the implementation of it would be key to avoiding overloading child protective services which was, in part, responsible for 6000 cases reported to Arizona’s Child Protective Services division, dating back to 2009, not being investigated as caseloads were on the rise and staff were over-burdened (77% above standards)<sup>73</sup>.

### **9.3.20 Arguments in favour of mandatory reporting**

Policies aimed at improving detection and referrals of suspected child abuse have not been effective overall. Unless mandatory reporting by clinicians is legally enforced, existing organisational and professional barriers may continue to hinder the ability of agencies to safeguard children from harm<sup>74</sup>.

**9.3.21** In New South Wales, Australia, in July 1987, the category of professionals required to report suspected cases of child sexual assault to the Department of Family and Community Services was extended to include teachers and other school professionals. There was a significant increase in the number and proportion of reports of suspected sexual assault received from teachers but there was no change in the quality of teachers' reports as measured by the percentage of reports which were verified on assessment<sup>75</sup>.

**9.3.22** The consistent observation that reporting falls short even in the presence of a legal mandate should not be interpreted as undermining the importance of these mandatory reporting laws. The experience in the USA supports the importance of a reporting mandate in the UK as well, at the very least as a counterweight to the considerable systemic bias against proper child protection. Mandatory reporting must be accompanied by effective quality improvement and educational and policy efforts<sup>64</sup>.

**9.3.23** Although the reporting process can be time-consuming and, at times, confrontational a physician's moral and professional obligation to keep children safe from harm should outweigh all of these concerns and they must report cases of suspected child abuse and neglect in accordance with the laws of the jurisdiction in which they are working<sup>76</sup>.

**9.3.24** Individuals responsible for the spiritual, emotional, athletic or educational upbringing of children such as teachers, coaches, health care professionals, religious officials and scout leaders are in positions of trust. Parents rely on these adults to safeguard the health and well-being of their children. Children placed under the supervision of a responsible adult are uniquely vulnerable and may be fearful of reporting abusive offenses. There are, therefore, strong moral and ethical reasons the law should require adults in close supervision of children to report any individual who they have good reason to believe has abused a child<sup>95</sup>.

**9.3.25** In the UK, [Dr Tom Sanders](#) and [Cathy Cobley](#) present a convincing case for the introduction of mandatory reporting. They argue that a law imposing a legal duty on doctors to report non-accidental injury in children cannot function effectively without a support structure enabling reporting procedures to be conducted in collaboration with clinicians and other child protection professionals. They believe that a sea-change, greatly assisted by a mandatory system of reporting, is required<sup>63</sup>:

- Greater open collaboration and dialogue between clinicians during the initial clinical investigation of suspected non-accidental injury.
- The removal of the institutional stigma attached to the child protection process.
- A culture change where clinicians begin to view non-accidental injury as requiring the application of both scientific and social evidence.

**9.3.26** Many professionals who were spoken to during the Travelling Fellowship that resulted in the publication of *[Living on a Railway Line](#)* acknowledged the impact mandatory reporting can have on referral rates to child protective services but believed that mandatory reporting laws help encourage the referral of all children who have been clinically investigated for possible abuse. Moreover, it was a common belief that a system of mandatory reporting that is widely known and accepted by society makes conversations with families about possible abuse a lot easier for both parties and facilitates the ability of educational professionals working in child advocacy centres to deliver comprehensive educational programmes to both professionals and the community alike.

**9.3.27** In Australia and the USA, Professors [Benjamin Mathews](#) and [Donald Bross](#) strongly believe that mandated reporting is still a policy with reason on empirical evidence and philosophical grounds. Without a system of mandated reporting, they say, a society will be far less able to protect children and assist parents and families, because many cases of abuse and neglect will not come to the attention of authorities and helping agencies<sup>77</sup>.

**9.3.28** It is accepted that mandated reporting schemes are imperfect but using child safety as the primary concern and drawing on evidence from several nations they argue that a child protection system needs a form of case identification beyond voluntary help-seeking; that mandated reporting produces a large number of substantiated reports and to sacrifice this compromises child protection; that the most serious problems in systems having mandated reporting appear to lie not within the reports, but with the responses; and that the economic and social justice advantages of mandated reporting far outweigh any disadvantages<sup>77</sup>.

**9.3.29** A society with mandated reporting will have more cases of abuse and neglect brought to the attention of authorities than will a society with no such system and substantiation rates of abuse and neglect per 1000 children in jurisdictions with mandatory reporting compared to those without it indicate the superiority of mandatory reporting in revealing true cases:

- England 2005/2006 (no mandated reporting): 2.4/1000<sup>78</sup>
- Western Australia 2004/2005 (no mandated reporting at that time): 2.3/1000<sup>79</sup>
- USA 2004 (mandated reporting): 11.9/1000<sup>80</sup>
- Canada 2003 (mandated reporting): 13.9/1000<sup>81</sup>
- Australia 2004/2005 (jurisdictions with mandated reporting): 5.5-14.1/1000<sup>79</sup>.

**9.3.30** Mandatory reporting would be a mechanism by which to prevent and reduce child abuse by signalling to society a clear statement of intent through legislation so to do and to ensure the by-products of this, such as increased public and professional awareness, contribute to the overall aim. Introducing such legislation would demonstrate the seriousness of intent in reducing levels of maltreatment and would afford greater protection to victims of abuse<sup>58</sup>.

**9.3.31** Professors Mathews and Bross argue that enhancing voluntary help-seeking by parents in communities that provide family support would be welcome, as would more widely delivered primary prevention programmes, but they believe that there is insufficient evidence in experience or science to justify leaving child protection to voluntary help-seeking by parents alone. Even with a good system of mandated reporting in place, many children's adverse experiences as they grow up will go undetected. Without a system of mandated reporting, and without a scientifically proven alternative, many hundreds of thousands more children will be left to suffer, incurring even more health and economic costs<sup>77</sup> and social injustice.

## **9.4 Reporting of cases**

- 9.4.1** Not all children who have suffered from, or who are at risk of, maltreatment are recognised or reported to the relevant authorities<sup>82</sup>. Several barriers may impede physician recognition of child abuse<sup>83</sup> and it is a reasonable supposition that if those clinicians involved in the examination process do not always recognise or report abuse this is likely to be the same for other professionals. Physicians simply may not be familiar with the typical syndromes associated with abuse, or they may have other psychological and subconscious biases that interfere with recognition of abuse. The child abuse reporting system in use in the USA has been evaluated to investigate the reasons behind widespread inefficiencies and failures, by professionals, to comply with mandatory abuse reporting laws<sup>84</sup>.
- 9.4.2** Physicians often fail to ask caretakers for sufficient information to determine the cause of an injury and it can be difficult for physicians and others to comprehend that a parent would intentionally harm a child<sup>85</sup>, especially so when familiarity with the family may make the recognition of maltreatment even more difficult.
- 9.4.3** Many practitioners do not report suspected maltreatment because they do not want to hurt their relationship with the family. In some cases they believe that they can work with the family without outside intervention and that they can manage the maltreatment better than child protective services. Many physicians mistrust child protective services because of negative experiences with only a minority of physicians reporting that they were kept informed about the status of an investigation<sup>86</sup>.
- 9.4.4** Mandated reporters have indicated that they would rather handle cases themselves and provide the adequate intervention to help the family better care for the child than turn the case over to child protective services with some believing that contact with child protective services could produce more harm than good by violating confidentiality and breaking trust in families where resistance and ambivalence were already issues that created treatment compliance complications<sup>87</sup>.

**9.4.5** Although some physicians fail to report suspected maltreatment there are differences in the reporting levels of professionals from varying backgrounds. It has been shown that smaller numbers of nurse practitioners fail to report suspected child abuse than their physician colleagues but that both nurse practitioners and physicians encountered similar perceived barriers to reporting and used similar processes when dealing with them. Both physicians and nurse practitioners with recent child abuse continuing education expressed greater confidence in child abuse management skills and were more likely to report suspected cases of abuse<sup>88</sup>.

**9.4.6** Encouraging nurses to share clinical case studies and experiences to assist in the development of model vignettes that best represent these more subtle findings is important. Two themes have emerged when investigating hesitations in the reporting of child maltreatment by nurses. The first is “easy reporting decisions” and the second is “complex reporting decisions”<sup>89</sup>.

*Theme 1: Easy reporting decisions (it's the law)*

In those cases where objective evidence is clearly indicative of physical abuse, nurses tend to report suspected child maltreatment immediately without further questioning or reassessment.

*Theme 2: Complex reporting decisions (the ones that haunt you)*

The decision to report child maltreatment increases in complexity when the constellation of signs and symptoms are less overt or include subjective data alone. The subjective data could be from the child or from the nurse and, interestingly, sometimes the child's own disclosure has not been seen by nurses as adequate evidence – whilst many nurses would report such incidents immediately, some have reported that there are times when they felt it necessary to assess the veracity of the child's disclosure before making a report to child protective services.

**9.4.7** Experiences with the child protection system are important for those people who are mandated reporters. Even if positive about experiences in filing a report to child protective services mandated reporters are less positive about the dearth of feedback they receive especially when they are undecided about whether there was a positive outcome to their report. Their perceptions of the reasons colleagues might fail to report emphasized dissatisfaction with child protective services, concern with loss of relationship with the child's parents and a desire to avoid Court proceedings. These concerns are best highlighted using the words of the participants themselves<sup>85</sup>:

*Problems with CPS*

"They never get feedback"

"If physicians could be assured of a competent, prompt response to a report I feel there would be less reluctance to report"

"Notably, sometimes I seem to have to convince them they should look into things even when physical evidence is reported"

"The social worker over-reacted despite my every effort to prevent this"

*Physicians' loyalty to parents*

"Physicians feel the trust between doctors and parents might be destroyed if they report"

"Physicians might make a mistake involving families they know and like, and the relationship with the family would be put in jeopardy or changed"

"Physicians view the child's caregivers as their patients and find it difficult to believe they would abuse or neglect their child"

*Court problems*

"Physicians do not want to be involved in a possible legal proceeding"

"Physicians are afraid to go to court"

"Physicians feel that the legal ramifications and potential abuse of their time by the justice system is significant"

"Physicians feel they would have to produce legal reports"



- 9.4.8** The mandatory reporting laws themselves may give some further insight into why some professionals fail to report abuse or suspected abuse. Problematic features, such as the use of ambiguous concepts like “reasonable” suspicion and “significant” harm have been identified previously<sup>90</sup>. Significant problems arise from a lack of clarity that has been set for reporting<sup>91</sup>.
- 9.4.9** Significant variability has been shown in how paediatricians interpret reasonable suspicion with a range of responses so broad as to question the assumption that any general consensus exists<sup>92</sup>. Even child abuse experts disagree about the threshold for mandatory reporting with a study of clinical and research experts finding no consensus in how experts on child abuse interpret reasonable suspicion.
- 9.4.10** Individuals identify significantly different thresholds depending on the framework used to represent likelihood. Such a degree of variability among experts raises serious questions about whether other professionals can be expected to reliably understand and consistently interpret the meaning of *reasonable suspicion*. Educational interventions are needed that can standardise and legitimate the continued use of this threshold in any future legislation<sup>93</sup>.
- 9.4.11** The lack of definition of ambiguous concepts in legislation may cause professionals to interpret them in different ways and, as a result, may serve as a barrier to reporting rather than supporting reporting. In any future introduction of mandatory reporting legislation bringing clarity to the meaning of the language used within the law will be one step that will help protect children from maltreatment<sup>94</sup>.
- 9.4.12** Understanding why professionals do not comply with reporting requirements, be they legally required or professionally required, is crucial to be able to modify systems and processes to ensure that children who are at risk of, or who have suffered from, significant harm and drawn to the attention of the appropriate authorities and their cases acted upon.

**9.4.13** Issues such as distrust of social care, amongst professionals from other backgrounds, and vice versa, the need to preserve professional relationships with families, losing sight of the intervention (not being informed of the outcome of a referral), wishing to avoid legal proceedings, lack of training and lack of confidence all have to be addressed.

**9.4.14** Introduction of any form of mandatory reporting in the UK would not address these issues and it is vital that if there is to be a law change in the UK, these determining features, of whether or not a report is made, are strongly highlighted and focussed on. It will require an exploration of the full reasons behind these features before work can be put in place to modify them. This exploratory work must begin in earnest.

## **9.5 Public opinion**

- 9.5.1** The general public has been bewildered by the magnitude of child abuse cases and widespread failures by pillars of the community to notify appropriate authorities<sup>95</sup>. For over two decades law enforcement agencies have been investigating allegations of crimes against children allegedly committed by persons in a position of responsibility or care, including religious leaders, school teachers and, more recently, media celebrities.
- 9.5.2** In 2011 prosecutors in the USA accused a retired assistant football coach at Penn State University of making inappropriate sexual advances or assaults on boys from 1994 to 2009. The coach allegedly interacted with the children through a charity and during this period several junior employees at Penn State University reported to their immediate supervisors that the coach had engaged in sexual activities with children however these observations were apparently never reported to the authorities. On 22 June 2012 Gerald “Jerry” Sandusky was convicted of 45 out of 48 counts of sexual abuse<sup>96</sup>.
- 9.5.3** It is not just in the USA that such scandals have occurred. In the UK over recent years, two incredibly high profile cases have been at the forefront of media attention.
- 9.5.4** The late Jimmy Savile has been accused of hundreds of counts of historic sexual assault spanning many decades. In the report of Operation Yewtree, police and the NSPCC concluded that Jimmy Savile was one of the UK’s most prolific known sexual offenders<sup>97</sup>.
- 9.5.5** Rolf Harris, a world-famous children’s entertainer, was convicted of the sexual assault of a number of young girls over a period of 18 years<sup>98</sup>.
- 9.5.6** It has to be remembered that, horrendous though these cases have been, they are a small number compared with the significant number of other child protection cases (neglect, physical abuse, emotional abuse and sexual abuse) that go on in society in general in the UK.

- 9.5.7** The crimes against victims involved in high profile cases are heinous in their own right but what is deeply worrying, in addition to the crimes themselves per se, is the allegations of cover-ups or concealment that accompanied them. That is to say that there have been allegations put forwards that people knew about these crimes in the past but that, for a variety of reasons, they were not investigated thoroughly enough or that the allegations were not always reported to the necessary people or agencies who should have taken action or that the reports if received were concealed.
- 9.5.8** As a natural consequence of these allegations being drawn to the attention of the public it is no surprise that some people in society, the former Director of Public Prosecutions included, have been calling for a change in the law such that teachers and other professionals who do not report abuse would face prosecution<sup>99</sup>.
- 9.5.9** Public opinion is important to consider when evaluating whether mandatory reporting of child abuse should be introduced in the UK. The term “policy window” has been used to describe events that come together and as a result lead political systems to adapt a particular solution to a specific policy problem<sup>100</sup>.
- 9.5.10** The emergence of policy solutions can occur as a result of the merging of different agendas of decision makers and, as such, a policy window may end with an idea gaining greater support than it otherwise would have done and becoming part of a public policy agenda.
- 9.5.11** Policy windows can occur due to the appearance of problems that are so compelling that they capture the attention of all of those involved in the policy formulation process, including professionals and the public. Is mandatory reporting an example of such a compelling problem?

**9.5.12** Theories surrounding democratic responsiveness might suggest that, in the case of mandatory reporting, there is a link between public opinion and policy formation. Although the effect of public opinion on policy formation can be difficult to assess, it could be the case that, so horrendous were the crimes against children in recent high profile cases, the authorities have been forced into a position where they have to do something. Responding to the issues raised in a public forum, such as widespread media interest and reporting, may be as important as the substance of the response itself<sup>101</sup>.

**9.5.13** For policy makers who want to be seen to be doing something, it might be appealing to introduce mandatory reporting but this should be approached with extreme caution as there is a risk that more gets embroiled within the sphere of discussion than originally intended because of the momentum of public and media attention.

**9.5.14** Of course, that public and media attention may have created a window of opportunity to introduce mandatory reporting and this could be something that is harnessed, provided that harnessing takes place with caution and in full knowledge of the potential risks involved relating to any new policy taking on a life of it's own.

## **9.6 Social justice**

- 9.6.1** In considering whether or not there needs to be legislative change in the UK it is important, at the outset, to determine what the goal of any such change would be and what society would like to do with that change. If that change would be to introduce mandatory reporting of child abuse concerns the next question to ask would be what should be done with that new legislation once enacted? Effectively, the question that needs to be answered is should there be a change to the law and, if so, what would be the intended response?
- 9.6.2** A liberal society must not ignore wrongs committed by adults against children. Propagating a system without mandatory reporting may undermine children's rights to safety and increase their vulnerability to harm<sup>79</sup>. The introduction of a law of mandatory reporting of child abuse would be aspirational in nature. That is to say that any new law would set out the legal framework for something that does not currently happen universally in society. The aim would be by entrenching a particular right, in this case the right, if you are a child, to have your case of abuse reported to the appropriate authorities, into a positive law, in the long term a less unjust society will be produced.
- 9.6.3** Mandatory reporting would legally mandate the reporting of child abuse when, at the present time, it is known that although professionals may be morally, ethically and professionally obliged to report, including by requirements set out in statutory guidance, some of them do not. A society must be careful about passing too many laws that are aspirational in nature and which that same society is not prepared to enforce. So if there is to be legislative change that change must be something that is rigorously enforced and not a law that is weak and ignored both by those people to whom it is intended to apply and those who are charged with investigating alleged breaches. Any such legislative change must find a way of diminishing human suffering, increasing human equality and increasing the ability of all children to start, and continue, their lives with equal chances of happiness<sup>102</sup>.

- 9.6.4** Trying to achieve social change by passing laws can be difficult. If the situation in society is viewed as so serious that a law is required to try to achieve such change, whether it be secondary prevention measures such as the reporting of alleged offences or the primary prevention of those same offences, that legislative change must be accompanied by a whole raft of associated material including, in this instance, a fully resourced child welfare system to deal with the resulting reports, a validated and robust process of screening and triage of reports, and a series of primary prevention measures to try and stop cases from occurring in the first place.
- 9.6.5** The law should be the ultimate aim of interventions – not the primary focus – and any new legislation must be about enabling legislation, rather than conclusive law, in the first instance with the possibility for modification in the future. The law may not change society in the short term but it is the measures that are put in place associated with that law and what is done with that law that are important.
- 9.6.6** Development and implementation of legislation is an asynchronous process where mandatory reporting is concerned and one single effect will not achieve the change that is seen as being required. It is important to recognise the evolution that must occur of any new legislation such as this, to start small and to test and pilot legislation that is implemented before making huge, whole scale changes to a system that may not be able to cope with those changes in the short term.
- 9.6.7** Prior to the introduction of new legislation a system and framework of recognition and reporting structures would need to be put into place depending on the individual needs of the community to which any new legislation may apply. It is possible that there may be associated legislative change required in parallel to any introduction of a law on mandatory reporting in the UK, including further enabling legislation to address the weaknesses of the first enactment<sup>xxxiii</sup>.

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<sup>xxxiii</sup> Particular thanks to Professor Donald Bross, Professor of Pediatrics at the Kempe Center, Colorado for mentoring the creation of this chapter

## **9.7 Implications for the UK**

- 9.7.1** Simplistic dichotomous arguments about whether or not mandatory reporting laws are justifiable are at the very least misguided because they do not distinguish between the different forms, purposes and contexts of the laws<sup>103</sup>. There is not, in essence, a single “yes” or “no” answer to the question surrounding whether or not the UK should introduce mandatory reporting legislation the current time. The arguments, and the background, to the concepts of mandatory reporting as they may apply to the UK and other jurisdictions are complex and cannot simply be summarised into a question that has but one of only two possible answers.
- 9.7.2** No scientific evidence exists which shows, categorically, that the UK should change the law to introduce mandatory reporting of child abuse suspicions. There is plenty of evidence, on a worldwide basis, put forwards in support of such a change and there is equally evidence that identifies international unintended consequences of the introduction of such legislation. Given the difficulties that may exist simply lifting public policy or legislation from one jurisdiction to another and expecting it to work perfectly, it is safe to say that, no matter what international evidence may exist, it cannot be confidently said that there is robust UK evidence to support legislative change towards mandatory reporting in this country.
- 9.7.3** So if the decision, as it applies to the UK, is not one that has a robust scientific basis is there another argument upon which a decision should be based? That alternative argument might be the views of society itself. Not all laws are introduced with robust scientific basis underpinning them – some are introduced because that is what society, at that moment in time, holds as its majority belief, demonstrated by the actions of the Parliamentary process set up to decide upon statute in this country. Mandatory reporting laws officially affirm the wrong of maltreatment and uphold the rights of children.
- 9.7.4** Many people in society take the view that crimes against children are abhorrent and must not be tolerated under any circumstances. One way in which a society can mark its disapproval of a set of circumstances or of a particular issue is to introduce a law, legislating on that issue, to make clear the views of society at that moment in time.



- 9.7.5** It may be, therefore, that in order to mark the seriousness of some of the child abuse cases over recent times, especially those high profile cases in the media, society requires and needs a change in the law to send a signal out to everyone within that society, and international observers, that the society itself will no longer tolerate the heinous behaviour that led to the introduction of the law.
- 9.7.6** Such a signal may have the effect of empowering victims to come forwards, when they might otherwise not have done, it may encourage members of the community to be more vigilant to spot cases of abuse at an earlier stage and it may, in time, have a preventative effect to reduce the number of cases of abuse that occur. Such a strategy is not without risk and before making any legislative change the risks of such change need to be properly evaluated in light of the arguments put forwards by those people who are against mandatory reporting of child abuse.
- 9.7.7** Despite the many justified criticisms of mandatory reporting its presence in any child protection system does reflect the standard the community expects for the care of children and facilitates widespread community awareness of child protection. Mandatory reporting should only occur when there is legitimate concern that a child may need protection from abuse. It should not be considered the avenue for the provision of “welfare services”<sup>104</sup>. If there were to be a change in the law it is clear that the need for further training and education of professionals dealing with children cannot be underestimated<sup>105</sup> to reduce the chances of professionals making unnecessary reports out of confusion or misinformation<sup>106</sup>.

**9.7.8** Having assessed the evidence both for and against the introduction of a child protection mandatory reporting law in the UK it is clear that there are a number of issues that need to be considered<sup>59 58</sup>:

- What would the impact of introducing mandatory reporting be?
- Would mandatory reporting effectively safeguard children against maltreatment in the future?
- What is the clear definition of mandatory reporting?
- To which organisations and/or institutions should the proposed duty apply?
- To which individuals should the proposed duty attach?
- What behaviour should be the subject of a duty to report?
- Which individuals would be protected under a proposed duty?
- Whose behaviour should be subject of a duty to report?
- What level of knowledge of abuse would trigger the proposed reporting duty?
- Is a mandatory reporting mechanism necessary or desirable?
- How would any reporting mechanism operate?
- What sanctions would apply for failing to report?
- Are there any exemptions to mandatory reporting legislation?
- The cost of, and cost effectiveness of, introducing mandatory reporting
- What would the evidential burden be for proving an offence against a professional for failing to report?

**9.7.9** Moving from the system currently in operation in the UK to an entirely revised system of mandatory reporting placing a legal obligation on all members of society to report suspected child abuse in whatever circumstance is neither desirable nor workable at the present time. If there is to be a change in the law to introduce legislation concerning mandatory reporting then it must be appropriately targeted.

**9.7.10** It is important to separate out abuse of children that occurs within an institution or organisation (however they may be defined) from child abuse occurring elsewhere in society (usually in families and communities). To do otherwise would be likely to cause failure of any new system as soon as it is implemented for all of the reasons that people who are not supportive of mandatory reporting cite.

**9.7.11** As an initial step there should be a new law introduced in the UK to require the reporting of suspected child abuse of any type occurring within any organisation or institution exercising care, supervision or authority over children, whether as part of its primary functions or otherwise<sup>107</sup>.

**9.7.12 Key Recommendation ONE**

**There should be a new law introduced in the UK to make it a legal (mandatory) requirement to report any reasonable suspicion of child abuse (of any type) occurring within any organisation or institution exercising care, supervision or authority over children, whether as part of its primary functions or otherwise. This new law should comply with the principles set out in Recommendation THREE.**

**9.7.13** Introduction of the new law would require a full evaluation before contemplating extension of the requirement to other organisations, institutions or to the wider society. “Reasonable suspicion” should either be defined within the primary legislation or statutory guidance should be issued to assist individuals determining whether any suspicions they may have would meet the threshold of reasonable. It is accepted that this area of the legislation may change, either via statutory instrument, or by common law, over time.

**9.7.14** In considering to whom the new duty to report should apply within the organisation or institution there should be a two-step process.

**9.7.15** First, all persons associated with the organisation should be legally required to report suspicions of child abuse occurring within that organisation or institution to a designated officer within that institution. If the suspicions relate to the designated officer the persons associated with the organisation should be legally required to report those suspicions to a Local Authority Designated Officer (LADO) outside of the organisation concerned.

- 9.7.16** Should the suspicions relate to the LADO then the persons associated with the organisations, and to whom the legal duty to notify the designated officer would apply, should be legally required to report their suspicions directly to child protective services and such reports should be treated as a referral falling within the auspices of Section 47 of the Children Act 1989. The definition of a person associated with an organisation should include officers, office holders, employees, managers, owners, volunteers, contractors and agents but should not include a person solely because the person is receiving a service from the organisation such as, for example, a pupil in a school, a patient admitted to a hospital (on a voluntary basis or by detention) or a child attending a sports club.
- 9.7.17** Second, the designated officer of the organisation should be legally required to report any suspicions of child abuse so reported to the local authority and such a report should be treated as a referral falling within the auspices of Section 47 of the Children Act 1989.
- 9.7.18** Timescales must be introduced within the new legislation covering the time in which the person associated with the organisation or institution has to make a report to the designated officer, the timescale in which the designated officer has to make a report to the local authority and the timescale that the local authority has to respond to the reported suspicions.
- 9.7.19** Feedback from the local authority to the designated officer should be made mandatory under the new legislation<sup>86</sup>, unless the allegation concerned the designated officer in which case the feedback should be provided to the individual(s) making the report to the LADO. Provision of feedback received by the designated officer to the individual(s) who made the original report should also be made mandatory. This would have two purposes. First, it would give feedback to the individuals who have made the reports, which is important to keep them engaged within the system, and second it would allow them to be reassured that the local authority has received the information on the suspicions of child abuse and that this information has not become lost within the system either by commission or omission.

- 9.7.20** If feedback is not received within the timescales to be set out in the legislation, the designated officer and individual(s) who made the original report should be legally obliged to report this to the local authority so that appropriate action can be taken. Improving communication between the child protective services and those people who would be mandated reporters is essential<sup>108</sup>.
- 9.7.21** Moving from the current system in the UK to the outlined mandatory reporting system, with the potential for criminal prosecutions for failure to comply with it, would be a significant change within the UK and a full evaluation of the introduction of such new legislation must occur before consideration is given to extending the scope of the legislation to other organisations, institutions, individuals or situations. It is important to not make the same mistakes that were made when the CSA was introduced in the UK in a manner that was, in one aspect, too hasty.
- 9.7.22** When society assumes responsibility to protect children from profound assaults on their bodily and psychological integrity the duty to protect children from less egregious but chronic threats to their personal security may be unlikely to be recognised<sup>71</sup>. The harm from such situations is clear and any change in policy must recognise the subtle nuances of the effects of different types of abuse on children, the presentation of those different types of abuse and the responses needed to deal with them. It is only possible to guard against unintended adverse consequences of a new piece of legislation by starting small, with a full scientific evaluation of the impact of any change in public policy or legislation occurring before there is any extension of that policy or law.
- 9.7.23** There is a clear need for continuing education of medical practitioners, and other professionals, regarding the symptoms and signs of physical abuse and the role of professionals in the multi-disciplinary management of child abuse. To some extent, the outcomes for children when presenting as a result of child abuse or neglect has been cited as being no better than a lottery, dependent on who they happen to see<sup>109</sup>.

- 9.7.24** Decisions about reporting to child protective services are guided by injury circumstances and history, knowledge of and experiences with the family, consultation with others, and previous experiences with child protective services<sup>110</sup>. Training of professionals is, thus, crucially important and the introduction of any new legislation in relation to mandatory reporting must be accompanied by a comprehensive, standardised, multi-disciplinary training package to ensure that all professionals fully understand the new legislation and are able to use it to properly protect children.
- 9.7.25** This training package must be in place, and must have been delivered to the necessary professionals, before any legislative change is enacted. To do otherwise risks further chaos in a system already stretched towards breaking point with professionals not fully understanding what they have to report, how to make those reports and exactly what their legal obligations are.
- 9.7.26** In addition to the training of professionals it is vital that the community understands the rationale behind any new legislation and the implications of this for children, families, professionals and organisations. This will require a community engagement programme across the UK.
- 9.7.27** In New York, all physicians, as well as certain other professionals, are mandated to take a standardised two-hour course called *Identification and Reporting of Child Abuse and Maltreatment* prior to licensing<sup>111</sup>. Such a mandate might reasonably be expected to improve identification and reporting and is slightly different from mandatory training programmes offered at a local level in the UK as it is standardised at the licensing level (by the regulator) rather than each employer having discretion to deliver such training in a different way.
- 9.7.28** There are numerous modalities that can address the issue of under-reporting of cases within a system of mandatory reporting. Education remains high on the list, starting with pre-qualification studies and continuing in the era of post-qualification continuing education.

**9.7.29** Although widely enacted law on worldwide basis, sizeable research gaps exist in terms of statistics on mandatory reporting compliance in key settings; obstacles and processes in mandatory reporting; the provisions of evidence-based training to support any duty to report and the training-reporting-child outcomes relationship in areas that have mandatory reporting already introduced<sup>112</sup>.

#### **9.7.30 Recommendation TWO**

**Further research should be conducted in the UK to assess the training-reporting-outcomes relationship for children where suspicions of possible child abuse have arisen looking, in detail, at the outcomes for the child of a referral to child protective services.**

**9.7.31** Whatever happens to any new law surrounding mandatory reporting of child abuse in the UK it is of the utmost importance that it is recognised that the majority of child abuse and neglect occurs within homes, families and communities not within organisations and institutions.

**9.7.32** Society must never lose sight of that, or be distracted by a media frenzy of high-profile cases related to public figures and celebrities which, disturbing though they are, do not reflect the majority of abuse cases that do occur within our communities.

**9.7.33** To fail to protect those silent majority of children who are abused within the community itself, via an unintended consequence of a law designed to protect a minority of children who are abused in organisations or institutions, would be as egregious as failing to take action to protect those vulnerable children who are at risk of abuse in a most heinous manner by people who occupy positions of trust, responsibility and power.

#### 9.7.34 Recommendation THREE

##### **Principles for the introduction of a new law on mandatory reporting of child abuse:**

- All persons associated with an organisation or institution exercising care, supervision or authority over children, whether as part of its primary functions or otherwise, should be legally required to report suspicions of child abuse occurring within that organisation or by a person associated with that organisation, to a designated officer.
- All designated officers who are aware of suspicions of child abuse either from their own knowledge or as a result of a report from another person should be legally required to report this to the local authority and such a report should be treated as a referral falling within the auspices of Section 47 of the Children Act 1989.
- The local authority should be legally obliged to give feedback to the designated officer who, in turn, should be legally obliged to provide this feedback to the individual(s) who made the initial report(s). There should be mechanisms put into place within the legislation to ensure that if feedback is not received by persons entitled to receive it, this is both reported and acted upon.
- Timescales should be introduced within the new legislation covering the timescale for reporting, both by the person associated with the organisation and the designated officer, and the timescale for a response by the local authority.
- There must be introduction of a comprehensive, standardised, multi-disciplinary training package delivered to the necessary professionals in advance of the new legislation becoming law combined with a UK-wide community engagement programme relating to the new legal provisions.
- It should be an offence for any organisation, institution or individual to take action to prevent or discourage a person from making a report.
- There must be a full scientific evaluation of the impact of the new mandatory reporting legislation before consideration is given to extending the scope of the legislation to other organisations, institutions, individuals or situations.



# Physical punishment of children



***"It is easier to build strong children than to repair broken men"***

Frederick Douglass, 1817-1895

## About this chapter

This chapter recommends prohibition of physical punishment of children in the UK, in common with many other countries around the world, and concludes that legislative change is necessary to remove the defence of "reasonable punishment" from UK law.

## 10.0 Physical punishment of children

### 10.1 Overview

**10.1.1** Physical (corporal) punishment of children violates international human rights law. Physical punishment is the use of physical force with the intention of causing the child to experience bodily pain or discomfort so as to correct or punish the child's behaviour<sup>113 114 115</sup>.



*Figure 6: Physical punishment of children using a paddle in Texas<sup>117</sup>*

**10.1.2** Physical punishment, often used interchangeably with corporal punishment, includes slapping, spanking or smacking and hitting with a hard object – such as a wooden paddle (often 60 cm long, 7.5 cm wide and over 1 cm thick). It can also include things such as washing a child's mouth out with soap and water, making a child kneel on sharp or painful objects, forcing a child to sit or stand in painful positions for a long period of time or compelling a child to engage in excessive exercise or physical exertion.

**10.1.3** Physical punishment is, thus, very different from physical restraint – that which is necessary to protect a child from self-harm or harming others. Physical punishment is known by a number of names including smack, slap, beat, tap, paddle and hit but, logically, it cannot be possible for a young child, or indeed society, to differentiate between a smack and an assault since both are forms of violence. The motivation behind the physical punishment cannot reduce the hurtful impact that it has on the child<sup>116</sup>.

**10.1.4** In the UK parents have not been explicitly prohibited from smacking their children. However, section 58 of the Children Act 2004<sup>118</sup> limited the use of the defence of reasonable punishment so that parents and those acting in loco parentis who cause physical injury to their children can no longer use the “reasonable punishment” defence where they are charged with assaults occasioning cruelty, actual or grievous bodily harm. The defence of “reasonable punishment” is only available to parents, or others acting in loco parentis (provided they are not expressly prohibited from using physical punishment, for example in schools), where the charge is one of common assault.

**10.1.5** Physical punishment is prohibited in all maintained and full-time independent schools, in children’s homes, in local authority foster homes and early years provision. Section 58 of the Children Act 2004 limits the defence of reasonable punishment as follows:

- (1) In relation to any offence specified in subsection (2), battery of a child cannot be justified on the ground that it constituted reasonable punishment.*
- (2) The offences referred to in subsection (1) are –*
  - a) an offence under section 18 or 20 of the Offences against the Person Act 1861 (c. 100) (wounding and causing grievous bodily harm);*
  - b) an offence under section 47 of that Act (assault occasioning actual bodily harm);*
  - c) an offence under section 1 of the Children and Young Persons Act 1933 (c. 12) (cruelty to persons under 16).*
- (3) Battery of a child causing actual bodily harm to the child cannot be justified in any civil proceedings on the ground that it constituted reasonable punishment.*
- (4) For the purposes of subsection (3) “actual bodily harm” has the same meaning as it has for the purposes of section 47 of the Offences against the Person Act 1861.*
- (5) In section 1 of the Children and Young Persons Act 1933, omit subsection (7).*

**10.1.6** Effectively, physical punishment is illegal if it leaves a mark on a child or an implement (such as a cane or belt) is used to physically punish the child. However, the law in the UK does not go so far as to make all forms of physical punishment illegal and it remains legal for parents to physically punish their child, for example in the form of smacking, provided no actual bodily harm is caused (effectively, provided a mark is not left).

**10.1.7** The work of Elizabeth Gershoff<sup>119</sup>, in conjunction with Phoenix Children's Hospital, into physical punishment in the United States is particularly interesting and relevant to the UK. Based on this work it is right to question whether it is logical that a parent can hit a child aged under 18 but if that child were to hit another adult this may be considered illegal if the child were above the age of criminal responsibility.

## 10.2 Paddling in the USA

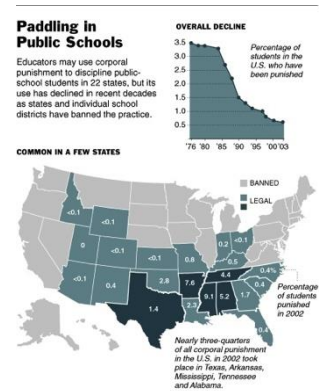
**10.2.1** Spanking/smacking and paddling (striking the buttocks with a wooden paddle) are not punishments of a bygone era in schools in the USA.

**10.2.2** In the USA nearly two thirds of parents of very young children reported using physical punishment and in schools many children continue to receive physical punishment in the form of paddling (up to three strikes on the buttocks by a wooden paddle). During 2009 over two hundred thousand children are estimated to have received physical punishment in schools in the USA and although this decreased from over a quarter of a million children during the 2004-2005 school year (where Mississippi, for example, physically punished over 45000 students and Texas physically punished over 57000 students)<sup>120</sup> it is still a worryingly high number.

**10.2.3** In some districts in Texas, for example, parents are asked, on enrolment of their child in school, whether physical punishment (paddling) of the child is to be allowed. A form must be completed with three options:

- Physical punishment of the child is allowed
- Physical punishment of the child is not allowed
- Physical punishment of the child is allowed but the parent must be contacted each time its use is proposed by the school (allowing the parent the final decision or, in some cases, facilitating the parent attending the school to administer the physical punishment or to administer the punishment at home).

**10.2.4** School Principals who have delivered physical punishment in schools are acting in accordance with the policy of the organisation that they work for and in accordance with the law.



Source: Center for Effective Discipline, U.S. Department of Education, Office for Civil Rights  
**Figure 7: Paddling in public schools in the USA<sup>121</sup>**

### 10.3 Support for physical punishment of children

- 10.3.1** The practice of hitting children as part of discipline is deeply embedded in cultural views, government law and social policy. Indeed this is also apparent from some religious texts including the Bible, *“He that spareth his rod hateth his son: but he that loveth him chasteneth him betimes”*<sup>122</sup>. Some proponents of corporal punishment of children believe that physical punishment of children is thought to teach respect for authority and failure to physically punish them leads to uncontrolled, disrespectful, acting-out behaviour. This implies that lack of sufficient discipline increases the level of societal discord and violence<sup>123</sup>.
- 10.3.2** Not everyone agrees that corporal punishment of children violates international human rights laws and is inherently wrong with views being expressed that parents need to be empowered with more effective alternatives, not disempowered by premature bans on traditional disciplinary tactics<sup>124</sup>, that occasional smacking does no harm<sup>125</sup> and that although the harmful effects of physical abuse and other extreme punishments are clear, a blanket injunction against spanking is not justified<sup>126</sup>.
- 10.3.3** Research conducted on behalf of the [Singapore Children’s Society](#) looking at public attitudes to actions suggesting child abuse or neglect found that whilst respondents considered sexual abuse to be the most serious form of abuse they were less concerned with emotional maltreatment than other types of abuse. In relation to physical punishment of children, caning was stated to be a widely accepted form of physical punishment and was regarded by the fewest respondents to be *“never acceptable”* or *“abuse/neglect”*<sup>127</sup>.
- 10.3.4** Physicians’ attitudes are important in this area as these clinicians may be asked to assess children for evidence of physical abuse and part of the history that will be taken from the caregivers ought to relate to disciplinary measures used with the children. In a study assessing physicians’ attitudes towards corporal punishment in childhood and their subsequent actions regarding the reporting of child abuse, corporal punishment was approved by 58% of physicians was perceived as an acceptable disciplinary act by a significant proportion of physicians responsible for the healthcare of children.

- 10.3.5** Attitudes towards corporal punishment were different between immigrants and native doctors and paediatricians, in this study, were more tolerant of corporal punishment than family practitioners<sup>128</sup>. That surely has got to affect the individual thresholds of these clinicians when assessing children for potential physical abuse or when deciding to make a report to the relevant child protective services.
- 10.3.6** Support for corporal punishment of children has also come from within Judicial circles with one Justice of the Peace in Montgomery County, Texas ordering an 11 year old child to be spanked, with a wooden paddle, in his Courtroom<sup>129</sup>. The 11 year old child who was in foster care and was sent to Court for misbehaviour at school, is reported to have been bent over a table in the Courtroom and struck three times with a paddle.
- 10.3.7** Defending his sentence, the Justice of the Peace is reported to have said, *"He doesn't understand any other punishment but corporal punishment. That was the way I was raised and you were raised and we were much better kids than the current generation. He was using profanity real bad. I said what he needs is corporal punishment"*<sup>130</sup>. Those people who are anti-corporal punishment of children will surely find this punishment of an 11 year old child in foster care, or indeed any child no matter what the care status, to be abhorrent.
- 10.3.8** In a debate about smacking one parent, who was smacked as a child by his mother and by a number of teachers at primary and secondary school said, *"I believe that the use of smacking, within the context of a loving relationship, is an effective means of discipline. I do not accept the argument that smacking inevitably escalates to child abuse... I worry about parents who have never smacked a child, and have perhaps never really given it any thought, but then in the heat of the moment lose their temper and really lash out at the child. Hitting a child in anger – smacking a child in anger is wrong"*<sup>131</sup>.
- 10.3.9** Those who report experiencing more corporal punishment during childhood but also more parental warmth/support hold more favourable attitudes toward spanking and those who report experiencing more corporal punishment during childhood and also more parental impulsiveness hold less favourable attitudes<sup>132</sup>.

**10.3.10** In a survey of 1000 adults from Quebec, Canada a majority of respondents endorsed spanking despite their recognition of potential harm associated with corporal punishment of children. Spanking was the most reported childhood experience and most violence and abuse predictors were significant and positively correlated. Older respondents who were spanked in childhood and who believed that spanking never or seldom results in physical injuries were the most in favour of spanking. On the other hand, respondents who reported more severe physical violence or psychological abuse in childhood were less in favour of spanking<sup>133</sup>.

**10.3.11** What about the voice of the child in this argument? Adolescents' endorsement of parental use of corporal punishment has been examined to elucidate processes underlying the intergenerational transmission of discipline strategies and adolescents' views varied widely. Those adolescents who had been spanked by their own mothers were more approving of this discipline method, regardless of the overall frequency, timing or chronicity of physical discipline that they had received. However, there was no correlation amongst adolescents for whom physical maltreatment in early or middle childhood was suspected<sup>134</sup>.

**10.3.12** Unfortunately some children seem to accept corporal punishment as a parental right and as part of the parental role<sup>135</sup> but others believe that violence isn't going to solve anything, all that it will do is to hurt children and cause more problems and that smacking children should not be legal under any circumstances<sup>131</sup>.



## **10.4 Research into physical punishment of children**

**10.4.1** It seems incongruous that physical punishment of children in some schools in the USA is still permitted despite many decades of research showing that<sup>119</sup>:

- children who are physically punished are at greater risk of serious injury and physical child abuse
- physical punishment of children puts them at risk of negative outcomes including mental health problems
- physical punishment of children makes it more, not less, likely that they will be defiant and aggressive in the future.

**10.4.2** However, it has to be recognised that physical punishment of children is used throughout the world as a disciplinary strategy even though it is related to negative outcomes for children regardless of the parental context in which it is used<sup>136</sup>. Not all research concludes that there should be a ban on physical punishment of children and it has been reported that verbal abuse is a more important predictor of conduct problems than corporal punishment<sup>137</sup>.

**10.4.3** It is difficult to find research which fully supports physical punishment of children and although a review of the impact of non-abusive physical punishment of African-American children was inconclusive it was suggested that it is possible that there are benefits to non-abusive physical punishment of this select group of children (who were involved in the study) but recognised that further longitudinal studies are needed that better assess the multiple confounders that impact the use of discipline, such as socio-economic status, parental education level and exposure to community or domestic (inter-partner) violence<sup>138</sup>.

**10.4.4** Studies have not always shown that corporal punishment is always associated with poor outcomes in certain groups of children<sup>139</sup> and it has been reported that the impact of spanking and corporal punishment on the negative outcomes of externalizing, internalizing behaviours and low cognitive performance may be minimal<sup>140</sup>.

**10.4.5** Physical punishment of children is no more effective as a long-term strategy for improving behaviour than other approaches<sup>141</sup>, and reliance on physical punishment makes other disciplinary strategies less effective<sup>142</sup>.

**10.4.6** Research<sup>119</sup> has demonstrated that parents are more likely to use physical punishment if:

- they strongly favour it and believe in its effectiveness or were physically punished as children<sup>143</sup>
- they have a cultural background (for example religion, ethnicity, country of origin) that they perceive approves of the use of physical punishment<sup>144 145</sup>
- they are socially disadvantaged (for example low income, low level of education or living in a socially deprived area)<sup>146</sup>
- they report being frustrated or aggravated with their children on a regular basis<sup>147</sup>
- the child is under the age of 5 years or the parent is under 30 years of age<sup>148</sup>
- they are experiencing stress (such as financial hardship, relationship conflict), adverse mental health symptoms or low emotional well-being<sup>149</sup>.

**10.4.7** However, the more parents use physical punishment the more aggressive their children become over time even when controlling for their initial levels of aggression, the frequency or severity with which children experience physical punishment is associated with increased childhood mental health problems and physical punishment is associated with poorer quality parent-child relationships.

**10.4.8** Children who are physically punished are at risk of significant harm with those that have been smacked by their parents being seven times more likely to be seriously assaulted (for example punched or kicked) than those who have not been physically punished and 2.3 times more likely to suffer an injury requiring medical attention than those who have not been smacked<sup>150</sup>.

**10.4.9** There are a number of possible reasons as to why physical punishment is not effective as a disciplinary technique including that:

- it does not teach children *why* their behaviour was wrong or *what* they should do instead
- it teaches children that they should behave in certain ways or risk physical punishment if they do not, rather than teaching them the important, positive reasons for behaving appropriately
- it indicates to children that it is acceptable to use physical force and aggression against another person
- it can increase the likelihood of children behaving aggressively themselves in other social interactions
- it may teach children to link violence with a relationship that is supposed to be built on the foundation of love.

## **10.5 Worldwide perspective**

**10.5.1** There are at least 38 countries around the world that have already prohibited physical punishment of children in all settings including in the home and removing the defence of “reasonable punishment” (year of ban)<sup>6</sup>:

- Brazil & Malta (2014)
- Honduras & The Former Yugoslav Republic of Macedonia (2013)
- South Sudan (2011)
- Albania, Republic of Congo, Kenya, Poland & Tunisia (2010)
- Liechtenstein, Republic of Moldova, Costa Rica & Luxembourg (2008)
- Togo, Spain, Venezuela, Uruguay, Portugal, New Zealand, The Netherlands (2007)
- Greece (2006)
- Hungary (2005)
- Romania & Ukraine (2004)
- Iceland (2003)
- Turkmenistan (2002)
- Germany, Israel & Bulgaria (2000)
- Croatia (1999)
- Latvia (1998)
- Denmark (1997)
- Cyprus (1994)
- Austria (1989)
- Norway (1987)
- Finland (1983)
- Sweden (1979)

**10.5.2** It is not an acceptable position for the UK and the USA to remain missing from the above list.

**10.5.3** Examples of specific legislation from some of the countries that have banned physical punishment of children, are set out below:

#### **10.5.4 Sweden**

Children are to be treated with respect for their person and individuality and may not be subjected to corporal punishment or any other humiliating treatment.

(Parenthood and Guardianship Code, 1983)

#### **10.5.5 Finland**

A child shall be brought up in the spirit of understanding, security and love. He shall not be subdued, corporally punished or otherwise humiliated.

(Child Custody and Rights of Access Act, 1983)

#### **10.5.6 Norway**

The child shall not be exposed to physical violence or to treatment which can threaten his physical or mental health.

(Parent and Child Act, 1987)

#### **10.5.7 Austria**

The use of force and infliction of physical or psychological suffering are not permitted.

(Section 146a, General Civil Code, 1989)

#### **10.5.8 Denmark**

A child has the right to care and security. He or she shall be treated with respect as an individual and may not be subjected to corporal punishment or other degrading treatment.

(Parental Custody and Care Act, 1997)

#### **10.5.9 Latvia**

Cruel treatment or a child, physical punishment and offences against the child's honour and respect are not allowed.

(On Children's Rights Protection, 1998)

#### **10.5.10 Ukraine**

Physical punishment of the child by the parents as well as other inhuman or degrading treatment or punishment are prohibited.

(Family Code of Ukraine, Article 150[7])

#### **10.5.11 The Netherlands**

In the care and upbringing of the child the parents will not use emotional or physical violence or any other humiliating treatment.

(Article 1:247 of the Civil Code, 6 March 2007)

#### **10.5.12 Costa Rica**

Parental authority confers the rights and imposes the duties to orient, educate, care, supervise and discipline the children, which in no case authorises the use of corporal punishment or any other form of degrading treatment against the minors.

(Article 143, Family Code, June 2008)

#### **10.5.13 Germany**

Physical punishment, the causing of psychological harm and other degrading measures are forbidden.

(Civil Law, 2000)

#### **10.5.14 International Recommendation ONE**

The USA, as a signatory to the UN CRC, should follow due process, commencing immediately, and ratify it so that children living in the USA can be assured of the protection that the UN CRC quite rightly affords them.

#### **10.5.15 International Recommendation TWO**

Countries that have not prohibited physical punishment of children aged under 18 years of age in all circumstances should do so as soon as possible.

## **10.6 Implications for the UK**

- 10.6.1** Given the risk factors for parents who are more likely to use physical punishment on their children, given the increased risk of further episodes of physical punishment when used by a parent<sup>151</sup> and given the risks that this poses to the children concerned, professionals need to be vigilant to look out for signs that any such punishment was not reasonable, or to carefully consider whether the risks of a particular situation are significant enough that the child in question is at risk of significant harm and that such harm is greater than the harm already caused by an outdated law which permits parents to physically punish their children at the current time.
- 10.6.2** Since the evidence against physical punishment of children appears to outweigh evidence to the contrary, the implications for health care professionals who are committed to evidence-based practice are fairly obvious: when working with families and communities, advice should be concentrated on developing interventions that empower parents to choose not to smack by helping them to develop effective strategies for dealing with stress and by raising self-esteem<sup>152 153</sup>.
- 10.6.3** Regardless of whether there is a statistically significant association or not between deaths from child maltreatment and the legal corporal punishment situation in a particular country or state, if there is to be a reduction in the number of cases of child death from child abuse and the number of cases of child maltreatment, given the role that society has in protecting those children, this must begin from a stand-point of taking the moral high ground which is that it is unacceptable to physically punish children, whatever the circumstances, and that there are much more effective and appropriate punishments to administer.
- 10.6.4** Disciplining children must not involve physical violence against them – indeed so to do perverts one of the origins of the word discipline, that is to come from the Latin *discipulus* meaning pupil, to educate, to follow (from *disciple*) or to learn. To discipline children through physical violence merely serves to educate them that such violence is accepted and encouraged by society which may teach them to behave in this way as they grow older. This surely cannot be a society in which the majority of people would wish to live in the future.

**10.6.5** The position of a society where physical punishment of children is permitted yet child abuse is forbidden is not a tenable one. Reducing the number of cases of child abuse must begin with a clear message from society that physical punishment of children, whatever the circumstances, is unacceptable.

**10.6.6** Either society must come to that conclusion itself and demand a change in the law or, if society cannot do this in a timely fashion, the law-makers in that society, in the form of Parliamentarians, must take the brave decision that, despite some public opinion, the situation is serious enough to introduce aspirational legislation to ban physical punishment of children with the aim of modifying behaviour within society – even if that is way into the future.

**10.6.7** Although the law is best seen as enforcing what a society is prepared to accept as appropriate conduct and whilst caution must be exercised when introducing aspirational legislation which may not have the immediate support of a significant number of members of society, the situation for children at risk of significant harm is serious enough to warrant legislative change in a number of jurisdictions, including here in the UK<sup>xxxiv</sup>.

**10.6.8 Key Recommendation TWO**

**There should be legislative change in the UK to prohibit physical punishment of children in all settings and to remove the defence of “reasonable punishment”.**

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<sup>xxxiv</sup> Particular thanks to Marcia Stanton, Social Worker at Phoenix Children’s Hospital, Arizona for mentoring the creation of this chapter



# Legislative considerations



***"Even when laws have been written down, they ought not always to remain unaltered"***

Aristotle, 384-322 BC

## About this chapter

This chapter highlights that some of the recommendations in this report would require new primary legislation to be enacted or a change in the law that is already in place. This chapter makes recommendations for changes to the Sexual Offences Act 2003 and the Children Act 2004 as well as underlines the importance of ensuring that any legislation introduced concerning Modern Slavery is appropriate to properly protect children.



## **11.0 Legislative considerations**

### **11.1 Overview**

- 11.1.1** Some of the themes and recommendations outlined in this report could, and should, be implemented as quickly as possible as many of them do not require any legislative change to happen.
- 11.1.2** Some of the recommendations in this report would require new primary legislation to be enacted and, where this is the case, these circumstances have been highlighted in the relevant section of this report.
- 11.1.3** There are a small number of the recommendations which do require a change in the law in the UK, or modification of legislation, at the time of writing, still in Bill form before the House of Commons.

## **11.2 Sexual Offences Act 2003**

**11.2.1** There are two problematic areas in the Sexual Offences Act 2003 which do not adequately protect children from abuse related to grooming and sexual exploitation.

**11.2.2** Under section 15 of the Sexual Offences Act 2003, for someone to be convicted of the offence of “meeting a child following sexual grooming” there must be at least two instances of contact before a meeting takes place.

**11.2.3** Since 2003 there has been a significant expansion in the accessibility of electronic communications to children and it is now possible for perpetrators to groom a child with much more ease prior to meeting with that child with the intention of abusing them.

**11.2.4** A law which says there must be at least two incidences of contact before that meeting takes place is not tenable in the era of such easy electronic communications and there must, therefore, be a change to the Sexual Offences Act 2003 to bring it up to date.

### **11.2.5 Key Recommendation THREE**

**Section 15(1)(a) of the Sexual Offences Act 2003 must be revised to change the number of times contact must be proven to have been made with a child, prior to meeting with that child with the intention of abusing him or her, from two to one. Consideration should also be given to raising the age in relation to sexual exploitation in section 15 from age 16 to age 18 to reflect that it is possible to treat someone in an exploitative manner who is above the age of legal consent to sexual intercourse but still a child aged under 18 years of age.**

**11.2.6** In addition, the terms “child prostitute” and “child prostitution” must be removed from legislation as they do not fully describe the true situation for these children which is that they are being sexually abused and sexually exploited.

#### **11.2.7 Key Recommendation FOUR**

**The Sexual Offences Act 2003 must be revised to remove the terms “child prostitute” and “child prostitution” and additional clauses should be inserted to better reflect the fact that children who were previously classed as being involved in “child prostitution” are actually victims of serious child sexual abuse and child sexual exploitation.**

### **11.3 The Children Act 2004**

**11.3.1** Physical punishment of children violates international human rights law. A quarter of a century ago, in 1989, the Human Rights of Children were recognised internationally when the United Nations Convention on the Rights of the Child (UN CRC<sup>15</sup>) was signed by world leaders.

**11.3.2** Article 19 of the UN CRC states:

*States Parties shall take all appropriate legislative, administrative, social and educational measures to protect children from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.*

**11.3.3** Physical punishment of children is clearly counter to the UN CRC which confers absolute protection for children against violence while in the care of parent(s), guardian(s) or any other person.

**11.3.4** That this convention has almost universal ratification is a testament to the importance placed on children's rights worldwide. It is deeply worrying, therefore, that Somalia and the USA have still failed to ratify the treaty. Accompanying the Convention are two optional protocols, one on children in armed conflict and one on the sale of children, child prostitution and child pornography which ought, also, to be ratified by those states that have not yet so done<sup>154</sup>.

**11.3.5** Within Europe the Council of Europe, Parliamentary Assembly Recommendation 1666 (2004) has stated that<sup>155</sup>:

*The Assembly considers that any corporal punishment of children is in breach of their fundamental right to human dignity and physical integrity. The fact that such corporal punishment is still lawful in certain member states violates their equally fundamental right to the same legal protection as adults. Striking a human being is prohibited in European society and children are human beings. The social and legal acceptance of corporal punishment of children must be ended.*

- 11.3.6** Section 58 of the Children Act 2004 is clearly inconsistent with Article 19 of the United Nations Convention on the Rights of the Child as surely any physical punishment of a child constitutes physical violence and should, within our own [legislative system](#)<sup>156</sup>, be classified as *at least* [Common Assault](#).
- 11.3.7** An offence of Common Assault is committed when a person either assaults another person or commits a battery. An assault is committed when a person intentionally or recklessly causes another to apprehend the immediate infliction of unlawful force. A battery is committed when a person intentionally and recklessly applies unlawful force to another<sup>157</sup>.
- 11.3.8** In October 2008 the UN Committee on the Rights of the Child stated in its concluding observations on the UK that, *"The committee is concerned at the failure of the State party to explicitly prohibit all corporal punishment in the home and emphasises its view that the existence of any defence in cases of corporal punishment of children does not comply with the principles and provisions of the Convention, since it would suggest that some forms of corporal punishment are acceptable"*.
- 11.3.9** The continued legality of physical punishment of children in the UK, and other countries, is a serious violation of the Convention on the Rights of the Child. Until the UK revises Section 58 of the Children Act 2004 and makes explicitly clear, in law, that physical punishment of children is illegal in all circumstances, even if it does not leave a mark, the UK will remain non-compliant with the UN Convention on the Rights of the Child and children living in the UK will not be afforded the protection from physical violence that they deserve and need.
- 11.3.10** This year (2014) will be a landmark year for the UN Convention on the Rights of the Child – it will mark the 25<sup>th</sup> anniversary of the adoption of the treaty which was unanimously adopted by the United Nations General Assembly on 20 November 1989 and became enforceable from 02 September 1990.

#### **11.3.11 Key Recommendation FIVE**

**Section 58 of the Children Act 2004 should be revised, and other legislation introduced as necessary, to make explicitly clear that there is no defence of “reasonable punishment” and that any corporal or physical punishment of a child, aged under 18 years of age, is strictly prohibited in law.**

## **11.4 Modern Slavery Legislation**

**11.4.1** Turning something as important as child trafficking and exploitation into a headline-grabbing piece of legislation, by using the emotive term “slavery”, is only appropriate if the substance of that legislation is comprehensive enough, and detailed enough, to really make a difference to the people it is designed to protect whether through punishment of offenders or prevention of offences. Upon publication of *Living on a Railway Line* it is likely that The Modern Slavery Bill 2014 will have returned to the House of Commons from the Committee stage. It is beholden upon everyone involved in our parliamentary processes to make any changes necessary to improve that Bill into powerful primary legislation that will be more likely to better protect children from exploitation and trafficking, and appropriately punish those people responsible for these heinous crimes against society.

**11.4.2** At the time of writing of this report the Bill has had its second reading in the House of Commons and is at the Committee stage. This means that the Bill has the possibility to change very rapidly over time and to give specific recommendations regarding individual sections of it is difficult as the numbering of these may change depending on what stage the Bill revisions are at.

**11.4.3** The original Bill as drafted inadequately defined slavery in accordance with Article 4 of the Human Rights Convention ([HRC](#)) however Article 4 doesn't actually define slavery in sufficient detail, without examining the case law that has resulted from it, therefore it was not possible to construe section 1 in accordance with Article 4 of the HRC in any meaningful way, for the non-legal professional, leaving this Modern Slavery Bill 2014 without a clear definition of slavery.



Article 4 reads as follows:

*“Prohibition of slavery and forced labour*

- 1. No one shall be held in slavery or servitude.*
- 2. No one shall be required to perform forced or compulsory labour.*
- 3. For the purpose of this Article the term “forced or compulsory labour” shall not include:*
  - (a) any work required to be done in the ordinary course of detention imposed according to the provisions of Article 5 of this Convention or during conditional release from such detention;*
  - (b) any service of a military character or, in case of conscientious objectors in countries where they are recognised, service exacted instead of compulsory military service;*
  - (c) any service exacted in case of an emergency or calamity threatening the life or well-being of the community;*
  - (d) any work or service which forms part of normal civic obligations.”*

**11.4.4** Without an adequate definition of slavery and servitude it was likely that the cases which would have been recognised or dealt with would have been the headline-grabbing ones, well publicised in the media, rather than the majority of cases where the evidence may be somewhat weaker or the cases themselves may not be as headline-grabbing. Without an adequate definition it was likely that professionals may have not recognised cases they were dealing with as “slavery” or other offences dealt with under this proposed legislation.

**11.4.5** Although the Bill is clearly intended to be a criminal Bill it is important that there is consistency with civil protection rights for children, such as under the [Children Act 1989](#), such that the cases where evidence is weaker, but children are still at risk, are properly dealt with. It is hoped that an adequate definition of slavery and servitude will be included in the Bill that goes back before the House of Commons after the Committee stage but, if it is not, Members of Parliament must ensure that the Bill goes no further without this clear definition included.

**11.4.6** Examples of definitions of slavery include *“the status or condition of a person over whom any or all of the powers attaching to the right of ownership are exercised”*<sup>158</sup> or *“a particularly serious form of denial of freedom”* including *“in addition to the obligation to perform certain services for others ... the obligation for the [person] to live on another person’s property and the impossibility of altering his condition”*<sup>159</sup>.

**11.4.7** Amendments to the Bill which are being considered by the committee at the time of writing of this report ought to, if accepted, resolve the matter relating to the definition of slavery and it is vital, therefore, that these are not lost in the final Act. It is unfortunate that the title of the Bill merely mentions slavery and not the other forms of abuse contained within it. If enacted the primary legislation should become *“The Human Trafficking, Exploitation and Modern Slavery Act 2014”*

**11.4.8** Proposed amendments to the Bill, if accepted, will address the issue of a child being someone under the age of 18 years of age and will resolve the issue of children with a disability being at increased vulnerability from exploitation.

**11.4.9** It is crucially important that that the provision of information and standardised educational or training material(s) is **mandatory** in order that duplication of effort at a regional or local level is minimised and so that standardisation of education and training across England and Wales is more likely to be facilitated.

#### **11.4.10 Recommendation FOUR**

**The Modern Slavery Bill 2014 must ensure that children aged under 18 years of age are properly protected from trafficking, exploitation and modern slavery and that provision of guidance, education and training is mandatory.**

# Safeguarding in the Emergency Department



**"Childhood should be carefree, playing in the sun; not living a nightmare in the darkness of the soul"**

Dave Pelzer, 1960-

## About this chapter

This chapter makes recommendations regarding two key areas relating to Emergency Medicine: screening for child abuse in the Emergency Department and the potential benefit of social worker presence in the Emergency Department.

## 12.0 Safeguarding children in the Emergency Department

### 12.1 Overview

**12.1.1** Three and a half million children are seen each year in UK Emergency Departments (EDs) and it is essential that multi-disciplinary professionals working in EDs are equipped with the knowledge, skills and experience to be able to not only manage the acutely unwell patient but also to recognise the symptoms and signs of potential child maltreatment.



*Figure 8: Children's Emergency Department, KK Hospital, Singapore*

**12.1.2** Each year in the UK, of those children physically abused:

- 379000 are injured
- 70000 require medical attention
- 2800 are taken to EDs

**12.1.3** Although 2800 out of 3.5 million children only represents 0.08% of annual attendances to EDs, the consequences of failing to identify or appropriately manage these patients is as devastating as failing to recognise or appropriately treat a child with meningococcal septicaemia.

## 12.2 The use of child abuse screening tools in the Emergency Department

**12.2.1** Given that child abuse is a condition that has a mortality associated with it and given how difficult it can be to identify some cases in an ED, some professionals advocate screening children who attend EDs to assess the risk that their presentation might be as a result of child maltreatment or that, in the future, they are at risk of significant harm occurring.



*Figure 9: Triage at Hospital Kuala Lumpur Emergency Department, Malaysia*

**12.2.2** The screening of children in this way is not a universally accepted concept with professionals arguing both for and against it. There is no standardised, universally validated, internationally applicable screening tool available to use in EDs to screen children for their risk of abuse.

**12.2.3** The UK national screening committee in the National Health Service (NHS) have reviewed the 1968 World Health Organisation screening criteria<sup>160</sup> to produce guidelines for appraising the viability, effectiveness and appropriateness of a screening programme. Whether or not screening for potential child abuse in EDs could be considered a screening programme is a point that could, in itself, be debated but it is worthwhile reviewing the criteria produced by the screening committee as they put into context some of the arguments for and against screening children who attend EDs for abuse.



*Figure 10: Drawing of a doctor by a school-age child<sup>162</sup>*

**12.2.4** It is the committee's view that ideally all of the following criteria should be met before screening for a condition is initiated<sup>161</sup>:

### **12.2.5** *The Condition*

- The condition should be an important health problem  
The epidemiology and natural history of the condition, including development from latent to declared disease, should be adequately understood and there should be a detectable risk factor, disease marker, latent period or early symptomatic stage
- All the cost-effective primary prevention interventions should have been implemented as far as practicable

### **12.2.6** *The Test*

- There should be a simple, safe, precise and validated screening test
- The distribution of test values in the target population should be known and a suitable cut-off level defined and agreed
- The test should be acceptable to the population
- There should be an agreed policy on the further diagnostic investigation of individuals with a positive test result and on the choices available to those individuals

### **12.2.7** *The Treatment*

- There should be an effective treatment or intervention for patients identified through early detection, with evidence of early treatment leading to better outcomes than late treatment
- There should be agreed evidence based policies covering which individuals should be offered treatment and the appropriate treatment to be offered
- Clinical management of the condition and patient outcomes should be optimised in all health care providers prior to participation in a screening programme

### **12.2.8** *The Screening Programme*

- There should be evidence from high quality randomised controlled trials (RCTs) that the screening programme is effective in reducing mortality or morbidity. Where screening is aimed solely at providing information to allow the person being screened to make an informed choice (for example, Trisomy 21 (Down syndrome), cystic fibrosis genes carrier screening), there must be evidence from high quality trials that the test accurately measures risk. The information that is provided about the test and its outcome must be of value and readily understood by the individual being screened
- There should be evidence that the complete screening programme (test, diagnostic procedures, treatment / intervention) is clinically, socially and ethically acceptable to health professionals and the public
- The benefit from the screening programme should outweigh the physical and psychological harm (caused by the test, diagnostic procedures and treatment)
- The opportunity cost of the screening programme (including testing, diagnosis and treatment, administration, training and quality assurance) should be economically balanced in relation to expenditure on medical care as a whole (ie value for money). Assessment against this criterion should have regard to evidence from cost benefit an/or cost effectiveness analyses and have regard to the effective use of available resource
- All other options for managing the condition should have been considered (for example improving treatment or providing other services) to ensure that no more cost effective intervention could be introduced or current interventions increased within the resources available
- There should be a plan for managing and monitoring the screening programme and an agreed set of quality assurance standards

- Adequate staffing and facilities for testing, diagnosis, treatment and programme management should be available prior to the commencement of the screening programme
- Evidence-based information, explaining the consequences of testing, investigation and treatment, should be made available to potential participants to assist them in making an informed choice
- Public pressure for widening the eligibility criteria, for reducing the screening interval and for increasing the sensitivity of the testing process, should be anticipated. Decisions about these parameters should be scientifically justifiable to the public.

**12.2.9** In a review of child protection views of senior medical and nursing staff working in Accident and Emergency (A&E) Departments in Northern Ireland, the NSPCC and Barnardo's concluded that the development of standardised regional guidance (which included the provision of checklists) on the diagnosis and recognition of child abuse should be considered and, once published, provided to all frontline medical staff in the ED<sup>163</sup>. They further recommended that there would be merit in piloting a flow chart to prompt A&E staff to consider the possibility of non-accidental injury, recognising that the benefit of such an approach may decline with time as staff become more familiar with it even if, initially at least, it improved the profile and recognition of abuse and standardised practice across hospitals.

**12.2.10** In 2008 a Health Technology Assessment (HTA) was undertaken by Woodman et al to investigate the performance of screening test for child physical abuse in accident and emergency departments<sup>164</sup>. This assessment found consistent evidence that physical abuse affects 1 in 11 children in the UK each year and that the proportion of abused children who require medical attention is small but poorly quantified. It was estimated that approximately 1% of all child attendances at A&E are for physical abuse, amounting to just under 1 in 50 of all physical abuse episodes in the community.



**12.2.11** The assessment also found clear evidence that physically abused children who do attend the ED are missed but that the performance of the clinical screening assessment was poorly quantified with no evidence being found that any test was highly predictive of physical abuse. There was weak evidence that the use of a checklist or community liaison nurse improved the performance of the screening assessment in A&E.

**12.2.12** The authors estimated that the best strategy involved the standard clinical assessment screen combined with a community liaison nurse which would result in about half of the abused children attending A&E being referred to social services but, given the poor quality of data available, this estimation was highly uncertain. Looking at implications for practice, the assessment suggested that improving the clinical screening assessment based on a clinical synthesis of findings in the history and examination is likely to be more useful than protocols, except where the paediatric expertise of assessors is minimal.

**12.2.13** At the Dell Children's Medical Center, Austin, Texas an alternative approach has been taken to selectively screen a subset of those children presenting with injuries which could be related to abuse. In an article published in 2014 the team found that the introduction of the screening guideline successfully decreased socioeconomic-related bias in screening<sup>165</sup>. Such screening is more akin to the types of clinical guidelines used in the UK for the investigation of possible non-accidental injury rather than being a screening programme per se when considered against the UK NHS Screening Committee's criteria.

**12.2.14** Screening for child abuse in EDs has been mandatory in the Netherlands since 2009 and a study, undertaken in 2011 looking at over 24000 ED visits by children, found that in hospitals complying with screening guidelines for child abuse the detection rate was significantly ( $p < 0.001$ ) higher (0.3%) compared with those hospitals that did not comply (0.1%). In light of this it was recommended that hospitals encouraged compliance with screening guidelines and implemented strict policies to improve the detection rate of suspected child abuse in EDs and that the results of these interventions should be used to develop an optimal screening protocol for EDs<sup>166</sup>.

**12.2.15** In a large study of over 100000 children presenting to EDs in the Netherlands between 2008 and 2009 it was found that the detection rate in children screened for child abuse (0.5%) was statistically significantly ( $p<0.001$ ) five times higher than that in children not screened (0.1%). The screening tool used in this study deserves further analysis. The checklist used for potential child abuse was:

- Is the history consistent?
- Was there unnecessary delay in seeking medical help?
- Does the onset of the injury fit with the development level of the child?
- Is the behaviour of the child/the carers and the interaction appropriate?
- Are the findings of the top-to-toe examination in accordance with the history?
- Are there any other signs that make you doubt the safety of the child or other family members?

**12.2.16** The authors concluded that systematic screening for child abuse in EDs is effective in increasing the detection of suspected child abuse and that training ED staff, and requiring screening legally at EDs, increases the extent of screening. They recommended that future studies should focus on the validation of a screening instrument for child abuse in EDs<sup>167</sup>.

**12.2.17** The ED at Phoenix Children's Hospital has a clinical guideline which is intended to promote coordination and communication with respect to patient care. It recommends consideration of child maltreatment when any of the following are identified<sup>168</sup>:

### *Concerning behaviours*

- Patient in-discriminant with affection
- Caregiver has unrealistic expectations for developmental stage
- No response by caregiver to patient cues
- Caregiver lacks concern for injury severity
- Patient response to caregiver is concerning
- Negative response by caregiver to social work

### *History*

- No history
- History is not consistent with development (is the child pre-ambulatory? Does the child roll?)
- History of how injury occurred changes
- Delay in calling 911 or seeking medical care
- Arrived by private vehicle with significant injury
- Injury inconsistent with stated mechanism
- Repetitive care-seeking
- History of domestic violence, child protective services or police department involvement
- Vulnerable child (neonatal intensive care history, developmental delay etc)

### *Physical examination – remove the patient’s clothing including shoes and socks*

- Bruises
  - Non-ambulatory child (“if they don’t cruise, they don’t bruise”)
  - Suspicious location (torso, ears, neck)
  - Patterns
- Marks or scars in patterns
- Torn frenulum
- Bite marks
- Burns

#### *Radiographic findings*

- Metaphyseal fractures (corner, child, bucket handle)
- Posterior rib fractures
- Any fracture in a non-ambulatory infant
- Multiple fractures
- Any unexpected finding of a healing fracture
- Subdural haemorrhage or subarachnoid haemorrhage on neuroimaging in young children, particularly in the absence of a skull fracture

**12.2.18** In the HTA undertaken in the UK, all of the strategies examined involved referral of at least 5% of injured children to paediatricians which may exceed capacity however lower rates of referral to paediatricians would substantially diminish the proportion of abused children detected<sup>164</sup>.

**12.2.19** What is clear, both from the evidence in the literature and the subjective experiences gained by visiting overseas centres, is that there is no clear, universally agreed, internationally utilised evidence that supports the introduction of any one screening tool in an ED to try and increase the detection rates of child maltreatment. Although a variety of clinical and educational tools and guidelines exist, there isn't one that is properly validated that could be immediately implemented in the UK and it is obvious that this represents a significant gap in our knowledge and it is something that should be the subject of further research in the future. The introduction of a screening tool should be combined with the development and usage of appropriate clinical decision rules.

#### **12.2.20 Recommendation FIVE**

**An international, multi-centre research study should be carried out to investigate, and validate, the sensitivity, specificity, positive predictive value (PPV) and negative predictive value (NPV) of a new screening tool and appropriate clinical decision rules, which all require development, to assess the risk of child maltreatment in children attending urgent and emergency care facilities.**

## 12.3 Social worker presence in the Emergency Department

**12.3.1** One of the most noteworthy features of the teams visited in the USA, but especially in Arizona and Texas, was the strong and crucial presence of hospital social worker input into the care of children who attended EDs.



*Figure 11: Paediatric trauma room, Austin, Texas*

**12.3.2** The role played by these social workers was wide and varied but on each and every occasion that was witnessed the presence and involvement of a social worker brought benefits to the child, the family and the ED.

**12.3.3** Child protective services in the USA can be inundated with referrals due to the mandatory reporting legislation that exists. In some cases this can mean that children and families who are in need of assistance may not get that assistance in a timely fashion. In the UK there is already provision within the Children Act 1989<sup>169</sup> for local authorities to provide services for children who are in need of assistance (Section 17) in addition to children who are in need of protection (Section 47) however that provision is based in the community.

**12.3.4** Children present to EDs throughout the whole 24 hour period in many situations where additional support and assistance for both the child and the family could be beneficial. Resources may not always be available within EDs to spend additional time with families and children who are in need of assistance but where that child is not at immediate risk of significant harm as priority has to be given to those situations where children are critically ill or injured or where there has been identification of issues which lead the clinician(s) to believe that the child may be at risk of, or have suffered from, significant harm.

- 12.6.5** In anything other than emergency situations referrals to community-based social workers introduce, by the very nature of the referral process, a delay in that child or the family receiving the advice or intervention that is deemed to be necessary.
- 12.6.6** A comprehensive hospital-based social worker service was clearly evident at both Phoenix Children's Hospital and the Dell Children's Medical Center, Austin. The social workers added significant value to the team and the assessment process of children who attended the ED in emergency situations ranging from health promotion advice, gathering of information relevant to potential child protection investigations, identification of supportive interventions that may be of benefit to the child and family and referral of children on to other services if the problems identified could not be resolved within the ED.
- 12.6.7** These social workers were not duplicating work nor were they taking on tasks that ought to have been done by other staff – they were giving added value to the service provision offered by the department and ensuring that children who, perhaps otherwise, would not have received an intervention at that time were able to access immediate support and advice.
- 12.6.8** At Dell Children's Medical Center, for example, a comprehensive protocol exists for the mandatory referral of children who attend the ED to the in-house social worker if any of the following features are present:

- Children whose condition is considered life-threatening, including children with a newly diagnosed or chronic, critical or terminal illness or traumatic injury
- All children under the age of five with a serious head injury
- All children under the age of five with any fracture
- All children under the age of five with a burn
- All children under the age of one, or who are non-ambulatory, who present with a chief complaint of a fall or other accident-related visit, regardless of injury or no injury
- Any child presenting with concern for his/her safety or well-being in the home, school, childcare or community environment
- All children presenting as unrestrained passengers in a motor vehicle collision (MVC) regardless of injury or no injury
- Any child with single or multiple injuries of questionable aetiology that cannot be reasonably explained
- All children under the age of five presenting with actual or possible ingestion of a poison
- Any child presenting with concern for drug or alcohol abuse or who tests positive for the presence of a controlled (unless medical prescribed for the child) or illegal substance
- Any child presenting with depression, anxiety, psychotic symptoms, suicidal threat, and/or other mental health issue

- Children presenting with concern for sexual abuse, including vaginal or penile discharge, or any unexplainable abnormality of the perineal area
- Any child under the age of 17 presenting with a positive result for pregnancy or sexually transmitted disease, or who has a history of sexual activity
- Children who appear not to have had appropriate medical or physical care or appropriate medical follow-up due to signs of neglect, or who potentially lack the resources to access this care (for example homeless, lack of transportation)
- Children accompanied by an individual who is not a parent, legal guardian, adult relative or caregiver and no reasonable explanation is given as to why any of the above is not accessible by phone
- Children accompanied by a parent, legal guardian, adult relative or caregiver who exhibits inappropriate behaviour (for example altered mental status, intoxication) especially in relation to the child, or who tells an inconsistent or questionable story about a child's injury
- Any child presenting with an animal bite where there is suspicion of neglect

**12.6.9** In the UK in 2011, 35% of EDs had in-house social care services and a study adds evidence pointing to the potential benefits of a variety of social care interventions being based in EDs and justifies the establishment of a research programme which can provide answers to key outstanding questions including<sup>170</sup>:

- Which patterns of social care services, staffed by what number and combination of professionals, open during which hours, based within EDs or elsewhere and linked to other services in what ways, best meet the long and short term needs of both ED service users and carers and the health and social care organisations that provide or commission the services?
- What are the costs of different configurations?



**12.6.10** There is a good case for the view that social care can have a significant impact on ED services through a directly attached social worker. Attaching social workers to EDs could have the effect of improving the efficiency and effectiveness of hospital services both within and beyond the ED itself while being recognised for improving the quality of the service by both staff and the users of hospital services alike. As a key site for identifying social disadvantage and inequality in a variety of norms, an attached social work service has the capacity to enhance the ED's potential role as a pivotal point of information about, and access to, a range of statutory and independent sector health and social care services<sup>171</sup>.

**12.6.11** The re-introduction of social workers into EDs in the UK could offer exciting possibilities in terms of increased detection of children, and vulnerable adults, who are at risk of harm or who have suffered from harm already, greater possibilities for preventative measures to reduce the number of injury and abuse cases in the future and more efficient running of an ED by ED-based social workers beginning the assessments and interventions that may be necessary with children and families to fully support them in the future.

**12.6.12 Key Recommendation SIX**

**There should be a funded research evaluation of attaching a social worker to a UK paediatric emergency department to investigate the benefits of such provision, to children, families and the ED, and to contribute to setting standards for children in emergency care settings in the future.**

# Professional education in child abuse and neglect



**"To strive, to seek, to find, and not to yield."**

Lord Alfred Tennyson FRS, 1809-1892

## About this chapter

This chapter discusses professional education in child abuse and neglect, makes recommendations for further work into the investigation of possible cases of physical child abuse and advocates peer review case management of child protection cases and recommends greater involvement of advanced (nurse) practitioners in child protection work.

## 13.0 Professional education in child abuse and neglect

- 13.0.1** *Working Together to Safeguard Children* has statutory authority to set out how agencies must work with each other to protect vulnerable children and how professionals should assess children who may be at risk of significant harm<sup>310</sup>. Education and training in relation to the identification of possible child maltreatment has become commonplace in the UK following a number of SCRs showing inter-agency communication failures and a lack of recognition of important clinical features have been associated with adverse outcomes for children.
- 13.0.2** To protect children and young people from harm all staff must have the competencies to recognise child maltreatment and to take effective action as appropriate to their role. They must also clearly understand their responsibilities, and should be supported by their organisation to fulfil their duties. The intercollegiate document on child protection training sets out the competencies that will be required by staff working with children and the level to which they should be trained<sup>172</sup>.
- 13.0.3** Although the inter-collegiate document is clear that it applies to healthcare students as well as employed staff it is obvious from delivering teaching sessions to newly qualified staff from a variety of backgrounds that the competency framework document has either not been applied in great detail during undergraduate training or the time devoted to teaching about safeguarding vulnerable children has been inadequate or the teaching has been, largely, ineffective in achieving the aim it ought to have had. Of course, that is a sweeping generalisation, but five year's worth of teaching both newly qualified staff and staff who have been qualified sometimes for many decades, has revealed, on more occasions than ought to be expected if the competency framework had been utilised effectively during pre-qualification years, subjective deficiencies in knowledge base or skills.
- 13.0.4** The issue of professional education in child abuse and neglect was expertly reviewed by Professor Cindy Christian from the Children's Hospital of Philadelphia who concluded that research on medical education in child maltreatment has been limited and suggests that improving knowledge, although not simple, is easier than influencing medical practice<sup>173</sup>.

**13.0.5** Professor Christian advocates a comprehensive approach for improving clinical competency in child protection starting within medical school with a multi-disciplinary approach to try and combat adverse attitudes and ambivalence towards the problem of child abuse<sup>173</sup>.

**13.0.6** Unless the issues related to safeguarding vulnerable children are highlighted at a very early stage in training, during the pre-qualification years, it is a reasonable assumption to make that it will be much more difficult to change any inadvertent poor practises that have been adopted during those undergraduate years – practises that could, potentially, have been avoided if more detailed training on safeguarding of vulnerable people had been delivered during those years, with a competency assessment at the end of that programme.

**13.0.7 Recommendation SIX**

**Institutions training pre-qualification professionals who may in the future work with vulnerable children and families should ensure that their training courses incorporate the necessary training from the Intercollegiate Document on Safeguarding Children and Young People competencies, with an appropriate competency assessment at the end of the training programme to ensure that the skills and knowledge required have been obtained.**

**13.0.8** The perceived competence and knowledge-based of doctors regarding child abuse is limited<sup>174</sup>. Studies have shown that doctors have low perceived confidence in their abilities to deal with potential physical or sexual abuse<sup>175 176</sup>. The efficacy of teaching programmes, for both undergraduates and postgraduates in the UK, needs further investigation as, at present, without a full validation of the impact of child protection teaching programmes on the competence of professionals to deal with child abuse it will not be possible to state with confidence that the educational programmes already instituted have a beneficial effect on the competence of the practitioners undertaking them, and the children who they will see in the future.

**13.0.9** Given that research has demonstrated that clinicians have reported<sup>177</sup> their training opportunities regarding child abuse and neglect to require improvement<sup>178 179 180 181</sup> there is a clear need for a standardised multi-disciplinary<sup>182</sup> educational programme regarding child maltreatment, rather than just competency levels which ought to be obtained. The creation and validation of such a programme would be incredibly beneficial to both the professionals involved<sup>183</sup> and, by extension, children and families.

#### **13.0.10 Recommendation SEVEN**

**Current educational programmes in child maltreatment ought to be formally validated including assessing the impact on the competence of the professional, both pre- and post- training, and, if possible, outcomes for children.**

#### **13.0.11 Key Recommendation SEVEN**

**A standardised, compulsory, multi-professional training programme, to complement the inter-collegiate competency levels, should be introduced in the UK for all professionals dealing with children and families. This must include specific training on the potential signs, features and vulnerabilities of children who are at risk of, or who are suffering from, exploitation including sexual exploitation. This coordinated educational programme would reduce inefficiencies of duplication of educational material preparation and would better quality assure the outcome of the educational programme.**

### **13.1 Radiological investigations of suspected child abuse**

- 13.1.1** The Royal College of Paediatrics and Child Health (RCPCH) and the Royal College of Radiologists (RCR) consider imaging of the injured child to be critical to the process of child protection. It is necessary to provide a framework, based on evidence, which supports the radiologist in contributing to child protection, provides education and training in all aspects of this work, stimulates recruitment and encourages best practice<sup>184</sup>. The processes of investigation must be standardised, robust and evidence-based where possible.
- 13.1.2** The joint Royal College standards indicate that a skeletal survey is the standard imaging method for the evaluation of children where non-accidental injury is one of the differential diagnoses.
- 13.1.3** In children under the age of two years where physical abuse is suspected, a full skeletal survey should always be performed. In children over the age of two years, the decision to perform a skeletal survey should be guided by the clinical and social history combined with physical findings.
- 13.1.4** A skeletal survey consists of a standard series of radiographic images that will visualise the entire skeleton and its purpose is to allow the detection of occult bony injuries, to obtain further information about a clinically suspected injury, to aid in the dating of any bony injuries located and to help in the diagnosis of any underlying disorder which may predispose to fractures<sup>184</sup>.
- 13.1.5** Section 9 of the joint Royal colleges standards indicates that follow-up radiographs may be of significant value in cases of suspected non-accidental injury providing, in some cases, confirmatory evidence and, in other cases, contributing to refuting the diagnosis.

- 13.1.6** A paper commonly referred to by centres visited in the USA is the 1996 paper in the American Journal of Roentgenology by Dr Paul Kleinman<sup>185</sup> which found that follow-up skeletal surveys, approximately two weeks after the initial evaluation, yielded additional information regarding skeletal injury in 61% of cases which significantly increased the number of fractures detected ( $p=0.005$ ). Most of the additional injuries were classical metaphyseal lesions or rib fractures and in 19% of the fractures previously identified, the follow-up skeletal survey also provided important information on the age of those injuries.
- 13.1.7** The paper concluded that when child abuse is strongly suspected on the basis of the findings on the initial skeletal survey, other imaging studies, history, or physical examination, a follow-up skeletal survey is recommended to provide a thorough and accurate assessment of osseous [bony] injuries.
- 13.1.8** In the UK, current guidance from the joint Royal colleges is that in cases where there is ongoing clinical concern, there is evidence that a repeat skeletal survey may detect occult fractures not seen on the initial skeletal survey. A full skeletal survey should be repeated with the exception of the skull, two weeks after the initial survey.

**13.1.9 Recommendation EIGHT**

**Healthcare organisations involved in providing or requesting skeletal surveys in cases of suspected non-accidental injury should review their policies to ensure that they contain specific guidelines, based on the joint Royal College of Paediatrics and Child Health and The Royal College of Radiologists standards, relating to the repeating of skeletal surveys two weeks after the initial survey.**

## 13.2 Haematological investigations of suspected child abuse

**13.2.1** In addition to children presenting with possible osseous injuries where non-accidental injury is one of the differential diagnoses, children also can present with bleeding or bruising which can raise concern for possible child abuse. In 2013 the American Academy of Pediatrics published a clinical report guideline for the evaluation of bleeding disorders in suspected child abuse. In this report a pathway is set out to determine an appropriate evaluation course when child abuse is suspected<sup>186</sup>:

### **Bruising:** *Does the child need an evaluation for bleeding disorders?*

Situations in which a bleeding disorder evaluation may not be needed:

- Clear disclosure of or independently witnessed abuse or non-abusive trauma
- Other medical findings consistent with abuse or non-abusive trauma
- Object- or hand-patterned bruising
- History clearly explains bruising

### **Clues to the presence of a bleeding disorder**

- Petechiae at clothing line pressure sites
- Bruising at sites of object pressure, such as in the pattern and location of infant seat fasteners
- Severe bleeding disorders may also present with excessive diffuse bruising

### **Intracranial haemorrhage:** *Does the child need an evaluation for bleeding disorders?*

Situations in which a bleeding disorder evaluation may not be needed:

- Independently witnessed trauma (abusive or otherwise)
- Other medical findings consistent with abuse



**13.2.2** For bruises requiring further investigation an initial testing panel of the following is recommended:

- Prothrombin time (PT)
- Activated partial thromboplastin time (APTT)
- Von Willebrand Factor (vWF) antigen
- vWF activity (Ristocetin cofactor)

- Factor VIII level
- Factor IX level
- Full blood count including platelet count

**13.2.3** For intracranial haemorrhages requiring further investigation an initial testing panel of the following is recommended:

- Prothrombin time (PT)
- Activated partial thromboplastin time (APTT)
- Factor VIII level
- Factor IX level
- Full blood count including platelet count
- D-dimer and fibrinogen

**13.2.4** Complete medical and family histories and a thorough physical examination are critical tools in evaluating the possibility of abuse or medical conditions that predispose to bleeding or bruising; laboratory testing suggestive or indicative of a possible bleeding disorder does not eliminate abuse from consideration.

**13.2.5** In those children with fractures where there is suspicion of possible physical child abuse it has been suggested that bone fragility secondary to suboptimal vitamin D status is an alternative explanation to non-accidental trauma in children with unexplained fractures. If suboptimal vitamin D status does increase fracture susceptibility, there is a potential for misdiagnosis of otherwise unexplained fractures as abuse. Alternatively, children who have suffered from abuse may be at additional risk if inflicted fractures are inappropriately attributed to suboptimal vitamin D status<sup>187</sup>.

- 13.2.6** Dr Samantha Schilling and the team at the Children's Hospital of Philadelphia investigated vitamin D status in abused and non-abused children younger than two years of age with fractures and determined that vitamin D insufficiency is common in young children with fractures but is not more common than in previously studied healthy children. Vitamin D insufficiency was not associated with multiple fractures or a diagnosis of child abuse<sup>187</sup>. This is important research as, faced with a young child with unexplained fractures in the UK, clinicians can be confronted with an argument that vitamin D insufficiency is the cause rather than non-accidental trauma.
- 13.2.7** Physical child abuse can cause intra-abdominal injuries as well as fractures, bleeding or bruising. Diagnosing these intra-abdominal injuries is important as it can help to protect a child from further abuse even if the injury itself, per se, would have been self-limiting. Physical examination alone is not sensitive enough to pick up all intra-abdominal injuries<sup>188</sup> and for this reason in the USA routine transaminase testing, with or without amylase and lipase testing, in children with concern for physical abuse has been recommended<sup>189</sup>.
- 13.2.8** Professor Daniel Lindberg works at Colorado Children's Hospital and during the Winston Churchill Fellowship travels that led to the preparation of this report, time was spent discussing the significant research portfolio in which both the children's hospital in Colorado and the Kempe Center for child protection are involved. In a study published in 2013, Professor Lindberg and his team investigated the routine testing of transaminases in children undergoing investigation for possible physical child abuse and attempted to validate the test characteristics of an 80IU/litre threshold as well as to determine the utility of amylase and lipase to detect occult abdominal injury.
- 13.2.9** The results are incredibly interesting and have potential implications for the UK. Abdominal injuries were identified in 82 of 2890 subjects (2.8%; 95% confidence interval 2.3%-3.5%). Hepatic transaminases were obtained in 1538 (53%) children. Hepatic transaminases had an area under the Receiver Operating Characteristics (ROC) curve of 0.87 and a threshold of 80IU/litre yielded sensitivity of 83.8% and specificity of 83.1%. The areas under the curve for amylase and lipase were 0.67 and 0.72, respectively.

**13.2.10** The team concluded that although intra-abdominal injuries are uncommon among children where there is a suspicion of physical child abuse, they can carry significant mortality. Hepatic transaminases can increase sensitivity for occult intra-abdominal injuries relative to the clinical examination alone in children with concern for possible physical child abuse. Therefore children with elevated transaminases (>80IU/litre) should undergo definitive testing (imaging) for abdominal injury<sup>190</sup>. No recommendations were made pertaining to amylase and lipase because amylase failed to identify injuries missed by both transaminases and lipase and although a threshold of 100IU/litre of lipase identified injuries missed by transaminases, it had a low estimate of positive predictive value due to the fact that most children with elevated lipase did not undergo definitive testing.

#### **13.2.11 Recommendation NINE**

**Research should be undertaken in the UK to investigate the sensitivity and specificity of using elevated hepatic transaminase levels as a potential marker for occult intra-abdominal injury in children in whom there is concern for possible physical child abuse. The results of this research should be used to determine if there is a level at which definitive abdominal radiological investigation should take place in cases of suspected non-accidental injury in a UK population.**

### 13.3 Case management and peer review of child protection cases

**13.3.1** Peer review is a process by which professionals can discuss cases between themselves in a structured way focussing on the needs of the child. Peer review has a role to play in maintaining public and Court confidence in the child protection process and is a way to provide assurance that standards are being met. Peer review and clinical supervision are part of an essential clinical governance framework which support the responsible paediatrician to reach a conclusion, with the issuance of an addendum to a report if necessary, but not providing a formal second opinion to be used in Court<sup>191</sup>.



*Figure 12: 156 children died from child abuse in Texas in 2013*

**13.3.2** The need for peer review of child protection cases is evident as even experts exhibit consensus in cases where the findings are normal and abnormal, but demonstrate much more variability in cases where the diagnostic decisions are less obvious<sup>192</sup>.

**13.3.3** In a study comparing professionals' views on child abuse scenarios with those of the public, the Singapore Children's Society found high levels of consensus among professionals and the public only for items related to sexual and physical abuse. There was moderate to high levels of consensus for abuse status for seven items among professionals (having sex with a child, not protecting a child from sexual advances of other family members, burning a child with a cigarette, tying a child up, caning a child, ignoring signs of illness and locking a child outside the home) but there was no clear trend on abuse ratings among professionals when compared with the public<sup>193</sup>.

- 13.3.4** The fact that experts and professionals do not always agree and that it has been shown that social workers have moderate to high levels of within-group consensus for the most number of items in acceptability and abuse status ratings and that lawyers have the lowest within-group consensus for acceptability but the highest consensus for abuse status<sup>193</sup> makes clear why peer review is needed. Without peer review the fate of a particular child and whether or not their presentation is classed as abusive or non-abusive is, to some extent, dependent on the subjective assessment of the individual seeing the child rather than an objective consensus view.
- 13.3.5** There needs to be greater open collaboration and dialogue between clinicians during the initial clinical investigation of suspected non-accidental injury, the removal of institutional stigma attached to the child protection process and a culture change where clinicians view non-accidental injury as requiring the application of both scientific and social evidence<sup>63</sup>.
- 13.3.6** The national public health service for Wales has produced some useful best practice guidance on the undertaking of peer-review meetings<sup>194</sup>:

*Process for discussion should be as follows:*

The doctor presents the case, including dilemmas and issues, the chair facilitates the discussion. In all cases where there is photo documentation available this should be reviewed first of all by participants at the peer review and then the history given subsequently. This is particularly important to avoid any bias with regard to the interpretation of the physical findings. The individual doctor writes notes of the discussion in the patient's files but does not attribute the comments to any individual doctor. The aim is to keep the process open, honest and formal.

*Decision making process:*

While the peer review group should seek to achieve a consensus statement, it is the responsibility of the presenting doctor to record the points of discussion including areas of agreement and disagreement in the child's hospital notes. This may be a separate section of the child protection proforma or directly written in the file.

*Recording opinions given during peer review:*

Names of specific individual doctors should only be recorded in the file or in any subsequent reports derived wherefrom with the permission of that individual and only after he or she has seen the notes and the report containing the opinion.

*Reference to peer review in reports for Court:*

It is appropriate in the opening paragraph of Court reports and witness statements to include a comment about regular attendance at peer review meetings. It is recommended however that the Court report does not include a statement that the individual case has been peer reviewed. This implies a very different meaning especially to the legal profession who may mistakenly believe that an in depth review of the case has been undertaken and a further more expert opinion obtained.

*Actions:*

Actions to be taken forward after peer review should always be recorded. Individual actions related to cases should be the responsibility of the presenting doctor. However, where this is not appropriate (doctor on leave, left employment) the action should clearly identify who will take forward any ongoing case management issues. Where there are actions relating to issues arising out of themes discussed, the minutes of the peer review will identify the individual responsible for this. The Chair will be responsible for checking that these actions are carried forward.

- 13.3.7** Although a peer review model does not always result in resolution of every case discussed, using a peer review model consistently provides closure for the primary professionals involved thus benefiting those staff working in the sphere of child protection. From the point of view of protecting the child involved, assessment of a specific peer-review process used in Colorado at the Kempe Center (the State and Regional Team – START) demonstrated that if it had not been for the peer review process one-third of cases studied would not have proceeded to an appropriate criminal or civil resolution, providing clear evidence of the benefit of the peer review process used<sup>195</sup>.

**13.3.8** In the USA each of the organisations visited had a comprehensive peer review programme taking place at regular intervals so that all of the cases of possible child abuse were discussed with colleagues, often in a multi-disciplinary environment. Although there were different formats of these meetings the common aspect to them all is that they were multi-professional meetings held on a regular basis to clinically case manage the cases of individual children often with input from child protective services, hospital social workers, law enforcement and, crucially, the legal team responsible for any future legal action that may be taken in the case.

**13.3.9** The importance of having early contact and discussion between the treating clinicians and the legal professionals (such as in the UK, Local Authority lawyers or the Crown Prosecution Service) cannot be underestimated and it is through this inter-professional collaboration that case management progressed more efficiently and robustly.

#### **13.3.10 Recommendation TEN**

**Child protection peer review meetings with clear terms of reference and involving representatives from the local authority (including, as an essential component, local authority, or Crown Prosecution (as appropriate) legal teams), the police and community health services, should be set up in all health organisations conducting child protection clinical work. Such peer review meetings should actively contribute to the case management of individual cases.**

**13.3.11** Telemedicine systems of hub consultants and consulting satellites for child sexual abuse have been piloted in some states in the USA including Alaska, California, Florida, Missouri, Oregon, Texas and Utah. A review, looking at the advantages, disadvantages and current status of child abuse consultations conducted through telemedicine networks was undertaken and published in 2000. It concluded that telemedicine consultations offer a unique opportunity to raise the standard of care in child abuse evaluations, but success depends on clinician motivation, appropriate infrastructure, and ongoing funding and technical support<sup>196</sup>.

**13.3.12** What could the future hold? With the increasing trend for centralisation of tertiary services in the NHS in England at least, it is likely that issues such as consideration of telemedicine support from regional experts will be considered in the future and there is no reason to suspect that this could not be applied, in the appropriate circumstances, to child protection work as well as other disciplines.



## **13.4 The role of advanced (nurse) practitioners in child protection teams**

- 13.4.1** Nurses, and other non-medical professionals, working in the UK are increasingly expanding and enhancing their skills beyond initial registration.
- 13.4.2** There are now a large number of inter-professional UK-based University courses available to achieve certification in advanced practice including Postgraduate Certificates, Postgraduate Diplomas and Masters Degrees, for example those at the University of Salford<sup>197</sup>.
- 13.4.3** These courses prepare the practitioner for the development of generic and specific practice at advanced level, engaging in critical self-assessment of knowledge and skills against appropriate competency frameworks in order to identify an appropriate learning pathway within the courses offered.
- 13.4.4** Advanced practitioners can encounter abused children in their practice and a competent medical evaluation for child abuse requires a specific set of skills and knowledge. Continuing education assists advanced practitioners to develop the skills necessary to recognise injuries that raise the concern for abuse based on characteristics of injuries such as appearance, location, severity or history<sup>198</sup>.
- 13.4.5** The visits undertaken in the USA highlighted the particular experience and expert nature of paediatric nurse practitioners working within the field of child abuse medicine. In addition to a role in clinical care, the enthusiastic and competent nurse practitioners that were encountered had interests in teaching, research<sup>88</sup> and professional representation.
- 13.4.6** The UK recognises the importance of advancing (nurse) practitioner practice with the Department of Health releasing a position statement on Advanced Nursing Practice in 2010<sup>199</sup> and the development of a competency framework for Advanced Nurse Practitioners by the Royal College of Nursing in 2008<sup>200</sup>.

**13.4.7** Advanced practitioners have highly specialised or highly developed knowledge and skills beyond those which are required for registration, encompassing the breadth and depth of current and future professional practice. This high standard is such that not only is the individual the expert in the base domain but they can also accept the full responsibilities for providing those services hitherto undertaken by others in defined circumstances<sup>201</sup>.

**13.4.8** There are a number of characteristics of advanced practitioners that have been identified in the UK including<sup>201</sup>:

- Working across organisations and different agencies providing advanced levels of practice, knowledge and skills
- Continually developing skills, knowledge and practice in the context of service needs
- Undertaking research mapped to service needs
- Being self-directed, managing risk and having high levels of communication skills as a member of a wider clinical or service team.

**13.4.9** Subjectively, the role that advanced practitioners appeared to play in the assessment and management of children who may have been maltreated in the USA was akin to the role played by Consultant Paediatricians dealing with potential child abuse cases in the UK. The professionals encountered were highly skilled, highly competent and highly sought-after, always working for the benefit of the child concerned.

**13.4.10** In the UK the use of advanced practitioners and specialised nurse practitioners is commonplace in services managing patients with, for example, diabetes, epilepsy or gastrointestinal conditions as well as many patients in primary care. Why should it be any different for child abuse medicine?

**13.4.11** Based on the experiences gained within the USA it is clear that there is a role, which could be beneficial to the whole multi-disciplinary team and the patient, for the further development of advanced practitioners working in child abuse medicine as members of the primary health care, secondary health care or social care team.

**13.4.12 Recommendation ELEVEN**

**The role that advanced practitioners can play within child protection work should be further explored and promoted in the UK. Multi-disciplinary teams should seek out opportunities to develop an advanced practitioner service working as part of a pan-professional medical and non-medical team within the sphere of child protection work. There should be an investigation of the benefits of this model of care for patients, families and health service effectiveness.**

# The role of society in protecting children



***“We, the grown-ups, have failed you deplorably...”***

Kofi Annan, 1938-

## About this chapter

This chapter examines the role that Adverse Childhood Experiences (ACEs) can have on outcomes for children in adulthood. It discusses community-based research which, once the results are available, ought to be able to recommend targeted child protection prevention work in the community; and describes the international collaborative efforts that can help protect children both in the UK and further afield.

## 14.0 The role of society in protecting children

### 14.1 Overview

#### 14.1.1 It takes a community to protect a child

The chapter on physical punishment of children began with a quote from Frederick Douglass. He was an African-American statesman who, having escaped from slavery, became a leader of the abolitionist movement and campaigned throughout his life for equality of all people regardless of background, saying, *"I would unite with anybody to do right and with nobody to do wrong"*.



Figure 13: Save the babies poster, Hospital Kuala Lumpur, Malaysia

**14.1.2** In 1855 Frederick Douglass had a series of dialogues with white slave-owners who could not, or would not, comprehend that slavery was morally wrong and it was during these communications that he wrote, *"it is easier to build strong children than to repair broken men"*.

**14.1.3** This statement still holds true today and it is inextricably linked to issues surrounding early childhood experiences; child abuse; the social determinants of health; and the development of individuals' roles, and functioning, within society.

## 14.2 Protecting children is everyone's business – even yours!

**14.2.1** The Adverse Childhood Experiences ([ACE](#)) study is a collaborative research project, involving 17421 adults, between the Center for Disease Control and Prevention and Kaiser Permanente Preventative Medicine, San Diego, California<sup>202</sup>.



**Figure 14: Adverse Childhood Experiences (ACEs) link with early death<sup>204</sup>**

**14.2.2** An Adverse Childhood Experience (ACE) is growing up with one or more of the following in the household prior to age 18:

- Recurrent physical abuse
- Recurrent emotional abuse
- Contact sexual abuse
- An alcohol and/or drug abuser in the household
- A household member in prison
- Domestic violence
- One or no parents
- Emotional or physical neglect
- Someone who is chronically depressed, mentally ill, institutionalised, or suicidal

**14.2.3** An ACE score [calculator](#) is available online<sup>203</sup>.

**14.2.4** Child abuse and trauma in the household leave a child incredibly vulnerable which has the potential, in the early years, to disrupt the normal development of the brain. ACEs appear to be associated with a predictable path towards disease and disability. Recognising this path and tackling it at the earliest possible opportunity is crucial to give children the chance to develop as they ought to so that they can play as full a role in society in the future, in the healthiest possible state, that they deserve to.



**Figure 15: Strong communities raise strong kids<sup>205</sup>**

**14.2.5** An emerging multidisciplinary science of development supports an ecobiodevelopmental framework for understanding the evolution of human health and disease across the lifespan of an individual. Epidemiological studies, developmental psychologists and longitudinal studies of early childhood interventions have demonstrated significant associations between the ecology of childhood and a wide range of developmental outcomes and life course trajectories<sup>206</sup>.

**14.2.6** What happens in early childhood can matter for a lifetime and sadly the children of Arizona lead the nation in experiencing one or more adverse childhood experiences in the ACE study conducted in the State:

- Living with someone who is mentally ill or who has suicidal ideation
- Experiencing divorce or parental separation
- Living with someone who has an alcohol or drug problem
- Being a victim or witness of neighbourhood violence
- Experiencing socioeconomic hardship
- Witnessing domestic violence
- Having a parent in prison
- Being treated or judged unfairly due to race or ethnicity
- Experiencing the death of a parent

**14.2.7** In Arizona, Phoenix Children's Hospital have been spearheading a State-wide ACE Consortium aimed at drawing attention to the crucial importance of ACEs and putting in place community projects to try to encourage parents to build Positive Childhood Experiences (PCEs) – protective factors that will enable children to succeed. Based on the findings of Arizona's ACE study the following have been recommended strategies to reduce ACEs in this area and to build stronger Arizona communities<sup>207</sup>:

- Increasing public understanding of ACEs and their impact on health and well-being
- Enhancing the capacity of families and healthcare providers to prevent and respond to ACEs
- Improving the effectiveness of public-health campaigns by refining their messages regarding ACEs
- Promoting identification and early intervention of ACEs within child and family health systems.

**14.2.8** Early childhood intervention is arguably one of the best ways to improve the chances of children growing up to succeed as best they can and to have the best possible chances in life.

**14.2.9** [Vermont](#) has already grasped the importance of combatting ACEs to build a healthy and successful society<sup>208</sup>.

**14.2.10** An individual with an ACE score of four has a three times higher risk of depression, is five times more likely to become dependent on alcohol, is eight times more likely to experience sexual assault and is up to 10 times more likely to attempt suicide. An individual with an ACE score of six or higher is 46 times more likely to abuse intravenous drugs. An individual with an ACE score of seven or higher is 31 times more likely to attempt suicide<sup>204</sup>.

**14.2.11** These are not just statistics that do not mean anything to an individual community or child within it – these are figures obtained from the longitudinal follow up of over 17000 adults and clearly show an association between adverse experiences in childhood and significant adverse outcomes during adult life. They clearly matter to individuals.



**14.2.12** Early experiences influence the developing brain, chronic stress can be toxic to this development, significant early adversity can lead to lifelong problems, early intervention can prevent the consequences of early adversity and stable, caring relationships are essential for health childhood development<sup>209</sup>.

**14.2.13** This is not just something that affects children living in Phoenix. It is not restricted to children living in Arizona. It is not only about children living in the United States of America. There is a lesson and a message for all of our societies obvious in this. Adverse Childhood Experiences have a terribly deleterious effect on children's lives. Living in households where domestic abuse and violence are the norm has a significant and adverse effect on the development and mental health of children. Suffering from abuse, be it physical, emotional, sexual, exploitative, trafficking or neglect, can have a profound effect on the emotional well-being of children and their ability to grow up and realise their true potential as the future of our society.

**14.2.14 Recommendation TWELVE**

**The concept of the importance of detecting and, where possible, eliminating Adverse Childhood Experiences (ACEs) in the UK, and beyond, ought to be included in undergraduate and postgraduate educational programmes for professionals working with children and families.**

**14.2.15** The "Darkness to Light's Stewards of Children" programme and publication seek to empower adults to prevent child sexual abuse and they are useful resources for professionals working on preventative measures within the community<sup>210</sup>.

**14.2.16** It takes a community to protect a child and it is clear that society has a role that is more important than ever before to protect those children within it who are at risk of, or who have suffered from, significant harm. The challenge for the people and organisations responsible for resourcing societies is what weight they will place on the importance of positive childhood experiences and what resources will be provided to allow children to maximise their potential.

#### **14.2.17 Recommendation THIRTEEN**

**Organisations working in the community on child abuse prevention programmes should incorporate material relating to Adverse Childhood Experiences (ACEs) and provide community education about the importance of minimising ACEs as well as recognising when they are present in the community and seeking appropriate community-based or professional assistance.**

**14.2.18** The challenge for communities and the societies in which they function is whether or not they are prepared to accept the responsibility that society clearly has in protecting children, for if they do not, and protecting children is seen as someone else's business, it cannot be expected that things will improve for the children who live within those communities in the future. Adverse Childhood Experiences certainly can last a lifetime.

**But they don't have to.**

### **14.3 Child abuse prevention in the community**

**14.3.1** A community in which people watch out for children and their families – in which neighbourly help is the norm – would be a good place to live. Such a network of relationships would be welcomed by many people in a society that is arguably becoming increasingly disconnected. Adoption of community-strengthening approaches that result in improved welfare for children in general and a stronger commitment to ensuring children's safety by focussing on community-wide prevention of child maltreatment would result in a substantial increase in children's safety<sup>211</sup>.

**14.3.2** Prevention of socially undesirable and hazardous behaviours cannot only save lives, but also precious resources. Whilst it may be impossible to completely eradicate maltreatment of children there are a number of preventative strategies that can be put into place to target the problem in society. These include primary prevention, secondary prevention and tertiary prevention strategies<sup>290</sup>:

#### *Primary Prevention*

These activities can be directed at the general population in an attempt to reduce the incidence of child maltreatment by seeking to raise awareness about the scope and problems associated with child maltreatment. Universal approaches to primary prevention might be:

- Public service announcements encouraging positive parenting
- Parent education programmes and support groups focussing on child development and age-appropriate expectations and the roles and responsibilities of parents
- Family support and family strengthening programmes that enhance the ability of families to access existing services and resources and support interaction between family members
- Public awareness campaigns that provide information on how, when and where to report suspected child abuse and neglect.

### *Secondary Prevention*

These activities are focussed on populations that may have one or more high-risk factors present that are associated with child maltreatment, such as poverty, substance misuse, young parental age, parental mental health concerns and parental or child disabilities. Programmes might be directed at communities or neighbourhoods such as:

- Parent education programmes located, for example, in high schools that focus on teenage parents, or within substance abuse treatment programmes for mothers and families with young children
- Parent support groups that help parents deal with their everyday stresses and meet the challenges and responsibilities of parenting
- Home visitation programmes that provide support and assistance to expecting and new mothers in their homes
- Respite care for families that have children with special needs
- Family resource centres that offer information and referral services in high-risk neighbourhoods

### *Tertiary Prevention*

These activities focus on families where maltreatment has already occurred and seek to reduce the negative consequences of the maltreatment and to prevent its recurrence. These programmes might include:

- Intensive family preservation services with trained mental health practitioners that are available 24 hours per day for a short period of time
- Parent mentorship programmes with stable, non-abusive families providing support to families in crisis
- Parent support groups that help parents transform negative practices and beliefs into positive parenting behaviours and attitudes
- Mental health services for children and families affected by maltreatment to improve family communication and functioning

**14.3.3** 12% of participants in one UK study stated that if they were worried that someone they knew might be sexually abusing a child they would contact child protection agencies other than the police or social services. Raising awareness (so that people understand the nature and scale of child abuse, the behaviour of offenders, early warning signs and the effects on children), changing attitudes (dispelling the myths so people are more willing to talk about abuse and see its prevention as part of all adults' responsibilities), changing behaviour (so that people take appropriate action to prevent abuse and to seek help if they are worried about themselves or others) and developing a public health approach (as child abuse requires a large-scale systematic approach to prevention) are all ways that the community could work together more collaboratively to prevent child abuse<sup>212</sup>.

- 14.3.4** The Academy Child Sexual Exploitation Working Group<sup>14</sup> recently recommended that the Faculty of Public Health should consider how they can encourage their members to work closely with local safeguarding children boards to improve awareness in parents, communities, and schools of indicators of child sexual exploitation and of available help. This would also include a focus on primary prevention to help build awareness and resilience in children and young people to prevent them being sexually exploited.
- 14.3.5** Health educators in schools can become a powerful force for a change to empower children to report more cases of child abuse and to facilitate interventions at an earlier stage if child maltreatment were to be added to school curricula on a widespread basis<sup>213</sup>.
- 14.3.6** It is not just educational programmes in schools that could contribute to earlier interventions in child maltreatment cases. A comprehensive, regional, hospital-based, parent education programme, administered at the time of a child's birth was evaluated in the USA to examine its impact on the incidence of abusive head injuries amongst children aged under 3 years. The study demonstrated that targeting parents of all newborn infants with a coordinated educational programme can significantly reduce the incidence of abusive head injuries amongst children aged under 3 years<sup>214</sup>.
- 14.3.7** The work of the Singapore Children's Society is crucially important in understanding why child maltreatment community preventative measures are vital. In a study designed to determine what is child abuse and neglect to the average Singaporean it was shown that, for example, caning was deemed to be acceptable if the child was older, the child was disobedient, the child was not physically or mentally handicapped, the child was not treated differently from his siblings, only limbs and buttocks were caned, there were no permanent marks or injuries, it happened infrequently, the adult had good intentions and the adult was not under stress<sup>127</sup>.
- 14.3.8** The majority of professionals and public only considered those actions that appeared to lead to obvious and severe physical harm as "never acceptable" such as, burning a child with cigarettes or hot water, or tying a child up, shaking a child hard and ignoring the signs of illness in a child.

**14.3.9** For actions that did not appear to lead to obvious injury to the physical wellbeing of the child, many people, both professional and from the general public, viewed them as “sometimes acceptable” such as caning a child or leaving the child alone in the house. For all of the items investigated to determine their professional and public abusiveness rating there was a greater tendency to regard items as “sometimes acceptable” or “never acceptable” rather than regarding it as “being abuse” or “possibly being abuse”<sup>215</sup>.



**Figure 16:** *Ending child abuse starts with you – Kempe Center, Aurora, Colorado*

**14.3.10** Looking specifically at emotional maltreatment of children in Singapore, there were significant differences in opinions between different professions as well as between professional groups and the public as to what categorised emotional abuse with varied opinions on the acceptability of locking a child in a room, calling a child useless and always criticising a child<sup>216</sup>.

**14.3.11** In terms of sexual abuse in Singapore, actions considered “never acceptable” by the majority of the public and professional groups studies included, having sex with a child or the parent not protecting the child from sexual advances of other family members. Respondents were less uniform in their ratings of acceptability of appearing naked in front of a child.

**14.3.12** Almost all professionals and the public rated “having sex with a child” as being abusive and the majority of professionals and the public rated “not protecting the child from sexual advances” as abusive. However, a higher proportion of professionals rated “appearing naked in front of the child” as “can be abuse” whereas a higher proportion of the public regarded this as not being abusive<sup>217</sup>.

**14.3.13** The combined conclusions from all of the evidence balancing this with the results of the studies carried out in Singapore, gives further weight to the argument that child abuse is a socially constructed phenomenon with some groups within society considering things to be abusive that other groups do not, and vice versa.

**14.3.14** To be able to full understand, in a scientific way, where and why primary preventative strategies need to be targeted in the UK it is essential that the research that was conducted in Singapore is repeated in the UK so that organisations and groups working on prevention of child maltreatment have the scientific data to support the location and type of their interventions.

**14.3.15 Key Recommendation EIGHT**

A research study should be conducted in the UK comparing professionals' and the public's views on the acceptability of various events which can occur to and around children and whether or not these are considered abusive. The results of this study should be used to inform organisations and groups working on primary prevention of child maltreatment in the community. To help facilitate achievement of this key recommendation there should be widespread support of The Academy of Medical Royal Colleges Child Sexual Exploitation Working Group recommendation (September 2014) that the Faculty of Public Health should consider how they can encourage their members to work closely with local safeguarding children boards to improve awareness in parents, communities, and schools of indicators of child sexual exploitation [and of other types of abuse] and of available help. This would also include a focus on primary prevention to help build awareness and resilience in children and young people to prevent them being exploited or abused in any way.



## **14.4 World Health Organisation (WHO) Health Needs Assessment**

**14.4.1** Principles of public health practice can be applied to problems, such as child maltreatment, that have behavioural antecedents and injury outcomes. Successful campaigns to promote bicycle helmet use to prevent brain injury, in some jurisdictions, and to promote supine sleeping (“back to sleep”<sup>218</sup>) to help prevent sudden infant death (“cot death”) are well known. These programmes were universally applied, featured simple behavioural goals, were based on the best evidence available at the time and monitored both behavioural and health-related outcomes<sup>219</sup>.

**14.4.2** There are a number of important lessons that can be learned from these campaigns that can be generalised to the problem of child maltreatment including establishing a strong scientific basis for intervention; focussing on a single, simple intervention; making the intervention inexpensive; considering a universal campaign; having perseverance; seeking out industry partnerships and monitoring results using sound evaluation methods. The same high-tech universal approach what was successful for helmet promotion and sudden infant death syndrome reduction can be taken for child maltreatment reduction. Evidence-based interventions to treat abusive parents and their maltreated children are scarce and expensive and will only affect a small proportion of the population. Whilst it is vital that those children who have been abused are recognised and treated, universal population-based approaches are needed in order to affect the incidence of child maltreatment<sup>219</sup>.

**14.4.3** Many existing prevention efforts consist of the early identification of cases of child maltreatment and interventions to protect the children involved. This strategy is a form of prevention and may well be beneficial to the children and families at an individual level but it will not lead to large-scale reductions in the incidence of child maltreatment that is possible using strategies that address the underlying causes and contributing factors. A number of preventative intervention strategies are possible including implementing legal reform and human rights, changing cultural and social norms, reducing economic inequalities and training children to recognise and avoid potentially abusive situations<sup>220</sup>.

**14.4.4** A Health Needs Assessment (HNA) is an objective and valid method of tailoring health services using an evidence-based approach to commissioning and planning health services delivery. The main output from an HNA in a specific community is a report outlining the specific needs and making recommendations that will aim to reduce inequalities and improve health.

**14.4.5** Health can be considered to be a state of complete physical, psychological, and social wellbeing and not simply the absence of disease or infirmity. In the context of child maltreatment it is vitally important to understand the health needs of children who might have been abused or communities in which there is a higher risk of child abuse, to establish the extent of child maltreatment in those communities, to examine the patterns of child maltreatment in those communities and to engage the members of those communities into preventative strategies, using best practice evidence that is available, with the ultimate aim of reducing the incidence and prevalence of child maltreatment in the communities worked with<sup>xxxv</sup>.

#### **14.4.6 Recommendation FOURTEEN**

**A formal Health Needs Assessment (HNA), from a secondary care point of view, should be conducted in a pilot community in the UK in relation to child maltreatment and its prevention. The result of this initial pilot should be used to conduct further HNAs in other regions of the country with the aim of building up a societal evidence base of the health needs of children who have suffered from, or who are at risk of, significant harm so that evidence-based preventative strategies can be appropriately designed and targeted.**

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<sup>xxxv</sup> Particular thanks to Dr Rachel Isba, Consultant in Paediatric Public Health Medicine, for mentoring the creation of this chapter.

# Child abuse awareness event



***"Raising a healthy next generation is both a moral obligation and a national imperative."***

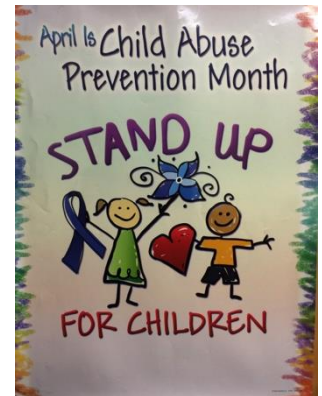
Barack Obama, 1961-

## About this chapter

This chapter examines the role public awareness and media campaigns can have in changing social and cultural norms and concludes that a Child Abuse Awareness event should be held as soon as possible after the 2015 UK General Election.

## 15.0 Child abuse awareness event

**15.0.1** Considering a universal campaign has been demonstrated to be successful in other public health related strategies to try to reduce the burden of disease<sup>219</sup>. Child maltreatment is, in its most general sense, no different from a slowly replicating disease within communities. A public health approach to its prevention is vital.



*Figure 17: Child Abuse Prevention Month, Dell Children's Medical Center, Austin, Texas*

**15.0.2** Social and cultural norms are powerful contributing factors to child maltreatment. They are frequently used to justify violence against children and whilst legal reform is essential it will only go so far to having an impact on the incidence of child maltreatment. What is required is a change in the norms regarding the status of children, the acceptability and effectiveness of violent punishment, gender roles and family privacy. To help change social and cultural norms, public awareness and media campaigns can play an incredibly important role. These can highlight the extent and nature of child maltreatment and encourage the provision of services to children and families<sup>220</sup>.

**15.0.3** Approximately 40% of all child protection reports are made by non-mandated reporters such as family members, friends and neighbours<sup>77</sup>. There is a clear need for education of the public about their role in child protection and to provide clearer and more constructive guidance to the public about what governments expect within an approach where child protection is everyone's business<sup>221</sup>.

**15.0.4** In Singapore, sharing information with partners is an important area of work for the Ministry of Social and Family Development with key public education initiatives centred around educating children on their rights, educating partners on the identification and referral of abuse victims and provision of general information for the public<sup>222</sup>.

**15.0.5** In the USA public awareness has been raised with the launch of Child Abuse Prevention month in April 2014 as proclaimed by the President of the United States of America<sup>223</sup>:

NATIONAL CHILD ABUSE PREVENTION MONTH, 2014

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BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

A PROCLAMATION

*In the United States of America, every child should have every chance in life, every chance at happiness, and every chance at success. Yet tragically, hundreds of thousands of young Americans shoulder the burden of abuse or neglect. As a Nation, we must do better. During National Child Abuse Prevention Month, we strengthen our resolve to give every young person the security, opportunity, and bright future they deserve.*

*We all have a role to play in preventing child abuse and neglect and in helping young victims recover. From parents and guardians to educators and community leaders, each of us can help carve out safe places for young people to build their confidence and pursue their dreams. I also encourage Americans to be aware of warning signs of child abuse and neglect, including sudden changes in behavior or school performance, untreated physical or medical issues, lack of adult supervision, and constant alertness, as though preparing for something bad to happen. To learn more about how you can prevent child abuse, visit [www.ChildWelfare.gov/Preventing](http://www.ChildWelfare.gov/Preventing).*

*Raising a healthy next generation is both a moral obligation and a national imperative. That is why my Administration is building awareness, strengthening responses to child abuse, and translating science and research -- what we know works for kids and families -- into practice. I also signed legislation to create the Commission to Eliminate Child Abuse and Neglect Fatalities, and we are providing additional resources and training to State and local governments and supporting extensive research into the causes and long-term consequences of abuse and neglect.*

*Our Nation thrives when we recognize that we all have a stake in each other. This month and throughout the year, let us come together -- as families, communities, and Americans -- to ensure every child can pursue their dreams in a safe and loving home.*

*NOW, THEREFORE, I, BARACK OBAMA, President of the United States of America, by virtue of the authority vested in me by the Constitution and the laws of the United States, do hereby proclaim April 2014 as National Child Abuse Prevention Month. I call upon all Americans to observe this month with programs and activities that help prevent child abuse and provide for children's physical, emotional, and developmental needs.*

*IN WITNESS WHEREOF, I have hereunto set my hand this thirty-first day of March, in the year of our Lord two thousand fourteen, and of the Independence of the United States of America the two hundred and thirty-eighth.*

**BARACK OBAMA**

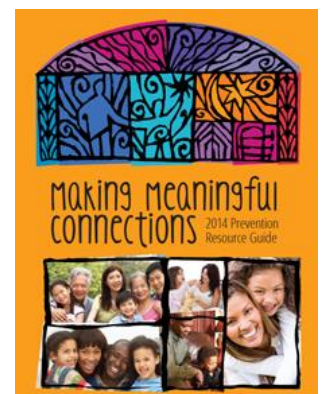
### 15.0.6 Child Abuse Prevention Month

National Child Abuse Prevention Month is a time to acknowledge the importance of families and communities working together to prevent child abuse and neglect, and to promote the social and emotional well-being of children and families. During the month of April and throughout the year, communities are encouraged to share child abuse and neglect prevention awareness strategies and activities and promote prevention across the country<sup>224</sup>.

**15.0.7** The National Child Abuse Prevention Month [website](#) is packed full of resources and publications for professionals and the public aimed at raising awareness of child abuse issues, with clear support from the USA government – as the prevention month was launched by the President, aiming to try to prevent some cases from occurring in the first place.

**15.0.8** Temporal factors and the incident of physical abuse in young children have been investigated in the USA during child abuse prevention month. A review of 672 cases of child abuse reported a linear increase in the number of cases per year ( $p < 0.001$ ). Sunday had fewer abuse cases than any other day of the week ( $p = 0.08$ ). Younger children were less likely to be injured during April (which is Child Abuse Prevention Month) and more likely to be injured during August and October ( $p < 0.05$ )<sup>225</sup>.

**15.0.9** Although the causes of these variations requires further study, there appears to be an association between the occurrence of Child Abuse Prevention Month and a decreased number of young children injured due to abuse in that month.



*Figure 18: National Child Abuse Prevention Month resource guide*

**15.0.10** If this association could be shown to be causative then that would represent even more powerful evidence to suggest launch of a Child Abuse Prevention event in other jurisdictions, whilst noting and accepting the significant caveats set out elsewhere in this report about the potential problems of trying to transfer a public policy from one jurisdiction to another, could be beneficial in reducing the incidence of child maltreatment.

**15.0.11 Key Recommendation NINE**

**The UK government should consult with key child protection stakeholders and prepare to launch a pilot Child Abuse Awareness Month as soon as is practicable after the 2015 General Election. This event should be evaluated and replicated in future years if it is found to be successful in either raising awareness of child abuse issues within society or decreasing the incidence of child maltreatment in different communities.**

# Children's advocacy



***"There can be no keener revelation of a society's soul than the way in which it treats its children"***

Nelson Mandela, 1918-2013

## **About this chapter**

This chapter highlights the importance of empowering children to be involved in decisions relating to the communities in which they live, avoiding tokenism, manipulation and decoration. It concludes with a recommendation to create a children's advocacy centre in the North West of England.



## 16.0 Children's advocacy

### 16.1 Overview

**16.1.1** Children have been afforded protection by international agreements dating as far back as 26 September 1924 when the Declaration of Geneva was adopted by the League of Nations, stating (in language we would not use today given the importance that is quite rightly placed on equality and diversity)<sup>226</sup>:

**16.1.2** *By the present Declaration of the Rights of the Child, commonly known as "Declaration of Geneva", men and women of all nations, recognising that mankind owes to the Child the best that it has to give, declare and accept it as their duty that, beyond and above all considerations of race, nationality or creed:*

- *The child must be given the means requisite for its normal development, both materially and spiritually;*
- *The child that is hungry must be fed; the child that is sick must be nursed; the child that is backward must be helped; the delinquent child must be reclaimed; and the orphan and the waif must be sheltered and succored;*
- *The child must be the first to receive relief in times of distress;*
- *The child must be put in a position to earn a livelihood, and must be protected against every form of exploitation;*
- *The child must be brought up in the consciousness that its talents must be devoted to the service of fellow men.*

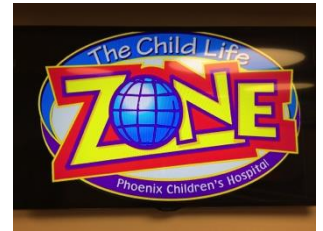


Figure 19: Child Life Zone: Phoenix Children's Hospital



Figure 20: The Children's Directing Chairs inside the Child Life Zone, Phoenix Children's Hospital, Arizona<sup>xxvii</sup>

<sup>xxvii</sup> Designed in partnership with children, the Child Life Zone at Phoenix Children's Hospital is a state-of-the-art play area that provides an escape for patients and their families from daily life in the hospital and is open seven days per week. The 3800 square foot, procedure-free area gives patients a safe place to forget about being in the hospital for a little while and just have fun.

- 16.1.3** Article 12 of the United Nations Convention on the Rights of the Child (CRC), adopted in 1989 and coming into force in September 1990, requires states parties to *“assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child”*<sup>227</sup>.
- 16.1.4** Article 13 of the CRC recognises the child’s right to freedom of expression which includes the freedom *“to seek, receive and impart information... either orally, in writing or in print, in the form of art, or through any other media of the child’s choice”*.
- 16.1.5** In 2009 the United Nations Committee on the Rights of the Child stated that, in the context of healthcare, *“children, including young children, should be included in decision-making processes, in a manner consistent with their evolving capacities”*<sup>228</sup>.
- 16.1.6** Section 22, paragraph 5(a) of the Children Act 1989<sup>169</sup> requires that “before making any decision with respect to a child... a local authority shall, so far as is reasonably practicable, ascertain the wishes and feelings of the child. Children and young people must be able to feed into the assessment process and be fully consulted about their views before any planning meeting<sup>229</sup>.
- 16.1.7** In relation to consent to treatment, children aged more than 16 years of age have had a statutory independent right to consent to treatment since the introduction of the Family Law Reform Act in 1969. Section 8 said, *“The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian”*<sup>230</sup>.
- 16.1.8** Children aged less than 16 years of age are able to consent to treatment if they meet the standard for competence that is set out in the Fraser guidelines as part of *Gillick v West Norfolk and Wisbech Area Health Authority* when the case reached the House of Lords<sup>231</sup>.

**16.1.9** In England and Wales at least, even though children under the age of 18 years are able, in the circumstances set out above, to consent to treatment they are unable to refuse treatment if someone with legal parental responsibility consents to that treatment and refusal decisions of the child may be overridden by the Courts on the basis of the best interests of the child or young person such as in *Re R (A Minor)* where the Court held that even if the child were Gillick competent she had no authority to refuse treatment<sup>232</sup>.

**16.1.10** Whilst the law is clearly an important component to mandate mechanisms to be developed to allow and encourage children to participate, it is not just the law that underlines the importance of giving children the right to be heard and to participate in healthcare decision making. There are much wider social policy reasons why these rights should be firmly secured. This chapter will consider the participation of children in healthcare and will conclude with an outline proposal to launch a new type of Child Advocacy Centre in the UK.

## 16.2 Involving children in healthcare

**16.2.1** Healthcare decision-making involving children can be a difficult process, especially in situations of serious illness. When children are ill, adults have an understandable desire to protect them from difficult decisions and to shield them from unpleasant information. Yet, children want and need to be heard by healthcare professionals and to be provided with age-appropriate explanations and information in order to help them cope with the consultation and treatment processes. There is a need for better training for professionals in dealing with both children and parents and more research is needed into how participation works in practice and into the impact of factors such as social exclusion or other forms of disadvantage on participation<sup>233</sup>.

**16.2.2** Participation covers a broad continuum of involvement in decisions; it is a multi-layer concept involving many different processes. For example it can simply mean taking part, being present or consulted or, alternatively, it can denote a transfer of power so that participants' views influence decisions with hierarchical or non-hierarchical distinctions between levels of participation according to the degree of power that is shared or transferred or the circumstances of the participating children<sup>234</sup>.



*Figure 21: The Emily Center<sup>xxxvii</sup>,  
Phoenix Children's Hospital,  
Arizona<sup>235</sup>*



*Figure 22: What healthy means to  
me – view from a ten year old  
child<sup>236</sup>*

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<sup>xxxvii</sup> The Emily Center, Phoenix Children's Hospital, was founded in 1990 and is named after Emily Anderson who died from a rare form of leukaemia a few days before her seventh birthday. Frustrated by the lack of easy to understand information about Emily's illness, her parents founded The Emily Center so that families, and children, have access to paediatric health information that is accurate, easy to understand and free of charge. The center incorporates a specific area for children where they can learn more about their own illness, or about an illness of a sibling, friend or parent. The center has registered nurses to help find the answers to questions as well as access to multi-media information about common or rare children's conditions.

- 16.2.3** The value of participation of children and young people in public decision-making is well accepted but there is an urgent need for internal and external evaluations of children's involvement<sup>237</sup>. Children have demonstrated that their level of understanding and interest qualifies them for a place in discussions about services for their age group. Collaborative work with children and young people is necessary for appropriate service development<sup>238</sup>.
- 16.2.4** Children and young people clearly wish to have some say in the way decisions are made about their lives and generally do not believe that they have adequate appropriate opportunities so to do. Genuine and effective participation depends on several conditions: opportunity and choice in ways to participate, access to relevant information, the availability of a trusted advocate, proper resourcing, and supportive policy and legislation. Feedback from children and young people is also required to indicate whether it is happening<sup>239</sup>.
- 16.2.5** Despite the importance of consulting with children, their views, in the past, were rarely sought nor acknowledged within the healthcare setting. Children were rarely involved in decision-making processes and appeared to occupy a marginalised position in healthcare encounters<sup>240</sup> yet children, like adults, want to be partners in their own health care, especially those with conditions that will require lifelong engagement with health professionals<sup>241</sup>.
- 16.2.6** In a cross border project against trafficking and exploitation of migrant and vulnerable children in South East Asia, Save the Children UK have actively engaged children and found that their participation in concrete actions and policy advocacy protects them from trafficking. It is only by involving children and young people in the project that lasting positive changes can be achieved in the children's lives.

- 16.2.7** In the project children are actively involved from the beginning when the needs assessments are undertaken, to planning, implementation through to monitoring and evaluation. Children conduct research on migration and human trafficking situations in their communities. Children are present in planning and discussing their project ideas with other project partners. With the support from adults, children and young people form their own committees and groups to carry out project activities. The project aims to develop the full leadership potential of children as partners, bringing them forward as the best champions for their own cause<sup>242</sup>.
- 16.2.8** At Phoenix Children's hospital a children's council has been set up to empower children to take an active role in the decision-making process of the hospital including robustly challenging members of the Executive team to deliver on promises made in response to proposals from the children.
- 16.2.9** Through the work of the Emily Center, patients are empowered to find out more about their illnesses, and those of people who are close to them, to raise educational levels and enable children to participate in decisions about their own care in a more meaningful way. The real benefits of engaging children in this way are not just that the children themselves develop and improve but also that the decisions that are made are far wiser than would otherwise be the case if children were not involved from the outset.
- 16.2.10** In 2010 the Royal College of Paediatrics and Child Health and their Young People's Health Special Interest Group published their guide to the participation of children and young people in health services<sup>243</sup>. The guide provides key information to ensure the safe, meaningful and ethical participation of children and young people within the delivery of health services and practically demonstrates how child health service providers can contribute towards creating a culture of participation within child health services. Participation, it says, involves a continuum from involvement of individual young people in decisions affecting their daily life to engagement of larger groups of young people making strategic decisions about the use of substantial healthcare resources.

**16.2.11** There are some key definitions that need to be highlighted:

*Involvement*

Describes the inclusion of children and young people in some form of decision making process

*Consultation*

The process by which children and young people are asked for their views and opinions

*Participation*

The process by which individuals and/or groups of individuals can influence the decision making process and bring about change

*Manipulation*

Adults can hijack or influence a participation project for their own means. Manipulation may involve exaggeration of the involvement of young people, coercing young people into projects without their informed consent or briefing young people to such a degree that the views expressed are those of the adult

*Decoration*

Young people may be represented at an event but not actually involved in the event or proceedings, the classic example being a child who presents a gift to a visiting dignitary without knowing who the dignitary is, why they deserve recognition or not being involved in the decision to present the gift.

*Tokenism*

This describes the situation where young people are offered the opportunity to participate but the project has been badly planned or poorly implemented. They may have no choice over the style of form of the process and too little time to either formulate an opinion or express it. The pretence is that children are being involved and will influence decisions but the reality is that the process is unlikely to be representative of young people's views and that their views will not be taken seriously or influence decision-making.

For example, asking children to complete a patient-satisfaction survey pending an NHS Trust's application to become a Foundation Trust but then not using the results of that survey during the application as the views are at odds with the views of the management team.

**16.2.12** The Royal College guidance concluded that it is important to avoid non-participation such as tokenism, manipulation and decoration. The evidence base for children and young people's participation is limited with no high quality systematic reviews of the effects of involving children and young people in the design and development of health services. Future research should concentrate on health outcomes and consider the cost effectiveness of different methods of participation and to how participation might reduce health inequality.

**16.2.13** In 2013 the Office of the Children's Commissioner for England launched a new publication called *We would like to make a change* championing children and young people's participation in strategic health decision-making. The foreword by the Commissioner, Dr Maggie Atkinson, highlights that good practice in the participation of children is not commonplace. There is no coherent national programme of activity to proactively encourage local bodies to include children and young people in strategic health service commissioning or other vital decision-making about NHS provision.

**16.2.14** Dr Atkinson was clear that children would like to take part and have their views taken seriously with as wide a range as possible to take part and to be shown that their opinions are valued.



**16.2.15** It was hoped that the report would:

- Provide assurance to health planners and commissioners that children are sensible, knowledgeable and valuable contributors to health decision-making when given a seat at the table, asked to represent their generation and supported to do so. They should not be treated as passive recipients who either have no views or whose views must defer to those of adults. Nor should their participation be feared because they may ask for the impossible or destabilise services if given a voice.
- Be used by areas and organisations to improve the way they involve children in strategic health decision-making. Many children have regular personal experience of a range of health services. All will have had at least some contact and experience. They are service users and have a right to have their views taken into account<sup>244</sup>.

**16.2.16** Locally, there is already excellent practice at the University of Salford Children, Young People & Families ([CYP @ Salford](#)) workstream<sup>245</sup>. The CYP @ Salford recognises that the participation of children and young people in the services they use is essential if meaningful improvements to their lives are to be achieved. They believe that this principle extends to the participation of children and young people in all aspects of research; a model that could do well to be replicated elsewhere.

**16.2.17** There has been some excellent work developing a child patient survey for urgent and emergency care in a collaboration between the College of Emergency Medicine, the Royal College of Paediatrics and Child Health, the Picker Institute and others<sup>246</sup>. Future versions of this tool would benefit from adaptation to be able to be used by pre-verbal children and those with learning difficulties.

**16.2.18** A great injustice is done to children when society fails to listen to their views, fails to facilitate their true participation in decision-making processes and fails to value their contributions towards shaping a better society for everyone in the future.

#### 16.2.19 Recommendation FIFTEEN

Children should be involved more in healthcare decisions and planning from the outset. A suitable version of the friends and family test, used to quality assure the service provided in healthcare facilities, should be developed for use by all children, including those with learning difficulties or who are pre-verbal. Children's Councils should be created in departments or hospitals seeing children in the UK.

## 16.3 Launch of a Children's Advocacy Centre

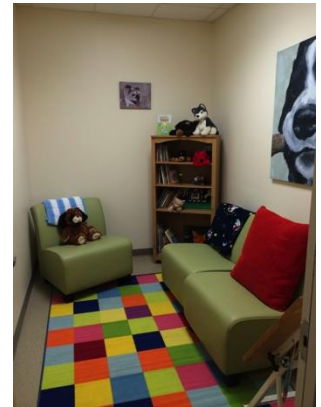
**16.3.1** A children's advocacy centre would fully involve children of all ages in the location, design and service-specification. It would be a place where children could self-refer to get advice, support and help with a wide range of problems including health (both physical and mental health), social care, child protection, relationship difficulties, bullying and schooling.

**16.3.2** A children's advocacy centre is much more than a Multi-Agency Safeguarding Hub (MASH).

**16.3.3** A MASH is an inter-agency collaboration usually involving the Police, Local Authority, Health, Education and other services that will receive referrals about children (and sometimes adults) who are thought to be at risk of harm set up, in differing formats, across the country in response to a number of serious case reviews all showing that inter-agency working could be improved in child protection cases. A screening, threshold assessment and triage process takes place to determine in a multi-disciplinary manner what, if any, further assessment should take place and how that will be conducted.

**16.3.4** An initial evaluation of the creation of a sample of MASHs from around the country was conducted by the [Home Office](#) in July 2013<sup>247</sup>.

**16.3.5** Children's advocacy centres are child-focussed, facility-based programmes with representatives from many disciplines working together to effectively investigate, prosecute and treat child abuse. The locations are not only child-focussed but are designed to create a sense of safety and security for child victims.



*Figure 23: The Center for Child Protection: A Children's Advocacy Center, Austin, Texas*



*Figure 24: What healthy means to me – view from a twelve year old child<sup>248</sup>*

- 16.3.6** The first children's advocacy centre in the USA was formed in 1985 in Alabama and now there are over 750 centres across the USA. Texas, alone, has 68 centres.
- 16.3.7** Creating a children's advocacy centre in the North West of England would be an exciting and innovative project that will result in real benefits for children in the area where it is located. The first centre could be opened as a pilot with a full evaluation taking place over time in order to make recommendations about the desirability, or otherwise, of opening further centres in other areas of the country.
- 16.3.8** The proposal will empower children to engage and contribute to health service design and development and will build a strong local community with children at the centre. These are not just words but a realistic and genuine possibility with just a little bit of creative thought required, a little bit of ground work and lots of enthusiasm to make the project succeed.
- 16.3.9** The first centre would start small but would have real potential to grow into something that the region could be proud of which would really change the lives of multiple children and families living in the area.
- 16.3.10** The centre would incorporate some of the functions of the MASH, which has proper multi-disciplinary involvement including child welfare services, health, education, police, legal teams, psychological services and long-term follow up of children who come into contact with the service. In addition to providing truly holistic health and social care for children at risk of significant harm, research possibilities and the potential to be a beacon of good practise would be huge.
- 16.3.11** The centre would co-locate key members of the team responsible for instigating investigations under Section 47 of the Children Act 1989 including the supporting legal team, key members responsible for the investigation and prosecution of criminal offences against children, key health members to provide advice and input right from the initial referral and a comprehensive, child-friendly environment where children can be assessed, examined, supported and followed up right the way through their journey within the child welfare and health system. All under one roof.

**16.3.12** Children and families would have the ability to self-refer to the centre; children and families would be involved in the design and service development; children and families would be empowered to critique how they would like the service to be modified in the future and children and their families would be key stake-holders to ensure that the environment, service and interaction with the local community are all fit for purpose.

**16.3.13** Based on the USA model of a number of children's advocacy centres there are potentially significant benefits to children, professionals and the local community from being truly creative and developing something new which society in the North West of England can be proud of. A review of the potential benefits of children's advocacy centres in the USA in 2008 concluded that a collaborative response would almost certainly improve the quality of child protection with better outcomes for children and decisions being made using more reliable information within a coordinated response<sup>249</sup>.

**16.3.14** To get this initiative started will require professionals who have an open mind, who are passionate about children's rights, who are keen to explore novel ways of working in the future and are enthusiastic about becoming involved in a new project that would be both professionally and personally very satisfying, to get together and discuss. Rather than finding barriers to stop this proposal from working what the professionals would need to do is to find solutions and to *make* the proposal work.

**16.3.15** There are some excellent examples in North America that can be looked at for ideas including:

- [Center for Child Protection](#), Austin
- [ChildHelp](#), Phoenix
- [Safe Place](#), Philadelphia
- [Children's Advocacy Centers](#)<sup>™</sup>, Texas
- Organised Response to Child Abuse ([ORCA](#)) Children's Advocacy Centre proposal, Victoria

**16.3.16** Within the UK there are examples of projects and centres which touch upon some aspects of the proposed child advocacy centre and which can be looked at for inspiration, including:

- [Duchy Health Charity's](#) Integrated Health Centres in Cornwall's Schools<sup>250</sup>
- [The Marketplace](#), Leeds<sup>251</sup>
- [STEPS](#): Weymouth Young People's Union, Dorset<sup>252</sup>
- [Children's Zones for England](#) (in collaboration between Save the Children and the University of Manchester), Manchester<sup>253</sup>
- Brighton and Hove [Youth Advocacy Project](#), Brighton & Hove<sup>254</sup>
- Preston [Youth Zone](#), Preston<sup>255</sup>

**16.3.17** If the UK is really serious about building strong and healthy communities with children at their heart, the proposal to launch a North West children's advocacy centre is something that should be tackled now to decide how this proposal could be made a reality.

**16.3.18** This new centre could lead the way in advocating for children to help build a better future for our society. Following a full evaluation it may be possible to provide the evidence necessary to recommend extension of this project to other areas of the UK.

**16.3.19 Key Recommendation TEN**

**A children's advocacy centre pilot should be launched in the North West of England with an initial evaluation after 12 months, an interim evaluation after 24 months and a full evaluation after 60 months of operation.**

# Adolescent health



**"A society that cuts itself off from its youth severs its lifeline; it is condemned to bleed to death."**

Kofi Annan, 1938-

## About this chapter

This chapter reviews the World Health Organisation's work highlighting the major health issues affecting adolescents and gives guidance that is relevant to all professionals working with adolescents in health and social care.

## 17.0 Adolescent health

**17.0.1** The World Health Organisation (WHO) estimate that there are 1.2 billion adolescents in the world and that in 2012, 1.3 million adolescents died - mostly from preventable causes of death; 330 adolescents died every day from road traffic accidents; and most cases of mental health problems, often starting in adolescents by the age of 14 years, were undiagnosed or untreated<sup>256</sup>.

**17.0.2** Although globally most adolescents are healthy there is still significant death, illness and disease prevalence amongst adolescents as a group where illnesses can severely hinder their ability to grow and develop to their full potential.

**17.0.3** Promoting healthy practices during adolescence, and taking steps to better protect young people from health risks are critical for the prevention of health problems in adulthood, and for countries' future health and social infrastructure<sup>256</sup>.

**17.0.4** The WHO consider that the main health issues affecting adolescents, all of which can jeopardize not only their current health, but often their health for years to come, are:

- Early pregnancy and childbirth
- Unprotected sex leading to HIV and sexually transmitted infections
- Infectious diseases including diarrhoea, meningitis and lower respiratory tract infections
- Adverse mental health
- Exposure to violence
- Alcohol, tobacco and drug use
- Unintentional injuries
- Malnutrition and obesity
- Poor exercise and nutrition
- Compromised human rights



- 17.0.5** In May 2014, WHO published a [major report](#) called *“Health for the world’s adolescents”*. The report analyses what is known about adolescents’ health, including what promotes or undermines it, highlights gaps in policies and services, and draws together guidance and recommendations from the WHO. The interactive report, which focuses on the health sector, examines areas of significant improvements and suggests approaches to consider in the future<sup>257</sup>.
- 17.0.6** The HEADSS (**H**ome & Environment, **E**ducation & Employment, **A**ctivities, **D**rugs, **S**exuality, **S**uicide & Depression) psychosocial history-taking for adolescents is an excellent aide memoire used in Phoenix, across the USA and other locations to help people working with adolescents gather the information that is necessary to help properly safeguard them and to assist them in achieving their full potential. The [HEADSS](#) assessment will be incredibly useful in Emergency Departments when assessing adolescent patients. The core elements are as follows, with further detail available [online](#)<sup>258</sup>:

## **Introduction**

Open the consultation by introducing yourself to the adolescent +/- parent(s) if present. It is good practise to introduce yourself to the adolescent and then get the adolescent to introduce you to the other people in the room and to indicate if the adolescent is happy for them to stay during a consultation that may be potentially embarrassing for them.

## **Confidentiality**

Ask the adolescent to explain their understanding of confidentiality or confidential healthcare and, if necessary, clarify the arrangements for the consultation.

## **Home**

- Where do you live and who lives there with you?
- How long have you lived there?
- Do you have your own room?
- How many brothers or sisters do you have and how old are they?
- Are there any new people living in your home?
- What do/does your parent(s) do for job?
- What are the rules like at home?
- How do you get along with the people you live with?
- What kind of things do you and the people you live with argue about?
- What happens in your house when there is an argument?
- Is there anything you would like to change about the people you live with?
- Working with people of your age I'm told by some of them that the relationship with the people they live with can be difficult – that sometimes they argue or fight. What do you think about that? Has anything like that happened to you?
- Some people tell me that they wish the people they live with didn't drink so much or use drugs. Is this something that happens in your house?

## **Education & Employment**

- Are you in school at the moment?
- What are you good at in school? What is hard for you?
- What sort of grades are you getting at the moment? Are these different from what you used to get?
- What do you like best and least about school? Which are your favourite subjects?
- Which subjects don't you like?
- How much school did you miss in the last year? Do you ever skip / bunk off any classes?
- Have you ever been excluded?
- What do you want to do when you finish school? Do you have a job at the moment?
- How do you get along with people who you go to school with or work with?
- Do any of your friends get bullied?
- Do you get bullied? If so, who bullies you?

## **Activities**

- What do you do for fun in your spare time?
- Are most of your friends from school or from somewhere else?
- Are your friends the same age as you?
- Do you hang out with mainly people of the same sex as you or is it a mixture?
- Do you have one best friend or a few friends?
- Do you spend time with your family? What do you like to do?
- Do you see your friends at school and at weekends too?
- Do you do any regular sport or exercise?
- What sort of hobbies and interests do you have?
- Do you have any kind of religious belief, spiritual belief or go to a church or temple or something like that?
- How much TV do you watch? What is your favourite programme?
- Do you like to read for fun? What do you read?
- What is your favourite music?
- Do you wear a seatbelt when you are in the car?
- Have you ever been involved with the police? What happened?
- Do you belong to a group or a gang?

## Drugs

- Lots of people that I have met of your age have tried cigarettes, alcohol or drugs. Have any of your friends tried them?
- Have you tried them?
- When you are out with your friends do many drink or smoke?
- Do any of your family members drink, smoke or use any drugs? If so, how do you feel about this? Is it a problem for you?
- Have you or your friends ever tried any drugs? What drugs did you try? Have you ever used a needle?
- Do any of your friends drive when they have been drinking or using drugs?
- Have you ever been in a car accident? Was this related to drugs or alcohol?
- Have you ever been in trouble with the police? Why was this?
- How do you pay for your cigarettes / drugs / alcohol?

## Sexuality

- Are you involved in a relationship? Have you ever been involved in a relationship? How was that experience for you?
- How would you describe your feelings towards other boys or girls?
- How do you see yourself in terms of sexual preference? Gay, straight, bisexual, trans?
- Have you ever had sex? Was it a good experience for you?
- Are you comfortable with sexual activity? How many partners have you had?
- Do you use contraception? How often?
- Have you ever been checked out for sexually transmitted infections?
- What do you know about hepatitis, HIV, chlamydia and gonorrhoea?
- Have you ever had anything happen in the past when someone did something to you that you did not feel comfortable with or that made you feel disrespected?
- What do you think you would do if someone did something to you that you didn't want them to? Who would you talk to?
- Girls: ask about last period, cycles and breast examination
- Boys: ask about testicular examination

## Suicide & Depression screening

### *Risk factors*

- Sleep disorders (teenagers who are anxious or depressed often have difficulty falling asleep. Generally it takes them more than 30 minutes to fall asleep and often more than an hour. Though many adolescents have sleep problems, difficulties falling asleep more than twice a month ought to be further considered. Sleep problems tend to make people feel miserable in the morning and are a big nuisance to normal functioning)
- Appetite or eating behaviour change (frequent fad dieting, crash diets, anorexia or bulimic behaviour and obesity with significant over-eating are all important features to enquire about).
- Feelings of boredom
- Emotional outbursts
- Impulsive behaviour
- History of withdrawal / isolation
- Hopeless / helpless feelings
- History of past deliberate self-harm, depression or suicide attempts
- Any history of depression, self-harm or suicide in peers or family
- History of drug / alcohol abuse
- Criminal activities
- Recent change in school performance
- History of recurrent serious “accidents”
- Psychosomatic symptomology
- Suicidal ideation
- Decreased affect
- Preoccupation with death
- History of psychosocial / emotional trauma
- Gay, lesbian, bisexual, transgender youth

## **Closing**

- Ask them to sum up their life If they are doing well, then say so
- If there are concerns then talk about these
- Ask who the adolescent trusts and why they trust that person
- Ensure there is appropriate support put in place if it is needed
- Provide any information you can on the topics discussed from an educational point of view
- Ensure the adolescent understands that you are interested in them as a whole person and that you are someone they can trust and help them to lead a fuller, healthier life

**17.0.7** Although a lot of focus in child protection work is on young children who cannot or will not speak for themselves sometimes adolescents can miss out and people with just as serious safeguarding problems as young babies can be overlooked.

**17.0.8** It is for that reason that all organisations dealing with children and families need to ensure they understand the different issues that can affect adolescents, that they have policies and procedures in place to recognise the vulnerability of this group of children and that they can provide the support or referrals necessary to provide assistance to those that are in need of it.

**17.0.9 Recommendation SIXTEEN**

**All professionals dealing with adolescents need to recognise the specific vulnerabilities that exist within this age group and ensure that these are not overlooked. Professionals should ensure they use an appropriate history-taking framework, such as HEADSS, when talking to children of adolescent age and Emergency Departments should provide an adolescent area with age-appropriate information available.**

# Paediatric Emergency Medicine

## Research Unit



**"If we knew what it was that we were doing, it would not be called research, would it?"**

Albert Einstein, 1879-1955

### About this chapter

This chapter sets out the different approaches taken to child protection and paediatric emergency medicine research in Singapore and the USA and advocates creation of local Paediatric Emergency Medicine Research Units (PEMRUs).



## 18.0 Paediatric Emergency Medicine Research Unit (PEMRU)

### 18.0.1 Improving the lives of patients through excellent clinical care, teaching and research

Research is at the heart of the ED at KK Women's and Children's Hospital (KKH) in Singapore. The mission of the hospital has always been to improve the lives of patients through relentless pursuit of academic medicine. This is widely promoted throughout the hospital and patients cannot fail to see the ethos of the organisation with numerous posters and public-facing displays evident throughout the buildings.



Figure 25: Research is high on the agenda at KK Hospital, Singapore

**18.0.2** In Austin, Dr Karla Lawson, the Trauma Research Manager, coordinates extensive research activities within the ED linking in with the Injury Free Coalition for Kids of Austin [work](#). This is an extensive community engagement programme aimed at preventing injury to children in central Texas and incorporating Education, Research and Advocacy<sup>259</sup>:

### 18.0.3 Education

Injury Prevention staff at Dell Children's Medical Center provide a variety of educational offerings. In the hospital, one-on-one Injury Prevention Consultations are provided to admitted trauma patients as a standard part of their care. These consultations provide access to age-appropriate information and prevention resources. The Safety Station, an on-site safety store, provides patients and the community with access to low-cost child safety devices, including car seats and bike helmets. In addition, courses training new child passenger safety technicians are offered on a periodic basis and each year child safety seat seminars are offered for medical residents.



Figure 26: Injury free coalition, Austin, Texas

### *Research*

The Trauma Services Department of Dell Children's Medical Center maintains a diverse research program. The program's focus is on the epidemiologic, clinical, and behavioral study of childhood injury, injury prevention, and trauma clinical practice. Areas of interest include injury prevention, non-accidental trauma, and clinical pathways. Current studies include evaluating an injury prevention curriculum in an urban summer camp setting, describing caregiver risky alcohol use, and assessing the living environments and social factors that influence injury prevention behaviors and beliefs of teenage parents. An active collaboration with researchers at the University of Texas, School of Social Work was established to examine risky alcohol use in adolescents and caregivers of injured pediatric patients.

### *Advocacy*

Injury Free Austin's activities also encompass advocacy efforts aimed at strengthening or creating safety legislation for residents of the State of Texas. Initiatives have included efforts to improve transportation legislation, and to secure funding and support for statewide injury-related data systems (specifically the state Trauma and Submersion Registries).

**18.0.4** In Phoenix, the Children's Hospital makes clear that it is through research that patient care is improved and the hospital is involved in over 200 different studies including<sup>260</sup>:

- Fontan follow-up study: altitude vs. attitude
- Car-seat challenge testing in pediatric cardio-thoracic surgical patients
- Clinical outcomes of chemotherapy-induced hyperglycemia in the pediatric setting
- The epidemiology of pediatric inflammatory bowel disease in the Western region of North America
- National marrow donor program (NMDP) protocol for a research database for allogeneic unrelated hematopoietic stem cell transplantation
- The treatment of down syndrome children with acute myeloid leukemia (AML) and myelodysplastic syndrome (MDS) under the age of 4 years

- Neurodevelopmental outcome following congenital heart surgery: evaluation of cooling and antegrade cerebral perfusion
- Treatment protocol for use of anascorp in patients with scorpion sting envenomation

**18.0.5** In Philadelphia, there is an entire research institute at the Children's Hospital, which is one of the most academic children's hospital centres in the world<sup>261</sup>.

**18.0.6** In Aurora, the Kempe Center and the associated Children's Hospital of Colorado have been involved in child protection research for over half a century<sup>262</sup> and, again, there is a dedicated paediatric research institute that is forward-facing and promoted to the public.

**18.0.7** Within the UK there are centres of excellence undertaking child protection research (for example, the [Core Info](#) research team at Cardiff University)<sup>263</sup> and paediatric emergency medicine research (for example, the [PERUKI](#) research collaborative)<sup>264</sup>.

**18.0.8** Formed in 2012, PERUKI brings together clinicians and researchers from England, Ireland, Northern Ireland, Scotland and Wales who share the vision of improving the emergency care of children through high quality multi-centre research. Working collaboratively with coordination of research activities, PERUKI aims to develop large-scale robust multi-centre clinical research with translation into clinical practice across the UK and Ireland.

**18.0.9** Branding is important and promoting research opportunities with patients and families is crucial to enable clinical care to be advanced in the future. Many hospitals are engaged in research projects throughout the UK but they don't always publicise this work as widely as they could do to encourage other units to participate and to assure the public that the highest possible standards of care are being investigated to make care enhanced for the generations in the future.

#### 18.0.10 Recommendation SEVENTEEN

Organisations involved in clinical research should promote this more widely with patients and the public. Those departments involved in paediatric emergency medicine research should consider the brand that is used to promote this important work and should set up a local Paediatric Emergency Medicine Research Unit (PEMRU) to coordinate the research arm of the clinical work that is delivered. Such units should collaborate with PERUKI (Paediatric Emergency Research in the UK and Ireland).

# International networks



***"It really boils down to this: that all life is interrelated. We are all caught in an inescapable network of mutuality, tied into a single garment of destiny. Whatever affects one destiny, affects all indirectly."***

Martin Luther King, Junior, 1929-1968

## About this chapter

This chapter highlights the importance of international collaboration in protecting children and makes recommendation for the promotion of ChildSafe travel destinations and services amongst the travel industry as well as introduces the possibility of a UK-specific ChildSafe programme to better protect children from exploitation in the UK.

## 19.0 International networks

**19.0.1** The 1996 Hague Convention<sup>265</sup> on Jurisdiction, Applicable Law, Recognition, Enforcement and Cooperation in Respect of Parental Responsibility and Measures for the Protection of Children (“the Hague Convention”) was implemented by the UK on 1 November 2012. This convention provides an agreed set of legal provisions and cooperation agreements covering the handling of cross-border cases where children’s safety or welfare may be compromised.

**19.0.2** Countries that have implemented the Convention are known as Contracting States (“States”) and under the Convention these States can ask each other for information or assistance when a child’s safety or welfare may be compromised or where protection is required. The Convention enables States to:

- Take action to protect a child who is at immediate risk of harm, even if that child is usually resident in another State
- Ask another State to provide information upon which to base decisions on whether child protection processes should be invoked
- Consult with other States about placing a child in foster care or residential care in that State
- Ask another State to transfer jurisdiction for a child if the requesting State believes it is better placed to make decisions about the child’s welfare (or vice versa)
- Ask another State to consider taking protective measures in relation to a child that lives in that State
- Provide information to support a parent’s case for contact with a child living in another State
- Ask for assistance in tracing a child in a State where the requesting State is concerned about the child’s welfare



*Figure 27: Building a network, Hospital Kuala Lumpur, Malaysia*

**19.0.3** The role of international cooperation in the promotion of basic human rights, including children's rights, appears in numerous international instruments and commitments<sup>266</sup> including the Hague Convention; Articles 55 and 56 of the United Nations Charter<sup>267</sup>; The UN Declaration 55/2 ("the Millennium Declaration") reaffirming the UN's fundamental values in relation to international relations including Freedom, Equality, Solidarity, Tolerance, Respect for Nature and Shared Responsibility<sup>268</sup>; the CRC<sup>15</sup>; the Optional Protocol on Child Rights on the sale of children, child prostitution [this is, effectively, sexual abuse] and the use of children in pornography [again, effectively sexual abuse]; the Council of Europe Convention on the Protection of Children Against Sexual Exploitation and Sexual Abuse<sup>269</sup>; and the Special Session on Children<sup>270</sup>.

**19.0.4** At this Special Session the then UN Secretary-General, Kofi Annan, addressed the children of the world:

*"We, the grown-ups, have failed you deplorably... One in three of you has suffered from malnutrition before you turned five years old. One in four of you has not been immunised against any disease. Almost one in five of you is not attending school.... We, the grown-ups, must reverse this list of failures".*

**19.0.5** Within the CRC<sup>15</sup> itself there are basic principles set out in Articles 2, 3, 6 and 12 (non-discrimination; best interests of the child; right to life, survival and equipment; respect for the views of the child) which should be upheld in all circumstances and Article 4 sets out clearly the expectation that there will be International Cooperation in implementing the rights recognised in the Convention:

*States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention. With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation.*

**19.0.6** The Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse<sup>271</sup> (“the Lanzarote declaration”) set out, in Article 38, the standards expected of International Cooperation:

*Article 38 – General principles and measures for international co-operation*

*1. The Parties shall co-operate with each other, in accordance with the provisions of this Convention, and through the application of relevant applicable international and regional instruments, arrangements agreed on the basis of uniform or reciprocal legislation and internal laws, to the widest extent possible, for the purpose of:*

- a. Preventing and combatting sexual exploitation and sexual abuse of children*
- b. Protecting and providing assistance to victims*
- c. Investigations or proceedings concerning the offences established in accordance with this convention*

*2. Each Party shall take the necessary legislative or other measures to ensure that victims of an offence established in accordance with this Convention in the territory of a Party other than the one where they reside may make a complaint before the competent authorities of their State of residence.*

**19.0.7** Although this Lanzarote Declaration refers specifically to sexual exploitation and sexual abuse, the principles of international cooperation that are outlined are useful and potentially applicable elsewhere in other areas of work.

**19.0.8** There is not just a theoretical legal basis upon which international cooperation is encouraged, promoted or required. There is practical evidence in the literature showing support for international cooperation. Two examples of this involve the International Society for the Prevention of Child Abuse and Neglect (ISCPAN) where it has been demonstrated that international cooperation in the development of child abuse screening tools is successful<sup>272 273</sup>.



**19.0.9** Throughout the Winston Churchill Fellowship visits to overseas centres, networks have been developed with interested professionals and the hope is that these will facilitate closer working relationships in the future from an emergency medicine and child protection point of view – which has got to be good for children who come into contact with both of these services.

**19.0.10** These partnerships can involve sharing of research ideas and proposals, sharing of teaching materials, joint multi-centre research studies and the possibility for professional exchanges and further professional visits. All of these have the potential for mutually beneficial outcomes in the future for both professionals and children on a worldwide basis. Children throughout the whole world must be better protected in the future and developing networks is one way to start the challenge to, as Kofi Annan said, “reverse the list of [previous] failures”.

**19.0.11 Recommendation EIGHTEEN**

**Organisations and individuals interested in strengthening international partnerships, either from an Emergency Medicine or Child Protection viewpoint, should seek out and foster lasting relationships with overseas individuals and organisations that will be of mutual benefit.**

**19.0.12** The Foreign and Commonwealth Office (FCO) Pro-Bono Medical Panel was set up in 2002<sup>274</sup> to advise the FCO in relation to the health of serious medical cases in relation to, at that time, 3000 British citizens who were in foreign jails. This panel was launched as part of on-going reforms to help protect the human rights of prisoners overseas. The initiative was developed in conjunction with the British Medical Association and the Medical Royal Colleges.

**19.0.13** The issue of the health of British Citizens overseas is not restricted to prisoners in jails. There are many children living, or visiting, abroad on a temporary or permanent basis who are also British Citizens. Some of these children are involved in child protection issues or there is concern for the safety or welfare of the child.

**19.0.14** It was apparent from discussions overseas that assistance and input into the most serious of these cases would be both welcomed and helpful. It appears that there is an argument for the extension of the FCO Pro-Bono Medical Panel to cover serious child protection cases.

**19.0.15** Due to the nature of child protection work any extension would need to be multi-professional but there is no apparent immediately obvious reason why such an extension would not be successful and provide Consular Officers, working overseas, with additional support where serious cases are involved.

**19.0.16 Recommendation NINETEEN**

**The Foreign and Commonwealth Office Medical Pro-bono Panel should be enhanced by creating a multi-disciplinary sub-panel focussing on child protection issues.**

**19.0.17** The Winston Churchill Memorial Trust Fellowships are a fantastic opportunity for British Citizens to travel abroad to bring back best practice and recommendations to enhance the communities in which they work in the UK. The benefits gained by travelling overseas and experiencing other cultures and organisations as well as meeting different professionals engaged in a similar line of work, are bi-directional.

**19.0.18** Professional visits can assist individuals to more fully understand the context in which other groups work and how, given the potential difficulties of international public policy transfer, the experiences gained could be transferred and useful in the UK.

**19.0.19** As well as travelling abroad to gain new experiences it is possible to gain benefits from hosting overseas visitors in units in the UK as an alternative means of advancing knowledge and procedures, with international considerations being properly considered.

**19.0.20** Commonwealth Professional [Fellowships](#)<sup>275</sup> are available each year to support mid-career professionals from developing Commonwealth countries to spend a period of time with a UK host organisation working in their field for a programme of professional development.

- 19.0.21** Fellowships are typically three months in duration but can be between one and six months in length. Justification is required for programmes of more than three months duration.
- 19.0.22** Programmes must have demonstrable development impact in the Fellow's home country and the Fellow must be able to show how the knowledge and skills they will gain during the Fellowship will be disseminated after their return home.
- 19.0.23** Organisations in any sector in the UK can apply to host a Professional Fellowship. The Fellowship programme can include time spent within their own organisation, learning from colleagues in a structured manner and undertaking project work which meets their learning objectives, as well as time spent at other organisations within the UK and at conferences and a limited time on short courses.
- 19.0.24** Applications are sought for programmes within the broadly defined fields of agriculture, fisheries, forestry, economic growth, education, engineering, science, technology, environment, governance, and public health.
- 19.0.25** UK organisations can apply to host up to ten Fellows in one year, with no more than six in any round.
- 19.0.26** Fellows must be Commonwealth citizens, refugees, or British protected persons and must be permanently resident in a developing Commonwealth country.
- 19.0.27** Fellows must normally have at least five years' relevant work experience in the field within which they wish to undertake the Fellowship.
- 19.0.28** A Commonwealth Professional Fellowship covers the living expenses for the Fellow as well as a return airfare to the UK. It also provides £800 funding support to the host organisation, with a budget of up to £3000 available for attendance at conferences, on short courses, and other eligible costs.

**19.0.29** Commonwealth Professional Fellowships are not for academic study or research of any sort. However, academics can be nominated for programmes of professional development in academic management.

**19.0.30** Seven types of Commonwealth Scholarship Commission Awards are available, including the Fellowship programme, for a variety of purposes<sup>276</sup>.

**19.0.31** **Recommendation TWENTY**

**Organisations in the UK interested in hosting Overseas Fellows should investigate the possibilities offered by The Commonwealth Scholarship Commission Awards.**

## 19.1 The travel industry and creating a ChildSafe pilot in the UK

**19.1.1** Travellers can often unwittingly and unknowingly increase the vulnerability of children living in the areas visited. [ChildSafe](#) is a proactive child protection network involving key members of society, protecting children from all forms of abuse and preventing child exploitation and trafficking.



*Figure 28: The ChildSafe network Logo*

**19.1.2** Children are put at risk because communities either facilitate or ignore situations that can lead to abuse. The ChildSafe project builds a network of key people to protect children. These key people can either make the access to child abuse easy – or they can stop it. They are in situations that allow them, by adopting certain behaviours, to improve the protection of children.

**19.1.3** The ChildSafe network doesn't just work in Cambodia. They have projects running in [Thailand](#), Lao PDR and [Indonesia](#). They help to protect children on the beaches, on the streets, in internet cafés, in hotels and guesthouses, in restaurants, and in the transport and tuk-tuk industry<sup>277</sup>.

**19.1.4** The network of key people consists of, amongst others:

- Taxi drivers
- Hotel and guesthouse staff
- Restaurant staff
- Internet café staff
- Travel agencies
- Tour operators
- Travellers
- Foreign residents
- Government officials and local authorities
- Communities where children live and spend their time

- 19.1.5** These people are trained to recognize children who might be in dangerous situations and can take appropriate action to prevent them. Specific information as well as individual and adapted training on behaviours concerning children is delivered to these key people and they are supported, and receive on-going training, to develop their child protection skills.
- 19.1.6** While carefully trained, selected and monitored, these ChildSafe partners are able to protect and support children at risk and provide a community-based social work function.
- 19.1.7** ChildSafe is linked to a series of services for these vulnerable children, including information and support to minimize risk, legal support, emotional and psychological recovery and access to options and alternatives to the situation that puts them at risk.
- 19.1.8** A wider global campaign is being developed to target tourists in their country of origin as well as the travel industry service-providers to promote a ChildSafe attitude of travel to at-risk countries and areas.
- 19.1.9** There are seven simple ways to help to better protect children that have international applicability even when there is not a formal ChildSafe network in place in a specific location:

*Support ChildSafe Network members*

Mototaxis, tuktuks, hotels, guesthouses, restaurants, internet cafés, tour operators and many others have been trained to protect children from abusive situations. The ChildSafe logo is usually prominently displayed when a service-provider is a ChildSafe member.

*Think twice before buying anything from children on the street, beach or at temples and don't give money to begging children or parents with infants*

Buying things or giving money in this way helps keep them on the streets. Spare money is better donated to support services that help children have a better future. A number of shops and services support the ChildSafe initiative in Cambodia, including [Tapang's](#).

*Purchase ChildSafe certified products to support vulnerable children and their families*

This is a really effective alternative to giving money directly to children. These products are made by parents so children can go back to school or they are made by former street children in training for they can find employment.

*Be aware of the dangers of orphanage tourism*

A lot of orphanages in the region visited do not have child protection policies in place to ensure the safety of children in their care. Good organisations do have policies in place and these should not allow visitors to just drop in and have access to children.

*Don't take children back to a hotel no matter what level of concern*

These children are better protected by being referred to local social workers or ChildSafe referral partners who can help.

*Avoid places that tolerate prostitution*

With around one third of sex workers in the Mekong region being between 12-17 years of age, going to places that tolerate this form of sexual abuse supports an environment that places those vulnerable children at risk of significant harm.

*Keep eyes wide open – things will be spotted!*

Any child in danger should be reported to the local authorities or it is also possible to call one of the ChildSafe hotlines widely promoted in this region.

**19.1.10** Global tourism is big business. A significant number of people from within the UK travel abroad throughout the year and London has one of the busiest airports in the world bringing people to or through the UK. Travellers who think carefully and choose services that are ChildSafe can make a real difference.

**19.1.11** It is not just internationally that ChildSafe has a role that could be incredibly important. The question has to be asked about whether the circumstances that occurred in Rochdale or Rotherham, in relation to child abuse and exploitation, could and would have occurred if there were a ChildSafe network in place...?

#### 19.1.12 Recommendation TWENTY-ONE

The ChildSafe initiative, and other similar schemes, should be promoted by the UK travel industry when products they sell, including flights, hotels and packages, involve travel to areas where child protection issues are abundant and children are at significant risk of harm from issues such as sexual abuse, sexual exploitation and child labour. A pilot region-specific ChildSafe initiative should be introduced, and evaluated, in the UK to contribute towards better protecting children who might be at risk of exploitation in that particular area.



# Travel itinerary



***"I am prepared to go anywhere, provided it be forward."***

David Livingstone, 1813-1873

## About this chapter

This chapter details the international meetings that led to the production of this report and highlights the organisations visited during the Winston Churchill Memorial Trust Fellowship travels.

## 20.0 Itinerary

### 20.1 Map



Figure 29: Map of work-related flights

### 20.2 Detailed diary

Dates	Activity
3 & 4 March 2014	Pre-fellowship planning visit to Phnom Penh, Cambodia to lecture at the Child Exploitation and Online Protection (CEOP) <a href="#">Regional Workshop</a> on Safeguarding Vulnerable Children in Emergency Medicine, to undertake an initial scoping questionnaire with participants and to network with contacts for the next stage of the Fellowship project.
13 April 2014	Formal Fellowship travels began. Flight from Manchester to Austin, Texas, USA
14 April 2014	Child Abuse, Resource and Education Program ( <a href="#">CARE</a> ), Dell Children's Medical Center of Central Texas, 4900 Mueller Boulevard, Austin, Texas, 78723, USA
15 April 2014	<a href="#">Center for Child Protection: A children's advocacy center</a> , 8509 FM 969 Bldg 2, Austin, Texas, 78724, USA
16 & 17 April 2014	<a href="#">Emergency Department</a> , Dell Children's Medical Center of Central Texas, 4900 Mueller Boulevard, Austin, Texas, 78723, USA
18 April 2014	<a href="#">Heman Marion Sweatt</a> , Travis County Courthouse, 1000 Guadalupe, Austin, Texas, 78701, USA
19 – 21 April 2014	Easter weekend in Paris, Texas, USA with the Sharrock/Pursifull family
22 April 2014	<a href="#">Child Protection Team</a> , Phoenix Children's Hospital, 1919 E Thomas Road, Phoenix, Arizona, 85016, USA
23 April 2014	<a href="#">Trauma Team</a> , Phoenix Children's Hospital, 1919 E Thomas Road, Phoenix, Arizona, 85016, USA
24 April 2014	<a href="#">Childhelp</a> , Children's Advocacy Center, 2120 North Central Avenue, Suite 130, Phoenix, Arizona, 85004, USA
25 April 2014	<a href="#">Crews'n Healthmobile</a> , <a href="#">UMOM Family Shelter</a> , 3333 East Van Buren Street, Phoenix, Arizona, USA
28 April 2014	<a href="#">Department of Human Services</a> , 1515 Arch Street, Philadelphia, Pennsylvania, 19102, USA
29 April 2014	<a href="#">The Pennsylvania State Capitol Building</a> , Harrisburg, Pennsylvania, 17120, USA

30 April 2014	<a href="#">Child Protection Team</a> , Children's Hospital of Philadelphia, 34 <sup>th</sup> Street and Civic Center Boulevard, Philadelphia, Pennsylvania, 19104, USA
1 May 2014	<a href="#">Safe Place</a> : The Center for Child Protection and Health, Children's Hospital of Philadelphia, 34 <sup>th</sup> Street and Civic Center Boulevard, Philadelphia, Pennsylvania, 19104, USA
2 May 2014	Philadelphia (Report writing, consolidation and reflection)
5 May 2014	Denver (Report writing, consolidation and preparing for the week)
6 May 2014	<a href="#">The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect</a> , Children's Hospital of Colorado, 13123 E 16 <sup>th</sup> Avenue, B390, Aurora, Colorado, 80045, USA <a href="#">Emergency Department</a> , Children's Hospital of Colorado, 13123 E 16 <sup>th</sup> Avenue, Aurora, Colorado, 80045, USA
7 May 2014	<a href="#">The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect</a> , Children's Hospital of Colorado, 13123 E 16 <sup>th</sup> Avenue, B390, Aurora, Colorado, 80045, USA <a href="#">National Association of Counsel for Children</a> , 13123 E 16 <sup>th</sup> Avenue, B390, Aurora, Colorado, 80045, USA
8 & 9 May 2014	<a href="#">The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect</a> , Children's Hospital of Colorado, 13123 E 16 <sup>th</sup> Avenue, B390, Aurora, Colorado, 80045, USA
20 – 22 May 2014	<a href="#">Children's Emergency Department</a> , KK Women's and Children's Hospital, 100 Bukit Timah Road, Singapore, 229899
23 May 2014	<a href="#">Children's Emergency Department</a> , KK Women's and Children's Hospital, 100 Bukit Timah Road, Singapore, 229899 <a href="#">Ministry of Social and Family Development</a> , 512A Thomson Road, #02-01/09 SLF Podium, Singapore, 298137
24 May 2014	Singapore (Blog writing)
26 May 2014	<a href="#">Institute of Paediatrics</a> , Hospital Kuala Lumpur, Jalan Pahang, 50586, Kuala Lumpur, Malaysia <a href="#">Ministry of Health</a> , Federal Government Administration Centre, 62590, Putrajaya, Malaysia
27 May 2014	<a href="#">Institute of Paediatrics</a> , Hospital Kuala Lumpur, Jalan Pahang, 50586, Kuala Lumpur, Malaysia
28 May 2014	Delivering grand round at <a href="#">Hospital Kuala Lumpur</a> , Jalan Pahang, 50586, Kuala Lumpur, Malaysia <a href="#">Emergency Department</a> , Hospital Kuala Lumpur, Jalan Pahang, 50586, Kuala Lumpur, Malaysia
29 May 2014	Delivered safeguarding training to <a href="#">MCRI</a> and <a href="#">British High Commission</a> staff at <a href="#">HELP University</a> , Jalan Damansutra, Pusat Bandar Damansara, 50490 Kuala Lumpur, Wilayah Persekutuan Kuala Lumpur, Malaysia <a href="#">PS the Children</a> , No. 5, Jalan 7/14, Section 7, 46050, Petaling Jaya, Selangor, Malaysia
30 May 2014	Meeting with The Honourable <a href="#">Minister for Women, Family and Community Development</a> , Level 38, Number 55, Persiaran Perdana, Presint 4, 62100, Putrajaya, Malaysia
31 May 2014	<a href="#">Hospital Raja Permaisuri Bainun</a> , Jalan Hospital, 30990, Ipoh, Perak, Malaysia <a href="#">Perak State Welfare Department</a> , Jabatan Kebajikan Masyarakat Negeri Perak, Lot 1516, Jalan Panglima Bukit Gantang Wahab, 30000 Ipoh, Perak Darul Ridzuan, Malaysia
3 – 5 June 2014	<a href="#">M'Lop Tapang</a> , Sihanoukville, Cambodia
10 – 11 June	The International Conference on Emergency Medicine ( <a href="#">ICEM 2014</a> ), Hong Kong Convention and Exhibition Centre
12 June 2014	Delivered safeguarding training to <a href="#">British Consulate</a> , some <a href="#">FVEY</a> representatives and other friendly missions staff in Hong Kong, 1 Supreme Court Road, Admiralty, Hong Kong
13 June 2014	Delivered invited lecture on Safeguarding Vulnerable Children at <a href="#">ICEM 2014</a>
15 – 16 June 2014	Singapore (Report writing, consolidation and reflection)
19 June 2014	Flight from Singapore to London, UK
20 June 2014	Flight from London to Manchester, UK. Formal Fellowship travels ended.

# The USA, Singapore, Malaysia and Cambodia



*"We shall not cease from exploration, and the end of all our explorations will be to arrive where we started and know the place for the first time."*

Thomas Elliott OM, 1888-1965

## About this chapter

This chapter summarises the experiences gained in the USA, Singapore, Malaysia and Cambodia which have been used as a basis for the creation of this report.

## 21.0 United States of America

<b>Area:</b>	9 629 091 km <sup>2</sup>
<b>Population (2013):</b>	316 513 000
<b>Population density (2013):</b>	32.8 per km <sup>2</sup>
<b>Time zone:</b>	GMT -4 to GMT -10
<b>GDP per capita 2013:</b>	\$52839
<b>GDP total 2013:</b>	\$16724.272 billion <sup>278</sup>

\*GDP = Gross Domestic Product in United States Dollars (USD).



### 21.1 Austin, Texas

<b>Texas Area:</b>	696 241 km <sup>2</sup>
<b>Texas Population:</b>	26 448 193
<b>Population density:</b>	38 per km <sup>2</sup>
<b>Time zone:</b>	GMT -5 to GMT -7
<b>Median Household Income (2013):</b>	\$41225 (1 person household) per annum <sup>279</sup>

Monetary figures in USD.



Figure 30: Map of USA showing Austin, Texas

#### 21.1.1 Mandatory Reporting of Child Abuse in Texas

##### Professionals required to report suspected child abuse and neglect<sup>xxxviii</sup>

The following persons are required to report:

- Professionals (including teachers or daycare employees, nurses, doctors, employees of a clinic or health-care facility that provides reproductive services, juvenile probation officers or juvenile detention or correctional officers) who are licensed or certified by the State or who are an employee of facilities licensed, certified or operated by the State and who, in the normal course of official duties or duties for which licensure or certification is required, have direct contact with children.



Figure 31: Texas State Flag

<sup>xxxviii</sup> Family Code §261.101



### 21.1.2 Reporting by other persons

- A person who has cause to believe that a child has been adversely affected by abuse or neglect shall immediately make a report.

### 21.1.3 Institutional Responsibility to Report

- A professional may not delegate to or rely on another person to make the report.

### 21.1.4 Austin

The Center for Child Protection, a nationally accredited Children's Advocacy Center, is the first stop for children who are suspected victims of sexual abuse, physical abuse, and neglect and for children who have witnessed a violent crime. The center is a child-friendly, specially equipped facility where children can have forensic interviews, medical examinations, counselling and follow up treatment during, and after, the investigation and prosecution of child abuse cases.



*Figure 32: Giving abused children a voice: Christopher's Chair<sup>xxxxix</sup>, Center for Child Protection, Austin, Texas*

**21.1.5** The center offers a comprehensive educational programme to professionals, parents and community organisations on the identification, reporting and preventing of child abuse.

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<sup>xxxxix</sup> Christopher's Chair is named for [Christopher Wohlers](#) – a 20 month old child who was beaten to death in Austin in 1990. A series of system failures were associated with his death.



**21.1.6** The following services are provided by the Center for Child Protection in both English and Spanish:

- Forensic interviews
- Forensic medical examinations
- Crisis intervention
- Individual and family therapy
- Court orientation
- Multi-disciplinary team assessments of cases
- Case tracking and follow up
- Case management and assessment
- Emergency funding and direct assistance
- Protective parenting groups
- Physical abuse assessment
- Referrals for psychiatric services
- Community outreach and education
- Mandated reporter education

**21.1.7** Since the center opened in 1989 there have been 70192 services provided to children, 40207 services provided to adults and 13150 forensic interviews for children. Looking specifically at the services provided in 2012, 2063 children received 5515 services (such as individual therapy and case management), 1344 adults received 4820 services (such as parent coaching and group therapy) and 784 children received forensic interviews.



*Figure 33: Center for Child Protection, Austin, Texas*



**21.1.8** In 2012, 70% of children attended for possible sexual abuse, 15% for possible physical abuse, 13% because they had witnessed violent crimes and 2% for multiple reasons. In 21% of cases domestic abuse was involved and 92% of children who were seen at the center knew the person who had allegedly harmed them. 65% of children were female and 35% male with 24% being aged under 6 years, 63% between 6-13 years and 13% aged over 13 years.

**21.1.9** The mission of the center is to reduce the trauma for children during the investigation and prosecution of child abuse cases through specialised services and treatment. Additionally the center strives to educate the community on the identification of child abuse so that together the cycle of abuse can be ended with a new generation.

**21.1.10** In 2012 around 3.8 million children in the USA were reported to child protective services with concerns regarding child abuse. Around one fifth were substantiated and 678810 victims of child abuse and neglect were recorded in the USA during that year, representing 9.2 victims per 1000 children. Over 75% of these suffered from neglect, over 15% from physical abuse and just under 10% from sexual abuse. Emotional abuse was not recorded as a discrete category at a national level although states could record this locally so it is difficult to be sure exactly how the national statistics were derived and into which category those cases of emotional abuse were placed, if any. Sadly, around 1640 children died from abuse and neglect that year giving a fatality rate of 2.2 deaths per 100000 children<sup>280</sup>.



*Figure 34: Dell Children's Medical Center, Austin, Texas*





**21.1.11** In Texas, during 2013, there were 229334 separate reports of alleged abuse or neglect of children reported from the following sources:

- 18.5% of reports from medical personnel
- 12.5% of reports from schools
- 12.2% of reports from relatives
- 11.5% of reports from law enforcement officers
- 45.4% of reports from other sources (combined)

**21.1.12** The 2013 child population of Texas was 7159172 meaning that on average 3.2% of children were referred to child protective services for assessment that year. Within the Texas Family Code there are defined different categories of abuse or neglect that can be investigated by Child Protective Services<sup>281</sup>:

- *Physical Abuse*: physical injury that results in substantial harm to the child or genuine threat of substantial harm from physical injury to the child...
- *Sexual Abuse*: sexual conduct harmful to a child's mental, emotional or physical welfare, including conduct that constitutes the offense of indecency...
- *Emotional Abuse*: mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning...
- *Neglectful Supervision*: placing the child in or failing to remove the child from a situation that a reasonable person would realise requires judgement or actions beyond the child's level of maturity, physical condition or mental abilities and that results in bodily injury or a substantial risk of immediate harm to the child...
- *Medical Neglect*: failing to seek, obtain or follow through with medical care for a child with the failure resulting in, or presenting a substantial risk of, death, disfigurement or bodily injury...



- *Physical Neglect*: failure to provide the child with food, clothing or shelter necessary to sustain the life or health of the child...
- *Refusal to Assume Parental Responsibility*: failure by the person responsible for the child's care, custody or welfare to permit the child to return to the child's home without arranging for the necessary care for the child after the child has been absent from the home for any reason...
- *Abandonment*: the leaving of a child in a situation where the child would be exposed to a substantial risk of physical or mental harm...

**21.1.13** Having spent time with an Assistant District Attorney involved in the prosecution of alleged child abuse cases, and having spent time in Court in Texas, it was a matter of great surprise that children, except in extenuating circumstances where special permission has to be applied for, have to give evidence against an alleged perpetrator from the witness box in Court.

**21.1.14** In the UK for all child witnesses there is a presumption that they will give their evidence in chief by video recorded interview and any further evidence by live link unless the Court is satisfied that this will not improve the quality of the child's evidence<sup>282</sup>.

**21.1.15** A child witness may opt out of giving their evidence by either video recorded interview or by live link or both, subject to the agreement of the Court. If the child witness opts out then there is a presumption that they will give their evidence in Court from behind a screen. Should the child witness not wish to use a screen they may also be allowed to opt out of using it, again subject to the agreement of the Court. In deciding whether or not to agree to the wish of the child witness the Court must be satisfied that the quality of the child's evidence will not be diminished.



**21.1.16** The protection of children in legal cases where they may be required to give evidence against an alleged perpetrator, who may be a relative, is of the utmost importance. Despite the fantastic facilities provided at the Center for Child Protection, and the excellent clinical services provided by the medical and nursing teams (both Emergency Medicine and Child Protection) at Dell Children's Hospital, it is disappointing that children often have to give evidence in USA Courts from inside the Court room rather than remotely.

**21.1.17 International Recommendation THREE**

**The USA should review legislation to facilitate the ability of children to be able to routinely give evidence in chief by pre-recorded video and to be able to be cross-examined by remote video link, preferably from outwith the Court building.**

**21.1.18** Even in the UK many of the rooms which enable video link evidence to be given are in the same building as the Court room where the case is being heard. Being made to go to a Court building can be a terrifying experience for a child as it can be an intimidating environment where children fear seeing or coming into contact with, their alleged attacker. This can make it much harder for them to give evidence and to get the justice that they deserve<sup>283</sup>.

**21.1.19** In 2013 the NSPCC helpline in the UK helped 1200 children who were deeply concerned about giving evidence in Court. This was a greater than 10% increase on the year previously. In a bid to help these children the NSPCC have launched an *Order in Court* campaign which aims to help reduce the distress that children feel when participating in criminal proceedings.



**21.1.20** For over 25 years it has been recommended that no young witness should be required to appear in Court during a trial unless he or she wished to do so yet in the UK at the moment whilst there is availability of video link for children many of the facilities for this are in the Court building which can terrify children. There are only a small number of video link sites around the country that allow children to give their evidence remotely from outwith the Court building and, as at June 2014, for example, according to the NSPCC there were none in London.

**21.1.21** The [NSPCC's Order in Court campaign](#) has called for the ability for all young witnesses to be able to give evidence from a building away from the Court premises and for compulsory training for lawyers and barristers involved in child sexual abuse cases

**21.1.22 Recommendation TWENTY-TWO**

**Judges and lawyers involved in all child abuse cases should be required to undertake mandatory specialist training. The public, and professionals involved in child protection work, should support the NSPCC's campaign *Order in Court* to try to ensure that in every region there is at least one remote site for children to be able to give evidence from outwith the Court building.**



## 21.2 Phoenix, Arizona

Arizona Area:	295 234 km <sup>2</sup>
Arizona Population:	6 626 624
Population density:	22 per km <sup>2</sup>
Time Zone:	GMT -6 to GMT -7
Median Household Income (2013):	\$42107 (1 person household) per annum <sup>279</sup>

Monetary figures in USD.



**Figure 35: Map of USA showing Phoenix, Arizona**

### 21.2.1 Mandatory Reporting of Child Abuse in Arizona

#### Professionals required to report suspected child abuse and neglect<sup>xl</sup>

The following persons are required to report:

- Physicians, Physicians Assistants, Optometrists, Dentists, Behavioural Health Professionals, Nurses, Psychologists, Counsellors or Social Workers
- Peace Officers, Child Welfare Investigators, or Child Protective Services Workers
- Members of the Clergy, Priests or Christian Science Practitioners
- Parents, Step-parents or Guardians
- School personnel or Domestic Violence Victims Advocates
- Any other person who has responsibility for the care or treatment of minors



**Figure 36: Arizona State Flag**

### 21.2.2 Reporting by other persons

- Any other person who reasonable believes that a minor is a victim of abuse or neglect may report

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<sup>xl</sup> Revised Statutes §13-3620



### 21.2.3 Phoenix

Phoenix, Arizona is a city of 517 square miles, stretching 67 miles across. With a city population of around 1.5 million people and a Metropolitan Area containing 4.5 million people, Phoenix is the 6th most populous city in the United States of America.



Figure 37: Phoenix Children's Hospital, Arizona

21.2.4 The week spent in Phoenix, avoiding rattlesnake bites, offered excellent insight into the significant benefits that nurse practitioners can bring to a child protection service, both from a research, educational and clinical point of view, and how skilled forensic interviewers are a crucial component of the USA's version of the achieving best evidence from children process<sup>284</sup>.

21.2.5 Over 8000 children and young people aged 14-24 years are homeless in Phoenix each year. Regardless of the demographics of these individuals all of them are at increased risk of illness (both physical and mental), injuries, exploitation, sexual exploitation, trafficking and all other forms of abuse. Most of them lack health insurance and don't have access to appropriate health care.

21.2.6 In 2000, an innovative partnership was formed between Phoenix Children's Hospital<sup>285</sup>, Children's Health Fund<sup>286</sup> and HomeBase Youth Services<sup>287</sup> resulting in the *Crews'n Healthmobile*, a 35-foot Mobile Medical Unit (MMU) that brought free, comprehensive medical help directly to this special population living in Phoenix.



Figure 38: Crews 'n Healthmobile II, Phoenix Children's Hospital project



**21.2.7** In October 2007, *Crews'n Healthmobile II* hit the streets. This 38-foot MMU has three examination rooms and the latest technology to be able to provide point of care testing and link to the individual electronic patient record.

**21.2.8** 100% of the children and young people living on the streets of Phoenix are below the Federal poverty line. It is all too common for them to pay for food or a place to stay with sex as this may be the only resource this incredibly vulnerable group of people have available to them. The Crews'n Healthmobile is a fantastic non-judgmental resource which takes free and comprehensive healthcare directly to the children and young people in whichever area of the city they may currently be in.

**21.2.9** In addition to the mobile unit, Crews'n staff manage the UMOM Wellness Center<sup>288</sup> on the campus of the UMOM New Day Family Shelter<sup>289</sup>. This shelter accepts people in family units of whatever they consider their family to be. The Center does not discriminate against people because of the family situation that they are living in.

**21.2.10** A significant number of the people using this service have substance misuse problems, have limited, if any, financial resources and many have escaped from violent and abusive relationships. At any one time there can be up to 500 children staying overnight in this shelter and the staff have a key role in helping to protect those vulnerable young people from abuse.

**21.2.11** 20% of the adolescents in the shelter programme hear voices (auditory hallucinations) and at least 40% of the girls have been sexually abused prior to coming there.



**21.2.12** Working with families on the edge means that professionals could be in a situation where a Child Protective Services (CPS) referral could be warranted on an incredibly frequent basis but the system is overwhelmed.

**21.2.13** Staff need to maintain a working relationship with the families they are there to protect, support and re-integrate. These professionals may be the only stability that a family, parent or young person has. The staff are continually advancing their education, skills and knowledge so that they can provide immediate help to families in crisis to de-escalate incredibly volatile situations to ensure the protection of children and to help ensure that the healthcare needs of all members of the family are assessed and addressed with a friendly and welcoming approach.

**21.2.14** Many of the families are living in a continual state of crisis, at least during the early stages following arrival at the shelter. They live in concrete worlds with no sugar coating and the staff have to be realistic, pragmatic and clear with them. Many of them have so many people already trying to input into their lives that they don't know if they are coming or going. If they don't even know where dinner is coming from that night, or even if there will be a dinner that night, it is no wonder that they find it difficult to engage with a plurality of services many of which, not least the health insurance sector, can be difficult, or impossible, to understand.



*Figure 39: Andrew and Dr Cody Conklin-Aguilera, Crews 'n Healthmobile II, Phoenix, Arizona*





**21.2.15** The dedication and expertise of the Crews'n staff is amazing and their collective passion to do the best they can, and to provide the highest quality of care, for the children and families they interact with, regardless of what the rules or regulations might try to prevent, hamper or interfere with, is outstanding and they are a clear beacon of good practice in holistic healthcare. The staff have clear tenacity to succeed whatever barriers may be placed in their way and there are lessons for everyone in the way that they conduct themselves and the way that they stay enthusiastic and dedicated despite significantly challenging working conditions.

**21.2.16** If the city of Phoenix were to be overlaid across the North of England, the diameter at its widest part would stretch almost from Manchester to Leeds. The need for a mobile health unit, such as the Crews'n Healthmobile, is clear in Phoenix not just because of the geography of the city but because of the socio-economic status of many people living within it, including those who are homeless, and the difficulties many people face accessing reliable public transport to get them to and from locations where their health needs can be cared for.

**21.2.17** The sheer size of the Crews'n Healthmobile would make it difficult to manoeuvre around many UK cities but there are parallels than can be drawn from the fantastic service that the Crews'n Healthmobile staff provide to the children, young people and families in Phoenix, and the kind of exemplary service that children and families deserve to receive in the UK. People living in very rural areas, away from metropolitan hubs, should question whether they can access the same high standard of care that others have available:



- Those people that cannot access services distant from where they are situated should, wherever possible, have services provided to them at a location they can access even if that means breaking down traditional or long-standing barriers between different parts of the health sector or the interaction between health and social care.
- Those people who may not have English as their first language, or who may not understand the intricacies of the UK health service should be guided through the processes to help them to get the best possible care from the services they access.
- Healthcare staff are not immigration police and should not be expected, or required, to place someone's immigration status above urgent and emergency healthcare needs.
- Families, children and young people with complex and multiple needs, be they health, social care or a mixture of both, need one lead person to advocate on their behalf and to simplify and streamline the services offered and provided.

**21.2.18** Initiatives such as “hospital at home” teams or “children’s community nursing” teams are two examples of how services can be commissioned to provide more care in the community or at home, freeing up secondary care services for those patients who definitely need to be in hospital, and providing high quality care that is convenient to patients.

#### **21.2.19** **Recommendation TWENTY-THREE**

**Economically viable services should be commissioned which allow patients who might have difficult accessing healthcare in a hospital setting to have their care provided more locally in the community.**



## 21.3 Philadelphia, Pennsylvania

<b>Pennsylvania Area:</b>	119 283 km <sup>2</sup>
<b>Pennsylvania Population:</b>	12 773 801
<b>Population density:</b>	107 per km <sup>2</sup>
<b>Time Zone:</b>	GMT -4 to GMT -5
<b>Median Household Income (2013):</b>	\$47439 (1 person household) per annum <sup>279</sup>

Monetary figures in USD.



**Figure 40: Map of USA showing Philadelphia, Pennsylvania**

### 21.3.1 Mandatory Reporting of Child Abuse in Pennsylvania

#### Professionals required to report suspected child abuse and neglect<sup>xli</sup>

Persons required to report include, but are not limited to:

- Licensed physicians, osteopaths, medical examiners, coroners, funeral directors, dentists, optometrists, chiropractors, podiatrists, interns, nurses or hospital personnel
- Christian Science practitioners or members of the clergy
- School administrators, teachers, school nurses, social services workers, day care centre workers, or any other child care or foster care workers
- Mental health professionals
- Peace officers or law enforcement officials



**Figure 41: Pennsylvania State Flag**

### 21.3.2 Reporting by other persons<sup>xlii</sup>

- A person who has reason to suspect that a child is abused or neglected may make a report.

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<sup>xli</sup> Cons. Stat. Tit. 23 §6311

<sup>xlii</sup> Cons. Stat. Tit. 23 §6312



### **21.3.3 Institutional Responsibility to Report<sup>xliii</sup>**

Whenever a person is required to report in his or her capacity as a member of the staff of a medical or other public or private institution, school, facility, or agency, that person shall immediately notify the person in charge of the institution, school, facility or agency or the designated agent of the person in charge. Upon notification the person in charge or the designated agent, if any, shall assume the responsibility and have the legal obligation to report or cause a report to be made in accordance with §6313. This chapter does not require more than one report from any such institution, school, facility or agency.

### **21.3.4 Philadelphia**

Child maltreatment prevention services are in existence in society today and include a number of activities: public awareness activities, skills-based curricula for children, home visitation programmes, respite and crisis care programmes, and family resource centres<sup>290</sup>.



*Figure 42: State Capitol Building, Harrisburg, Pennsylvania*

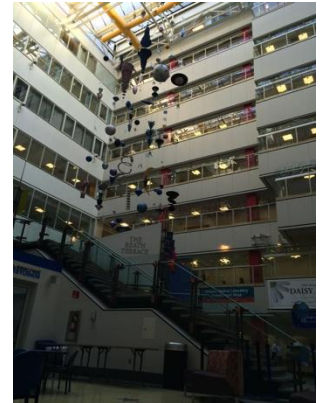
**21.3.5** A number of themes were hypothesised during the visit to Philadelphia as to why the levels of child maltreatment in the USA are such that they are:

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<sup>xliii</sup> Cons. Stat. Tit. 23 §6311



- Social isolation including isolation within big cities, not just rural areas
- Estranged families
- Crime levels
- Violence within society
- Corporal punishment of children
- Lack of gun control
- Gang activity
- Chronic stress within a community
- Lack of ability to protect a child and to effectively parent
- Social deprivation
- Economic deprivation and poverty



**Figure 43:** Atrium, Children's Hospital of Philadelphia (CHOP), Pennsylvania

**21.3.6** It is important to be alert to the factors which might make children at higher risk of maltreatment and to target specific questions to their caregivers to look for alcohol or drug misuse, domestic violence or mental health problems. One of the really effective ways to obtain information relevant to the assessment of the child is to ask the care givers, *"what was it like for you when you were growing up?"*

**21.3.7** The use of open ended questions can be helpful in assessing children particularly when there is a possibility of higher risk of harm than other children or if the child has presented with behavioural problems.

**21.3.8** Separate to asking questions of children, the issue of screening in Emergency Departments for inter-partner (domestic) violence is something that has been evaluated in relatively recent studies. The efficacy (of reducing short-term re-victimisation) of an Emergency Department brief intimate-partner-violence screening intervention was evaluated in a study in New Zealand.



**21.3.9** A randomised controlled trial with blinded three-month follow up was conducted in an urban Emergency Department. Participants received usual emergency health care but those in the treatment group also received a standardised three-item intimate partner violence screen, statements about the unacceptability of violence, risk assessment and referral by a health professional research assistant. The main outcome measure was self-reported intimate partner violence exposure with secondary outcomes including self-care strategies. The screening intervention did not significantly reduce short-term violence exposure and it was recommended that continuing work is needed to maximise the effectiveness of such screening interventions and to monitor medium- and long-term outcomes<sup>291</sup>.

**21.3.10** A USA study looking at the effectiveness of computerised screening for inter-partner violence plus provision of a partner violence resource list versus provision of a partner violence resource list only was conducted on women presenting in primary health care settings. At 1-year follow-up, there were no significant differences in the quality of life physical health component between the screen plus partner violence resource list group, the partner violence resource list only group, and the control group, or in the mental health component of any group. There were also no differences between groups in days unable to work or complete housework; number of hospitalizations, emergency department, or ambulatory care visits; proportion who contacted a partner violence agency; or recurrence of partner violence. It was concluded that among women receiving care in primary care clinics, providing a partner violence resource list with or without screening did not result in improved health<sup>292</sup>.

**21.3.11** Thanks to an inspirational Grand Round presentation and workshop by Professor Harriet MacMillan from McMaster University, Hamilton, Ontario, Canada it has been possible to consider the effectiveness of various child maltreatment and risk assessment screening programmes as well as to look at some specific questions that can be used to assess children, particularly those who present with behavioural problems, for a risk of abuse:



- Who are you worried about in your family?
- Sometimes in families people get hurt. What about in your family?
- I'm wondering whether there was ever a time that someone in your family was hurt
- Has anything happened to someone you know that they did not want to happen to them?
- I'm just wondering if anything else might have happened?
- What happens when someone gets into trouble in your house?
- What is it like at home?
- What do you do together with the rest of your family?
- What are you frightened about?
- What are you worried about?
- What happens if you are hurt?

**21.3.12** Although domestic (inter-partner) violence screening has been endorsed by many health organisations and there are examples of such interventions in place in the UK, there is insufficient evidence that it has beneficial health outcomes. There is a difference between offering something because it is thought that it will work and offering something because the full evidence behind it has been established. In the absence of any evidence that an intervention, such as domestic violence screening, causes any harm it is possible to advocate for it now but there is an associated responsibility in such situations to undertake a formal evaluation to assess the effectiveness of that intervention.

**21.3.13** **Recommendation TWENTY-FOUR**

**Domestic (inter-partner) violence interventions being undertaken in Emergency Departments should be subject to validation and a multi-centre research study should be undertaken looking at their short-term, medium-term and long-term benefits.**



## 21.4 Aurora, Denver, Colorado

Colorado Area:	269 837 km <sup>2</sup>
Colorado Population:	5 268 367
Population density:	19.5 per km <sup>2</sup>
Time Zone:	GMT -6 to GMT -6
Median Household Income:	\$49549 (1 person household) per annum <sup>279</sup>

Monetary figures in USD.



Figure 44: Map of USA showing Aurora (Denver), Colorado

### 21.4.1 Mandatory Reporting of Child Abuse in Colorado

#### Professionals required to report suspected child abuse and neglect<sup>xliv</sup>

Persons required to report include:

- Physicians, surgeons, physicians in training, child health associates, medical examiners, coroners, dentists, osteopaths, optometrists, chiropractors, podiatrists, nurses, hospital personnel, dental hygienists, physical therapists, pharmacists, registered dieticians
- Public or private school officials or employees
- Social workers, Christian Science practitioners, mental health practitioners, psychologists, professional counsellors, marriage and family therapists
- Vets, peace officers, fire fighters or victim's advocates
- Commercial film and photographic print processors
- Counsellors, marriage and family therapists or psychotherapists
- Clergy members, including priests; rabbis; duly ordained, commissioned or licensed ministers of a church; members of religious orders; or recognised leaders of any religious bodies
- Workers in the State Department of Human Services



Figure 45: Colorado State Flag

<sup>xliv</sup> Rev. Stat. §19-3-304





- Juvenile parole and probation officers
- Child and family investigators
- Officers and agents of the State Bureau of Animal Protection and animal control officers
- The child protection ombudsman
- Educators providing services through a Federal special supplemental nutrition programme for women, infants and children
- Directors, coaches, assistant coaches, or athletic programme personnel employed by private sports organisations or programs
- Persons registered as psychologist candidates, marriage and family therapist candidates or licensed professional counsellor candidates
- Emergency medical service providers

#### **21.4.2 Reporting by other persons<sup>xlv</sup>**

- Any other person may report known or suspected child abuse or neglect.

#### **21.4.3 Institutional Responsibility to Report**

- This issue is not addressed in the statutes.

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<sup>xlv</sup> Rev. Stat. §19-3-304



#### 21.4.4 Aurora, Denver

The Kempe Center opened in 1972 with one vision: to recognize that children were being abused, that the threat was real, and that something must be done about it. As a section of the Department of Pediatrics at the University of Colorado School of Medicine, The Kempe Center has built a reputation as a world leader in child protection by:

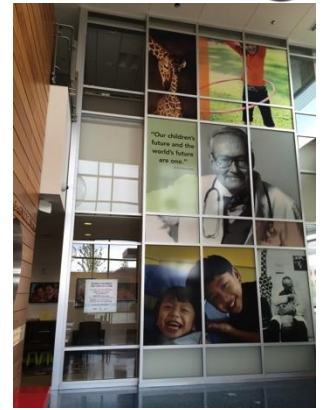


Figure 46: Dr C. Henry Kempe

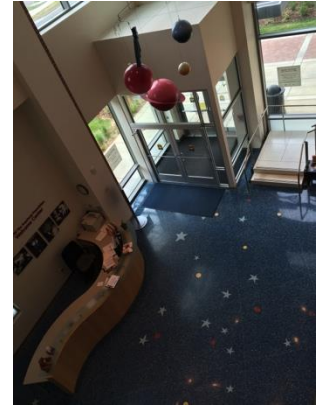
- Evaluating and diagnosing children who are suspected victims of abuse and neglect
- Providing treatment and therapy for abused and neglected children and their families
- Developing and testing new programs to help children
- Training professionals such as doctors, teachers and social workers to protect and heal abused children and support good parenting skills
- Conducting studies that assist in program development and public policy making

**21.4.5** Dr Kempe recognised that practitioners and professionals would need the help of the entire community to end child abuse. The Kempe Foundation was established and community leaders, philanthropists and business people were called upon to spearhead fundraising, awareness and advocacy efforts in order to recognise and do something about child abuse and neglect.



**21.4.6** In 2012 The Kempe Foundation celebrated its 40th anniversary. Their mission is to increase awareness, engage in advocacy and secure and provide resources for the prevention and treatment of child abuse.

**21.4.7** The Kempe Foundation recognises Dr Kempe’s view that to solve the problem of child abuse, it would take the collaborative efforts of trained multidisciplinary professionals working with elected officials and community leaders to raise awareness and secure the needed resources for this work<sup>293</sup>. There are a huge number of [programmes](#) available at The Kempe Center.



**Figure 47:** Atrium of Kempe Center, Aurora, Colorado

**21.4.8** In the USA, the National [Coalition](#) to prevent Child Sexual Abuse and Exploitation have developed a “*National Plan to Prevent the Sexual Abuse and Exploitation of Children*”<sup>xlvi</sup>

**21.4.9** The national plan pays special attention to primary prevention and positive youth development – actions that take place before child sexual abuse or exploitation has been perpetrated in order to:

- Decrease the future perpetration of child sexual abuse and exploitation
- Increase the engagement of effective bystander actions that can aid in the prevention of child sexual abuse and exploitation

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<sup>xlvi</sup> The content of the National Plan to Prevent the Sexual Abuse and Exploitation of Children has been reprinted, with permission, from the National Coalition to Prevent Child Sexual Abuse and Exploitation’s publication entitled *National Plan to Prevent the Sexual Abuse and Exploitation of Children* (2012 edition). This plan is available [online](#).



- Promote norms that support healthy behaviours, images and messages
- Promote environments and education that support healthy development, relationships, and sexuality
- Collaborate with media, businesses and policymakers to develop and implement strategies to prevent child sexual abuse and exploitation
- Challenge media messages that normalize and promote children as sexual objects
- Promote safe, stable, nurturing relationships for children in their homes and broader environments to decrease future risk of sexual abuse perpetration.

**21.4.10** The goals of prevention are attempted, within the plan, to be accomplished by six action areas:

*Research*

To promote the use of research to guide prevention practice and to serve as a catalyst for social change.

*Public Awareness*

To increase public awareness of effective child sexual abuse and exploitation prevention strategies.

*End the Demand*

To identify and reduce the factors that fuel the demand for children to be sexually exploited and abused and the conditions that create an environment where individuals are willing and able to cause or to profit from the sexual harm of children.



### *Policies and organisational practices*

To encourage the development and implementation of local, state and national policies, practices, norms, and beliefs that advance the primary prevention of child sexual abuse and exploitation and that strengthen comprehensive prevention measures.

### *Collaborative practices*

To promote creative multi-disciplinary and grassroots collaborations to align resources that will foster successful prevention initiatives.

### *Funding*

To increase the money invested in prevention and positive development in proportion to the harm done and the costs of child sexual abuse and exploitation.

**21.4.11** The plan sets out key things that individuals in society can do (such as education, encouraging victims to speak up and looking for examples of exploitative practices and reporting these) as well as what communities can do (such as identification of warning signs, participating in research and engaging members of the community in preventative measures) to try and primarily prevent child abuse. Some of these themes are referred to indirectly in the chapter about protecting children from abuse being everyone's responsibility, **even yours!**

## 22.0 Singapore

<b>Area:</b>	716.1 km <sup>2</sup>
<b>Population 2013:</b>	5 431 000
<b>Population density 2013:</b>	7584 per km <sup>2</sup>
<b>Time Zone:</b>	GMT +8
<b>GDP per capita 2013:</b>	\$5298
<b>GDP total 2013:</b>	\$287.374 billion <sup>278</sup>
<b>Median household income 2013:</b>	\$75534 (in working households) per annum <sup>294</sup>

\*GDP = Gross Domestic Product. Monetary figures in USD.



### 22.1 Singapore

**22.1.1** KK Women's and Children's Hospital (KKH) has evolved, since its founding in 1858, into a regional leader in Obstetrics, Gynaecology, Paediatrics and Neonatology. The 830-bed hospital is a referral centre providing tertiary services to handle high-risk conditions in women and children.



**Figure 48: Map of Asia showing Singapore**

**22.1.2** More than 400 specialists adopt a multi-disciplinary and holistic approach to treatment, and harness the latest innovations and technology for the best medical care possible.



**Figure 49: Map of Singapore<sup>297</sup>**

**22.1.3** As an academic healthcare institution, KKH believes that world-class clinical training and research are imperative in raising the standard of care. Hence, KKH has adopted a culture of innovation as it strives for world-class clinical leadership.

**22.1.4** As KKH continually raises the bar on clinical excellence, they are sensitive to their patients' needs for a pleasant hospital experience – one where patients receive seamless service and enjoy the warmth of compassionate care in a healing environment<sup>295</sup>.



**22.1.5** In an incredibly efficiently run Emergency Department seeing up to 500 children per day, the clinicians are taught to be vigilant about the possibility of child abuse and are given a series of diagnostic clues to look out for when assessing each child<sup>296</sup>.



*Figure 50: Children's Emergency Department, KK Hospital, Singapore*

**22.1.6** Although this does not represent screening per se, having a series of clinical clues or warning signs to look out for is something that many of the departments visited during this project have adopted. The ones used in Singapore are to recommend a history should be taken in a non-accusatory but detailed manner, covering:

- Is there an unexplained or vaguely explained injury or condition?
- Do important details regarding the explanation change dramatically from one time to another?
- Are there repeated injuries or ingestions?
- Is there alleged self-inflicted injury?
- Is there a delay in seeking medical help?
- Has the child or parent accused the other parent or caregiver?
- Is there a history of drug abuse in the parents?
- Is there a history of mental illness in the caregiver?
- Is there a history of abrupt changes in the child's behaviour or school performance?
- Are there any accidents occurring between midnight and 6am?
- Are there any injuries that are inconsistent with the child's developmental capabilities?



**22.1.7** Of course, no system is perfect and there are still inter-agency difficulties when it comes to managing child protection cases and there are areas that can be focussed on to improve things for children who might have been abused. These include encouraging more paediatricians to become interested in child protection work and following up on the interest that was shown by the Ministry of Social and Family Development in learning more about the function of Multi-agency Safeguarding Hubs and the Adult and Child Sexual Assault Referral Centres that exist in the UK.

**22.1.8** The Emergency Department at KKH sees 176000 children per year aged under 16 years of age. Approximately 2-4% of these are priority one patients, 40% priority two patients and 56-58% priority three patients.

**22.1.9** The sheer size of the department, the running of it in a very similar manner to the way medicine is practised in the UK, the very high standards of care delivered and the efficient processing of patients and collecting of data makes KKH Children's Emergency Department a perfect research partner for the future.



*Figure 51: Pre-hospital care, Singapore*



## 23.0 Malaysia

<b>Area:</b>	329 847 km <sup>2</sup>
<b>Population 2013:</b>	29 957 000
<b>Population density 2013:</b>	90.8 per km <sup>2</sup>
<b>Time Zone:</b>	GMT +8
<b>GDP per capita 2013:</b>	\$10429
<b>GDP total 2013:</b>	\$312.413 billion (2013) <sup>278</sup>
<b>Median household income 2009:</b>	\$10739 <sup>298</sup> (\$18901 in 2012) per annum <sup>299</sup>

\*GDP = Gross Domestic Product. Monetary figures in USD.



### 23.1 Kuala Lumpur, Selangor

<b>Selangor Area:</b>	8104 km <sup>2</sup>
<b>Population:</b>	5 411 324
<b>Population density:</b>	668 per km <sup>2</sup>
<b>Time Zone:</b>	GMT +8
<b>Median Household Income 2009:</b>	\$16277 per annum <sup>298</sup>

Monetary figures in USD.



Figure 52: Map of Asia showing Malaysia

**23.1.1** Dating from 1870, Hospital Kuala Lumpur (HKL) has 53 different departments and is the biggest hospital under the control of the Ministry of Health in Malaysia. It is located on 150 acres of ground and has 83 wards and 2300 beds. There are around 200 Consultants and Specialists employed as part of the 7000 staffing level.



Figure 53: Map of Malaysia showing Kuala Lumpur<sup>303</sup>

**23.1.2** The Ministry recognises that it is not just the health, well-being and happiness of generations of children that are at stake if child abuse and neglect is left unattended, but at fundamental risk is also the future of the society that the children will construct out of their childhood experiences. Child abuse prevention and recognition is, therefore, incredibly important in Malaysia and the Ministry of Health *Guidelines for the Hospital Management of Child Abuse and Neglect* are a useful companion to anyone working in Paediatrics or Emergency Medicine<sup>300</sup>.



Figure 54: Selangor State flag



**23.1.3** A UNICEF investigation into the implementation of children's rights with equity in Malaysian society<sup>301</sup> concluded that behind overall progress over the last decade in the implementation of children's rights there are significant discrepancies – between states, between ethnic groups and, in some instances, between boys and girls.

**23.1.4** It is significantly worrying that young girls who become pregnant are sometimes classed as being beyond control and parents may request the Department of Social Welfare to place their daughters in a special Sekolah Tunas Bakti<sup>xlvii</sup>. Sometimes magistrates and child protectors have agreed to such placements for the protection of the girl through fear that the girl may be expelled from the family home and exposed to exploitation on the streets.

**23.1.5** UNICEF's further analysis of the system for prevention and response to abuse, violence and exploitation against children<sup>302</sup> in Malaysia recommended a number of areas to focus work on, including:

- Designing a comprehensive child and family welfare system
- Mapping out the roles of partner agencies
- Developing a clear outline of the structure for managing and implementing child and family welfare service delivery
- Reviewing policies and procedures for children without documents
- Professionalisation of social work

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<sup>xlvii</sup> Tunas Bakti – a reformatory institution under Section 61(1) of the Child Act 2001 for the rehabilitation and care of children who are involved in a crime or children who are unrestrained. The recovery period is one to three years but the child may be released prior to the expiration after more than one year with the approval of the board of visitors.

**23.1.6** The Malaysian Child Resource Institute (MCRI) was incorporated in 1993 as a non-governmental and not-for-profit organisation dedicated to promoting quality early childcare and education through training of child-based services. The results of the research survey conducted in collaboration with MCRI will be submitted to a peer-reviewed scientific journal for publication once a full analysis has taken place.



**Figure 55: Malaysian Child Resource Institute**

**23.1.7** MCRI supports the UN CRC in all aspects of its work and helped to form Protect and Save the Children (P.S. The Children), a major player in the child rights landscape in Malaysia. MCRI was also instrumental in establishing the Montessori Association of Malaysia (MAM). In addition, MCRI, especially through its founder, Mrs Liew Sau Pheng, has contributed to the development of child rights in Malaysia through numerous initiatives including workshops, training and awareness raising events.

**23.1.8** The mission of MCRI is to promote the healthy development of children by raising awareness on the Rights of the Child and advocating for better standards in the provision of early childhood care and education. They also provide research to inform and influence policy particularly monitoring and reporting on the UN CRC in Malaysia.

**23.1.9** P. S. The Children was set up by MCRI to create safer communities by establishing effective prevention education as well as by providing treatment and support services for child survivors and their families. They envisage a society that upholds the rights and dignity of all children through protection from sexual abuse and sexual exploitation.



**23.1.10** The core programmes available from P. S. The Children include policy development, personal safety education for children, capacity enhancement programmes for adults, healing service for survivors of child sexual abuse and exploitation and advocacy on child rights at a local, national and global level:



Figure 56: Institute of Paediatrics, Hospital Kuala Lumpur, Malaysia

#### *Prevention*

The organisation educates adults about the problem of child sexual abuse through awareness talks and training workshops. Children are helped to confront the issue of abuse and rights by equipping them with personal safety knowledge information via a personal safety programme. Research and public engagement helps the communities in which the organisation works to better understand the definition of child sexual abuse through the child's experiences.

#### *Support*

Children are supported through the reporting process and a holistic services is provided to clients in association with partner agencies.

#### *Treatment*

The healing process from child sexual abuse can take time and the organisation provides individual and/or group family therapy if required, on a case by case basis, together with drama, art, play and sand activities as appropriate according to the age of the child involved.

**23.1.11** The organisation has particular expertise at identifying children who might be at risk of, or who might have suffered from, trafficking or child sexual exploitation.



**23.1.12** There are a number of features that P. S. The Children have identified, through working in their community, any of which should raise the level of concern of potential child sexual abuse in one form or another:

- Sexualised behaviour or recurrent drawing of genitalia
- Exposing themselves, or masturbation, in public places
- Children who go missing
- Behavioural change
- Suicidal ideation and mental health presentations
- Children presenting with unexplained physical injuries
- Children who are reluctant to let others see their electronic devices or who have multiple online profiles that their carers may not be aware of
- Children who are involved in *sexting*<sup>xlviii</sup>

**23.1.13** These warning features are things that can, potentially, be identified by professionals working with children in any circumstances, not just in Emergency Departments.

**23.1.14** In the UK, the major police investigation Operation Span and the associated serious case review<sup>11</sup> into seven young people who suffered sexual exploitation in Rochdale highlighted a number of areas of improvement that ought to be tackled:



**Figure 57:** Tour of the Emergency Department, Hospital Kuala Lumpur, Malaysia

<sup>xlviii</sup> *Sexting* is the act of sending sexually-explicit text messages, or images, between two or more people – usually using a mobile telephone and/or a messaging application



- Recognise the importance of social issues on child protection
- Do not just focus on the immediate issues when assessing children
- Share information
- Document effectively
- Escalate concerns
- Communicate with colleagues about concerning behaviours

**23.1.15** Some questions that can be useful when talking to children to help explore issues or concerns raised include:

- Tell me what makes you feel safe
- When do you not feel safe?
- Who are you worried about?
- What worries you?
- Tell me about your family
- Tell me who you are worried about in your family
- What makes you feel sad?
- What makes you happy?
- What do you do when you feel sad? It is important to find out what the child's coping mechanism is

**23.1.16** [Flixton Girls School](#) in the UK has produced innovative work teaching their students about child sexual abuse and protection from child sexual exploitation and the basis of this educational programme can be tailored to use with other groups, including with professionals<sup>304</sup>.

**23.1.17** It is important to recognise that child sexual abuse is not something that solely affects girls nor is it something that does not affect people who do not identify themselves as heterosexual (or who may not identify as having any particular sexuality at present).

**23.1.18** Boys and the LGBT community can be forgotten as potential victims of child sexual abuse, exploitation and trafficking and this must be remembered.



**23.1.19** On 30 September 2014 the Academy of Medical Royal Colleges published their report<sup>14</sup> into improving recognition of, and response to, child sexual exploitation, particularly focussed on health settings. This report, combined with the experiences gained in Malaysia, have identified a number of vulnerabilities for children who might be at risk of, or who have suffered from, CSE including:

- Children who go missing from their home or school or who run away
- Children with unexplained physical injuries
- Attachment issues
- Homelessness
- Substance misuse (drugs or alcohol)
- Children with offending behaviour
- Disengagement from education
- Social isolation
- Low self esteem
- Socio-economic disadvantage
- Change in appearance
- Children involved in violent relationships with peers
- Children identifying as gay, lesbian, bisexual or transgender (LGBT)
- Children living in institutions
- Children living in chaotic households and in dysfunctional families
- History of abuse in families
- Bereaved children
- Children with learning difficulties or a disability
- Children living in a gang-affected neighbourhood
- Prior (sexual) abuse or neglect
- Peers who are sexually exploited



**23.1.20** Possible warning signs of potential CSE identified in Malaysia and in other reports<sup>14 305</sup> include:

- Children who go missing from their home or care
- Children with unexplained or repeated physical injuries
- Children with offending behaviour
- Worries about sexual health or pregnancy
- Change in physical appearance
- Evidence of sexual bullying or vulnerability through the internet or social networking sites
- Estranged from family
- Receipt of gifts from unknown sources

**23.1.21** Possible features of CSE which might be identified in healthcare settings in particular include<sup>14</sup>:

- Poor self care
- Injuries – especially if repeated or unexplained
- Sexually transmitted infections
- Contraceptive advice
- Pregnancy or termination of pregnancy
- Drug and alcohol problems
- Medically unexplained symptoms
- Emotional symptoms
- Trauma symptoms
- Self-harming behaviour
- Problem behaviours including risk-taking
- Problems in relationships

**23.1.22** A sensitive and careful risk assessment ought to take place if any of the warning features or vulnerabilities are identified in children presenting to professionals.





**23.1.23** The Academy of Medical Royal Colleges report identifies a number of good practice examples and six key components to improving the response of health professionals to child sexual exploitation:

- Training
- Awareness
- Recognition
- Response
- Supervision
- Support

**23.1.24** The Academy Child Sexual Exploitation Working Group<sup>14</sup> have made a number of useful recommendations including:

- Review of curricula by medical Royal Colleges and Faculties to ensure that CSE is appropriately reflected.
- That the Generic Capabilities Review, being led by the GMC, should include consideration of skills relevant to engaging with hard to reach young people.
- The medical Royal Colleges and Faculties should provide backing to individual members seeking to make contributions to tackling sexual exploitation. Following release of *Living on a Railway Line* it is hoped that the College of Emergency Medicine, the Royal College of Paediatrics and Child Health and other medical Royal Colleges and Faculties will be able to take advantage of this backing to move forwards with many of the recommendations contained within this report.
- The medical Royal Colleges and Faculties should consider how they can encourage the availability and access to appropriate support and supervision for their members working with children who present safeguarding risks.



**23.1.25** In October 2014, figures obtained by [Channel 4 News](#), in conjunction with [OpenWorld News](#), found that more than 6000 children across England have been reported as at risk of child sexual exploitation since the beginning of 2013<sup>306</sup>.

**23.1.26** In the UK the charity Barnardos has been working for over fifteen years supporting children who are the victims of child sexual abuse, exploitation and trafficking and they believe that the hidden nature of the problem means more needs to be done to prevent the abuse in the first place, to recognise those children who have suffered from it and to intervene to support those children and young people<sup>307</sup> and it is interesting to see the similarities between the findings in Malaysia and those in the UK.



## 23.2 Ipoh, Perak

<b>Area:</b>	21035 km <sup>2</sup>
<b>Population:</b>	2 258 428
<b>Population density:</b>	107.4 per km <sup>2</sup>
<b>Time Zone:</b>	GMT +8
<b>Median Household Income 2009:</b>	\$7099 per annum <sup>298</sup>

Monetary figures in USD.



Figure 58: Map of Malaysia showing Ipoh<sup>308</sup>

### 23.2.1 Ipoh

Ipoh is a very different city from Kuala Lumpur. In the far North of mainland Malaysia, relatively close to the international border with Thailand, remnants of the British Colonial era were still visible including the impressive Railway Station, Town Hall and Court House.

**23.2.2** In this city the local paediatricians and regional welfare director are working extremely closely together, in a multi-disciplinary way, to try to combat child maltreatment. The system is, in common with Kuala Lumpur, not without its problems but there was an obvious willingness to look for new strategies that would have the potential to improve inter-agency working, to identify cases of child abuse at an earlier stage, to ensure a more standardised response and, over time, to encourage the communities in which children live to look towards primary prevention of child abuse rather than secondary recognition.



Figure 59: Perak State Flag

**23.2.3** The open and transparent nature of the discussions that took place in Kuala Lumpur, following meeting with the Minister for Women, Family and Community Development, and in Ipoh, led to some unexpected opportunities to advise on future Malaysian child protection policy.



Figure 60: Blue and white Mosque, Ipoh, Malaysia



**23.2.4** As set out in the introduction to this report, the intention was to bring learning from overseas back to the UK however, being given the opportunity to give some recommendations directly to the Malaysian government, and to use the experiences gained both in the UK as well as whilst travelling as a Churchill Fellow, was something that was a great honour and could not be passed over.

**23.2.5** In light of the totality of the experiences in Malaysia there are four key recommendations that should be considered to improve the protection of children within the country.

**23.2.6 International Recommendation FOUR**

An expert advisory panel, working in conjunction with the National Advisory and Consultative Council for Children, UNICEF and other partner organisations, should be created in Malaysia to guide future developments concerning safeguarding vulnerable people in Malaysia and to ensure that the other three recommendations relating specifically to Malaysia are completed effectively.

**23.2.7 International Recommendation FIVE**

There should be creation and launch of a publication, with statutory function, concerning protection of children in Malaysia including new guidance on when to suspect child maltreatment, the inter-agency investigation of suspected cases and the standardised management thereof within Malaysia.

**23.2.8 International Recommendation SIX**

There should be creation and evaluation of a pilot Multi-Agency Safeguarding Hub (MASH) or Children's Advocacy Centre of Malaysia.



### 23.2.9 International Recommendation SEVEN

**There should be production and promotion of a coordinated standardised educational programme for all professionals working with families and children in Malaysia.**

**23.2.10** With almost 10 million children living in Malaysia and a third of the country's population being children, in light of recent serious cases which have sadly been reported in both Malaysian and International media, the time is right for the Government in Malaysia to proactively launch new strategies to deal with child protection in the country.

**23.2.11** On 5 March 2014 the Ministry of Women, Family and Community Development and the United Nations Children's Fund (UNICEF) launched a [report](#) into the system for prevention and response to abuse, violence and exploitation against children in Malaysia<sup>302</sup>. In addition to this Dr Irene Cheah undertook a [report](#) commissioned by the World Health Organisation (WHO) into Child Maltreatment Prevention readiness assessment in Malaysia<sup>309</sup>.

**23.2.12** None of the proposals contained within *Living on a Railway Line* would, in any way, undermine the good work that has already been done in Malaysia relating to child protection nor would they seek to replace the recommendations contained within previous reports or the action plans contained within the National Policy on Children and the National Child Protection Policy.

**23.2.13** Instead, they would complement the recommendations that have already been made and would offer some practically-focused, SMART (Specific, Measurable, Achievable and Agreed, Realistic and Resourced and Timely) ideas to work on in the short to medium term which ought to improve the way in which child protection is dealt with in Malaysia and hopefully, by extension in due course, reduce the number of tragic cases that do occur through primary prevention, earlier recognition and early intervention.



**23.2.14** The proposed expert panel should be made up of a majority of Malaysian members and should be chaired by a key individual from Malaysia to ensure that there is buy-in from all parties and that the proposals have a much greater chance of being acted upon.

**23.2.15** The panel would have four main functions:

- 1) to facilitate production of new statutory guidance on the identification, investigation and management of potential cases of child abuse
- 2) to oversee and commission
  - a. the creation of the first Multi-Agency Safeguarding Hub (MASH) in Malaysia
  - b. an evaluation of the effectiveness of this initiative within one year of commencement of the MASH
- 3) to commission production of a standardised educational programme and to promote and ensure its use throughout Malaysia within all public agencies
- 4) to identify projects and areas of good practice in primary prevention, early recognition and early intervention in child protection and to promote replication of these initiatives throughout Malaysia

**23.2.16** The expert panel would need to be comprised of professionals from a number of different backgrounds involving the whole sphere of child protection work, including:

- Law enforcement and the judiciary
- Social work
- Health
- Education of children
- Non-Governmental Organisations (NGOs)
- Academic representation (to assist with the evaluation process)



- 23.2.17** There would undoubtedly be other organisations within Malaysia, both governmental and non-governmental, that need to participate in this panel however in order that the panel is effective it would be important to keep the membership sufficiently small that discussions are productive and focused and there is clear accountability and action plans carried out in the timescales required.
- 23.2.18** A small number of international advisors could be invited to join this panel in order to provide an international perspective and to assist the panel with its functions given the resources that are available elsewhere in other countries.
- 23.2.19** Initially, that this expert panel would have a 2-year lifespan. From creation, the first year would be spent working on functions 1) and 2a) and the second year would be focused on functions 2b) and 3) as described above. It is likely that the projects and areas of work involved in function 4) would take place throughout the 2-year lifespan of the panel.
- 23.2.20** The key is that this must be Malaysian-led to be successful and the International Advisors must be there to advise and assist rather than to lead the process so that the end result is sustainable and is able to be disseminated widely.
- 23.2.21** The panel would need to meet regularly in order that workstreams created are tightly controlled and timescales adhered to. It is likely that this panel would need to meet monthly over the course of the first year following its creation, with meetings scheduled for at least either one day or two consecutive half-days. It would require strong leadership with a commitment to deliver the necessary outcomes within the timescales required.
- 23.2.22** One of the key outputs from the Expert Panel would be the creation and launch of a new Statutory Document which would ensure a fully coordinated, multi-agency assessment of children who are identified as being at risk of significant harm or who may have suffered from child abuse. This new document would give statutory guidance on how the laws that are already in place in Malaysia relating to child protection ought to be followed and implemented and would facilitate the creation of a standardised educational programme to ensure that everyone involved in child protection work is acting in a coordinated, standardised and equitable manner.



**23.2.23** This document could take a similar form to the statutory document used in the United Kingdom<sup>310</sup> (with the significant caveats referred to elsewhere in this report concerning the transfer of public policy from one jurisdiction to another).

**23.2.24** Although legislation concerning the assessment, investigation and management of child protection cases does exist in Malaysia, those laws are, on all too many occasions, interpreted in a non-standardised way and agencies sometimes do not work together in a coordinated fashion to protect children.

**23.2.25** The creation of a pilot Multi-agency Safeguarding Hub (MASH) in one region of Malaysia would unite all of the relevant agencies together to ensure that every single child identified as being at risk of significant harm is assessed and managed in accordance with a standardised protocol. There would need to be input, from the outset, of all necessary agencies which would be one way to address inter-agency difficulties.

**23.2.26** The MASH would be the central resource for the whole of the pilot region receiving all safeguarding and child protection enquiries. Staffed with professionals from a range of agencies including social care, police, the judiciary, health and education, the team would share information to ensure early identification of potential significant harm, and trigger interventions to prevent further harm.

**23.2.27** MASH staff would gather information from every agency and use this to decide the most appropriate intervention to respond to the child's identified needs. Where appropriate, the MASH team could trigger an immediate response to protect a child. The emphasis would be on triggering interventions to the child or young person and their family to prevent harm. Working together in this way would ensure that the agencies are sharing information and are able to respond to a child's needs quickly and efficiently.





**23.2.28** There is experience in the UK, for example in Devon<sup>311</sup>, where the MASH method has resulted in more effective and earlier identification of vulnerable children. It has reduced the number of different professionals being involved, while keeping the most appropriate professional to deliver interventions to meet the needs identified in any particular case. It has avoided unnecessary duplication and visits, and simplified processes. It has also improved communication between professionals.

**23.2.29** The selection of the area for the pilot MASH would be crucially important. This would involve a new way of working and a new process for dealing with child protection referrals and concerns. It is likely that the area which would need to be chosen would be one where inter-agency working has already begun in an effective manner and that there is a willingness and enthusiasm on the part of all key professionals involved in that area to trial a new way of working. Only in this way would the MASH have a realistic prospect of success. It may be possible to consider somewhere such as Perak or another smaller region, but the choice of the location would need to be decided following an evaluation of the chances of a MASH being accepted and utilised by the professionals and the community involved in that region.

**23.2.30** There are, in some respects, many similarities between the function and operation of some child advocacy centers in the USA and MASHs in the UK so there is international experience to support the creation of such a provision within Malaysia, provided whatever is introduced is appropriate for the local community and legislation that exists, and provided its introduction would be accepted by professionals and the community alike.

**23.2.31** Reviews of cases in the UK where child protection cases have not been identified as early as they ought to have been, or where agencies have failed to work together effectively to protect children, have time and time again identified inter-agency communication failures and a lack of standardised approach as being associated, or causative, in failing to protect children from abuse or failing to recognise that abuse when it has occurred.



**23.2.32** During the visit to Malaysia it was reported that similar inter-agency communication failures to those found in the UK also exist. The key to combating many of these failures in Malaysia is coordinated, standardised operating procedures and the core to that success is comprehensive, standardised, joint training based on the new statutory guidance that should be introduced in Malaysia under the direction of the expert panel. There needs to be defined standardised operating processes underpinned with guidance that supports clinical decision making.

**23.2.33** International collaboration combined with intra-country and inter-country support is at the heart of improving things for children no matter where in the world they live. These proposals for Malaysia, if implemented appropriately and with sensitivity to the needs of communities and the country as a whole, should contribute to the development of a national strategic vision for the reform of the child and family welfare system.

## 24.0 Kingdom of Cambodia

Area:	181 035 km <sup>2</sup>
Population 2013:	15 407 000
Population density 2013:	85 per km <sup>2</sup>
Time Zone:	GMT +7
GDP per capita 2013:	\$1015
GDP total 2013:	\$15.642 billion <sup>278</sup>
Average per capita income 2011:	\$711 per annum <sup>312</sup> (equivalent to \$1.90 USD per person/day)

\*GDP = Gross Domestic Product. Monetary figures in USD.



### 24.1 Sihanoukville

**24.1.1** It is estimated that over 14000 street children live in Cambodia and on a worldwide basis around 168 million children are affected by child labour which is approximately 11% of all children in the world aged over five years of age. “Street children” refers to “children who live or work on the streets or beaches of countries around the world”. All of these children are at greater risk of being abused and often have difficulty, for a variety of reasons, accessing healthcare including in an emergency. They are often dependent on healthcare being taken to them rather than expecting them to access fixed facilities.



Figure 61: Map of Asia showing Cambodia

**24.1.2** Sihanoukville is a beach town located in South West Cambodia on a peninsula. Although this is an area of beautiful untouched beach landscapes and surrounding tropical islands, Sihanoukville has a huge child protection problem given the number of children and families who have flocked to the area either in search of work or shelter.

**24.1.3** A significant number of children work on the streets and beaches of Sihanoukville either gathering bottles and cans or selling sunglasses, and jewellery items. All of these children are at significant risk of abuse and they often stay out late trying to make money.



Figure 62: Map of Cambodia showing Sihanoukville<sup>313</sup>



## 24.2 M'Lop Tapang

**24.2.1** The social problems in Sihanoukville are clearly evident to anyone who visits and this section will focus on two specific initiatives that try to provide support and protection for children who live and work in the area. Both of these initiatives have specific relevance to the UK.



*Figure 63: 11% of all children aged ≥5 years work in child labour<sup>314</sup>*

**24.2.2** [M'lop Tapang](#) has been working with the street and beach children of Sihanoukville since 2003. They currently work with over 1200 families and over 3500 children at ten specialised centres in the Sihanoukville area providing shelter, medical care, sports and arts, education and training, counseling, family support and protection from all types of abuse.

**24.2.3** Many of the children and families M'Lop Tapang works with are living in poverty stricken, desperate situations including in a community living entirely beside a railway line. It is from visiting this community and undertaking a mobile medical clinic with the Medical Team Leader of M'Lop Tapang that the inspiration came for the title of this report. It isn't necessary to show photographs of the abject poverty and horrendous living conditions that are rife in Sihanoukville. That wouldn't be dignified for the children and families who are involved the vast majority of whom are trying their utter best to make ends meet, and to improve the situation for themselves and their families, none of whom chose this way of life. These living conditions are very real and they have a disastrous effect on the lives of the families and children involved.



*Figure 64: Sihanoukville beach, Cambodia*



**24.2.4** What is necessary is to explain about the success stories because out of each one of the horrendous stories that exists there is real hope for the children and families involved. That hope comes not from statutory services provided by a government agency, which are shockingly absent in the community in Sihanoukville - but it comes, instead, from the fantastic work that is being done by the M'Lop Tapang development organisation, co-founded by British nurse Maggie Eno <sup>MBE</sup> over 11 years ago. M'Lop Tapang is helping each and every family or child whose tragic story exists and their ethos, professionalism, expertise and community-engagement are things everyone can learn from and translate into improvements everyone can make, no matter what individual's backgrounds or home countries may be.

**24.2.5** M'Lop Tapang creates an environment where all children are allowed to grow up in their families feeling safe, healthy and happy, a society where all children are respected and treated equally and a community where all children are given choices about their future.



*Figure 65: Andrew teaching about safeguarding children to M'Lop Tapang staff, Sihanoukville, Cambodia*

**24.2.6** So, why is this needed? Primarily the services provided by M'Lop Tapang do not complement other government or State funded services. There are simply no other such services here. If M'Lop Tapang did not exist the government would seemingly not step in to provide help to the people living and working on the streets of this region, the people would be, quite simply, left to fend for themselves with all of the problems that this would bring.

**24.2.7** There are a significant number of children who end up here in Sihanoukville separated from their families who might live in other parts of the country.



**24.2.8** Children often run away from an environment where domestic violence prevails and whole families, with a very broad definition of what a family is, migrate here and end up living on the streets, or beside a railway line, and working on those same streets or on the beaches.

**24.2.9** The excellent team of social workers that are part of M'Lop Tapang are able to find out about a new child or family moving into the area within 24 hours of them arriving. It is then that the rapport building can begin and that educational work can take place with the family to show them that there is a different way of life they can access for free. The outstanding work done by M'Lop Tapang can help families and individuals to find employment, to come off drugs and to find accommodation. M'Lop Tapang also helps to educate children, provides nutritional advice and supplementation where appropriate and helps to protect the vulnerable from all forms of abuse.

**24.2.10** There are a number of programmes offered to children and families with the key focus of M'Lop Tapang's work being reintegration of children to their families even if that means a lengthy search throughout many regions of the country.

**24.2.11** The sheer volume of children helped by M'Lop Tapang – which grew out of a simple desire to make things better for the children who were living and working on the streets and beaches of this region over 10 years ago – is amazing.

**24.2.12** There is a comprehensive educational programme for the older children including mechanics, plumbing, electrics, sewing, screen-printing and the very tasty, training restaurant, [Sandan](#).



*Figure 66: M'Lop Tapang school, Sihanoukville, Cambodia*



**24.2.13** Part of the battle that the staff have is convincing the children that they can have an education, that this will serve them much better than street selling as they grow older, and that there are significant dangers to living and working on the streets and beaches including all forms of exploitation and abuse. This can be an uphill struggle for the staff and it takes patience and dedication to slowly build trust with the families and children.

**24.2.14** The children and families with whom they work are acutely aware that given a choice between earning up to \$20 per day selling things on the beaches or in the absence of any other work earn \$1 per day collecting litter and going into an educational programme that does not have a wage attached, some very difficult decisions have to be made. It is for that reason that M'Lop Tapang have to make their programmes not only educationally beneficial for the children and young people entering them, but also that they must be financially viable for the people accessing them.



*Figure 67: Living on a Railway Line, Sihanoukville, Cambodia*

**24.2.15** In 2014 M'Lop Tapang has outreach programmes which include:

- Family reintegration
- Street and beach working programme
- Community education
- Baby care programme
- Back to school programme
- Mobile library programme
- Home repair business set up
- Alcohol programme
- Home based programme



**24.2.16** Parents with young children and no resources may have no option other than to send the children out to work on the streets to bring in money so that the family has food to eat and shelter from the extreme elements (torrential rain to bright sunshine in the space of a morning). That is where the real benefit of the baby care programme comes in. As well as enabling these children to access health and developmental support for 5.5 days a week, it also allows the parent(s) to go out to work, rather than the children, as they are being cared for by a trusted organisation.

**24.2.17** Children who have been living and working on the streets for as long as they can remember, may not know what a school is let alone whether they ought to go. That is where the educational programme comes in. By delivering an accelerated national curriculum programme in M’Lop Tapang’s main centre in a way that is fun, interesting and stimulating for the children, the team is able to educate children so that they can be reintegrated into government education and so that they have a much better chance in the future.

**24.2.18** M’Lop Tapang isn’t a health organisation but they have had to set up a clinic as the burden of disease and serious clinical pathology which exists in Sihanoukville is significant. It is a very clean and efficient health centre. Providing care, assessment and treatment to hundreds of children and their families, this is an incredibly impressive programme at M’Lop Tapang and it doesn’t just stop there – they take that clinical expertise into the community, to the railway lines, to the areas where people are living in make-shift houses and in communities on the streets via their Mobile Medical Clinic programme.



*Figure 68: M’Lop Tapang outreach activities 2014*





**24.2.19** The clinical expertise of the Medical Team Leader is superb and the coordinated, efficient way that the healthcare delivery is organised is excellent.

**24.2.20** And what if a child goes missing, does not attend for follow up or does not appear to be being treated appropriately? The comprehensive team of social workers are very rapidly on the case to locate the family and the child and to work with them to ensure that the child's health improvement is of paramount importance.

**24.2.21** Through the educational programme provided at the main centre, M'Lop Tapang have educated hundreds of children ranging right from babies to those nearing the normal school leaving age with specific classes for IT, Art, Music, Special Needs and Sports in addition to the traditional school subjects.



*Figure 69: Mobile health clinic, Sihanoukville, Cambodia*

**24.2.22** The efficiency and incredibly high level of professional activities within the M'Lop Tapang community is stunning. The organisation is visible throughout the town, be that between bars and restaurants, on the streets, in the hotels, on the beaches or even on a tuk-tuk. They have managed to create an atmosphere where the community is looking out for children and families at risk of abuse and where everyone is moulding together. Further information about the work of M'Lop Tapang can be seen in their [video](#) on the internet.

**24.2.23** There are clear ways in which the experiences gained in Sihanoukville can be used in the UK. Experiencing other cultures, other countries and the work of other organisations enhances knowledge, makes people more attuned to the specific strengths and weaknesses of the communities that people live in, gives people a worldwide perspective to their



work and enables individuals to more fully understand the background circumstances that some of their patients, or the people with whom they interact or work, may have come from.

**24.2.24** There is a huge amount of learning from M'Lop Tapang and Sihanoukville that is transferrable back to the UK. The value and necessity of integrated care that embraces acute care, community care, public health and social welfare cannot be underestimated. The circumstances which place children at risk of exploitation, and some of the presenting features of those who have been exploited, are a timely reminder to everyone working in urgent care settings that the background of the patient being seen may not be very clear and some will have come from risky environments.

**24.2.25** Non-governmental Organisations (NGOs) such as M'Lop Tapang and others, provide essential services to children and young people when government services are either absent or inadequate and they often need support from overseas. Such support does not have to be in the form of money or donations of equipment. Setting up academic and other links with organisations, such as in the UK, can help develop services overseas, protecting children on a worldwide basis, as well as contributing to continuing professional development of staff in the partner organisation.

**24.2.25 Recommendation TWENTY-FIVE**

**Further academic, clinical and other partnerships should be developed between UK organisations, professionals and NGOs who are providing essential child protective services in countries overseas where local statutory services are inadequate or absent.**

**24.2.26** The social determinants of health are crucially important and through education and social support, health can be improved without necessarily focusing on health as the primary target of the intervention, whatever that might be.



**24.2.27** Services that help protect children from abuse rather than simply respond to it when it does occur are something prevention groups can learn from in the UK. Through teaching and case discussions it is clear that the issues faced by communities in the UK are similar, in some ways, to those faced by the people living in Cambodia – of course, the reference scale is different, but fundamentally the core problems, and potentially some of the solutions, are incredibly similar and inextricably linked.

**24.2.28** The real positive successes that a community can have when that community works together towards a common goal are something every community and society should aspire to

# Appendices



***"Ask not what your country can do for you, ask what you can do for your country."***

John F. Kennedy, 1917-1963

## About this chapter

These appendices set out the biography of the author, details of the two major funders of this research project (The Winston Churchill Memorial Trust and The Association of Paediatric Emergency Medicine), the acknowledgements, the research questionnaire used in Singapore and Malaysia, the list of figures in this report and the press-release used to launch ***Living on a Railway Line***.

## 25.0 Appendix ONE

### 25.1 Author's biography

#### 25.1.1 Professor Andrew Graeme Rowland

BMedSci (Hons) BMBS (Hons) MFMLM MACadMed FCEM FRCPC FRSA

**25.1.2** Professor Rowland graduated from [The University of Nottingham Medical School](#), UK with a First Class Honours Bachelor of Medical Sciences (BMedSci) and Bachelor of Medicine and Bachelor of Surgery (BMBS) with Honours and Distinction in Paediatrics and Child Health. He is currently Consultant in Paediatric Emergency Medicine at [North Manchester General Hospital](#), UK and was made Honorary Professor at the [University of Salford](#), UK in 2014. He was one of the first five doctors in the UK to complete the newly approved Royal College of Paediatrics and Child Health national [GRID training scheme](#) in Paediatric Emergency Medicine, receiving his Certificate of Completion of Training in May 2009. Professor Rowland is certified as a subspecialist in Paediatric Emergency Medicine with the UK [General Medical Council](#).

**25.1.3** Professor Rowland has been awarded Fellowship of the Royal College of Paediatrics and Child Health ([FRCPC](#)) and Fellowship of the College of Emergency Medicine ([FCEM](#)). He is a member of the Association of Paediatric Emergency Medicine ([APEM](#)) and was awarded their 2013 Liz Molyneux Prize and 2014 travel bursary.



*Figure 70: Professor Andrew Rowland, 2014*



*Figure 71: Andrew at work in Manchester, 2014*

**25.1.4** Professor Rowland is currently the only Consultant in Paediatric Emergency Medicine employed by The Pennine Acute Hospitals NHS Trust, working in a unit seeing 30000 children per year in the Emergency Department, as part of a collaboration between four hospitals in the North West of England seeing in excess of 80000 children per year in the Emergency Departments and Urgent Care Centre – making the Trust one of the largest providers of paediatric emergency medicine care in the UK.



*Figure 72: Andrew lecturing in Malaysia, 2014*

**25.1.5** With a special interest in the child protection (safeguarding vulnerable children) aspects of Paediatric Emergency Medicine, Professor Rowland is a member of the organisation's Safeguarding Children Group and he has lectured internationally (USA, Singapore, Malaysia, Cambodia and Hong Kong) on issues relating to protecting children from harm as well as recognising and responding to possible child abuse and developing processes and organisational systems to protect children at risk of significant harm. Professor Rowland was awarded membership of the Academy of Medical Educators ([MAcadMEd](#)) as well as membership of the Faculty of Medical Leadership and Management ([MFMLM](#)) in 2013.

**25.1.6** As a fully trained sub-specialist Consultant in Paediatric Emergency Medicine and Advanced Paediatric Life Support ([APLS](#)) Course Director, Professor Rowland has the clinical skills to provide complete emergency care to children. His research interests include development of a bespoke Emergency Department (ED) specific early warning track-and-trigger score to predict admission or discharge potential in children attending the ED as well as investigating professionals' views on issues including mandatory legal reporting of child abuse and the development of child protection networks.



*Figure 73: Andrew at the Staff Awards Ceremony with Ruby Wax<sup>316</sup>, Manchester, 2013*

**25.1.7** Professor Rowland was given his employer's 2013 Division of Medicine and Community Health Services Doctor of the Year [Award](#) with the citation, *"Dr Rowland is an inspirational mentor and teacher with a wealth of knowledge about the law and procedures designed to protect children from significant harm. He is a passionate and sensitive advocate for children, always having the welfare of the child at his paramount consideration. He is a valued colleague who has contributed to the operational and strategic direction of the organisation, challenging and supportive of initiatives which protect children from harm"*.

**25.1.8** Professor Rowland is an Examiner for the University of Manchester Medical School.

**25.1.9** At an international level Professor Rowland is Head of the UK delegation to the Union Européenne des Médecins Spécialistes ([UEMS](#)). Nationally he was a [Judge](#) for the 2013 and 2014 Health Service Journal ([HSJ](#)) Awards. Professor Rowland is also a member of the British Medical Association's ([BMA](#)'s) International Committee and a member of the BMA's UK Consultants Committee and its Executive Committee. At a regional level he is a member of the North West Regional Consultants Committee. Professor Rowland is a former Company Director, and former member of Council, of the BMA.

**25.1.10** At the Royal College of Paediatrics and Child Health, Professor Rowland is a member of an international group helping to re-write the next edition of *Physical Signs of Child Sexual Abuse: an evidence based review and guideline for best practice*<sup>315</sup>.



**Figure 74:** Andrew meeting the Minister for Women, Family and Community Development, Malaysia, 2014

**25.1.11** In 2014, Professor Rowland was made a Fellow of the Royal Society for the encouragement of Arts, Manufactures and Commerce ([FRSA](#)) and was awarded a prestigious [Life Fellowship](#) by The Winston Churchill Memorial Trust. The grant accompanying the Fellowship Award combined with a bursary from APEM and a Clinical Excellence Award, allowed him to travel internationally to produce ***Living on a Railway Line*** - a report to improve the safeguarding of vulnerable children in the UK and beyond.

**25.1.12** Contact Professor Rowland via [andrewrowland77@gmail.com](mailto:andrewrowland77@gmail.com) or via his website:  
<http://drandrewrowland.wordpress.com/contact-me/>



## 26.0 Appendix TWO

### 26.1 The Winston Churchill Memorial Trust (WCMT)

#### 26.1.1 What does the Trust do?

Each year over 100 British citizens are awarded Fellowships for a wide range of projects. A Fellow must travel overseas for between four to eight weeks. Past award winners include nurses, artists, scientists, engineers, farmers, conservationists, carers, craft workers, artisans, members of the emergency services, sportsmen and women and young people. Since 1966, over 4800 Fellowships have been awarded.



#### 26.1.2 What is the purpose of a Churchill Travelling Fellowship?

To widen an individual's experience in such a way that he or she grows in confidence, knowledge, authority and ambition. To bring benefit to others in the UK through sharing the results of the experience. This is achieved through the inspiration provided by the individual's example (his or her subsequent performance and achievements) and the dissemination and application of new knowledge, different perspectives and innovative solutions.

#### 26.1.3 What is the objective for Churchill Travelling Fellowships?

The Trust's objective for the Travelling Fellowships is to provide opportunities for British citizens to go abroad on a worthwhile enterprise of their own choosing, with the aim of enriching their lives by their wider experience – through the knowledge, understanding, and/or skills they gain - and, on their return, enhancing the life of their community by their example and the dissemination of the benefit of their travels. These opportunities are provided to people of any age, gender, ethnicity or religion, with or without educational qualifications, and in any occupation or none.



Figure 75: Sir Winston Churchill<sup>317</sup>

#### **26.1.4 What is the Trust?**

The [Winston Churchill Memorial Trust](#) was established when Sir Winston Churchill died in 1965. Thousands of people, out of respect for Churchill and in gratitude for his inspired leadership, gave generously so that a living memorial to the great man could benefit future generations of British people. As Sir Winston's national memorial, the Trust carries forward his legacy by funding British citizens from all backgrounds to travel overseas, to bring back knowledge and best practice for the benefit of others in their UK professions and communities.

#### **26.1.5 How do I apply for a Churchill Fellowship in the UK?**

Applications are made online via the Trust's [website](#).

## 27.0 Appendix THREE

### 27.1 The Association of Paediatric Emergency Medicine (APEM)

#### 27.1.1 What is APEM?

[APEM](#) is a charity affiliated to the [Royal College of Paediatrics and Child Health](#) (RCPCH), promoting excellence, training and research into Paediatric Emergency Medicine. It has a crucial role in setting training requirements and competencies in Paediatric Emergency Medicine in the UK.



#### 27.1.2 What is APEM's history?

Since 1959 various committees and recommendations have agreed on the need for audio-visual separation for children from adults in Emergency Departments, training and supervision for junior staff seeing dealing with children and liaison between senior paediatric and emergency medicine staff. APEM acts to develop these areas, promoting, developing and propagating best practice.

#### 27.1.3 What standards exist for children in Emergency Departments?

Standards have been developed by the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings which provide healthcare professionals, providers and service planners with measurable and auditable standards of care applicable to all urgent and emergency care settings in the UK. A copy of the standards can be downloaded from the RCPCH [website](#).

#### **27.1.4 What is the APEM travel bursary?**

Each year APEM awards a travel bursary to allow an APEM member to travel abroad with the intention of bringing back new ideas to develop Paediatric Emergency Medicine in the UK. The winner of the 2014 APEM travel bursary was Dr Andrew Rowland who used the bursary to fund the Malaysian component of the project described in this report.

#### **27.1.5 How do I apply for the APEM travel bursary?**

You will need to be a member of APEM – the application form is available [online](#). A call for applications for the travel bursary is sent out to all members each year with full instructions on how to apply.

## 28.0 Appendix FOUR

### 28.1 Participant consent form: Singapore and Malaysia survey

#### PARTICIPANT CONSENT FORM

**Project title** The interaction between Paediatric Emergency Medicine Services and Child Protective Services

**Researcher's name** Professor Andrew Graeme Rowland

- I understand and agree to take part in this research study
- I understand the purpose of the research project and my involvement in it
- I understand that I may withdraw from the research project at any stage and that this will not affect my status now or in the future
- I understand that while information gained during the study may be published, I will not be identified and my personal results will remain confidential
- I understand that I will be audiotaped during the interview and that a summary of the discussions
- I understand that data will be stored electronically and will be able to be accessed by Professor Andrew Rowland in order to assist compilation of the final research report
- The data will be shared with the MCRI
- I understand that I may contact the researcher if I require further information about the research
- I understand that further details about the research can be found overleaf and here:

- <http://www.salford.ac.uk/chsc/about/health-sciences-news/distinguished-honour-for-salford-professor>
- <http://www.pat.nhs.uk/north-manchester-news/Prestigious-honour-for-North-Manchester-General-Hospital-consultant.htm>

**Signed** ..... (research participant)

**Print name** ..... **Date** .....

#### Contact details:

**Professor Andrew Rowland BMedSci (Hons) BMBS (Hons) MFMLM MAcadMED FCEM FRCPC FRSA**  
Consultant in Paediatric Emergency Medicine  
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# **Association of Paediatric Emergency Medicine (APEM)**

## **Malaysian study, May 2014**

### **TITLE:**

Identification of cases of suspected child trafficking and child sexual exploitation (CSE)

### **BACKGROUND:**

Figures released in February 2014 from the UK National Crime Agency have shown that the number of children identified as potential victims of trafficking rose by 186% last year to 63. These figures are almost certainly an underestimate and recognition, and protection, of these children continues to be problematic. Many of the children who have been trafficked or who have suffered from CSE will come into contact with emergency medicine services and it is vital that we have appropriate mechanisms in place within emergency medicine to identify suspected cases early so that intervention can take place and children can be protected from further or future harm.

### **WHAT HAS THIS GOT TO DO WITH PAEDIATRIC EMERGENCY MEDICINE?**

The health findings of the recent CSE serious case reviews in Rochdale (<http://www.rbscb.org/news.aspx?ID=23>), which is an area covered by Professor Rowland's own healthcare organisation, specifically focussed on the warning signs that were not recognised when children presented to emergency care facilities, having being sexually exploited, and where opportunities for earlier intervention and protection were missed.

### **PURPOSE:**

APEM (<http://www.apem.me.uk>) have part-funded Professor Andrew Rowland to travel to Malaysia in May 2014 to look, in an ethnomethodological-type way, at Paediatric and Emergency Departments and projects supported looking at the identification and management of children who have suffered from child trafficking or CSE. Taking part in a MCRI-hosted workshop is a key, and most welcome, part of the project.

### **AIM:**

The qualitative data gathered would be used to promote awareness of these serious, but under recognised, issues amongst clinicians working in Paediatric Emergency Medicine. The experiences gained from direct observation and discussions with professionals working in areas where CSE is a major problem would be used in the production of new teaching materials, designed to help clinicians seeing children in emergency departments to be more confident about recognising the potential warning signs and identifying possible cases of trafficking or CSE.

### **SUMMARY:**

There is an urgent need to increase education about trafficking and CSE amongst clinicians working in emergency medicine so that in future cases can be identified earlier and the likelihood of repeat occurrences of the tragic Rochdale cases is reduced. The experiences gained in Malaysia will be ideal to put together new educational resources which will be able to be used in the training of emergency medicine clinicians from multi-disciplinary backgrounds to hopefully result in better identification of trafficking and CSE victims over time.

## 29.0 Appendix FIVE

### 29.1 Singapore and Malaysia survey

**29.1.1** The results of this Child Protection Research Survey will be submitted for publication to a scientific peer-reviewed journal separate to this Winston Churchill Memorial Trust Fellowship Report.

#### CHILD PROTECTION RESEARCH SURVEY

Thank you for taking part in this survey and discussion workshop the results of which we hope to be able to publish in a peer-reviewed journal.

All responses are anonymous and will be used in aggregate form only so that no individual can be identified in any future publication. If you have any queries about this survey please contact Professor Andrew Rowland, Consultant in Paediatric Emergency Medicine, North Manchester General Hospital, Delaunays Road, Manchester, M8 5RB, UK:

[andrew.rowland@pat.nhs.uk](mailto:andrew.rowland@pat.nhs.uk)

#### PART ONE: BACKGROUND

(please tick ☐ the relevant answer for each question)

1.0 Demographics		<input type="checkbox"/>
1.1 Which country are you from originally?	USA	
	Canada	
	UK	
	Singapore	
	Malaysia	
	Hong Kong	
	Other (please state: _____)	
1.2 Which country do you currently work in?	USA (please write your State: _____)	
	Canada	
	UK	
	Singapore	
	Malaysia	
	Hong Kong	
	Other (please state: _____)	
1.3 What is your job role?	Doctor	
	Nurse	
	Healthcare worker (write job: _____)	
	Education worker	
	Law enforcement officer	
	Social worker	
	Charity worker	
Other (please state: _____)		

## PART TWO: TRAINING

(please tick ☐ YES or NO for each question)

2.0 Training		YES <input type="checkbox"/>	NO <input type="checkbox"/>
2.1 Have you had child protection training?			
2.2 Is child protection training mandatory in your organisation?			
2.3 If yes, do all employees undergo the same training?			
2.4 Does your organisation provide child protection training?			
2.5 If yes, what format does this take?	Online		
	Face-to-face		
	Computer based		
	Other (please state: _____)		
2.6 If yes, is your child protection training programme available for me to look at?			
2.7 If yes, please can you write your e-mail address so I can contact you to ask to see it, or please can you write below where I can find it, or please can you describe the training programme...?			



## PART THREE: TYPES OF ABUSE

(please tick ☐ YES or NO for each question)

3.0 Types of abuse in the country where you work		YES <input type="checkbox"/>	NO <input type="checkbox"/>
3.1 Are the following types of child abuse recognised in the country where you work?	Physical abuse		
	Sexual abuse		
	Emotional abuse		
	Neglect		
	Sexual exploitation		
	Human trafficking		
	Other (please state: _____)		
3.2 Is child sexual exploitation defined separately from child sexual abuse?			
3.3 Is child sexual exploitation included in the definition of child sexual abuse?			
3.4 Are the following types of child abuse criminal offences in the country where you work?	Physical abuse of a child		
	Sexual abuse of a child		
	Emotional abuse of a child		
	Neglect of a child		
	Sexual exploitation of a child		
	Trafficking of a child		
	Other (please state: _____)		
3.5 Are the following types of child discipline legal in the country where you work?	Corporal punishment of a child by their parent (no implement used)		
	Corporal punishment of a child by their parent (using an implement)		
	Corporal punishment of a child in a school (no implement used)		
	Corporal punishment of a child in a school (using an implement)		
3.6 The UK government is currently considering introducing a new 'Modern Slavery' law to specifically list exploitation, trafficking and slavery offences in one legal act of Parliament. Do you have similar legislation in the country where you work?			
3.7 If yes, please can you write the name of the legislation or where I can find it?			

## PART FOUR: CHILD PROTECTION REPORTING LEGISLATION

(please tick ☐ YES or NO for each question)

4.0 Reporting of child protection concerns in the country where you work		YES <input type="checkbox"/>	NO <input type="checkbox"/>
4.1 To which service(s) would a professional initially report child protection concerns in the country where you work?	Health services		
	Social services		
	Law enforcement		
	Other (please state: _____)		
4.2 Are professionals <b>legally</b> obliged to report child protection concerns to the authorities*?			
4.3 If yes, to which professionals does this legal obligation apply?	Health workers		
	Education workers		
	Social services		
	Sports team coaches		
	Other (please state: _____)		
	Other (please state: _____)		
	Other (please state: _____)		
	Other (please state: _____)		
	Other (please state: _____)		
4.4 If yes, please can you write the name of the legislation which covers 'Mandatory Reporting' and where I can find a copy?			
4.5 Are members of the public <b>legally</b> obliged to report child protection concerns to the authorities*?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	

\*Mandatory Reporting

## PART FIVE: BARRIERS TO THE RECOGNITION OF ABUSE

(please tick ☐ any answers you believe are correct. You MAY tick ☐ more than one answer)

5.0 Barriers to the recognition of child abuse in the country where you work		<input type="checkbox"/>
5.1 What do you think are the barriers to the recognition of child abuse by professionals?	Lack of training	<input type="checkbox"/>
	Lack of organisational policy, procedures or professional guidance	<input type="checkbox"/>
	Lack of legal protection of professionals	<input type="checkbox"/>
	Poor inter-professional relationships	<input type="checkbox"/>
	Poor communication pathways with other professionals	<input type="checkbox"/>
	Poor access to advice and support	<input type="checkbox"/>
	Lack of time	<input type="checkbox"/>
	Lack of money	<input type="checkbox"/>
	Lack of resources (please state: _____)	<input type="checkbox"/>
	Professionals unwilling to confront the problem	<input type="checkbox"/>
	Professionals discouraged from confronting the problem	<input type="checkbox"/>
	Other(s) please state:	<input type="checkbox"/>
5.2 What do you think are the barriers to the recognition of child abuse by society?	Fear	<input type="checkbox"/>
	Lack of understanding of the problem	<input type="checkbox"/>
	Lack of public awareness of the problem	<input type="checkbox"/>
	Lack of legal protection for those people who report concerns	<input type="checkbox"/>
	Subject matter is hidden by society	<input type="checkbox"/>
	Other(s) please state:	<input type="checkbox"/>

**PART SIX: OUTCOMES FOR CHILDREN (please tick ☐ YES or NO for each question)**

6.0 Outcomes for children in the country where you work	YES <input type="checkbox"/>	NO <input type="checkbox"/>
6.1 Are outcomes measured for children who have been referred to child protective services?		
6.2 If outcomes are measured, how does this occur? Please write your answer here:		
6.3 Do you have any examples of good-practice relating to the child protection issues for adolescents (16 and 17 year olds in particular) and where can I find information on these? Please write your answer here:		

## PART SEVEN: MULTI-AGENCY LEARNING FROM CASES

(please tick ☐ YES or NO for each question)

7.0 Serious case reviews in the country where you work	YES <input type="checkbox"/>	NO <input type="checkbox"/>
7.1 Does your country have a process by which cases of child abuse are reviewed by a multi-agency team to see what lessons can be learned from them to try to prevent reoccurrence of the issues?		
7.2 If yes, what is this process and can you direct me to where I can find more information about it?		
7.3 Does your country have a process by which all cases of child death are reviewed by a multi-agency team to see what lessons can be learned from them to try to prevent reoccurrence of the issues?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
7.4 If yes, what is this process and can you direct me to where I can find more information about it?		

**PART EIGHT: AGE OF A CHILD (please write in the relevant age – in years)**

<b>8.0 Demographics in the country where you work</b>	<b>?? (years)</b>
8.1 At what age in the country where you work does a child legally become an adult?	
8.2 At what age in the country where you work can a child consent to sexual activity?	
8.3 At what age in the country where you work can a child legally marry with parental consent?	
8.4 At what age in the country where you work can a child legally marry without parental consent?	
8.5 At what age in the country where you work can a child NOT consent to sexual activity under any circumstances*?	

\*Statutory rape in the UK

**Please write any other comments here:**

**PART NINE: NETWORKS (please tick ☐ YES or NO for each question)**

9.0 Child protection networks	YES <input type="checkbox"/>	NO <input type="checkbox"/>
9.1 Are you part of a <b>local</b> (organisational) child protection professional network?		
9.2 Are you part of a <b>regional</b> child protection professional network?		
9.3 Are you part of a <b>national</b> child protection professional network?		
9.4 Are you part of an <b>international</b> child protection professional network?		
9.5 Please write the name of any networks to which you belong together with where I can find out further information about them...		

**Please write any other comments here:**

## PART TEN: INFORMATION SHARING BETWEEN AGENCIES

10.0 Information sharing in the country where you work	YES ?	NO ?
10.1 Are protocols in place to facilitate information sharing about individual child protection cases between agencies?		
10.2 Do confidentiality rules or legislation prevent you from sharing information between agencies relating to child protection cases?		
10.3 Do civil liberties impact on your ability to share child protection information with professionals <i>within</i> your organisation?		
10.4 Do civil liberties impact on your ability to share child protection information with professionals <i>outside</i> of your organisation?		
10.5 Do lack of resources in the 'system' mean that some cases of child abuse or child protection concerns are not reported (ie if you know there are a limited range of services available to provide a particular type of support does this mean that you may be less likely to refer a particular individual case)?		
10.6 What are the barriers to sharing information between professionals about child protection cases?		
10.7 Please describe or provide a link to any protocols or guidance you have relating to inter-agency information sharing in child protection cases?		
10.8 What confidentiality rules apply to child protection information sharing?		
10.9 Do law enforcement services proactively develop local problem profiles on a regular basis to understand the scale/nature of child protection issues (for example sexual exploitation), to enable the development of a proportionate multi-agency response to prevent and deal with cases?	YES ?	NO ?
10.10 How might we improve earlier identification of child protection concerns in a particular community and intervene to try and prevent cases escalating?		



## **DISCUSSION ONE**

What training is given to clinicians working in emergency medicine to help them to spot the more subtle cases of children who are at risk of, or who have suffered from, child abuse/non-accidental injury/non-accidental trauma?

## **DISCUSSION TWO**

What role does society play in identifying children who might be at risk of, or who have suffered from, child abuse?

- a) If mandatory reporting exists in your jurisdiction what is the impact on referral rates to child protection services, how does the system cope and what are your views on the mandatory reporting legislation?
- b) If mandatory reporting does not exist do you believe it should and, if so, who should it apply to?

## **DISCUSSION THREE**

What are the barriers to the recognition of child abuse and how can we address these?

## **DISCUSSION FOUR**

What are the common presenting features of children who have been sexually exploited in your country and how does your agency recognise these cases or support other agencies to recognise them?

## **DISCUSSION FIVE**

In the UK it has been observed that multi-agency services for child sexual exploitation are very successful at identifying children at risk and early intervention, as referrals are more likely to be received from a wide range of partners (schools, police, health services, etc.). What are the sources of referrals to the services you work in?

## **DISCUSSION SIX**

What is the role of non-statutory services (such as non-governmental organisations (NGOs) or charities) in child protection work, how do you manage data sharing and how do you incorporate these organisations into child protection protocols?

## **DISCUSSION SEVEN**

How is 'risk of abuse' understood, both within a multi-agency framework and within individual agencies and what measurements or indicators of risk (in a society, community or for an individual child) are used?

## **DISCUSSION EIGHT**

How do children express views about child protection services, how can we improve their involvement, how can we encourage children to make more self-disclosures of child abuse and what support do professionals think that children might need that they currently do not have?

## **DISCUSSION NINE**

Is early help available for families where their children may be at risk of child abuse – to provide support to them to try and prevent cases of child abuse? What early help and early intervention services exist in the country where you work?

## **DISCUSSION TEN**

Are thresholds (the level of concern at which a child protection referral would be made) a barrier to working with children identified as being at risk of abuse? Do thresholds vary across different sectors, organisations and particular communities in the country where you work?

## 30.0 Appendix SIX

### 30.1 Acknowledgements

#### 30.1.1 Summary

This project would have been impossible without input from key organisations in the United Kingdom (UK) as well as amazing support, guidance and assistance from a huge number of people and organisations across the world many of whom, in order to protect their identities in a report containing sensitive themes, cannot be thanked publicly here. You know who you are and I'm incredibly grateful to you all for your help and interminable kindness.

#### 30.1.2 UK

[The Winston Churchill Memorial Trust](#), [The Association of Paediatric Emergency Medicine](#), [The Pennine Acute Hospitals NHS Trust](#), [the University of Salford](#), [The Royal College of Paediatrics and Child Health](#), [The National Society for the Prevention of Cruelty to Children](#), [The Office of the Children's Commissioner for England](#), [Child Exploitation and Online Protection Centre \(CEOP\)](#), [Bury Multi-Agency Safeguarding Hub](#)

Denise Rowland MBE JP, James Rowland, Den Carter, Susannah Nightingale, Dr Suzanne Smith, Dr M. James Stuart, Deana Bates, Deborah Dunton, Dr Emad El-Malek, Dr Jim Butler, Dr Mark Coates, Dr Rachel Isba, Dr Sabine Maguire, Emily Roberts, David Tucker, Dr Geoff Debelle, Dr Linda Teebay, Professor Jacqui Mok, Professor Vivienne Nathanson, Professor Tong Long, Dr Joan Livesley, Timothy Gerrish OBE, Major General Jamie Balfour CBE DL, Julia Weston, Helen Aherne, Harj Garcha, Elizabeth Heeles, Maureen O'Hara, Hannah Shaw, Professor Sir Al Aynsley-Green Kt, Dr Ffion Davies

### **30.1.3 Austin, Texas, United States of America (USA)**

[Dell Children's Medical Center of Central Texas](#), [Austin Police Department](#), [Children's Advocacy Centers™ of Texas](#), [Center for Child Protection](#), [Travis County District Attorney's Office](#)

Dr George Edwards, Michael Svoboda, Heather Ashley, Lisa Butterworth, Kim Wilson, Heather van Diest, Dr Karla Lawson, Michael Torres, Dr Amanda van Hoozer, Barbara Jefferson, Cyndi Cantu, Kate Nyquist, Laurie Toth, Alison Benesch, Beth Fagin, Dr Ada Earp, Dr Coburn Allen, Dr Winnie Whittaker, Dr Sujit Iyer, Kasey Bourbon Jackson, Samantha Thompson, Catherine Bass, His Honour Judge James Arth

### **30.1.4 Paris, Texas, USA**

Justin Sharrock, Claudia Pursifull

### **30.1.5 Phoenix, Arizona, USA**

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Dr Kathy Coffman, Dr Wendy Dutton, Roger Blevins, Dr Lisa Kirsch, Jackie Hess, Nicole Schuren, Cindy Nelson, Alaina Raetz, Summer Magoteaux, Rachel Mitchell, Marcia Stanton, Teresa Boeger, Dr Blake Bulloch, Dr Stephanie Zimmerman, Sergeant Joseph Smelter, Dr Cody Conklin-Aguilera, Mo Basenberg

### **30.1.6 Canada**

[Professor Harriet MacMillan](#)

### **30.1.7 Philadelphia, Pennsylvania, USA**

[Children's Hospital of Philadelphia](#), [Bucks County District Attorney](#), [Department of Human Services](#)

Professor Cindy W. Christian, The Honourable David Heckler, Dr Samantha Schilling, Dr Stephanie Deutsch, Laura Coll, Dr Laura Brennan, Dr Philip Scribano

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Professor Donald Bross, Professor Desmond Runyan, Megan Richardson, Dr Erika McElroy, Professor Daniel Lindberg, Professor Edward Goldson, Professor Andrew Sirotnak, Professor Lisa Merkel-Holguin, Kendall Marlowe, Andrea Steinberg, Dr Antonia Chiesa

### **30.1.9 Singapore**

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Professor Ng Kee Chong, Dr Lee Khai Pin, Dr Tham Lai Peng, Dr Angelina Ang Su Yin, Dr Sashikumar Ganapathy, Tammy Yap, Alfred Tan, Stefan Phang, Philip Shepherd, Andrew Couttie

### **30.1.10 Malaysia**

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Mrs Liew Neé Ng Sau Pheng, YB Dato' Sri Rohani Abdul Karim, YB Dato' Sri Professor Dr Abu Hassan Asaari Abdullah, YB Dato' Phaik Kee Chong, Dr Aminah Kassim, Dr Rosnah bt. Ramly, YB Dato' Dr Amar Singh, Dr Irene Cheah, Nicole Helwig, P. Nagasayee Malathy, Vijaya Baskar, Aisha Zanariah Abdullah, Ruth Liew, Dr Mahathar Wahab, Dr Izrilfairuz binti Ismail

### **30.1.11 Cambodia**

[M'Lop Tapang](#)

Maggie Eno MBE, Ngov Chanrary

### **30.1.12 Hong Kong**

[British Consulate General, International Conference on Emergency Medicine 2014](#)

Caroline Acheson

### **30.1.13 Australia**

[Belinda Mawhinney](#), Scott Austin, Craig Stevenson

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## 32.0 Appendix EIGHT

### 32.1 Abbreviations and Glossary

A&E	Accident and Emergency Department
AAP	American Academy of Pediatrics
ACE	Adverse childhood experience
APEM	Association of Paediatric Emergency Medicine
BMA	British Medical Association
CAPTA	Child Abuse Prevention and Treatment Act
CEM	College of Emergency Medicine
CEOP	Child Exploitation and Online Protection
CPD	Continuing professional development
CPS	Child Protective Services
CRC	Convention on the Rights of the Child
CSA	Child sexual abuse
CSA	Child Support Agency
CSE	Child sexual exploitation
CSES	Child Support Enforcement System
DV	Domestic violence
ED	Emergency Department
GBP	Great British Pounds (Sterling)
GMC	General Medical Council
HKL	Hospital Kuala Lumpur
HNA	Health needs assessment
HRC	Human Rights Convention
HTA	Health Technology Assessment
IPV	Inter-partner violence (domestic violence)
KKH	KK Women's and Children's Hospital
LGBT	Lesbian, Gay, bisexual, transgender
LSCB	Local Safeguarding Children Board
MASH	Multi-agency safeguarding hub
MCRI	Malaysian Child Resource Institute

MYR	Malaysian Ringgits
NCA	National Crime Agency
NGO	Non-Governmental Organisation
NHS	National Health Service
NPV	Negative predictive value
NRM	National Referral Mechanism
NSPCC	National Society for the Prevention of Cruelty to Children
P.S. the Children	Protect and Save the Children
PDR	People's Democratic Republic
PEMRU	Paediatric Emergency Medicine Research Unit
PERUKI	Paediatric Emergency Research in the UK and Ireland
PPV	Positive predictive value
PSBR	Public Sector Borrowing Requirement
RCPCH	Royal College of Paediatrics and Child Health
RCR	Royal College of Radiologists
ROC	Receiver Operating Characteristics
SCR	Serious Case Review
SGD	Singapore Dollars
UK	United Kingdom of Great Britain and Northern Ireland
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
USA	United States of America
USD	United States Dollars
WCMT	Winston Churchill Memorial Trust
WHO	World Health Organisation

## 33.0 Appendix NINE

### 33.1 Press release used to launch *Living on a Railway Line*

The following News Release (under embargo of 11:30am, 20 October 2014) was used to launch the publication of *Living on a Railway Line*:



UNIVERSITY OF SALFORD NEWS RELEASE

20 October 2014

**New report says: “It is of the utmost importance that we recognise that the majority of child abuse and neglect occurs within homes, families and communities”**

Today, Monday 20 October 2014, sees the launch of a new report into how different countries tackle child abuse, in particular sexual exploitation, and how the UK can benefit from this learning.

**‘Living on a railway line. Turning the tide of child abuse and exploitation in the UK and overseas: international lessons and evidence-based recommendations’** is a work by The Pennine Acute Hospitals NHS Trust’s Professor Andrew Rowland, in association with The Winston Churchill Memorial Trust and University of Salford.

There are 10 key recommendations for the UK together with 25 associated and enabling recommendations and seven international recommendations. All of the recommendations are designed to build strong and healthy communities with children at their hearts.

**There are five major themes that run throughout the report:**

- Mandatory reporting of child abuse occurring within organisations exercising care, supervision or authority over children
- Better training to recognise and respond to cases of potential child sexual exploitation
- The launch of a children's advocacy centre pilot and advocating on behalf of children
- Prohibition of physical punishment of children
- The need for further research surrounding child protection in the UK, including ascertaining the views of society to help develop preventative strategies

The launch coincides with the 25th anniversary of the signing of the UN Convention on the Rights of the Child. According to Professor Rowland's report, a quarter of a century later there are still laws, policies and procedures in the UK and internationally which fall way short of properly protecting children.

Professor Rowland gathered evidence from USA (Texas, Arizona, Pennsylvania, Colorado), Singapore, Malaysia (Kuala Lumpur, Ipoh) and Cambodia (Sihanoukville). He investigated the impact of mandatory reporting of child abuse, the work of children's advocacy centres and learned about strategies used to identify children at risk of child sexual exploitation and trafficking. He uses his international experiences to make recommendations for the UK and the international community. The work contains over 300 scientific and other references.

The report's title 'Living on a Railway Line' comes from Professor Rowland's experience in Cambodia, where children and their families are literally living beside train tracks. This dangerous environment, where one is never sure when or from where harm is coming next, is a metaphor for what many people experience world-wide, including in the UK, through their exposure to abuse.

**Professor Rowland said:** “It is of the utmost importance that we recognise that the majority of child abuse and neglect occurs within homes, families and communities. We must not be distracted by a media frenzy of high-profile cases related to public figures and celebrities - disturbing though they are, they do not reflect the majority of abuse cases that occur within our communities. However, it is time for the UK to take an unequivocal stand against child abuse cases occurring in association with positions of power or responsibility, and the law in the UK should be changed to introduce mandatory reporting of them. We need much better research to understand, in more detail, society’s views about child abuse. There needs to be a standardised educational programme delivered to all professionals working with children and families, not just a competency framework. Professionals working with children need to advocate much more on behalf of children and empower them to participate more fully in decisions relating to the communities in which they live. It takes a community to protect a child: protecting children really is everyone’s business, including **yours**.”

**Lisa Harker, Director of Strategy Policy and Evidence at NSPCC, said:** “This report provides a valuable consideration of a diverse range of challenges faced by professionals and members of the community when seeking to improve safeguarding of vulnerable children in the UK. By drawing on the insights gained from reviewing and observing practices in a wide range of international contexts this report offers a fresh perspective on these issues and the potential responses.”

**Jamie Balfour CBE DL, Director General of The Winston Churchill Memorial Trust, said:** “Dr Rowland’s excellent report demonstrates the significant results that can come from a Winston Churchill Memorial Trust Travelling Fellowship. These Fellowships provide a unique opportunity for British citizens to travel overseas to bring back fresh ideas and new solutions in order to address many of the current social challenges facing the UK.”

**A spokesperson for Barnardo's, the UK's leading children's charity, said:** "Barnardo's welcomes this report and the evidence it draws together to gain a better understanding of what needs to change to ensure that vulnerable children are being safeguarded. Barnardo's supports the recommendations relating to child sexual exploitation, particularly around changes to grooming legislation and the need to remove the term 'child prostitute' from our laws."

**Dr Geoff DeBelle, Officer for Child Protection at the Royal College of Paediatrics and Child Health, said:** "This is a timely, wide-ranging and comprehensive report on vital aspects of child safeguarding. Its recommendations are global in their reach, and pertinent to many jurisdictions, particularly the UK. For example, consistent high quality training in child abuse and neglect for all professionals who work with children and families should be the norm, and organisations involved in clinical research should indeed promote this more widely with patients and the public. We will take time to consider all the recommendations in order to determine how they can be best supported by the RCPCH and, where appropriate, implemented. This report is written with a sense of urgency and I urge others to read it, digest it and engage in active discussion on how safeguarding children in the UK and abroad can be improved."

**Dr John Devaney MBE, Chair of the British Association for the Study and Prevention of Child Abuse and Neglect, said:** "I welcome this important and timely report on child abuse and neglect. While recent high profile cases, of both a recent and historical nature, have raised public awareness of the very difficult lives many children lead, the findings and conclusions in Professor Rowland's report highlight what can be achieved through the promotion of greater inter-agency and multi-professional co-operation and working, greater support and training for professionals and a more robust evidence base to inform policy and practice. I hope that the findings can further the debates and discussions about how we deal both nationally and internationally with the issue of the abuse and neglect of children and young people in all its forms."

**Dr Gillian Fairfield, Chief Executive of The Pennine Acute Hospitals NHS Trust, said:** “We are delighted that one of our senior consultants in emergency medicine has been involved in such an important area of research. Professor Rowland has taken the opportunity to use his wealth of clinical experience and research to further explore ways we as healthcare professionals and multi-agencies, including those in emergency medicine, can improve the protection and safeguarding of vulnerable children. On behalf of the Trust we would like to congratulate Professor Rowland on this report and hope that it creates wider debate and work across health and social care at all levels.”

**The President of the College of Emergency Medicine, Dr Clifford Mann said:** “This report is excellent and represents a substantial body of important work. There are some recommendations relating to Emergency Medicine which have merit and we look forward to working on these in due course.”

**Maggie Eno MBE, Co-founder and Coordinator of M'Lop Tapang, said:** “Professor Rowland has identified so intuitively how, with a little effort but with an open mind, lessons from UK can benefit partners across the world and, significantly, how the UK can utilise successful models from international partners who work with far less resources. Working together in communities simply works. It is very apparent that we all have significant changes and urgent, yet lasting, improvements to make before we can safely claim to be protecting our children effectively. It is unique and motivating to see a senior health care professional display such an inclusive, holistic approach fully understanding of the need for all of us to step up our safeguarding strategies: as parents, families, child protection organisations, health care professionals, the judiciary and law enforcement. This report gives us clear evidence that it is everybody’s key role in life to protect children and we need to listen to and learn from successful strategies around the world, adapting and applying them to our own settings fast, before another child gets harmed. This crucial and opportune report highlights the importance of what many of us have forgotten. Effective safeguarding of children does not start with child protection experts or high level professionals working with child victims, it begins with empowering the children themselves: working closely with their parents, their families, their friends and neighbours, within the communities in which they belong, and in the places where they spend most of their time. These key, trusted community members are often in the best position to protect children from being harmed. If every community is alert and engaged in protecting their own children, offenders may continue to pursue, but they will meet far too many obstacles, and therefore will be less able to harm our children. It is by partnering and listening to the close community that really creates sustainable safe environments for children to grow up in, feeling safe, being protected, as they should be by adults, in any part of the world.”

*M'Lop Tapang is a local non-profit organisation registered with the Royal Government of Cambodia and has been working with the street children of Sihanoukville since 2003. They currently work with over 4000 children and 1500 families in the Sihanoukville area providing shelter, medical care, sports and arts, education and training, counselling, family support and protection from all types of abuse.*



**Mrs Liew Sau Pheng, Founder of the Malaysian Child Resource Institute (MCRI), said:** “Professor Rowland’s work is the best advocacy I have ever known for safeguarding and protecting children. It is clear that Professor Rowland has put his heart into his research and that he truly cares about bringing impactful and positive outcomes for vulnerable children and families.

His report is a clarion call to all who long for a peaceful and non-violent world to start with educating and improving on a continuous basis if they are to be effectual in preventing child abuse and neglect. Children are our future and we have to join hands across the globe to ensure that they grow up to be fully-functioning adults who become peace-loving and contributing citizens of their countries. Child protection issues are becoming more complex and challenging not just in the UK or Malaysia but globally. These issues truly demand that professionals working for children and families are regularly fed with a diet of research-based evidence and theoretical knowledge to tackle them hence Professor Rowland’s recommendation for a standardised educational programme gives all of us who work with children and families a dynamic and instant blueprint for action.

As a Non-Governmental Organisation MCRI has always been at the forefront of child rights and child advocacy and we agree with Professor Rowland that while most countries have the laws and policies in place for the protection of children and their well-being, advocacy by stakeholders, the community and the children themselves are crucial to ensure that issues that concern children are always at the forefront of every national agenda. Professor Rowland’s report is indeed timely. His recommendations will enable organisations who are working on behalf of children, MCRI included, to mobilise a groundswell of support to assemble resources to make things happen for the benefit of children globally.

As the Chinese philosopher, Lao Tzu, said, "A journey of a thousand miles begins with a single step". That journey has begun and Professor Rowland’s recommendations will now take on a life of their own – projects stemming from his recommendations will sustain themselves because they are done ‘In the Service of Children’”.

*MCRI is a non-governmental, not-for-profit organisation dedicated to promoting quality early child care and education through training of child-based services. MCRI supports the UN CRC in all aspects of their work. MCRI, especially through its founder, has contributed to the development of child rights through numerous initiatives including workshops, training and awareness raising events.*

**Sebastien Marot, Founder and Executive Director of Friends International, said:** “ChildSafe grew from the need for effective child protection in developing countries however its innovative multi-layered approach, including community based protection systems, resources for travellers and the business sector can be adapted to work just as well in the developed world, where the effectiveness of existing child protection initiatives is often called into question.”

**Dr Julia Surridge, Chair of The Association of Paediatric Emergency Medicine (APEM), welcomed this report and said:**

“Professor Rowland's in-depth and timely report starts by highlighting many issues that have, unfortunately, been raised in previous reports of child sexual abuse, both in individual cases and in cases involving multiple victims. The recommendations in his report are clear - we, as professionals caring for these vulnerable children and adolescents, need to act promptly, and move forwards in the training of recognition of those individuals who are at risk of, or who have already been subject to, sexual exploitation. APEM is in a unique position to be able to join with Colleges and other groups to work, in detail, on implementing Professor Rowland's recommendations relating to training and to the urgent care setting.”

*APEM is a charity affiliated to the Royal College of Paediatrics and Child Health, promoting excellence, training and research into Paediatric Emergency Medicine.*

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***"All religions, arts and sciences are branches of the same tree. All these aspirations are directed toward ennobling man's life, lifting it from the sphere of mere physical existence and leading the individual towards freedom."***

Albert Einstein, 1879-1955

## About this chapter

This final chapter is the bibliography of the published research and other evidence that underpins the evidence, conclusions and recommendations contained within *Living on a Railway Line*.

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Turning the tide of child abuse and exploitation in the UK and overseas:

*Living on a Railway Line* is a start... who will join in and continue the work?

**Andrew Graeme Rowland**

10 October 2014