Mandated to report? A practitioner’s study of the role of doctors in child protection procedure within in a paediatric hospital setting in Ireland.

A Thesis submitted for Partial fulfilment of the

MSc in Child Protection and Welfare.

Author: Gary James McGovern.
Student Number: 13311871.
Tutor: Dr. Helen Buckley.
Word Count: 20,354 (excluding abstract)
Submission Date: 26/5/2016
Declaration

I hereby certify that the material in this thesis is entirely my own and that, to the best of my knowledge, all sources and references have been acknowledged accordingly. I confirm that this work has not been submitted in whole or in part for any academic assessment other than for partial fulfilment of this Master of Science in Child Protection and Welfare at Trinity College Dublin.

Gary James McGovern

Signed: __________________________

Date: __________________________
Acknowledgements

In prelude to this study I owe many people a great deal of gratitude for their patience, kindness and support. Firstly I would like thank my academic supervisor Dr. Helen Buckley, who has provided me with direction, wisdom, and at times a refreshing take on social research during this year of study on the MSc course. I would also like thank my loving wife, Fionnuala who has not only been a constant form of support, but also my best reader and critic. She is also the mother of our wonderful new son, Séamus, who was born in the middle of this research thesis, in Dublin on the 29.12.2015. I intend to replace the library and the lap top with more quality time with both of them in the coming months, which is no doubt long overdue! I hope that one day Séamus will have the opportunity to experience the benefits of third level education and the contribution that this can make not only to one’s own development, but to that of the world in which we live. Thirdly, I would like to express gratitude to the doctors who were willing participants in this study, without them there would simply be no study.

Gary James McGovern
May 2016
“Nobody ever talked to me. I was dying that somebody would take me out of that house. I would have told them everything.”

(Sophia McColgan when she was in hospital after an incident. West of Ireland Farmer Case (1998, p.14).
Abstract

Ireland recently signed into law the Children First Act (2015) which when fully implemented will introduce mandated reporting for all professionals who work directly with children, including hospital doctors. This legislation marks a significant change in governmental policy and is a consequence of failings in the child protection system highlighted in serious case enquiries. A significant number of children at the centre of these enquiries presented to hospitals prior to serious injury or death.

This study was conducted by a researcher who is employed as a Senior Social Worker in a large paediatric hospital. It evaluates the pivotal role of the hospital doctor and their contribution to safeguarding children against the backdrop of the new legislation. Consideration was given to international literature regarding the significance of the doctor’s role in safeguarding and the experience of mandated reporting in other Anglophone countries. Contextually the evolution in understanding maltreatment is discussed from the work of Kempe (1962) and the battered baby syndrome to more contemporary understandings of maltreatment; including neglect and the impact of domestic abuse on the child. Participants in this study worked as doctors at varying professional grades in the four prominent clinical areas that report abuse; Emergency Medicine, General Paediatrics, Burns and Plastics, and Orthopaedics. Data was collected from participants using qualitative structured interviews.

Findings reflect similarities with the literature highlighting a need for effective training at both undergraduate and postgraduate levels for doctors in child protection recognition and response. The findings were consistent with Laming (2003), who found that a functional multidisciplinary approach with inclusive consultant leadership were key influences for effective safeguarding. Organisational culture was found to be an influential factor in the safeguarding processes particularly within surgical specialisms. Change is required within the traditional hierarchical models that are more prevalent in surgical specialism’s to reflect that which exists in ED and general paediatrics to improve processes. The data indicates that clinicians generally wanted to act to safeguard children but often felt ill equipped. Anxiety for doctors was also evident in findings regarding under and over reporting abuse.
Participants had limited understanding of formal processes and algorithms that are in existence in the setting to assist in non-accidental injury (NAI) cases. Comprehension about the role of statutory Child Protection Services (CPS) was also found to be insufficient. Knowledge largely came via osmosis or from a personal interest in NAI. Awareness was a particular issue for doctors that trained in non EU countries that may have more embryonic child protection systems than those that exist in Ireland.

The introduction of mandated reporting will act to make compulsory training accessible to all doctors. This will be implemented via the use of modern technology and ELearning programmes (HSE 2015). It will make reporting a legal requirement in addition to a moral and corporate responsibility. Training will need to be evaluated as studies show that training alone does not guarantee compliance (Kaminski & Tan 2014). Experience in other jurisdictions shows numbers of unsubstantiated referrals increase making it difficult for CPS to respond effectively due to additional demands (Donald 2012). In the Irish context this is noteworthy given the widely acknowledged resource pressures on the Child and Family Agency (Tusla), and the additional demands that the new legislation and policy will now place upon it.
# Contents

Declaration........................................................................................................................................... i  
Acknowledgements .............................................................................................................................. ii  
Abstract................................................................................................................................................ iv  
List of Figures ........................................................................................................................................ vii  
List of Tables .......................................................................................................................................... vii  
Glossary of Terms ................................................................................................................................ viii  
Chapter 1: Introduction .......................................................................................................................... 1  
1.1. Setting for the study ....................................................................................................................... 1  
1.2. Research Context and the hospital doctor’s role in child protection ........................................... 1  
1.3. Aims, objectives and structure ...................................................................................................... 2  
Chapter 2: Literature Review .................................................................................................................. 4  
2.1. Policy context: Prelude to the implementation of mandated reporting in Ireland ....................... 4  
2.2. The debate surrounding the effectiveness of mandatory reporting ............................................. 8  
2.3. The role of the hospital doctor in child protection ........................................................................ 12  
2.4. Training for hospital doctors in child protection recognition and response ............................... 17  
2.5. Organisational culture, doctors and its influence on effective safeguarding ............................... 19  
Chapter 3: Methodology ....................................................................................................................... 23  
3.1. Sample selection and participants .............................................................................................. 23  
3.2. Research Design ......................................................................................................................... 25  
3.3. Structure and presentation of data findings .................................................................................. 27  
3.4. Ethical issues ............................................................................................................................... 27  
3.5. Limitations of the study ............................................................................................................... 28  
Chapter 4: Findings, Discussion and Analysis ......................................................................................... 30  
4.1. Introduction .................................................................................................................................. 30  
4.2. Coding of participants .................................................................................................................. 31  
4.3. Participants Training in Child Protection procedure ................................................................... 32  
4.4. Participants’ Experience and role in the Child Safeguarding Process ......................................... 39  
4.5. Organisational Culture and Hierarchical Factors ....................................................................... 47  
4.6. The Introduction of Mandated Reporting and the Hospital Doctor .............................................. 52  
Chapter 5: Conclusion ............................................................................................................................ 55  
Bibliography .......................................................................................................................................... 60  
Appendices ............................................................................................................................................. 69
Appendix (1) Coding of Participants Interviewed in the Study.......................................................... 69
Appendix (2) Participant Information Letter .................................................................................................. 70
Appendix (3) Participant Consent Form........................................................................................................... 71
Appendix (4) Interview Questions .................................................................................................................... 72
Appendix (5) Hospital Ethics Committee Approval for the Study................................................................. 74

List of Figures
Figure 1: Hospital’s Child Protection Algorithm assisting doctors in reporting NAI & maltreatment... 14
Figure 2 Making it Safe: A model of professional status on psychological safety in health settings. 22
Figure 3: Child protection referrals to social work department 2010-2015 by medical specialism... 24
Figure 4: Cross hospital representation of participants by clinical specialism involved in study... 25
Figure 5: Representation of Participants by Professional Grade in the Setting ........................................ 30
Figure 6: Representation of Participants by Clinical Specialism ............................................................... 31

List of Tables
Table 1: HSE & S.38 Funded staff who will be mandated under the Children First Act (2015)* .......... 11
Table 2: Codes Applied to Each of the Research Participants Presented in the Findings ..................... 31
Glossary of Terms

CEO  Chief Executive officer.
CNM  Clinical Nurse Manager.
CPS  Child Protection Services.
CRA  Children’s Rights Alliance.
CSA  Child Sexual Abuse.
Dáil Éireann  Principle Chamber of the Oireachtas (Irish Parliament).
DCYA  Department of Children and Youth Affairs.
DLP  Designated Liaison Person.
DP  Designated Person.
EU  European Union.
ED  Emergency Department.
ELEARNING  Online training for HSE Employees in Child Protection Recognition & Response.
GAL  Guardian ad Litem.
HMSW  Head Medical Social Worker.
HSE  Heath Service Executive (Ireland).
HSE Land  ELEARNING Training Platform for the HSE/HSE Funded Agencies.
MDT  Multi-Disciplinary Team.
MSW  Medical Social Worker.
NAI  Non Accidental Injury.
NCHD  Non Consultant Hospital Doctor.
NHS  National Health Service (UK).
NCH  National Children’s Hospital Dublin.
NPHDB  National Paediatric Hospital Development Board.
Oireachtas  National Parliament of the Republic of Ireland.
SHO  Senior House Officer.
SMSW  Senior Medical Social Worker.
SPR  Specialist Registrar.
SRF  Standard Report Form (to Tusla, the Child and Family Agency)
Tusla  Child and Family Agency (Statutory Child Protection Agency in Ireland).
Chapter 1: Introduction

In this section the study’s context will be outlined. The basis for the study will be explained including the central themes surrounding the role of the hospital doctor in the child protection process, and the overall aims and objectives of the research.

1.1. Setting for the study

This study was undertaken by a researcher who is employed in a paediatric hospital in Ireland as a Senior Medical Social Worker. The setting is Ireland’s largest provider of paediatric care employing in excess of 1500 staff with 248 inpatient beds. The hospital is also involved in the training and education for all the major clinical disciplines that concern children’s healthcare within the State. A large amount of the day-to-day work involves the assessment and investigation of suspected non-accidental injury (NAI) concerning children who present to the hospital. As Scott and Fraiser (2015:383) acknowledge. “The health system provides a first point of contact capable of intervening in child abuse and neglect”. Given this, the role of the doctor requires further analysis and forms the basis for this study. The recognition and response to child maltreatment in a paediatric setting requires effective collaboration with doctors who work in a variety of clinical specialisms.

1.2. Research Context and the hospital doctor’s role in child protection

As Kodner & Wetherton (2013:669) found, “child abuse is the third leading cause of death for children globally between the age of one and four years”. Therefore doctors have a pivotal position in cases where maltreatment presents. The study will also contextually draw on the researcher’s own professional experience in the setting. Findings of an earlier study by the author into effective collaboration in child protection procedure in the clinical setting between allied health professionals (McGovern, 2015) was also an influential factor in the focus and development of this research project. As a starting point the hospital policy is unequivocal and stresses the importance for doctors to be conversant with procedures to identify the maltreatment of children. This is evident in the Joint Child Protection Guidelines for the three Children’s Hospitals, in Dublin (2008:30), it recommends:
‘[That] all NCHDs [non consultant hospital doctors] must be familiar with the legislation, conventions and guidelines relevant to child protection work’ (Joint Child Protection Sub-Committee of Council for the Children’s Hospitals Care, Dublin. P.30).

The study critically assesses to what extent this objective is being realised in practice by doctors across four clinical disciplines were NAI is significant. It also gathers data across different professional grades. Consideration is given to the understanding doctors have of the current Children First Guidelines (2011). And is set against the back drop of the enactment of the Children First Act (2015) which will introduce mandated reporting in Ireland. This Act, once implemented will place the current 2011 guidelines on a statutory footing. Mandated reporting will be a requirement for all professionals who “by virtue of their training, responsibilities, and experience will have an awareness of issues relating to child protection” (HSE 2015:8). Comparisons are made with other jurisdictions that have introduced mandated reporting. The debate regarding the effectiveness of mandated reporting is also discussed using the relevant international literature.

In the literature review presented in chapter 2, the experiential role of the physician in the child protection process is critiqued. The issue of training for doctors is explored and consideration given to the effectiveness of training undertaken by clinicians. The organisational culture and hierarchy that pervades within systematic medical models are considered. In doing this, an analysis is made on how the culture in different clinical specialisms help or hinder the process of safeguarding children. Comparisons are also made between doctors who trained outside the state who are currently employed in Ireland.

1.3. Aims, objectives and structure

The aim of the study is to examine the views and significance of child protection reporting by doctors in the paediatric hospital environment. This is particularly relevant as the role of the hospital doctor in recognising and reporting abuse will very soon be a legal requirement under the Children First Act (2015). Doctors and other professionals who come into contact with children by the nature of their work are to be mandated to report a child they may feel is at risk. The remaining sections of the report are structured as follows:
• The central issues that concern the research are discussed in chapter 2 with a review of relevant international literature on the subject broken down into relevant sections concerning the hospital doctor.

• In Chapter 3 the research methodology is presented and the context and method of participant data collection is explained.

• Chapter 4 contains the research findings from participants interviewed in the study. An analysis of the data is conducted and comparisons made with the literature.

• Conclusions are presented in Chapter 5 based on the analysis of the research findings and with consideration to the literature on the topic.
Chapter 2: Literature Review

In this chapter relevant literature is considered in detail starting with a brief background concerning the evolution and development of child protection policy in Ireland. It owes much of its advancement due to numerous serious case inquiries undertaken as a consequence of the historical failings of the system. This culminated in the enactment of the Children First Act (2015). The chapter continues by discussing the role of the hospital doctor in the child protection process across grades and clinical specialisms. Training for doctors in child protection is also considered and the impact of training on clinicians’ effectiveness in the area. Finally the chapter offers some critique of the organisational culture and the traditional hierarchy present in the hospital context and how it influences effective child safe guarding processes.

2.1. Policy context: Prelude to the implementation of mandated reporting in Ireland

The impetus behind the first mandatory reporting laws relating to the identification of child abuse and neglect stems from the seminal work of the Colorado paediatrician C. Henry Kempe (1962) (Mathews 2015). Kempe and his colleagues did a great service in the development of awareness in the clinical setting with their concept of the Battered Baby Syndrome. This drew attention to the issue that many supposedly accidental injuries to young children were in fact the result of being hit by adults (Beckett 2007). From this pioneering work a “major new clinical practice emerged: child abuse and neglect”. (Bennett, et al 2005:1112). Kempe not only highlighted the issue of intentional harm inflicted on children by their care givers, but also raised the widespread reluctance, or inability by many in the medical profession to recognise and report abuse appropriately to services (Bross & Mathews: 2014). “Child Abuse was now fully recognised as a clinical entity” (Tenenbaum et al 2013:145).

Since then we have seen some refinement and a widening of our understanding and consciousness of child maltreatment from Kempe’s initial, and perhaps somewhat medicalised premise of ‘syndrome’. It primarily related to acts of physical abuse by parents. The consciousness has grown in the developed world about more subtle forms of maltreatment that are perhaps less apparent, such as child neglect in its many
configurations. This evolution in awareness follows a trajectory which is largely based on social construction theory. In the developed world this is also evidenced in the growing awareness of the concept of the ‘rights of the child’. Ireland is a willing participant in this process and became a signatory of the United Nations Convention on the Rights of the Child (UNCRC) in 1992. More recently a referendum in 2012 to amend Article 42 the Irish Constitution culminated in the formal recognition of the rights of the child in its most fundamental basis of law:

“In exceptional cases, where the parents, regardless of their marital status, fail in their duty towards their children to such extent that the safety or welfare of any of their children is likely to be prejudicially affected, the State as guardian of the common good shall, by proportionate means as provided by law, endeavour to supply the place of the parents, but always with due regard for the natural and imprescriptible rights of the child”. (Thirty First Amendment to Article 42.A of the Irish Constitution Bunreacht na hÉireann [2012])

The need for change and the development of more effective and robust procedures regarding child protection systems were required due to numerous serious case inquiries that highlighted the failure of child protection systems (Carter, et al 2006). Buckley & Buckley (2015:277) outline that over the past four decades the Irish system has “developed from an embryonic system to one which is comparable with that that exists in the Anglophone world and is based on similar principles”. The impact of these changes has a direct relevance to the paediatric hospital setting and it’s response to children that present with NAI or concerns regarding their welfare.

Similar comparisons can be made in the UK where a number of changes to policy have been implemented stemming from serious case inquiries. The Laming Report (2003) into the death of Victoria Climbie, who died at the hand of her caregivers, is seminal. The report details that she had numerous presentations to three separate hospitals prior to her death. The Home Office pathologist undertaking the post mortem on Victoria’s body detailed 128 separate injuries, advising the formal inquiry that it was the “worst case of deliberate harm to a child he had ever seen” (2003:366). The report made 27 recommendations that specifically relate to the hospital and health care settings.

In the Irish context the backdrop to the reforms is highlighted in the findings from several high profile reports commissioned by the State. Most notably: The Ferns Report (2005);
the Report of the Commission to Inquire into Child Abuse, (also known as the Ryan Report (2009); the Roscommon Report (2010), which focused on the failings of the Health Service Executive (HSE) in a particular case located in the west of Ireland; the Cloyne Report (2010), which addressed how the Catholic Church and the State agencies handled and responded to allegations of child abuse in the diocese of Cloyne (Cork) and finally, The Report of the Independent Child Death Review Group (2012), which investigated the concerns surrounding children who were known to or in the care of the HSE who had died.

Many of the report findings were covered in the media and contributed to raising public criticism of the system. Kilkelly (2012) suggests, from a children’s rights perspective, that the inquiries identify the systematic failure of the authorities to protect children from harm. The impetus drawn from these reports and the scandal that they present has influenced the political arena, culminating in the appointment of Frances Fitzgerald as the State’s first appointed (full) Minister for Children and Youth Affairs in 2011.

In January 2014 Tusla, (Child and Family Agency) was established in Ireland. It became “the first legal entity in the state solely dedicated to the support of children and families” (Tusla 2014:10). The agency brings together the former Children and Family Services from the Heath Service Executive (HSE), The Family Support Agency (FSA), the National Educational Welfare Board (NEWB) and services responding to domestic, sexual and gender based violence (Tusla, 2014). The agency employs more than 3,800 staff (Tusla, 2014). As we have seen in other CPS in other jurisdictions accountability, and standardised business processes are a new consideration for the agency. The agency’s Statement of Purpose, claims to

"build on the reform programmes already underway within the former organisations [but] will also seek out new opportunities and partnerships through alignment and enhanced productivity” (Tusla 2014:11).

Mandatory reporting for professionals who come into contact with children by nature of their profession was first recommended in the serious case inquiry into the Kilkenny Incest case, authored by Ms Justice McGuinness (1993). The victim at the centre of this case “had had a number of hospital admissions which clinicians failed to respond to" (McGuinness, 1993:9). Putting Children First: A Discussion Document on Mandatory Reporting of Child Abuse, (1996) is another document that also raised the issue of mandated reporting in Ireland. However, some considerable time has elapsed before it has been realised in the
form of the Children First Act (2015). Children First: National Guidance for the Protection of Children, was implemented as national policy in 1999 and revised by the Department of Children and Youth Affairs (DCYA) in 2011. On 25th April 2012, Ms. Frances Fitzgerald TD, the then Minister for Children and Youth Affairs published the Heads of the Children First Bill’ (HSE: 2015:5). The Children First Bill was enacted on the 19th of November 2015 and has since been signed into statue by President Michael D Higgins. It is currently under implementation on a phased basis. The Act now places much of what was contained within the Children First Guidelines (2011) on a statutory footing.

The Children First Act (2015) is intended to “raise awareness of abuse in order to make greater levels of reporting and the statutory obligation is being placed on scheduled reporters” (Buckley R 2014:36), which includes hospital doctors. The Act under S.14 now outlines the obligation of doctors and other scheduled reporters as:

“where a mandated person knows, believes or has reasonable grounds to suspect, on the basis of information that he or she has received, acquired or becomes aware of in the course of his or her employment or profession as such a mandated person, that a child has been harmed, is being harmed, or, is at risk of being harmed, he or she shall, as soon as practicable, report that knowledge, belief or suspicion, as the case may be, to the Agency”. (Children Fist Act (2015). Part 3. s.14 (1). (Under implementation).

The implementation of the recommendations and the sheer volume of the changes have its critics. There is also a realistic aspect that needs to be considered in relation to the impact of the changes for organisations and state bodies that are required to implement them. In October 2014 the then CEO of Tusla, Gordon Jeyes, in an interview with Irish Times, remarked that there has been a “tsunami” of recommendations from inquiries that are now expected to be implemented by the comparatively new Tusla. These, by their very nature, will have serious resource implications for the organisation. Burns and McCarthy (2012) in a study which examined the volume of referrals and workloads on social workers in the state’s child protection agency found that the sheer number of inquiries and the accompanying recommendations have left the system overwhelmed and have given rise to unrealistic expectations of it.
2.2. The debate surrounding the effectiveness of mandatory reporting

“The impetus behind the first mandated reporting law about any kind of child abuse or neglect was the work of C Henry Kempe (1962)” (Mathews 2015:4). Since Kempe’s ground breaking work, several forms of reporting have developed globally. Internationally there remain many gaps in the evaluation of our understanding of mandated reporting and voluntary child protection systems. As Drake & Jonson-Reid (2015:49) argue, “much of the data in this area is limited to the USA, Canada the UK and Australia”. It needs to be also acknowledged that a number of countries in the Nordic and Scandinavian part of northern Europe have formal systems of mandatory reporting in place. They have traditionally had state funded social insurance systems that differ to that of North America. Therefore comparisons are in some ways difficult to ascertain given the ethos and fundamental differences in the organisation of healthcare systems.

Much of the international research relating to mandated reporting has its predominance in Anglophone countries. It is broadly divided between proponents and critics with some who are in favour but argue that the systematic demands that mandatory reporting brings needs to be addressed for it to be an effective tool in the overall goal to improve the process of safeguarding children.

In describing mandatory reporting processes Svevo-Cianci et al (2010) divide mandated reporting systems into three main areas “(1) mandates (laws, regulations, and policies); (2) mechanisms/interventions (education, service programs, and data management); and (3) child outcomes (performance measures of the child's health, development, and well-being)” This illustrates the complexity and breath of the mandated reporting process. The assessment and reporting of alleged child maltreatment is in its very essence often thwarted with complexity and difficulties given the nature of child abuse (Melton 2004). Proponents argue that the implementation of mandated reporting systems assists in clarifying the situation for health professionals who are required to respond as their statutory duty. Whatever the process, from the author’s experience, the belief amongst most health professionals would broadly support Goldson’s (2015) view that the “the failure to report neglect is one way of denying the child of her or his rights” (2015:224). Strong proponents of mandatory reporting, such as the Children Rights Alliance (CRA) have
long campaigned for the imposition of mandatory reporting in Ireland. Ward (2012:1) proposes that the implementation of mandated reporting will “change the culture of putting our heads in the sand, to one where we turn the lights on and tackle abuse in the full glare of the law”. This radical view is understandable in the Irish context given the publicity surrounding the failings of the system and the subsequent public discourse arising from the serious case inquiries. It is therefore logical that expectations are high from groups that are concerned with advocating for the rights of the child, adding political weight to the need for formal legislation.

Paradoxically, Buckley & Buckley (2015), advise some caution in this regard and question if mandatory reporting is the best response within the Irish context at this time. They suggest that we must be careful of what we wish for, and outline their concerns regarding the current system and the demands on the state’s fledgling Child and Family Agency, describing it as “brittle and under pressure”. They are somewhat sceptical of the overall impact and outcome of mandated reporting and question its effectiveness. And suggest that the historical failings of the system and the subsequent public outcry surrounding large organisations within the State (such as the Catholic Church failing to adequately protect children) are significant factors in the rush for its implementation.

In the Irish context, the Catholic Church culturally and politically has traditionally held an influential role which is woven into the fabric of Irish society since the establishment of the state in 1922 (O'Sullivan & Rafferty 1999). However, Buckley & Buckley argue that the “actual numbers of children who were abused by religious clergy are in fact very low when compared to the maltreatment inflicted on children by their own families” (2015:280). Since 2000 approximately 300,000 reports have been made to the CPS, the majority of which relate to neglect or welfare issues occurring within the family in which the child lives. By comparison eight allegations were made during the same period regarding priests or members of religious orders (NSBCCC 2012). This supports research that claims that the vast majority of abuse of children occurs within an intra-familial context within the family home.

Donald (2012) is also critical of the effect of mandated reporting and its consequences from an Australian experience. The author argues that whenever and wherever
mandatory reporting has been introduced the number of notifications to statutory authorities dramatically increases making it difficult to adequately manage. Melton (2005:10) goes further and argues that in the USA were mandated reporting has been present in 50 states for some time “many of the catastrophic problems in contemporary child protection work [in the USA] are a direct product of the failure of mandatory systems”. Melton goes on to suggest that there is still a problem with under reporting even when compulsory mandated reporting is in place as in the USA, arguing that “the policy is bankrupt, and the systems on which mandated reporting is built are plainly erroneous”. Melton proposes that systems should be “revised to facilitate voluntary assistance to children and families” (2005:15). Even supporters of mandated reporting such as, Drake & Jonson-Reid (2015:39) acknowledge that “most maltreatment still goes unreported” and have acknowledged the difficulties that surround the phenomena of the actual rate of maltreatment compared to that which is reported to child protection services.

Goldson (2015) acknowledges some of the documented criticisms of mandatory reporting and understands that there may be concerns regarding its implementation. However in response to the view held by opponents, such as Worley and Melton (2013) who maintain that it has not worked and it is a “flawed concept”, Goldson argues that the flaws and failures reside in the system designed to respond to the reports of abuse and advocates that “you should not discard a concept because you have not put in adequate resources and thought to operationalise it” (Goldson 2015:219).

Karson (2013:7), conducted a piece of research regarding the volume of referrals to child protection services in the USA since the implementation of mandatory reporting in the early 1960’s. The study found that “calls to CPS services in the USA increased from 150,000 in 1963 to 3.3 million in 2009”. This is a substantial rise even when you factor in the likely increase in referrals to child protection services due to society’s improved consciousness and general awareness about child abuse since the 1960’s within the developed world.

Often the fiscal cost implications of mandated reporting are cited by opponents in other jurisdictions where it has been implemented. Ainsworth (2002:62) found: “The analysis presented [in New South Wales] suggests that mandatory reporting systems are overburdened with notifications, many of which prove to be not substantiated, but which
are time consuming and costly”. However, Drake & Jonson-Reid challenge this popular view about mandated reporting in the USA and argue that “investigations are proportionately a very small burden on the system” (2015:41). They argue that by comparison other large areas of expenditure within the budgets of child protection departments in the USA, such as foster care, residential services and legal fees are considerable.

In Ireland the HSE bears the largest responsibility in the state to ensure that doctors and other health professionals who are to be mandated reporters are sufficiently aware of the statutory responsibilities required of them under the Children First Act (2015). By its own projections in their Children First Implementation Plan (2015) there are 9,265 medical and dental practitioners who will come under the requirement as mandated reporters outlined in the Act. (HSE 2015:19). The HSE’s own implementation plan outlines that:

“The policy objective of the Bill [pre enactment] is to make further and better provision for the care and protection of children; to raise awareness of child abuse and neglect; to provide for mandatory reporting by key professionals; to improve child protection arrangements in organisations providing services to children, and to provide for inter-agency working and information-sharing in relation to assessments by the Agency”. (HSE March 2015:5).

Table 1 shows the professionals who are either employed directly or as funded organisations by the HSE (S.38 Agencies) that will come under the requirements of the Act and who will also require training. This totals over 67,000 people within the State:

<table>
<thead>
<tr>
<th>Grade</th>
<th>HSE Staff</th>
<th>Section 38. HSE Funded Agencies &amp; staff</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental Practitioners</td>
<td>5,907</td>
<td>3,358</td>
<td>9,265</td>
</tr>
<tr>
<td>Nursing</td>
<td>26,429</td>
<td>14,524</td>
<td>40,953</td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>1,554</td>
<td>8</td>
<td>1,562</td>
</tr>
<tr>
<td>Health and Social Care Professionals</td>
<td>8,643</td>
<td>6,957</td>
<td>15,600</td>
</tr>
<tr>
<td>Clergy and Pastoral Care Staff</td>
<td>160</td>
<td>77</td>
<td>237</td>
</tr>
<tr>
<td>Total</td>
<td>42,693</td>
<td>24,924</td>
<td>67,617</td>
</tr>
</tbody>
</table>

*Table 1: HSE & S.38 Funded staff who will be mandated under the Children First Act (2015)*
*Source: Children First Implementation Plan for the HSE (2015:19). (*under commencement).*
2.3. The role of the hospital doctor in child protection

Child abuse is the third leading cause of death in children under four years. In almost 20% of child homicides the children who died had contact with a health care professional in the month prior to their death. (Kodner et al 2013). Regardless of the debate surrounding the outcomes and effectiveness of the introduction of mandated reporting for health professionals the doctor is clearly well placed to act to protect children. Much has been written about the pivotal role that the hospital doctor has in safeguarding children at risk. As Mathews (2015:4) suggests, ‘the fundamental premise is that doctors regularly encounter children by virtue of their profession, and because of this are well placed to identify cases of severe maltreatment, and by reporting it to enable intervention’. Similarly Goldson (2015:221) shares this view of the key and systematic responsibility of the doctor and comments that ‘neglect occurs when those responsible at whatever level for meeting the basic needs of children fail to do so’. Internationally this understanding has evolved from the pioneering work of Kempe et al (1962). Kempe, who as a paediatrician in the US, talked of the concept of the ‘battered baby syndrome’ raising the issue that doctors in the clinical setting need to be aware of and to act upon the concept of child abuse and to report matters to Child Protection Services (CPS). As Drake & Jonson-Reid (2015:44) put it, ‘Kempe exhorts each physician to acquaint himself with the facilities available in private and public agencies that provide services for children’. Melton (2004:9) acknowledges that ‘the world owes a great deal of gratitude’ to doctors like Kempe and his colleagues in raising the awareness of the key role that paediatricians and other doctors can play in the protection of children who are deemed to be at risk.

As a supporter of mandated reporting Melton goes onto say that Kempe reached the conclusion ‘that the best policy response in the US would be to require health professionals to report those egregious cases to public authorities with a legal mandate’ (2004:9). More recently Scott & Frasier (2015) build on this premise, and they also acknowledge the key role that doctors have in terms of their professional access to children. They conclude that until a child starts formal education, the outside world will be largely unaware of what occurs within families. ‘This magnifies the responsibility of doctors in terms of identifying, documenting and reporting child maltreatment’. (2015: 383). As outlined earlier in this chapter there has been significant learning from findings into child
abuse from the serious case inquiries conducted in the UK and Ireland. Hospital doctors and other allied health professionals are highlighted for failing to recognise and act regarding children who were subjected to repeated and systematic abuse after presentation to them in the clinical setting.

In Laming’s (2003) report into the death of Victoria Climbié in the UK, some 27 recommendations were made that specifically relate to the hospital environment. Significantly parts of the Laming’s report focuses the importance of the key role of the hospital doctor in the detection and reporting of suspected or identified non-accidental injury. A recommendation in the report called for improved training for doctors to help them recognise and act upon signs of suspected maltreatment.

The hospital setting in which this study is undertaken has developed some procedural guidelines to assist doctors, nurses and social workers in the process if they suspect that a child has been harmed. A child protection algorithm was developed in 2008 to help staff deal with the complex process via the multi-disciplinary team. Figure 1 is the part of the algorithm that was developed to support doctors in the identification of child maltreatment.

Studies on the topic of child safeguarding by several authors including Goad (2008), and Raman et al (2011), have found that despite the consensual agreed importance of the role that doctors can play in safeguarding children, child abuse and neglect is still under reported by doctors who work in hospitals. As a consequence of the failings highlighted in Laming’s report (2003), compulsory child protection training was introduced in the UK for all doctors throughout the NHS. The key question in this process is whether or not doctors see the need or are suitably aware of the issues concerning child maltreatment. As Buckley R (2015:37) argues ‘the focus should not be what will motivate [doctors] to report; instead it should be what is deterring them’.

In 2014, Kaminski & Tan conducted an anonymous study into the attitudes to safeguarding children in the UK with doctors in a Manchester Hospital NHS Trust. Ironically their study found that ‘45% of all practitioners did not feel that child welfare was everyone’s responsibility’ (2014:78). Paradoxically “child Protection: The Responsibility of all Doctors
“14 (2012)” is the title of a book which was distributed to all NCHD’s within the NHS by the General Medical Council which was post Lamming (2003) and prior to Kaminski and Tan’s study.

Figure 1: Hospital’s Child Protection Algorithm assisting doctors in reporting NAI & maltreatment.
Anomalies like this, which is also reflected in the authors practice experience the paediatric setting, can often present with cause for concern and in some cases fuel conflict between stake holders in the multi-disciplinary team. It raises the question of the potentiality of child maltreatment being ignored or missed by the clinician’s lack of understanding or awareness of the issue or inherent organisational, cultural or systematic factors that may deter doctors from reporting.

Throughout the literature on the topic on doctors and child safeguarding the argument that is commonly put forward tends to focus on the need for more training in child abuse recognition and response. This is of course to be welcomed, but as Kaminski and Tan’s research has shown perhaps a more sophisticated evaluation of the culture in which doctor’s train and work is required if improvements are to be made in reporting.

Buckley R’s (2015) question on what deters reporters and a further question surrounding the culture in which doctor’s train and how this influences reporting needs to be examined. Bunting et al (2010) comment on the need for training to go beyond simple ‘awareness raising’ for doctors to tackle the issue of non-reporting in a meaningful way. The training needs to be ‘tailored to address the range of different factors which impact on reporting attitudes and behaviours’ (2010: 187). This adds weight to the need for further evaluation of the culture in which doctors train and work and how child protection training is delivered to them.

Flaherty et al (2005) in a study in the USA offers some explanation on the issue of doctors’ underreporting. They found that the attitudes of doctors and their views regarding the identification and reporting of child abuse caused several barriers that commonly exist which inhibit reporting. Initially they cite a general lack of knowledge and training amongst doctors. Psychological barriers were considered in participant’s responses including a lack of comprehension that, parents for example, could be capable of harming their own children. The type of maltreatment that the child was subjected to was also a contributory factor influencing the clinician’s decision to report to the CPS. For example the study showed that neglect, medical neglect, or emotional abuse were less likely to be reported than signs of physical abuse or sexual abuse. This is despite the fact that neglect is the most common and on-going form of maltreatment. The study found that socio–economic and demographic factors were also influential in the decision to report. Parents from lower
socio-economic backgrounds found themselves more likely to be reported to CPS than those from middle class backgrounds. Fear of being wrong was also cited by participants where the prospect of civil litigation was considered. The perception that an unsubstantiated or false allegation may result in unnecessary stress to the child or parents can also influence the decision to report. Perhaps most interestingly, the study considered the doctor’s previous experiences of the CPS as a factor that influences their future reporting. ‘Many physicians mistrust CPS because of negative experiences. Only a minority report that they were kept informed about the status of the investigation once reported’ (Flaherty et al 2005:353). The conclusion drawn from this was that ‘this lack of feedback from the services can become a barrier to referring in the future with 49% of the sample advising that their last experience made them less likely to report in the future’ (2005:353).

Finally, another important finding in the study by Flaherty et al established that differing attitudes to reporting abuse existed within different medical specialisms in which the doctors were employed. For example, GP’s and doctors working general paediatrics were more likely to report abuse than that of doctors working in orthopaedic and surgical disciplines. These findings are very comprehensive and shed light on some of the issues that need to be addressed if doctors across the medical specialisms are to become more commonly effective in responding to NAI. The idea that doctors working in different clinical areas respond differently and have differing thresholds for reporting is a concern, particularly with regard to that of orthopaedic injuries. As ‘non accidental paediatric injuries are a major cause of morbidity and mortality, with fractures being second to soft tissue injuries as the most common presentation’ (Tenenbaum et al 2013:145). This echoes similar findings in relation to under-reporting within the orthopaedic specialism of child maltreatment also presented in an earlier study by Baldwin & Scherl (2012).

In their retrospective study entitled ‘Paediatric Non accidental Injury: Are Orthopaedic Surgeon’s vigilant enough?’ Tenenbaum et al (2013) acknowledge that the orthopaedic surgeon may be the only physician that an abused child may encounter. Their study was undertaken in Israel, were mandated reporting is in place and failure to report may result in a custodial sentence. Despite this, the research found that under reporting is common. Orthopaedic doctors are pivotal as ‘one third of physically abused children are diagnosed by orthopaedic surgeons’ (2013:145). The study findings indicate that more experienced
surgeons had less awareness of CPS processes and where less likely to refer to CPS than less experienced doctors. If these findings are reciprocated in other countries it raises the question of the need for specific training for orthopaedic surgeons. This is particularly important if consideration is given the numbers of children that present to them in the clinical setting with suspected NAI.

2.4. Training for hospital doctors in child protection recognition and response

Firstly, when considering the training that doctors need and require in child protection procedure it is helpful to acknowledge the complexities of identifying child maltreatment and the circumstances in which it occurs. Buckley R, acknowledges this and argues that “detection of abuse is not a simple process, instead for the most part it is extremely problematic and requires a trained eye, confidence and continual engagement with the child and family” (2015: 38). “Physicians have often reported that they were not adequately trained to identify and report child abuse” Cindy & Christian (2008:13). Research indicates that a fear of getting things wrong can be a factor that is present in doctor’s mind-set. The impact that a referral to CPS can have, perhaps needlessly, on the parents or the child is also a realistic consideration if a concern is unsubstantiated.

Much has been written about parental experience of the CPS system in an age where children’s rights are at the forefront of the child protection agenda and policy. In a study of service users’ experiences of the child protection system in Ireland by Buckley H, et al (2010) cite a parent interviewed for their study who described the process as “like waking up in a Franz Kaffka novel” (2010:126). This is consistent with other studies in the area including that of Pietrantonio et al, (2013:102), who argue that “caregivers often perceive the CPS authorities as a highly powerful force dictating the direction of their lives”. When all these factors are considered it then becomes essential that the hospital doctor is both aware and equipped as best as possible to detect and to respond to maltreatment and to make informed judgements. Carter et al, (2006:742) also acknowledge that the child protection process is challenging and argue that “professionals should be well supported by sound procedural guidance and properly designed models of training”.
By its very nature medicine is a transitory profession that requires junior doctors to move around to obtain the necessary clinical experience to progress. In the hospital where this study was undertaken there are a considerable number of doctors that undertook their undergraduate training overseas in developing countries. The doctors rotate every three or six months according to their grade and specialism which makes for a fluid situation of constant change. Child protection training, awareness, and procedures vary greatly globally from country to country with no formal definitions of child abuse in some countries (Fung & Chow 1998).

The hospital setting where the study was undertaken does not audit junior doctors in relation to their knowledge of safeguarding and experience of training prior to appointment. In a study in the UK in 2010 of international junior paediatricians working in the NHS by Hosduga & Finaly, 73% of participants had no prior training in child protection as undergraduates, 68% had no postgraduate training. Only 16% had an induction that contained child protection procedures in their first hospital placement overseas. (2010:370). The hospital in which this study was conducted has compulsory training for all allied health staff excluding doctors in the form of Child Protection Awareness Training (CPAT). The training is facilitated by the hospital social workers and nursing staff. It is loosely based on the current Children First Guidelines (2011) adapted for the paediatric hospital setting.

Thompson (2011) conducted an internal study of CPAT participants in the hospital. It explored if knowledge gained from the CPAT training was effective to everyday practice within the setting. Findings presented indicate that participants thought “that when equipped with knowledge skills and support [it] can make a difference in responding to concerns of child protection”. However, CPAT training is “non-mandatory for non-consultant hospital doctors, and certain management personnel” (Thompson 2011:27). This is at odds with good practice recommended by Cindy & Christian (200:13) where “physicians are sentinels for child maltreatment”. And interestingly the hospital’s own policy document advises that: “The hospital has a responsibility to provide induction and on-going training to staff [including doctors] to ensure that they are sufficiently skilled to identify suspected child abuse” (Joint Child Protection Sub-Committee of Council for the Children’s Hospitals Care, Dublin. p7).
The HSE has the principle responsibility to train its staff and those working in agencies they fund. This includes voluntary hospital settings like the one in which this study was conducted, in order to compile with the Children First Act (2015). The HSE has ear-marked €2.5 million to address this need (HSE 2015). As part of its implementation plan new posts have been created nationally and former social work managers have been appointed as Children First Training and Development Officers to oversee training and development of the Act’s implementation to ensure compliance and develop training resources for its staff (HSE 2015). The HSE’s implementation plan advises that much of the compulsory learning will be delivered through an ELearning platforms, given the numbers of clinicians and others who will require this training. More conventional training will also be provided which is currently being devised by the HSE for Designated Liaison Persons (DLP’s) who will assist mandated reporters in the reporting process in the clinical setting. At the time of writing this training initiative is currently under implementation.

2.5. Organisational culture, doctors and its influence on effective safeguarding

In any study concerning child protection and the clinicians’ involvement in the process of safeguarding, the culture in which doctors work and learn needs to be considered. “Organisational culture determines greatly how individuals behave, what people pay attention to, and how they may respond to different situations in that setting” (Spataro 2005). In the medical setting traditional hierarchical and professional structures are well defined as progression is made through a doctor’s career from the generic, to the specialist, resulting ultimately in a position as a consultant within a particular specialism. The organisational culture in which this training process occurs is also significant. As Montgomery et al (2011:110) found that:

“typically organisations form hierarchical bureaucracies. Thus power derives from a person’s position, and responses to changes in the work environment generally begin by ignoring changes in circumstances and by relying on the existing set of routines”.

There is a well-established set of routines within the medical model which are generally adhered to within hospitals. Medical literature comments extensively on the advantages of the medical model with its diagnostic properties and is often critical about the conflict
between social models present in the hospital environment. This is particularly apparent in the area of child abuse recognition and response (Charon 2001).

The conflict between these models can often bring physicians into disagreement with other health professionals including that of medical social workers who by the very nature and role have significant knowledge and expertise of the child protection process. “Social workers undertaking child protection work in health care often argue that they must be professionally assertive in order to keep their values afloat in a stormy sea of change”. Beddoe (2011:24). According to Abramson & Mizrahi (1996:271) this conflict arises from “distinct variations in the professional socialization processes between these two key professions concerned with the child protection process”. Members of these professions “define their role with patients differently and impart distinct values and culture in training their recruits”. What is apparent in much of the literature on the subject is that where a consultant provides leadership, dialogue and on-going support to junior doctors and other professionals the child protection process is more effective. Abramson & Mizrahi (1996) advocate that “collegiality” and “reciprocity” are required by all professionals concerned to make the professional relationship more functional in its overall objectives to safeguard children.

Cindy & Christian (2008:15) echo the significance of the role of the consultant in child abuse cases and claim that “senior physician participation in the interdisciplinary process of child protection would underscore the difficulty of the work and lead to improved decision making”. Laming (2003) poignantly addressed similar cultural issues in the clinical setting in his enquiry into Victoria Climbié’s death. The report found that the multi-disciplinary meetings in one of the hospitals she presented had poor leadership from senior doctors and poor interdisciplinary collaboration. The social workers in the hospital had long since ceased to attend both the psychosocial meetings and the weekly non-accidental injury forum prior to her [Victoria’s] admission. Social workers involved in the case advised that when they did attend the meeting, they felt “deskilled and devalued, their professional expertise and opinions were not appreciated and feedback was not provided to them” (Laming 2003:225). The report is balanced and also is also critical of the social workers contribution to the failings in the overall process. “It was in their job description to attend the meetings and the social work mangers failed to address this issue
in supervision with their staff” (Laming 2003: 225). This example perhaps exemplifies the conflict that can occur between doctors and social workers in the child protection process which has its roots in the organisational culture and professional identity which eclipsed effective collaboration.

From the authors experience in practice, as in literature on the topic, it is clear that medical opinion is still regarded as a very powerful thing in child protection cases. It arises from the concept of the expertise that doctors possess. And it is arguably reinforced by the social standing that the medical profession holds generally. Doctors traditionally have become adept at recognising physical symptoms in children by the nature of what they do and how they are trained. However, as Beckett (2015:12) argues, “we should not assume that this expertise extends to all aspects of the problem regarding child maltreatment”. Often more subtle forms of abuse are missed such as neglect as there is very little scientific base for establishing these most common forms of child maltreatment as they often occur over time in the psycho- social context of the family (Children First 2001:8). It can be difficult to get doctors to commit to take action on these more subtle forms of maltreatment as they do not always see this as their role. Beckett (2015) contends that medical opinion and the culture of acceptance that follows it among other non-medical professionals should not always be seen as an “exact science”, arguing that it can be wrong and it can be prone to change with time. An example could be that two different doctors examining a child and disagree on the cause of injury. In the Cleveland Report (1988) in the UK, criticism was made of social workers involved in the case who accepted too readily the opinions the paediatricians that conducted the initial investigations of the children that were at the centre of the inquiry.

Junior doctors themselves who rely on senior clinicians for their professional progression may also find it difficult to challenge the authority of consultants by the very nature of the hierarchical structure in which they train. Hospital culture emphasises a collaborative multi-disciplinary approach of shared leadership, but this may be challenging for junior clinicians working within a traditional hierarchy’s.

Nembhard & Edmondson (2006:949) offer a framework for improvement and functionality in multi-disciplinary teams (MDT) in health settings. They propose that by “openly recognizing and discussing the tensions between traditional and inter-professional
discourses it may be possible to help inter-professional teams, physicians and health professionals alike, work together more effectively”. Involvement of the leader [consultant] is essential in this process. They argue that there needs to be a “psychological security” between all members of the MDT in the hospital setting for the effectiveness of safeguarding to improve. Figure 2 illustrates this process:

![Figure 2: Making it Safe: A model of professional status on psychological safety in health settings. (Nembhard & Edmondson 2006: 949)](image)

In conclusion, the context of the study has been explained and the international literature has been discussed including the policy context in Ireland which has culminated in the introduction of mandatory reporting. The importance of the hospital doctor in the child protection process and the importance of training for doctors have been considered. Finally the organisation culture and hierarchy in which doctor’s work has been critiqued in terms of the impact that this can have on reporting and responding to child maltreatment. In the next chapter the methodology utilised in the study will be outlined.
Chapter 3: Methodology

This chapter outlines the methodology applied in the study. The participant selection process is explained and consideration given to some of the theoretical concepts involved the design of the study. The method utilised in the data collection will be explained and justified and the rational for choosing qualitative interviews. Several ethical considerations were undertaken in the process of gathering participant data. Finally some of the limitations of a study of this nature will be acknowledged.

3.1. Sample selection and participants

The study was conducted in the setting in which the researcher is employed as a Senior Social Worker. A large degree of the day-to-day work involves the investigation of suspected non accidental injury to children who present to the hospital. The researcher is also involved in providing training to hospital staff on child protection procedure. These factors were a consideration in focusing on the topic of the study. Experience in the setting indicates that the effectiveness of the child safeguarding process has been mixed. There are with elements of very good practice in some clinical areas that operate functional systems. Paradoxically in other areas effective processes are often found to be lacking and problematic. This raises the question of why these differences exist in the clinical environment that should be uniform in its approach to safeguarding children as its policy suggests. These differences formed the basis for the selection of participants.

Objectivity was an essential requirement as a starting point. Denscombe (2010:195) advises that “generalisations in qualitative studies in the clinical setting need to be made cautiously, particularly with regard to the selection of participants”. So therefore it was important to focus on the participants who could provide honest and authentic data to counteract stereotypical professional viewpoints.

In light of this the hospital statistics detailing with child protection referrals to the medical social work department from 20110-2015 were reviewed. Figure 3 below shows the proportion of cases and illustrates that the four highest referring clinical specialisms for NAI in the hospital were: the Emergency Department (ED), Burns and Plastics, General Medical and Orthopaedics. This enabled a good sample of views to be established. ‘Sampling refers to the process of selecting a subset of items found from a defined
population for inclusion in a study’ (Guest, et al 2013:41). From the statistical data a decision was then made to focus the study on doctors that worked in each of these particular clinical specialisms. The objective of this was to provide a richness of data given the participants regular exposure to NAI cases.

![Breakdown of Child Protection Referrals to Social Work Department 2010-2015 by Medical Specialism in the Hospital](image)

Figure 3: Child protection referrals to social work department 2010-2015 by medical specialism (Source: Hospital Social Work Department child protection statistics in the setting in which the study was conducted).

It was also important to select participants that have varying levels of clinical experience within the four specialisms. Consequently participants were selected from varying grades including Consultants, Registrar’s (SPR’s), and Senior House Officers (SHO’s). For several of the more junior participants the setting was their first job in paediatric medicine. This then allowed for participant’s experience of the organisational culture, and professional hierarchy in the medical setting to be considered in findings. Finally some interesting international perspectives could be gained from the data obtained as several of the participants had trained or worked overseas.

Participants were approached by the researcher directly based on their specialism. In some cases the participants had worked directly with the researcher on child protection cases. In other cases some of the doctors were not known to him and were contacted utilising a snowballing approach. For example a consultant may have been interviewed first in the specialism and then the researcher requested the contact details of another doctor who they thought may be interested in participating in the study. They were then subsequently
approached directly. Figure 4 shows the cross repetition of participants by clinical specialism.

![Cross Hospital Representation by Clinical Specialism Involved in the Study](image)

*Figure 4: Cross hospital representation of participants by clinical specialism involved in study*

3.2. **Research Design**

The research design utilised qualitative structured interviews that were undertaken with participants from the selected sample groups. Qualitative interviews were selected as the most viable data gathering option as opposed to other methods such as questionnaires given the complexity of the clinical context. As Darlington and Scott (2002) supports, “qualitative interviews are particularly well suited to exploring questions in the human services which relate to the meaning of experiences and to deciphering the complexity of human behaviour”.

Consequently a meaningful thematic narrative including differentials concerning the overall research question emerged in the data findings and analysis. Davies (2007) advises that interviews regarding a study of this nature should be person centred and holistic in order to understand human experiences. The merits of this perspective was acknowledged by the researcher given the complexities of child protection work and the fact that most
participants wanted to be seen to be doing the right thing in relation to the protection of children. They were given reassurance regarding this and advised that the process was not a ‘test’ about what they knew about child abuse, but their views and experiences on the process would be useful for the study. Participants were provided with a letter of information explaining the purpose of the study (see Appendix 2). All the interviews were conducted within the hospital setting and formal consent forms were signed by each participant’ (see Appendix 3).

Structured open ended questions were utilised and an initial pilot interview was undertaken to check for effectiveness and relevance to the overall research question. Some subsequent amendments were made to encourage the participant’s breadth of views and experience to enable more objective data. “The inductive probing at the heart of in-depth interviewing requires that the interviewer shape the probing questions in a dynamic fashion- keeping in mind both the objectives of an interview and the substance of the participants answers” (Guest et al 2013:113). The interview questions (see Appendix 4) were arranged thematically which to a large extent was formed around common themes on the topic that are apparent from the literature in Chapter 2. The themes covered the following areas:


B) Participants Experience of and Their Role in the Safeguarding Process.

C) Organisational Culture and Hierarchical Factors.

D) Implications of Mandated Reporting for Doctors.

E) Any other Thoughts or Reflection’s on the Study Topic.

Every effort was taken to explain the purpose of the study, which as Gomm (2008:11) argues, encourages respondents to make “authentic disclosures about their thoughts and feelings”. The interviews were taped and subsequently transcribed by the researcher and written notes were also taken during each interview. Common themes were then established which are presented in the data findings in Chapter 4.

An appreciation of some of the methodological components of Grounded Theory, developed by Glaser & Strauss (1998), was useful during the research design. Notes were
taken after each interview in the form of memos to prompt the researcher and clarify significant themes made by each participant. As Edmonds & Kennedy advocate this helps to generate a theory based on data that is systematically gathered and analysed. “This is an inductive process where the theoretical propositions are not presented a priori; rather the theory emerges from the data that is being collected” (2013:115).

3.3. **Structure and presentation of data findings**

The data is outlined and presented in the five areas detailed above from A to E. Central themes were established based on the findings from the data, including participants’ training experience and knowledge of child protection procedure; their understanding of their role in the child protection process as a doctor; their experience of the organisational culture in which they operate and the understanding of the implementation of mandated reporting. The data was analysed and comparisons made with the central themes drawn from the literature in Chapter 2. Comparisons were also be made with the policy and procedure of the setting in relation to child protection processes that are currently in place and also the requirements of the new Children First Act (2015). The findings presented in Chapter 4 follow a clear structure based on the areas detailed as A-E above. The findings are presented with regard to the four different clinical specialisms within in each section to assist the reader in making comparisons between each of them. Finally some analysis will be provided at the end of each section.

3.4. **Ethical issues**

Given the nature of this study there were are a number of important ethical considerations to be made. Formal ethical approval was sought and granted by both the Hospital Ethics Committee (See Appendix 5) and that of Trinity College Ethics Committee. The committees were provided with an abstract of the study’s aims and objectives and the participant information letter detailing the purpose and process of the research study. Sanders and Wilkins’s (2010:254) comment that “It is axiomatic that any research you do should be designed in such a way as to avoid harm to the participants”. With this in mind the following factors are important.
1. No children or parents were involved directly in the research and the study did not require access to confidential data contained in patients’ medical charts.

2. The participants are all employed in the setting at the time of the study and participated in the study of their own free will.

3. English was not the first language of all the participants which was a consideration for the researcher. However all participants had a good command of English as it is a requirement of their day-to-day work as a hospital doctor.

4. Permission was sought to contact participants from the hospital authorities and their immediate clinical line managers.

5. A signed consent form was completed by each participant which details that the data findings would be coded and ammonised in respect of participant confidentiality.

Polit et al (2001) recommends that from an ethical standpoint if a participant withdraws from the process their transcript should be destroyed. Interviews were recorded and then deleted once they were transcribed by the researcher. The transcripts are to be kept in a locked filing cabinet during the write-up of the study and destroyed once the exam board has met to consider the study. The researcher and the researcher’s supervisor will be the only persons who have access to the transcripts. If, during the interview information was divulged were a child is needlessly at risk, participants were advised that the confidentiality of the interview would have to be compromised under the principle of the best interests of the child being paramount which is in line with Children First National Guidance (2011) - see Appendix 3.

3.5. **Limitations of the study**

There are several factors that need to be outlined with regard to the limitations of the study. Some consideration needs to be given to the fact that the researcher is employed in the setting in which the study was undertaken. This no doubt presents with both advantages and disadvantages. Some participants were known to the researcher prior to the interviews taking place. Every effort was made to ensure that the interviews were balanced and conducted appropriately. Sanders and Wilkins (2010:73) advise that
population samples such as the one used in this particular study can be potentially “defined and manipulated” by the researcher. Significant effort has been undertaken on the part of the researcher to prevent this to ensure that the collated participant data is authentic, objective, and an honest representation of the views of participants on the topic.

The sample study has been chosen to give the best representation of doctor’s views and experiences across grades and specialisms that deal with child protection cases on a regular basis. However account needs to be given to the fact that there are obvious limitations to a study of this nature given the relatively small sample size and the fact that it was conducted in one paediatric hospital in Ireland. Consequently the findings will be informative but will also need to be considered within these prescribed limitations.

In the next chapter the data findings will presented followed by some analysis of the key themes that have emerged from the participants involved in the research.
Chapter 4: Findings, Discussion and Analysis

4.1. Introduction

In this chapter the study’s findings and analysis are presented. The coding procedure for the participant data is outlined in Table 2 below. This was undertaken to protect the anonymity of each participant and the code applied in the findings and any subsequent analysis. The findings are presented in four central themes: The participants’ training in child protection procedure, their experience and role in the child safeguarding process, the influence of organisational culture and hierarchical factors and finally the participants’ views on mandated reporting are considered.

Figure 5 and Figure 6 provide a breakdown of the participant profile by professional grade and clinical specialism in which they work.

![Figure 5: Representation of Participants by Professional Grade in the Setting](image)
4.2. **Coding of participants**

Table 2 provides details of the coding system applied for each of the participants. The data presented is formatted by the code illustrated in the table below.

<table>
<thead>
<tr>
<th>Department</th>
<th>Participant's Role</th>
<th>Code Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department</td>
<td>Consultant</td>
<td>C ED</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>Specialist Registrar</td>
<td>SPR ED</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>Senior House Officer</td>
<td>SHO ED</td>
</tr>
<tr>
<td>Burns &amp; Plastics</td>
<td>Specialist Registrar</td>
<td>SPR BP1</td>
</tr>
<tr>
<td>Burns &amp; Plastics</td>
<td>Senior House Officer</td>
<td>SHO BP</td>
</tr>
<tr>
<td>General Medical</td>
<td>Consultant</td>
<td>CGM</td>
</tr>
<tr>
<td>General Medical</td>
<td>Senior House Officer</td>
<td>SHO GM</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>Specialist Registrar</td>
<td>SPR O</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>Senior House Officer</td>
<td>SHO O</td>
</tr>
</tbody>
</table>

*Table 2: Codes Applied to Each of the Research Participants Presented in the Findings*
4.3. Participants Training in Child Protection procedure.

4.3.1. Emergency Medicine

The Emergency Department (ED) in this study is the largest referrer of suspected maltreatment cases and NAI to the hospital social work department, accounting for 55% of the referrals from 2000-2005, (See Figure 3). Participants interviewed in ED spanned professional grades in terms of experience. Generally participants in this department understood the importance of child safeguarding and their role as a doctor. There was however, a differing response to questions concerning the training they had undertaken. C ED advised that they had undertaken some courses of their own volition during their medical training due to their motivation to become an ED consultant:

“As a Registrar I did a week’s long course in Birmingham [UK] on child protection for senior clinicians. This was not available in Ireland. At that time you had to leave the country to get that level of training. This is something I undertook myself”.

When the participant C ED was asked about their undergraduate training on child protection in medical school they advised that it was only a small part of the curriculum:

“It was quite rudimentary, there needed to be more of this. “It was touched on in lectures on paediatrics concerning atypical physical NAI’s…… but nothing on the legal and procedural aspects of child protection, which you need to know”.

C ED was able to reflect on their international experience in Australia prior to becoming a consultant. The participant made the following comparison with the Irish system.

“The training in Australia was compulsory and superior; it was operated by the hospital itself. You would not have been allowed to work with patients unless you had had undertaken this training there”.

A colleague who is more junior in the department, SPR ED, provided similar data when it came to training. Advising that much of the child protection training they undertook was “self-propelled”. And that, “you need to know this stuff if you want to work in paediatric emergency medicine with confidence”.

ED SPR had had some internal training in the setting organised by a consultant and a senior social worker, which they advised “was well presented and it covered both the diagnostic, procedural and legal issues surrounding child protection, it was useful”.

32
ED SPR also reflected on the positive experience in the Australian system after working there as an SHO, “by comparison it was great!..... it’s a completely different system than we have in Ireland. You felt a lot more supported regarding child protection cases”

The most junior participant in the department, SHO ED, had been qualified for two years and had only worked in the department for two months. This job was their first paediatric hospital role since qualifying. Answering the question on training they advised: As a under graduate.......I had very little, one lecture only sticks in my mind”. The participant advised that the opportunity to undertake training in child protection has been limited thus far:

“I haven’t received any training..........., when I first came to work in the ED department as a SHO there was training scheduled but it clashed with my shifts in the department so I could not attend”.

SHO ED spoke about their concern to “get things right” and spoke more generally in the interview that they thought that more training should be provided in line with the introduction of the Children First Act (2015). They commented: “I need more training on what to, or what not to, refer to social work I need more guidance in this area”.

4.3.2. Burns and Plastics

Referrals from the clinical specialism of burns and plastics to the hospital social work department account for 18% of the total referrals from 2000-2005 (See Figure 3). Participants from this specialism held similar views on training with colleagues that work in the ED. SPR BP1 reflected on their undergraduate and post graduate training:

“As an undergraduate we had a one hour didactic lecture from a paediatrician. It was far from adequate, it told us very little about what to do if you suspected abuse or what our role would be in the process”.

As a post graduate SPR BP1 training experience was equally insufficient. They advised: “I have had no formal post graduate training at all in child protection. I am now qualified 10 years and working in plastic surgery with children”. The participant was candid in their response about how the undergraduate and postgraduate experience affected their knowledge when asked if they felt confident in the area of child abuse recognition. They responded with:
“Absolutely not......the very fact that I came into a paediatric hospital and was handed a badge and had no induction, and within days I was exposed to children who had been severely burnt due to neglect left me feeling ill equipped to deal with the factors surrounding the harm that can affect children”.

One of the interesting factors that SPR BP1’s data highlighted was the inaccessibility of training for NCHD’s due to the rotation their clinical placements. This occurs every three or six months depending on the specialism. The hospital provides a child protection briefing periodically facilitated by a paediatrician as part of a Grand Rounds talk at lunch time for NSCHD’s, but it is only presented at certain times of the year.

“The training does take place in January and in June but if you start at any other time on rotation you do not get any training. I brought this up with the powers that be in the hospital and I was told that I would have to wait another six months .......In the meantime, I was expected to respond to children in the clinical setting who had been harmed”.

A colleague in the plastics specialism of the same grade SPR BP 2 echoed a lot of what SPR BP1 said with regards to training in child protection:

“As an undergraduate I had little, one or two lectures maybe”. Reflecting on the twelve years since qualifying they said: “as post graduate I have had very little as I have worked in adults in the main...... When I worked in the UK I received a compulsory E learning programme which was useful. To my knowledge this does not exist in Ireland”.

SPR BP2 was also concerned about the lack of training he had received given the role they have: “Increasingly as you advance as a doctor you realise that CP is important the more you know, the more you realise what you don’t know”. The means by which the knowledge on child maltreatment is disseminated among clinicians was also an important point for SPR BP2: “In our speciality [plastic surgery] you become blatantly aware of how important it is. Most of the stuff we learn about child protection is done informally.......is this the best way?” The participant made an interesting comparison with other compulsory hospital training “CP training is a bit hotch- potch.......if we compare the compulsivity of other training in hospitals like hand hygiene and manual handling etc.”.

The most junior doctor participant in plastic surgery SHO BP, was qualified two and a half years and had just enrolled onto the plastic surgery training scheme. It was also their first paediatric position. “There is no child protection training for an entrant on the plastic
surgery training course”. When SHO BP was asked about their undergraduate training, bearing in mind the participant was a more recent graduate than the senior colleagues involved in the study, there was little evidence of improvement: “At medical school in my second to last year we would have one lecture on child protection there has been no training since”. All the burns and plastics doctors where aware of the importance of child safeguarding but generally did not feel prepared for their role in this regard. SHO BP summed this up as: “I think we need routine and systematic training in the area and it should be compulsory. Generally we are poorly inducted when we arrive in this hospital”.

4.3.3. General Medicine

General medical child protection referrals to the social work department constituted 16% of the referrals from 2000-2015 (See Figure 3). This specialism has the broadest focus of the study’s four clinical specialisms of suspected NAI given the generic nature of the day-to-day work. This requires extensive interdisciplinary work throughout the hospital. The presentations can range from ingestion of substances, physical injury, to children admitted with psychiatric concerns, including various forms of self-harm.

C GM has many years’ experience working as a consultant paediatrician. Consistent views with other participants on training were found: “we had almost no formal training in child protection as an undergraduate and as NCHD”. I learned from observation and management of cases”. Similarly, as an Irish trained doctor, C GM commented that they benefitted from overseas experience in terms of the training they received: “I moved to work as a consultant in the UK. There is mandatory training there that you don’t get in the system in Ireland”.

Reflecting on their experience as NCHD, C GM said: “I remember vividly all of the cases that I was involved in either through the mistakes I made or by the cases that I thought that I approached correctly, It was rather like jumping off a ledge”. C GM summarised the nature of the training: “To be honest it was very informal and learning off the hoof as it were”.

Even after many years’ experience in this field C GM reflected on the difficulties of child protection work for doctors working in the acute setting:
“After all of these years as a consultant I will still walk away from an interview with parents were there is suspicion of harm and think…… there was bits of that that I got wrong”.

The difficulty of working directly with parents in cases of suspected maltreatment was also acknowledged by C GM:

“The most difficult part for my NCHD’s is broaching the issue with parents where there is suspicion surrounding harming a child. It’s not a communication skill that many doctors possess naturally, you get no training for this”

SHO GM who qualified in the UK provided a somewhat different experience to some of the Irish trained NCHD’s. Their experience was more positive: “As an undergraduate I had good information on child protection. It was built into the undergraduate curriculum”. As a newly qualified doctor SHO GM advised that:

“I remember being hyper aware as an intern you have to complete a mandatory eLearning portfolio on child protection before you see a patient, it is compulsory. It is part of your foundation there”.

In additional to the clinical and diagnostic aspects of training SHO GM’s experience of training in the UK including learning from serious case inquiries: “For example we had a full lecture on the baby P case which was useful as it included what went wrong systematically”. SHO GM also makes a significant point as a doctor that trained in a different jurisdiction regarding the need for foreign doctors to have an awareness of the Irish child protection processes and legislation: “I have had nothing [child protection training] since coming to work in Ireland, no induction on the legal and procedural thresholds etc….. The UK is similar enough so it is easier for me, but for doctors coming from developing counties to work here it is certainly a different kettle of fish”.

4.3.4. Orthopaedics

Orthopaedic injuries represented 11% of the overall referrals to the hospital social work department for suspected maltreatment between the years 2000-2015 (See Figure 3). SPR O reflected on the training they received as an undergraduate several years ago:

“As a undergraduate we had one or two lectures, but they tended to concentrate more of the physiological aspect or diagnosis of child protection cases other the systematic response”
SPR O advised that: “I have had little since I qualified, I had a one hour lecture last year. I went because it is an area that I feel as though I needed more training on.......It was useful but it is not enough”. Like all of the participants interviewed in the study it was clear that SPR O wanted to be more equipped with knowledge to respond more effectively to protect children that may have been subject to maltreatment:

“The social issues connected with some families we work with in orthopaedics are often complex, you need to consider this carefully........ You would never say no to more training in this area”.

A more junior colleague SHO O echoed the above and advised that at undergraduate level:

“I didn’t have a whole lot of it [Child Protection Training].... there was very little, the odd lecture. I am now qualified three years”. SHO O went on to say: “This is not a fair way for doctors to learn or a fair way for patients. If family members knew that I was learning things like this via osmosis they probably would not be impressed”.

4.3.5. Analysis on child protection training

Drawing together some common themes from the data it was abundantly clear that all of the participants interviewed were concerned about the protection of children they had contact with. They acknowledged an element of fear and expressed anxiety about “getting it right”. The complexities of child protection work was also mentioned by several participants which reflects the findings from several authors including Buckley R (2015:38), “detection of abuse is not a simple process, instead for the most part it is extremely problematic and requires a trained eye, confidence and continual engagement with the child and family”.

Given the fact that the study’s participants worked in the four highest clinical specialisms that refer child protection concerns to the hospital social work department, the data indicates that across grades and disciplines training was insufficient. This is consistent with Cindy & Christian’s findings (2008:13) ‘that physicians have often reported that they were not adequately trained to identify and report child abuse’. This is particularly apparent for the more junior NCHD’s on rotation who found it difficult to access training that was organised, with one participant advising this was due to it clashing with their shift. One participant SPR BP 1 missed the training as it did not occur at all during their six month
rotation in the hospital. This is at odds with the hospital’s current policy which outlines that: “The hospital has a responsibility to provide induction and on-going training to all staff to ensure that they are sufficiently skilled to identify suspected child abuse’ (Joint Child Protection Sub-Committee of Council for the Children’s Hospitals Care, Dublin. p7).

The findings also highlight that the training for undergraduates in child protection awareness is lacking at university. Notably there did not appear to be much increase in the amount of teaching in medical schools in the 25 years trajectory since two of the participants qualified. This is somewhat at odds with the increase in awareness generally about child abuse in public discourse during this period. Where lectures were given, they tended to focus on the physiological and diagnostic issues and lacked information about the procedure and information regarding agencies involved in the investigation of abuse that doctors are required to liaise with in the safeguarding process.

The more senior clinicians, C GM, C ED, SPR BP1, SPR BP2 and SPR O who have developed an interest in paediatric medicine undertook courses in this area of their own volition, which one participant termed as “self-propelled” involving travel to the UK. This is to be welcomed but as findings from inquiries informs us; child safeguarding needs to be a uniformed and compulsory process that all doctors must be aware of if children are to be adequately protected. As Kodner et al (2013), reminds us that in almost 20% of child homicides the children who died had contact with a health care professional in the month prior to their death.

The participants who had trained overseas, or who worked directly with other doctors who had trained in developing countries outside of Europe, made some interesting observations about a lack of knowledge about the Irish system. They require induction on arrival given the potential differences in child protection systems as Fung & Chow (1998) found child protection training, awareness, and procedures vary greatly globally from country to country with no formal definitions of child abuse in some countries as Hosduga and Finlay (2010) found.

At the time of writing the HSE is beginning to implement a new ELearning Child Protection Module for all people who come under the remit of mandated reporters under the Children First Act (2015). The idea is that compulsory child protection training can be
accessed remotely by clinicians online. The move is part of the HSE’s Children First Implementation Plan which outlines, ‘by virtue of their training, responsibilities, and experience doctors will have an awareness of issues relating to child protection’ (HSE 2015:8). Clearly, given the responses from participants in this study this is to be welcomed.

4.4. Participants’ Experience and role in the Child Safeguarding Process.

4.4.1. Emergency Medicine

The data indicated that participants that worked in the ED clearly saw the importance of their department in the safeguarding process. This was reinforced by a participant’s response to a question in describing ED as the ‘shop window’ of the assessment process, as it is often the initial place of contact that children present who have been abused. All participants commented on the difficulty in establishing if a child has been subject to more subtle forms of abuse such as neglect on presentation. They gave a flavour of the cases they deal with.

C ED spoke of their experience in dealing with different types of abuse:

“I find neglect cases difficult to call unless it is chronic, or there are obvious clinical signs. Also some forms of physical injury can be difficult, you have to really focus on the mechanism of injury and establish if the story is consistent with the clinical presentation before you”.

SPR ED outlined cases of: “Spiral fractures on very young children that don’t fit with the parent’s explanation. It rings alarm bells”. They cited examples of signs of abuse that they also find difficult to establish: “The tricky ones are emotional neglect cases when the parents and the children are not interacting properly. Still now I am not sure of how to deal with these cases”.

SPR ED also commented on what they described as an emerging and common form of abuse:

“Childhood obesity is an emerging from of neglect that we get very little training on. It is an emerging phenomenon that represents a big problem for children in Ireland. We need more information and training on how to address this in the paediatric ED setting”.

39
Participants in ED were very complimentary of the multi-disciplinary process in their department and valued the collective responsibility that this provided to assist in complex NAI cases. They were particularly complimentary of the senior nursing staff and of the social workers that were connected to the department. The most inexperienced participant SHO ED summed this up: “I didn’t feel equipped as I should be coming into the ED department. The nurse’s flag a lot of things.......... you’re not on your own as a new doctor, the nursing staff are an important cog in the wheel”.

All participants expressed fears concerning the process in the form of missing something or being wrong about a case of abuse C ED said:

“One of the biggest fears is getting it wrong regarding NAI and the impact that this can have on the family....... Getting it wrong and needlessly accusing a parent of an abhorrent act on a child does way heavily on my mind I must admit”.

SPR ED commented similarly: “A little anxiety is there all the time in case you miss something when a child presents with concerns with a possible NAI”.

A consistent finding was the limited knowledge and direct contact participants in ED had with regard to Tulsa. The hospital social workers tended to be the link and completed the Standard Report Form (SRF) for Tulsa. This occurred even when they were not present in the hospital when concerns came to light, at weekends for example. With regard to this the participants in ED offered some of the following responses:

“I provide them with medical reports upon request. I normally go through our hospital social workers who then contact them”. C ED participant

“I am aware they exist.... my main contact has been with the out of hour’s service when the hospital social workers are not present in the hospital”. SPR ED Participant.

“I have heard of them but have never had any contact with them”. SHO ED Participant.

“From what I have read the organisation is struggling to cope with the demand of referrals”. C ED Participant.
4.4.2. Burns and Plastics

The study participants who work in burns and plastics are often called into ED to review children who present to the hospital who have sustained soft tissue injuries and burns. Participants spoke generally about the type of concerns that they come across. SPR BP 1 advised that: “Very few of our patients are intentionally burned by their parents but often neglect can play a part, in poor supervision or awareness of the dangers of things like hot drinks”. SPR BP 2 commented on the types of injury that cause concern: “Burns under the age of 1 is always a consideration as the child has limited mobility”. The participant went on to say: “Very often we as plastic surgeons are like the first domino in a chain that picks up on neglect”.

Participants advised that there are a higher number of children that are injured from lower socio-economic backgrounds, non-Irish nationals and children from traveller backgrounds. Many of the families that they come into contact with have additional child welfare factors that are often not directly connected to the injury that the child has sustained. SHO BP commented that:

“There have been a few cases were things stood out were the social issues that run alongside the injury, recently we had to invoke S.12 with the Gardai as a child was taken from ED with a serious burn as the parent was unprepared to wait”.

SPR BP 1 made some distinctions about the difference between working in an adult hospital and that of the paediatric setting:

“Factors are different when you work in an adult hospital. Making the transition as I have found from the two clinical settings is hard....... you have to think differently when you see an injury”.

SHO BP provided a consistent response:

“It’s a scary prospect for doctors, you want to get it right, there was an initial fear when I was less experienced as a SHO particularly in this area, parents can be difficult to handle at the suggestion that they might have had a hand in harming their children”.

The participants were also able to point to things they found helped in the clinical setting to address some of the fears that they may have concerning suspected NAI cases. SPR BP1 commented that:
“When we are called into ED, when a child comes in, having a senior nurse on hand is useful to share concerns if they present. Having someone else is useful as you do not have a consultant plastic surgeon with you. Asking the question; are you reacting to this the same way I am? Or am I taking this out of context?”

The burns and plastic participants also seemed to value the multi-disciplinary approach to their work. SPR 2 commented: “Having a social worker on hand or available is essential to the systematic support we require”. The hospital in which the study was conducted houses the national paediatric burns unit. A weekly MDT meeting is attended by all of the clinical and allied health specialism’s. SHO BP advised that:

“Definitely having a functional weekly multi-disciplinary team meeting to discuss patient’s medical and social concerns is really helpful particularly with regard to child welfare”.

Similarities could be made with ED participants in relation to contact with Tusla. They were reliant on hospital social workers as an intermediary as SPR BP 1 commented:

“I know that they exist but I don’t know much about them or what they do”. SPR BP 2 had “no direct contact, I know who they are, we tend to go through the social worker when they require medical opinion”.

4.4.3. General Medicine

The general medical participants operate across the hospital and tend to get a wider exposure to the child and their family. There is no specific multidisciplinary team that the general medical paediatricians are attached to due to the generic nature of their work. C GM reflected on the types of cases they had involvement with in both Ireland and the UK:

“I have had a lot of unusual cases where it is much more difficult to assess than a clear cut injury. I have dealt with a lot of cases of fabricated illness for example. i.e. where parent has put phenomenal restrictions on a child’s life to wrongfully address a condition...... ...there is a lot of pressure in such cases to prove that this is the case medically”.

The general medical specialism often calls on the opinion of sub specialism’s to investigate NAI’s in children such as an orthopaedic surgeon to offer a specialist opinion. C GM spoke specifically about NAI and the difficulties surrounding it even after years of experience:
“In physical abuse cases I have been called to give evidence in court on numerous occasions...... your level of comfort effects how you approach it even after years in this field”.

SHO GM who also worked in the UK talked about a number of recent cases that she had been involved in and advised: “A lot of our difficulty as clinicians depends on the element of doubt in cases, you can only offer your opinion as best you can”. C GM provided some useful observations about the systematic things that a paediatrician can experience in the safeguarding process:

“For a lot of consultants who work in general paediatrics you don’t have a formal meeting with a MDT like in other specialisms’. This is quite a lonely prospect for consultants. There needs to be a structure that consultants can plug into in general medicine especially, when you consider the number of child welfare concerns we have”.

The leadership role that C GM undertakes in child maltreatment cases involving more junior NCHD’s was clear:

“The NCHD’s may express an opinion to us about a child welfare concern it is up to the consultant to make that real. My role is absolutely central to making sure that concern is followed up”.

SHO GM echoed this sentiment from a junior NCHD’s perspective and spoke positivity about their experience of support from consultants in her area: “Having an approachable consultant who has an interest in CP work is essential. It is good in this hospital within our specialism”.

Participants welcomed the collaboration they had with the hospital social workers on several cases they had made reports to Tulsa. Again this role seems to be seen as a ‘conduit’ to the statutory service in the community. This appreciation of medical social workers in the setting is acknowledged but the current understanding may have to change with the introduction of mandated reporting whereby doctors will have to assume the responsibility for filling in the SRF and liaising more directly with Tulsa themselves.

This is perhaps exemplified by SHO GM responses to a question about the child and family agency: “I know they [Tusla] are the statutory agency but only because I heard someone talking about it in a clinical review”.
4.4.4. Orthopaedics

The participants who worked in Orthopaedics provided some honest and useful data. They outlined the nature of the cases they came across, SPR O advised of “Fractures, where the injury’s is not consistent with the story”. And “cases were babies that fall or are dropped from parent’s arms sustaining fractures. The circumstances of the injury are very important for us to ascertain”. The participant went on to say that “we are often called in to review cases were the paediatrician needs a more specialist opinion on the mode of injury if the fracture is unusual”. SPR O spoke about several forms of neglect also being a factor in orthopaedics and advised that: “we have a lot of persistent failure to attend OPD appointments as follow-up after injuries”. SPR O was somewhat critical of their own clinical specialism and its priorities about child welfare and NAI in general:

“Orthopaedics’ is problematic in this area as most of the junior doctors that come through this clinical specialism are on a rotation. They are primarily trained in adult medicine and often arrive lacking the skills and find it difficult to understand the nuances and differences of working directly with children and their families”.

SHO O offered a similar critique of the situation despite the high degree of concerns of NAI to children that the specialism has in the clinical setting:

“A minority of orthopaedic junior doctors in training have little interest in working with children as a destination in their career path. So I think that for that cohort more emphasis is required to make these doctors aware of the importance of being vigilant. Especially when you consider that 10% of all paediatric fractures could be considered to be NAI and 20% for children below the age of 2 years”.

When asked about what factors are causal in the views of doctors outlined above both participants spoke about anxiety amongst their colleagues concerning child maltreatment cases. SHO O commented: “It has been a baptism of fire really, thankfully there are people to ask, some of the senior doctors are helpful but to a large degree it depends who you ask in orthopaedics”. SPR O expressed that often there was also anxiety about making mistakes in NAI cases: “Doing the wrong thing, or missing something in my initial assessment in the emergency department is a concern”.

SPR O advised that they had recently participated in an audit of orthopaedic cases in the hospital with regards to child maltreatment cases and spoke in the interview about some
of the findings, concluding that in SPR O’s view that: “It is clearly not a priority for a lot of surgical trainees.

“I have recently taken part in a child protection audit of cases where there were concerns. We found that often the documenting of the injury was poor and the mechanism of injury and the social history was lacking, which is essential”.

SPR O advised that they personally had a lot of respect for social workers and has welcomed their input in child maltreatment. The participant had a good appraisal of what Tulsa was and how it worked and reflected on her experience:

“I have provided lots of reports to Tulsa, I am concerned however many of the statutory social workers that have come into the hospital to investigate cases seen to be overwhelmed with the number of cases they are working - I hear that, I see it”.

However SPR O was clear to say that their views and understanding was not fully representative of a lot of senior doctors and NCHD’s who work in Orthopaedics: “Who often see liaising with social workers as problematic and not really connected with their primary function as surgeons”.

4.4.5. Analysis on the role of the doctor in the Child Protection Process

Participants’ views support much of what is found within the literature regarding the doctor’s role in the child protection process. They often found child protection cases difficult and thwart with complexities. Which is echoed in Buckley R (2008:13) who acknowledges in that “detection of abuse is not a simple process, instead for the most part it is extremely problematic and requires a trained eye, confidence and continual engagement with the child and family”. However all of the participants acknowledged the importance of their role given their contact with children, which concurs with Mathews (2015:4) view that, “the fundamental premise is that doctors regularly encounter children by virtue of their profession”.

Participant’s confidence and understanding differed concerning different types of abuse that present to them. For example more obvious forms of physical abuse as defined by Kempe (1962) would be something that the participants found easier to grasp. However participants felt less confident with the more subtle forms of abuse such as emotional abuse or some less obvious forms of neglect, or domestic abuse in the family home. One
participant spoke of not knowing what to do when a child looked emotionally withdrawn their interaction with the parents in ED for example. This may potentially contribute to under reporting by doctors concerning these types of abuse which are less obvious which is consistent with findings from Flaherty et al (2005).

There are different experiences between the clinical specialisms. ED participants felt supported and had access to a consultant who had a good knowledge base and training in child protection. This was less apparent in the two surgical specialisms. In the general medical specialism child welfare was seen as central to their role as paediatricians, in addition to other elements of clinical care. Finally participants that worked in orthopaedics offered some good insight into how their specialism responds to child maltreatment. One of the participants was critical of the priority given to child safeguarding in their own specialism. They expressed views that indicated that there was often a disinterest in the topic among NCHD’s and some consultants. They sighted the transitory nature of their specialism and that orthopaedic surgeons are primarily trained in adult medicine as contributory factors to this belief. This is a concern when orthopaedic injuries to children are the second most likely cause of NAI reflected in Tenenbaum et al (2013).

Participants generally thought that they were ill-prepared for the task and many spoke about the difficulties in the transition from adult medicine where they had primarily trained prior to the paediatric hospital setting. This was most explicitly felt in the two surgical specialisms involved in the study. Again the need for training and appropriate induction was lacking which could go some way to addressing this problem. For example, none of the participants ranging from the most senior clinician to the most junior mentioned the existence of the hospital child protection algorithm (See Chapter 2, Figure 1). This was seen as a much heralded development in hospital policy by its introduction several years ago.

Participant’s views were consistent with much of what has been discussed in the literature including Flaherty et al (2005), concerning doctor’s fear of getting things wrong by either missing something or overzealous reporting. For example few of the participants had knowledge of the Protection for Persons Reporting Child Abuse Act (1998) which under S.3 indemnifies professionals from civil action if they can demonstrate that they “have acted reasonably and in good faith in forming that opinion”.

46
All participants appreciated a functional multidisciplinary process in helping to alleviate some of the fears that they have surrounding complex cases. The burns and plastics, and ED specialisms have regular structured meetings in place of this kind which helped with this process. This is in keeping with one of the recommendations which were advocated by Laming (2003) after the death of Victoria Climbié.

Finally, participants tended to have minimal knowledge of the response and policy surrounding the wider child protection system outside of the clinical setting. This included knowledge of The Children First Guidelines (2011), knowledge of Tulsa, and a basic understanding of the Child Care Act (1991). This would be a concern as several of the participants indicted that they want to make a career in paediatric medicine. Ironically perhaps, contributory factors to this lack of knowledge is the presence of hospital social workers. If a concern was established the social workers would complete the SRF and liaise directly with Tusla. Although this expertise and knowledge is useful it can act to limit understanding with the wider system for the doctor and the role of Tusla. This raises two important questions. Firstly what role do doctors play in the process in hospitals where there are no medical social workers present? This is approximately half of the adult hospitals in the country (HSE 2015). And secondly it poses a question about how doctors are going to adapt to becoming mandated reporters under the Children First Act (2015) by which, when it is fully implemented under S .14 (1) ‘he or she shall, as soon as practicable, report that knowledge, belief or suspicion, as the case may be, to the Agency’. This infers more direct contact with Tusla.

4.5. Organisational Culture and Hierarchical Factors.

In the medical setting the hierarchical and professional structures are well defined as progression is made through a doctor’s career from the generic, to the specialist, resulting ultimately in a position as a consultant within a particular medical specialism. The organisation culture within the hospital and within each clinical specialism was considered by the participants and its influence on the child protection process.

4.5.1. Emergency Medicine

Participants in ED felt that they had an organisational culture within the department that helped the process of safeguarding. However C ED advised that their experience in
Australia was positive and there was “less of a ‘hierarchical feel’ in that jurisdiction: “we need to emulate a lot of that organisational culture across the hospitals here”. Reflecting on their own NCHD training C ED said. “It often depends which specialism you work in. They can have radically different systems and traditions, I had a few horror stories with regard to this as a young doctor”. C ED went on to say: “this stuck with me so when I assumed this position as a senior clinician I saw it as important that we have a culture of learning were junior doctors feel supported especially in NAI cases”.

SPR ED who is completing their consultant training in the setting also reflected on her junior doctor experiences:

“We have a very effective MDT here compared to other branches of medicine that I have worked in.......most people will tell your that in comparison to other clinical areas the hierarchy is not as explicit in ED everybody has a part to play”. Comparisons were made with surgical specialisms and some critique in how junior doctors relate to their more senior colleagues within these: its first names in here [in ED] for consultants not Mr or Mrs Etc....... I know through experience that this is not the same in other areas particularly the surgical specialisms.

When probed further about how this affects doctors in child protection cases SPR ED advised:

“We look at human factors in our training and in my opinion this is a big problem in the culture of some of the surgical specialism’s ......in fact I would say that it is a bit worse than it was a few years ago. I feel this culture is not helpful for junior doctors if they disagree with senior doctors in NAI cases...... It can go against the team approach that is required to successfully address child abuse”.

SHO ED who is currently undertaking their first paediatric position as part of their training and gave some positive feedback with regard their experience of the department so far: “The department works on an MDT approach, there is always a senior clinician at hand”.

4.5.2. Burns and Plastics

In burns and plastics SPR BP 1 advised that when they first came into the specialism it was apparent that: “plastics is very hierarchical, you have to work with this, it takes a long time to train”. In relation to the child protection process SPR BP 1 advised that often the consultant surgeon’s main priority is in theatre. Junior doctors generally have more patient contact outside of theatre. However, SPR 1 said that despite the hierarchical
culture that exists in the specialism: “You can pick up the phone and discuss things regarding say a child with a burn which could be NAI, you get an opinion if you require it.......They get the child protection thing, they are just not always a hand”.

SPR BP 2 held similar views on this: “generally I feel well supported by the bosses. I know that this is not the case in other surgical specialisms”. SPR BP 2 felt supported: “The buzz phrase is that a flattened hierarchy is required especially in child protection cases. We don’t have this but I have no fears informing up or down the hierarchy”.

The participants in this specialism were appreciative of the culture that has evolved in having a functional multi-disciplinary meeting as SPR BP 1 commented:

“The MDT is excellent it takes place on the burns unit, all of the allied health professionals attend including a social worker who is allocated to the unit. Each case in gone into and everybody knows where things are at both clinically and socially with the family”.

SPR BP 2 advised that: “It is essential in plastic surgery with kids as there so many other factors to consider including child protection”. However SPR BP 1 commented that it is not like this in other hospitals in which they have worked suggesting that the culture of the organisation and personalities are influential:

“The culture is a key factor some of the MDT’s I have worked. One had an eminent consultant, he did not want to hear anything other than their own opinion. Personalities are crucial. Meetings were a tick box exercise on the part of that consultant, he was very intimidating”.

What was also interesting was how SPR BP 1 dealt with the issue: I did not challenge the consultant directly, I approached another consultant – You have to pick the right person”.

4.5.3. General Medicine

The participants provided some interesting data on how organisational culture influenced their work. Participants indicated that they often felt isolated as a specialism from the multi-disciplinary meetings that help in the child protection process in other specialisms due to the generic nature of their work. SHO GM advised that: “In general paediatrics it is a constant difficulty...... we have no MDT team to sit down with so there is no process for reviewing child protection concerns like there is say in burns and plastics”.

49
SHO GM also talked about the additional need for support for doctors in dealing with child abuse cases and made a distinction between work and dealing with other clinical challenges such as breaking bad news or sudden the death of a child.

“Support…..? [Relating specifically to NAI cases] Yes and no………, the support is there in terms of what to do clinically, but it isn’t really there in terms of the psychological impact of the work on the individual in child abuse cases ....debriefing etc. My experience in Ireland isn’t particularly good in this area”.

As a very experienced paediatrician with overseas experience, C GM took a critical view of the culture that exists in the traditional medical hierarchy: “We have to create a culture that isn’t essentially about hierarchy at all. Student nurses will come up to me often and express concerns about a patient they are looking after for me and I welcome that”. C GM is clear in dispelling any form of traditional deference towards senior clinicians when considering effective safeguarding processes advising: “It is absolutely essential if we want to make sure that children are kept safe we all have a part to play regardless of grade, people need to feel confident”.

Furthermore C GM was somewhat critical of some of the policy that the hospital has adopted in relation to child protection procedure.

“Formalising processes in algorithms does not always work.......they are not always adhered too and it can depend on the culture of the medical specialism. Having a culture of communication however is essential where somebody is allowed to point something out irrespective of hierarchy or grade”.

4.5.4. Orthopaedics

Participants from orthopaedics provided data that out of all the specialism’s involved in the study illustrated the most explicit form of professional hierarchy. There is a generally accepted gulf between NCHD’s and that of consultants. The data also indicates that the culture that exists in this specialism makes the process of safeguarding more complex when compared to others. SPR O advised that: “paediatricians have a totally different mentality to Orthopaedics, they are defiantly more child centred than we are. Orthopaedic medicine it is very adult orientated generally”.

SPR O advised:
“I am a SPR and have a fair amount of experience I still find that my seniors are often difficult to approach, that is just the way it is. Surgical disciplines are like this....... it is quite regimented, you have to be quite tough to survive in it”.

A further point was made by another participant SHO O about support concerning NAI’s:

“If it is a clear cut child protection concern they [consultants] can be supportive, however if the case is more complex or the concern is less obvious you often find some reluctance to get involved”.

SPR O also mentioned: “I have seen consultants shy away from getting bogged down in this work as they do not fully believe that that this is their job”.

The participant SPR O went on to sight a specific case example that illustrates the organisational culture in this specialism in terms of the child safeguarding process:

“I had a patient [child] last year who presented with additional concerns unconnected to the orthopaedic injury, it was a neglect case with several issues surrounding the parents. After consultation I was discouraged to refer this from a consultant as he did not believe that this was our role. Despite this I referred it to Tusla. Subsequently it transpired that there were a whole load of other issues surrounding the child’s welfare that this exposed after Tusla investigated. That consultant has still not acknowledged that I did the right thing”.

The introduction of mandated reporting for all doctors are too be considered, it may act to clarify and take the ambiguity about the responsibility of the doctor to assist and report in cases like the example above. However it is clear from the participant’s responses in orthopaedics that the organisational culture within the specialism somewhat inhibits the safeguarding process.

4.5.5. Analysis of the impact of Organisational Culture

Findings from the data shows that participants had a good understanding of the pivotal role the hospital doctor has in the safeguarding process. There where however differing views held by the NCHD’s in the two surgical specialisms in how they felt supported by their senior clinical colleagues to perform this role.

There appears to be a correlation between the level of direct contact that senior clinicians have clinically with children and the culture that subsequently emerges in terms of interest and understanding of the safeguarding process. Findings show that a culture where
hierarchy and traditional processes have a reduced importance, i.e. ED and general paediatrics, a more functional process emerges to safeguard children. This reflects findings by several authors including; Spalto (2005), Cindy & Christian (2008) and Montgomery et al (2011). From this we can deduce that the role of the consultant within this hierarchy can affirm and assist junior doctors in their safeguarding role.

However, there was some distinction between the two surgical specialisms. The responses from burns and plastics participants advised that despite having a traditional hierarchy in place most of their senior clinicians were supportive in child protection cases even if it was via the phone. Participants in this area made use of a functional weekly MDT meeting to talk about child protection concerns. This appears to be lacking in Orthopaedics which gives cause for concern when the numbers children who present with NAI to them who are considered.

4.6. The Introduction of Mandated Reporting and the Hospital Doctor.

Participants had a limited awareness about the implementation of mandated reporting which is understandable as the Children First Act (2015) was only signed into law November 2015. At the time of writing the Act is under commencement in stages. However a study of this nature cannot ignore the implications of the Act for participants as it will greatly influence the role of the clinician in reporting NAI in a clinical setting. Participants’ views were broadly in favour of its implementation. There were many gaps in their knowledge when it came down to how and what to report which is indicative of the need for training. One significant finding is that there will need to be a greater understanding on behalf of the doctor about process outside of the hospital which will include the function of Tusla.

The views of participant SHO ED is consistent with the literature regarding the increase in referrals and thresholds being lowered: “I think if you know its mandatory you are going to report less serious welfare issues as you know at the back of your mind that it is mandatory to report concerns”. From the participants’ responses doctors are arguably over reliant on the medical social worker who is often seen as the coordinator of cases when a concern is identified and they are referred to Tusla. SHO BP had concerns about this: “I am not too familiar with the definition of this [reporting directly to Tusla]. We know we will need to do
this but we are not sure of what this exactly entails”. SPR BP 2 had similar views: “It is always intimidating to have a mandatory responsibility to do something as a doctor”.

Another training issue immerged from the data as participant’s knowledge of the Protection of Persons Reporting Child Abuse Act (1998) was limited which offers reassurance if they are acting in the best interests of the child. This arguably could instil some confidence in reporters. Although participants had a limited understanding of Tusla and its function C ED did show some insight about the concerns raised by many authors who advise caution about the impact of mandated reporting:

“My hopes would be that it [mandated reporting] prevents further harm to children. My fear is that it will be a under resourced model that will just peter long without adequate investment”. SPR ED shared similar views:

“Being appreciative of our economic climate there is underfunding everywhere, we have inadequate numbers of doctors on our ED floor and only two fulltime consultants against the backdrop of record patient numbers this [mandated reporting] will increase pressure on services in and outside of the hospital”.

Several of the participants were concerned about the process that they will have to undertake if they are making referrals and liaising with Designated Liaison Persons (DLP) regarding NAI. SHO GM made a salient point: “The thing about mandated reporting is that has to be easy to do – that is what I think is the biggest barrier to reporting for doctors if it takes longer than five minutes a lot of doctors will fail to report especially in ED”.

4.6.1. Analysis on the introduction of mandatory reporting for hospital doctors
The participants’ views are consistent with the themes that are present in literature. One of the points to draw out from the participant’s data is that there is a clear need for compulsory training for doctors of all grades regardless of their level of clinical experience. The training needs to be robust and effective and also needs to be reviewed to test its effectiveness in practice after clinicians have undertaken the training. As Kaminski & Tan’s (2014) study found in the UK that despite having compulsory training 45% of doctors in their study did not think that child protection was everybody’s responsibility. This suggests a change in culture particularly in the surgical specialisms if the implementation of mandated reporting is going to improve safeguarding procedure in hospitals.
The HSE has the responsibility to train its staff including all hospital doctors to comply with the Children First Act (2015). It has earmarked €2.5 million address this need (HSE 2015). As part of its implementation plan Training and Development Officers are to be employed throughout the country to ensure compliance and develop training resources. It is planned that much of the compulsory learning will be on an ELearning platform that all clinicians can access to ensure accessibility and compliance.

Findings from the literature indicate that there are two considerations concerning the implementation of mandated reporting. Firstly, that the individual who is mandated to report does so. And secondly the process and response after the report is received by CPS. Flaherty et al (2005) advise us that one of the factors preventing doctor’s reporting is previous negative experiences with CPS, including poor communication concerning case outcomes. It also need to be acknowledged that there is evidence from the US where mandated reporting has been in place for several decades that doctors still fail to report (Melton 2005).
Chapter 5: Conclusion

It is acknowledged that a great deal of development has been undertaken by government and policymakers over recent years which has culminated in the Children First Act (2015). The Act is currently under implementation and will place the current Children First Guidelines (2011) on a statutory footing. The Act has been designed to provide more clarity surrounding the systematic and procedural responsibilities that key professionals have regarding children under their care who may be at risk. The hospital doctor will soon have a legal responsibility, in addition to the moral and corporate responsibilities that are required to protect children.

This study’s findings provided some rich data across four different clinical specialisms which were chosen due to the high numbers of child protection referrals they make within the paediatric hospital setting. The data findings were broken down into four key areas: Firstly, doctor’s child protection training experience and needs. Secondly, the experience of identifying and responding to maltreatment in the clinical setting. Thirdly, the influence of the organisational culture in which hospital doctors work on effective safeguarding. Finally, the clinicians’ awareness of mandatory reporting and its implementation. The evolution of child protection policy and the likely impact of mandated reporting in the Irish context have also been evaluated in light of the international literature and findings from the participant data.

The findings strongly support the view that hospital doctors are significantly concerned about the welfare of the children that they come into contact with. However, this study has found a level of anxiety concerning doctors reporting cases of suspected maltreatment. This anxiety is twofold, on one hand it relates to overzealous reporting and on the other, a fear of missing cases of child maltreatment. These fears are a consequence of several factors; most significantly the evident lack of consistent and compulsory training for doctors of all professional grades across specialisms. Some training is given on an ad hoc fashion in the setting for NCHD’s. However participants considered this training insufficient for their needs and difficult to access. Participants advised that it was common for doctors who rotate as part of their training to receive no training at all. This failing is a particular concern for doctors who come to work in Ireland from overseas jurisdictions.
where the child protection systems are often more embryonic in their nature as Hosdurga & Finaly (2010) found.

Child safeguarding policy and procedure does exist in the setting but knowledge of this was found to be somewhat sketchy on an operational level amongst many of the participants of varying grades. For example there was little evidence of awareness of the hospitals child protection algorithm (See Figure 1.) This algorithm was introduced several years ago (in 2008) to assist clinicians in the child safeguarding process and subsequent liaison with CPS in the community. Paradoxically, the setting does have compulsory training in place for all nursing and allied health staff based on the Children First Guidelines (2011). However doctors do not participate in this training.

Another significant finding concerns the provision of child protection training for undergraduates in universities. There was little evidence to suggest that the content in the curriculum of courses has dramatically increased on this topic in the 25 years between the qualification of the most and least experienced clinicians involved in this study. This is a surprising finding given the increased awareness of child abuse in the public discourse in Ireland during this time. Participants advised when lectures were provided they focused more generally on diagnostic issues, with little information about procedure, processes, legislation and the function of CPS.

Findings show that the doctors working within the surgical specialisms of burns and plastics and orthopaedics found it more difficult to access training, mainly due to the rotation of surgical specialisms through different hospitals. The compulsory ELearning modules proposed by the HSE (2015) are to be welcomed given the access and flexibility they will provide. However this training will need to be systematically evaluated in terms of its impact as simply providing training for doctors is no guarantee of a change in the mindset of clinicians as Kaminski & Tan (2014) found.

Participants in the four clinical areas felt that their knowledge on child safeguarding procedure was to a large extent obtained by osmosis. A great deal of reliance was put on senior nurses and medical social workers in specialisms to help identify concerns about maltreatment. The participants were more confident in identifying cases of physical abuse and CSA, but less confident in identifying more subtle forms of maltreatment such as
neglect or the impact of domestic abuse on children. These, by their very nature, can take place over time.

All of the participants were appreciative of medical social workers in the setting which was a surprising finding, contradicting much of the literature that identifies historical conflict between these two professions as identified by authors including Charon (2011), and also Beddoe (2011). Participants were also appreciative of the wider multi-disciplinary teams in which they worked which helped safeguarding processes. This was particularly evident within ED and burns and plastics where there are formal weekly meetings to discuss issues on individual cases. This module was lacking in the orthopaedic and general medical areas where concerns are discussed on a case-by-case basis and were dependant on individual relationships rather than more transparent collective processes. Another factor that emerged from findings was a lack of knowledge participants had about provisions under the Protection of Persons Reporting Child Abuse Act (1998). Several participants said they sometimes feared the prospect of civil litigation for making a report that turned out to be unsubstantiated. Greater knowledge of legislation in general would act to inform and reassure clinicians.

Although positive relationships were evident between doctors and medical social workers findings show that participants tended to have an over reliance on medical social workers to report concerns for them to CPS. There was a strong belief among participants that this was the social workers raison d’être. Critically this process has perhaps contributed to the lack of knowledge among doctors, identified in this study, of Tusla, its function and the wider process. This presents a challenge when the proposed requirements for doctors under S.14 of the Children First Act (2015) are considered. Hospital doctors will soon need to make reports directly to Tulsa themselves. It may also present challenges for medical social workers who may have to relinquish some of responsibility that they have traditionally held in this area.

The organisational culture of each clinical specialism was considered greatly influential when effective safeguarding processes were studied. This was most evident when comparisons were made in relation to the support NCHD’s felt they received from senior clinicians. Both ED and general medicine doctors had easier access to their consultants who had developed an interest in child protection in the clinical setting. This compared
starkly with surgical colleagues who operated within a more traditional, hierarchical and deferential context. Burns and plastics NCHD’s did generally receive support if they contacted consultants. However participants in orthopaedics did feel that consultants in their own area were less vigilant about child protection issues when they present. These findings are also echoed in the literature and pose a concern given the numbers of potential NAI cases orthopaedics come into contact with. In light of these findings the introduction of mandatory reporting is likely to be problematic for some surgical specialisms.

In summation, overall findings from this study can be divided into to two fundamental outcomes. Firstly, the introduction of mandated reporting will reinforce the pivotal role of the hospital doctor in protecting children. It will act to dispel myths that the clinician should not concern themselves with matters regarding child maltreatment. Compulsory training will address the identified inadequacy in the current training models and provide doctors with more insight into recognising signs of abuse.

However, the second point drawn from this study, relates to the likely impact that mandatory reporting will realistically have at this time in the Irish context. Children’s rights campaigners have welcomed its implementation for ideologically sound reasons and largely in response to the failings identified in serious case enquiries. However, many authors and experts in the child protection field have advised caution. The Child and Family Agency, Tusla, will bear the biggest responsibility for its implementation. It will be responsible for investigating reports from the newly mandated reporters which by the HSE (2015) estimation totals 67,617 individuals across a wide range of services. Research conducted in other Anglophone countries confirms that when mandated reporting is introduced, the referrals to CPS increases, including a growth in unsubstantiated referrals. This needs to be seriously considered when the current resource demands on the relatively new agency are considered. Critics of the introduction of mandated reporting describe the system as being “brittle and under pressure” (Buckely H & Buckey R, 2015). A cautionary stance is then warranted in relation to the child protection system’s ability to deliver the comprehensive demands of the new legislation. This is an important consideration as Ireland moves towards a new purpose built National Children’s Hospital (NCH) that will aim
to have the health, wellbeing, and protection of all the children within the State as its fundamental objective.
Bibliography


Appendices

Appendix (1) Coding of Participants Interviewed in the Study

<table>
<thead>
<tr>
<th>Department</th>
<th>Participant's Role</th>
<th>Code Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department</td>
<td>Consultant</td>
<td>C ED</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>Specialist Registrar</td>
<td>SPR ED</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>Senior House Officer</td>
<td>SHO ED</td>
</tr>
<tr>
<td>Burns &amp; Plastics</td>
<td>Specialist Registrar</td>
<td>SPR BP1</td>
</tr>
<tr>
<td>Burns &amp; Plastics</td>
<td>Specialist Registrar</td>
<td>SPR BP2</td>
</tr>
<tr>
<td>Burns &amp; Plastics</td>
<td>Senior House Officer</td>
<td>SHO BP</td>
</tr>
<tr>
<td>General Medical</td>
<td>Consultant</td>
<td>CGM</td>
</tr>
<tr>
<td>General Medical</td>
<td>Senior House Officer</td>
<td>SHO GM</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>Specialist Registrar</td>
<td>SPR O</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>Senior House Officer</td>
<td>SHO O</td>
</tr>
</tbody>
</table>
Appendix (2) Participant Information Letter

Participant information letter regarding research study (typed on Hospital letter head)

Dear Participant,

You are invited to participate in a research study on child protection procedure in the hospital. The study concerns doctor’s views and experience regarding the child protection process. You have been selected to participate in the study as your clinical area of work according to the hospital child protection statistics from 2010-2015 has a high number of referrals to child protection services in the community. Your name has been given to me due to the specialism in which you work. Approval to participate has been also been granted from your line manager. The interview will take place in an interview room in the hospital setting.

The title of the study is: Mandated to report? A practitioner’s study of the role of doctors in child protection procedure within in a paediatric hospital setting in Ireland.

Academic Supervisor: Dr Helen Buckley T.C.D hbuckley@tcd.ie (Tel. 01 896 2065).

The researcher, Gary McGovern, is employed as a Senior Social Worker in the hospital. He is currently undertaking an MSc in Child Protection and Welfare at Trinity College Dublin. A requirement of the course is to undertake a research in the setting relevant to the area of child protection and welfare. Approval to conduct this study has been approved by the Hospital Ethics Research Committee and the Trinity College Ethics Committee following a formal application process. The research is also supported by the Head Medical Social Worker and the Hospital Child Protection Committee.

The research aims to explore the views and experience of doctors across medical disciplines and grades working in a paediatric setting hospital setting that refer cases to child protection services. Findings from research suggests that the role of the hospital doctor is invaluable in the safeguarding of children found to be or deemed to be at risk of maltreatment. The participant’s experience of child protection processes, multidisciplinary teams and Mandated Reporting will also be considered. A sample of 10 doctors of varying grades and disciplines has been chosen for this purpose.

Your participation in the research is entirely voluntary, and the information that you provide will be used to illustrate findings in the research project. This is not a formal test on your capacity and knowledge in the subject area. The information may be viewed by responsible representatives in Trinity College. Findings presented in the study will be coded to protect participant’s identity. A formal consent form will be signed prior to the interview which shall take approximately 30 minutes. The interviews will be recorded to assist with transcription. Written transcripts will be kept in a locked cabinet during the study. All recordings and transcripts will be destroyed on completion of the study. You may withdraw from the study at any time without prejudice. All recordings and transcripts will be destroyed should you chose to withdraw.

Thank you for your time and your participation in the research study.

Gary McGovern

Senior Medical Social Worker / Researcher Trinity College Dublin. March 2016
Appendix (3) Participant Consent Form

Participant Consent Form (Typed on headed hospital note paper)

Research project for part fulfilment of MSc in Child Protection and Welfare, Trinity College, Dublin.

Research Title: Mandated to report? A practitioner’s study of the role of doctors in child protection procedure within in a paediatric hospital setting in Ireland.

The Participant, at XXX Hospital,

I……………………………………………………………………………... agree to participate in this research project undertaken by Gary McGovern, Senior Social Worker/ Researcher in this hospital.

I have read and understood the letter provided to me detailing the purpose and remit of the study. I give permission for the researcher for the information I provided to be used in the report. I also understand that any identifying personal information will be removed and my personal role will be coded. I understand that I can withdraw from the process at any time if I chose to do so. The recordings and transcripts of my interview will be destroyed after the data has been processed.

1) Participant

signature……………………………………………………………………………..Date………………………………

2) Researcher

signature……………………………………………………………………………..Date………………………………

Thank you for your participation in this research study.

Gary McGovern

Researcher/ Senior Social Worker TCD

March 2016
Appendix (4) Interview Questions

Participant Interview Questions

A) Participants training in child protection procedure and processes.
1. What training have you had to date to inform your knowledge and awareness in the area of child protection policy and procedure? (Undergraduate post graduate)
2. Do you feel the training you have had was adequate given your role?
   (Why? / Why not)?
3. What training do you feel you require to improve your knowledge in the area?

B) Participants experience of and their role in the safeguarding process.
4. Generally what is your experience of cases that have presented to you professionally as a doctor where child abuse or neglect was identified or suspected?
5. How do you see the role of the hospital doctor in the child protection process?
6. What helps you in cases where child protection concerns present in the hospital setting?
7. What are the fears or difficulties you have about the process?
8. What is your experience of the Child and family Agency Tusla?
9. Do you have any international comparisons in other jurisdictions?

C) Organisational culture and hierarchical factors.
10. What is your current involvement and experience of multi-disciplinary teams that review patient’s clinical needs, including cases of suspected abuse?
11. What factors within the multi-disciplinary team do you feel help the in identifying and responding to suspected abuse?
12. What is your experience of social workers in the medical setting?
13. What factors do you feel are lacking in the multi-disciplinary approach that make effective collaboration difficult?
14. Do you feel supported by other senior clinicians/other managers in the hospital in dealing with cases that involve suspected abuse? Who?
15. Who do you think has the principle responsibility to respond to identified or suspected abuse in the hospital setting?
   (Consultant / Medical Social Worker/ NCHD/ other / Why?)
16. In light of this what do you consider your own role in the process?

D) **Implications of mandatory reporting for doctors.**

17. What is your view of the introduction of mandated reporting under the Children First Act (2015) for doctors in Ireland?

18. What information have you been given about the introduction of mandated reporting?

19. As a hospital doctor what do you feel you need to know about mandated reporting?

E) **MISC.**

    Do you have any further points to make regarding the topic concerning this study?
Appendix (5) Hospital Ethics Committee Approval for the Study
ETHICS (MEDICAL RESEARCH) COMMITTEE OFFICE

Mr Gary McGovern
Senior Medical Social Worker
Social Work Department

28th January 2016

Mandated to report? A practitioner’s study of the role of doctors in child protection procedure within a paediatric hospital setting in Ireland.

Principal Investigator: Mr. Gary McGovern

Dear Mr McGovern

Professor Chairperson, Ethics (Medical Research) Committee, at a review which took place on, 28th January 2016, approved the above Study.

Yours sincerely

Secretary
Ethics (Medical Research) Committee

CC: Head Medical Social Worker