

Mandatory reporting of non-accidental injury in children

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

Society bestows trust in the medical profession who it expects to act in the best interests of children. When a child presents with injuries which are suggestive of non-accidental injury, the child's future welfare will frequently depend on the clinician's decision as to what, if any, action should be taken. However, clinicians work in highly demanding clinical environments and such decisions, although crucial, are often made without adequate support from colleagues or sufficient information. The current policy response is to encourage the reporting of suspected non-accidental injury by raising awareness among clinical professionals, both of the existence of child abuse and the practical steps that should be taken when non-accidental injury is suspected. However, an alternative approach would be to impose a mandatory duty to report suspected non-accidental injury to child protection agencies.

Should reporting be mandatory?

This article presents a case for mandatory reporting. It argues that a law imposing a legal duty on doctors to report non-accidental injury in children cannot function effectively without a 'support' structure enabling reporting procedures to be conducted in collaboration with clinicians and other child protection professionals. As a result, a sea change is urgently required that promotes:

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

The authors believe that all three changes will be greatly assisted by a mandatory system of reporting.

Unlike many European countries and the USA, the law in England and Wales does not provide for the com-

pulsory reporting of suspected abuse in children. The possibility of introducing a mandatory duty to report suspected non-accidental injury to child protection agencies was considered as part of a review of child care law in 1985 (Department of Health and Social Security, 1985), but it was concluded that there was no demonstrable need for a mandatory duty, as those professionals who may be covered by such a duty were imbued by their training, tradition and character to prioritize the welfare of children and their families. In other words, it was felt that the 'moral' and professional character of the medical and allied health professions to 'do the right thing' in difficult circumstances removed the need for a law which would enforce mandatory reporting. This entailed placing the public's trust in the ability of clinical professionals to act in a 'responsible' way, capable of representing the best interests of the injured child.

The reason given for not introducing a mandatory duty was that its enactment would be counter-productive and increase the risk to children overall, first by weakening the clinician's personal sense of responsibility and, second, in casting the shadow of near-automatic reporting over their work which may raise barriers between clinicians and their patients or clients. It was also thought that the imposition of a mandatory duty to report would set back the advances made over the years in encouraging communication and cooperation between all those concerned with the health and welfare of children. Thus, the involvement of relevant agencies at the start of the reporting cycle is believed to promote a culture of inclusion, cooperation and hopefully a better system of decision making.

Given the advances in inter-agency cooperation since 1985, it seemed doubtful that further consideration would be given to the introduction of a mandatory duty to report in the foreseeable future. However, it may be timely to review the benefits that such a law could bring in the light of other developments that have taken place since the mid-1980s, in particular the recent high profile cases which illustrate the failure of agencies to recognize abused children, and question whether its absence serves the best interests of children and ultimately society.

The extent of the problem

The level of reporting of child physical abuse to child protection agencies is lower than would be expected

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(Sidebotham and Pearce, 1997). Possible reasons for this include the sceptical belief that child abuse does not exist and uncertainty about where the line is drawn and how it is defined. The definition of child abuse is an area of contention in child protection, especially when practitioners do not know how to interpret the evidence. Media coverage of child deaths and cases of physical harm has drawn attention to the disputed nature of scientific evidence, possibly fuelling scepticism about the very existence of certain kinds of alleged non-accidental injury. In recent years, however, medical practitioners have been made more aware of non-accidental injury in childhood, and have begun to acknowledge the importance of identifying it on presentation to hospital (Kempe et al, 1962).

Despite this, the evidence suggests that many cases still remain undetected (Sundell, 1997; Van Haeringen et al, 1998; Jenny et al, 1999). **For several years there have been growing concerns about the reluctance of paediatricians to become involved in child protection work and the diminishing number of professionals who are prepared to give expert evidence in child abuse cases (Kmietowicz, 2004; Thorpe, 2006).** The knowledge that a referral to child protection agencies could result in heavy commitments to the child protection process through the provision of testimony in court could act as a deterrent to paediatricians. It may be 'simpler' for a busy clinician to focus on treating the physical symptoms of abuse and to suppress doubts about the likely cause of the injuries.

Clinicians, of course, differ in their willingness to accept explanations that suggest a non-accidental cause. Some studies have shown that the likelihood of reporting a suspected case of child abuse is dependent on the expertise of the treating clinician and awareness of the 'tell-tale' signs of abuse (Van Haeringen et al, 1998). Medical practitioners in primary care are ideally placed to detect the clinical signs in very young children, especially in cases where they present with coexisting physical signs of neglect.

In recent years the responsibility for clinical child protection has largely passed to the community paediatrician, which has the advantage of using the skills of trained practitioners who can provide expert assessment and management based on extensive experience in community paediatrics (Royal College of Paediatrics and Child Health, 2003). However, the tendency to rely on specialists means that the general or acute paediatrician may become deskilled in the recognition of physical child abuse. As most young children who are victims of traumatic injury will be admitted to accident and emergency departments, the desire by treating professionals to alleviate the immediate symptoms and overlook the causes may lead to the under-recognition of abuse.

Studies have tended to pay limited attention to the role of subjective clinical assessments, identifying the interpersonal factors that influence medical decisions in raising suspicion of physical injury, such as the socio-

economic status, age or ethnic background of the carers. However, evidence suggests that the clinical identification of suspected non-accidental injury might sometimes be based on the clinician's subjective opinion rather than on examination of all the evidence. One study, for instance, found that infants who were severely symptomatic as a result of head trauma were more likely to be referred to child protection agencies than infants with less severe symptoms (Jenny et al, 1999). This finding is supported by other studies, raising the question of how often abused children are not fully investigated because they present with visibly mild symptoms (Morris et al, 1985; Sanders et al, 2003).

A 'culture' of under reporting

Benger and McCabe (2001) found that referral rates of children who were thought to be at a high risk of abuse were low, as was **staff awareness about the possibility of non-accidental injury.** Further, clinical personnel in hospital departments did not engage in discussions about suspected high-risk cases of abuse, and commonly showed a persistent lack of knowledge about clinical and social risk factors. They rarely consulted the child protection register because it was too time-consuming to gain access and bureaucratic and inter-professional barriers to accessing confidential information about children from social services registers often led to long delays in obtaining a rapid assessment of each suspected case of abuse. These and other studies indicate that there is a culture of under-reporting of suspected non-accidental injury in children, because of the lack of formal training and access to a paediatric opinion (King and Reid, 2003).

Studies have also found that coexisting signs of abuse are a common feature among young children who present to hospital with injuries, suggesting that serious physical trauma is rarely an isolated event (Sanders et al, 2003). There is therefore a need to build effective communication channels between clinical staff and other agencies so that information about previous child protection concerns can be disclosed to frontline medical professionals. In England, the development of the Contactpoint database, which contains basic information about every child in the country and contact details of any professionals working with the child, should facilitate such communication. Introduced as part of the government's Every Child Matters programme, the database allows practitioners immediate access to information about the child, thereby reducing delays and bureaucracy. However, simply ensuring access to other professionals will not guarantee that all children with non-accidental injury will be thoroughly investigated and reported.

Need for collaboration and dialogue

Medicine not only acts independently in the identification of child abuse, but often in collaboration with other authorities. Conrad (1979) suggests that such collaboration involves acting as 'information provider, gatekeeper,

institutional agent, and technician', emphasizing the interwoven nature of clinicians in the child protection process. Medical collaboration in cases of child abuse most frequently occurs in relation to the information provider and gatekeeper role that is adopted by the medical professional.

First, the clinician is sanctioned by the nature of his or her role to report suspected non-accidental injury to child protection agencies. At this stage the collaborative nature of the clinical role is apparent when the clinician is usually expected to provide a professional opinion on the probable cause of the injury, often to a child protection conference. These conferences are multidisciplinary events, often attended by professional representatives from social work, psychiatry, police, nursing and medicine, and it is here that decisions often hinge on the medical advice of the clinician. The doctor's opinion is primarily responsible for determining the severity and nature of the injuries, as well as the possible cause. Consequently, it is difficult to see why, given the significant dependence of 'external' agencies on medical opinion, clinicians are given such limited support and perhaps encouragement in dedicating more of their efforts to the investigation of suspected non-accidental injury.

Flaherty and Sege (2005) found that in the USA, where clinicians have a legal duty to report suspected non-accidental injury, it is systematically under-identified and under-reported. The introduction of a mandatory duty therefore does not necessarily mean that physicians will report suspected abuse to child protection agencies. Additional strategies will also be required. For instance, clinicians are often confused about their role in the investigation. The emotional 'burden' of reporting cases to child protection may be too great for many doctors, and the need to access 'expert' advice from qualified colleagues who have experience of investigating and reporting such cases will be fundamental to the success of any mandatory reporting law. Just as greater education and training on its own is unlikely to improve professionals' ability to detect and report cases of suspected abuse, a mandatory duty without adequate support systems is also doomed to fail.

More recently Jones et al (2008) found, in their telephone survey with primary care doctors, that organizational and social reasons played a major part in their reporting decisions. Familiarity of the physician with the family, availability of resources and anticipation of the expected future child protection outcomes if a referral was made hugely influenced referral decisions. It was common for GPs to make these decisions in relative isolation, with limited or no input from colleagues, and often with no prior discussion with more experienced health professionals working either in primary or secondary care. For these doctors, their personal knowledge of their patients may have prevented them from reporting suspicions to child protection agencies, since this would pose a risk of harming the long-term relationship with that family.

Flaherty et al (2008) also reported that doctors with limited previous experience of dealing with suspected non-accidental injury in children were more likely to report. This suggests that, in primary care at least, prior experience of the child protection process could have a negative effect on reporting behaviour. This could be because referring clinicians are not routinely informed of the outcome of each case or may perceive the 'system' to be ineffective in its ability to safeguard the welfare of children, discouraging future referrals to child protection agencies. Clearly, there is need for closer communication and interaction between clinicians and other agencies, each informing the other of relevant developments.

Child protection work: risking conflict and controversy?

The examples of medical collaboration provided above show how medicine performs reporting, definitional and technical tasks for other institutions, namely child protection and criminal justice agencies, enabling it to exercise significant influence over the process of child protection. However, according to Conrad (1979) individual clinicians may also become constrained by this relationship. In legal proceedings, medical expertise is often scrutinized and criticized by the demands of the collaborating institution (the court of law) or by the competing arguments of other professionals or clinicians who hold a different opinion. Consequently, medical influence in these proceedings is rarely left unchecked. In child abuse cases medical definitions and opinions are most effectively challenged not just by the collaborating institution, but by those within the medical profession itself.

Community paediatricians have previously been criticized by clinical colleagues for their close association with non-clinicians (e.g. social workers and police) whose role is explicitly concerned with child protection, rather than diagnosis and treatment of the patient. Medical collaborations with non-medical agencies can help to increase medicine's influence over child protection work, but can also lead to the stigmatization of practicing clinicians.

De Swaan (1989) contends that the threat of open conflict and controversy has led doctors to exercise caution and restraint in expanding into 'uncertain' areas of clinical practice such as child protection work. Despite this view medicine has increased its influence, not of its own choosing but because its services are frequently needed by other organizations, such as the legal system's demand for medical expert evidence. The extension of medical influence beyond its 'comfort zone' also exposes its knowledge to public scrutiny and legal debate precisely on those issues where the profession was vulnerable by definition, as its policies could not be fully justified on the grounds of medical expertise, the only base of legitimacy for its exercise of power. A mandatory reporting law would help to encourage the referral of all children who have been clinically investigated for possible

non-accidental injury, hopefully removing the stigma that has attached itself to such activities. If all health professionals recognize the need to investigate and report suspected cases of child abuse then there will be a greater willingness to view this role as a legitimate one, rather than something that is conducted voluntarily by a select group of clinicians with a 'special' interest in this field of medical practice.

Taking a broader view of non-accidental injury in children: it's not just about the science

Geddes and Plunkett (2004) claim that the lack of certainty resulting from research conducted on head trauma in infants casts doubt on its very existence. They suggest that 'good quality science' is required to identify more precisely the causes of head injuries, and claim that 'a natural desire to protect children should not lead anyone to proffer opinions unsupported by good quality science'. However, despite the scientific community's eagerness to deny subjectivity and uncertainty in clinical practice (e.g. child protection work) science can only provide part of the answer:

'although [evidence based medicine] comes out on top as the new paradigm and downplays its tensions with discretionary, context-based, clinical decision-making, it does not overcome medical and biomedical uncertainty.'
(Kuhlmann, 2004)

There is a need to use a variety of methodologies, and to dismantle the artificial separation of science and experience: '...science and practice are placed in a hierarchical order that devalues embodied knowledge of patients as well as providers, and clinical experience of clinicians'. Others have expressed a need for researchers and medical practitioners to pool clinical, social and epidemiological evidence in order to address the issue of causality:

'Child abuse is an enormous social, medical, and mental health problem and its evaluation and treatment have far reaching implications for children, families and society. To provide optimal diagnosis and treatment, careful objective research, intellectual honesty are needed and must prevail over entrenchment of ideological schools of thought and "winning" in court. Unfortunately there remains considerable difficulty for some doctors to accept that children are abused. We must locate cases using all the information available, including clinical experience and the synthesis of the best literature on the subject.' (Reece, 2004)

Barton (2000) proclaims that 'identifying the best evidence for any question requires detailed appraisal, relevance, allocation, concealment...', wherein scientific evidence does not stand alone, but needs to be appraised particularly in relation to the individual experience of the clinician as well as all relevant evidence – not only 'scien-

tific' evidence. The best available scientific evidence should be used through a process of critical appraisal, but should be used alongside other evidence such as carers' testimonies, witness statements, and existing histories from medical case files, social work and police records.

Although science can go some way in explaining the cause of injuries, it is fundamentally limited in its ability to determine whether they were accidental or otherwise. In this respect, the 'medicalization' of child maltreatment is insidiously misleading. Previous guidance refers to child abuse as a 'syndrome', 'health hazard' and medical 'condition': 'Just as in every other condition in medicine, accurate diagnosis depends on a careful history and relevant clinical examination...' (Department of Health and Welsh Office, 1988). Considerable confusion therefore remains between defining abuse-as-diagnosis and abuse-as-psychosocial-problem. Used independently, neither approach nor definition can on its own adequately explain the origin of the injuries in question.

Conclusions

Critics of mandatory reporting claim that the disadvantages of such a system outweigh any foreseeable advantages. However, the arguments they present seem to be largely concerned with the danger of 'overloading' child protection services, rather than the danger of under-detection of abuse. Other reasons include the view that such a system will deter self-referrals by parents or children, discriminate against vulnerable groups, redirect resources to clinical investigation at the expense of intervention, and encourage professionals to pass the buck rather than share responsibility. Conversely, those supporting mandatory reporting claim that it will send out a clear message, 'legitimizing' and integrating child protection work within medical practice, reinforce the integrity of health professionals by sponsoring their activities as important and necessary elements of clinical work, increase detection rates, and raise awareness of child abuse, as well as the creation of effective inter- and intra-agency communication and support channels. However, unless mandatory reporting is legally sanctioned, the current organizational and professional barriers described in this article will continue to affect the ability of agencies to safeguard children and protect them from harm. [BJHM](#)

KEY POINTS

- Many reporting decisions may be made in relative isolation and in the absence of effective communication between clinicians.
- Education and training on its own is unlikely to improve professionals' ability to detect and report cases.
- The success of a mandatory law will depend on effective peer support and inter-agency dialogue.
- Professionals need to debate the likely impact of a mandatory law on child protection services vs the risk of under detection and referral of non-accidental injury in children.

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