ORIGINAL ARTICLE

Accident and emergency department access to the child protection register: a questionnaire survey

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Objectives: To ascertain how UK accident and emergency (A&E) departments access the child protection register, their levels of satisfaction with that access and their criteria for checking the register.
Methods: A postal questionnaire was sent to 254 "major" A&E departments listed in the 1996 British Association for Accident and Emergency Medicine directory.
Results: 190 questionnaires were returned (response rate 75%). Ninety (48%) responding departments access the register through the duty social worker, 33 (17%) use a computerised copy, 32 (17%) a hard copy and 27 (14%) a combination. Twenty seven of 33 respondents (82%) using a computerised copy were satisfied with their mode of access. This compares with figures of 21 (66%) for hard copy, 45 (50%) for duty social worker and 14 (50%) for a combination. No departments using the duty social worker checked all patients routinely compared with 23 (72%) for hard copy, 22 (67%) for computer copy and 12 (44%) for departments using a combination of modes of access.
Conclusion: There is no uniformity of the way in which UK A&E departments access the child protection register and there is also substantial variation in the criteria used to check the register. This survey suggests that the most common form of access (via the duty social worker) often fails to meet the needs of A&E departments, principally because it takes so long.

It is recommended that accident and emergency (A&E) departments have ready access to the child protection register to aid the detection of non-accidental injury. The Audit Commission state that "there should be procedures enabling doctors and senior nurses to gain swift access at any time of the day and night to child protection registers, including those for other areas".[1] In its document Standards for Accident and Emergency Services, Health Services Accreditation suggest a direct link to the register, or, failing that, a clear mechanism to check A&E attendance with the child protection register.[2] "Working together to safeguard children" (a document issued jointly by the Department of Health, the Home Office and the Department for Education) emphasises the importance of police and health professionals having access to the register irrespective of the time of day.[3]

We observed that different A&E departments in our region accessed the child protection register in different ways, and some modes of access seemed to work better than others. We carried out a survey of UK A&E departments to establish patterns of access nationally, and the level of satisfaction with that access.

METHODS

We sent a questionnaire to consultants in 254 A&E departments described as "major" units in the 1996 British Association for Accident and Emergency Medicine directory. Minor units were not surveyed, as, in many cases, the supervising consultant is the same as the local major unit. The questionnaire (appendix 1; see emjonline.com for sample questionnaire) used a combination of open and closed questions and asked how the department accessed the child protection register, whether the department was satisfied with that access (specifying reasons for a negative response) and what criteria the department used for consulting the register. We initially carried out a pilot study of A&E departments in Wales and found that respondents appeared to interpret the questions as we had intended. Confidence intervals were calculated for the differences in proportions satisfied with the various modes of access.

Table 1 Responding departments' means of access to the child protection register

Mode of access	Number (%) of departments (total 190)
Duty social worker	90 (48)
Computerised copy	33 (17)
Hard copy	32 (17)
Combination*	27 (14)
Other*	8 (4)

*See text for details.

RESULTS

Altogether 190 questionnaires were returned (response rate 75%). Table 1 shows how responding departments access the child protection register. Combinations consisted of duty social worker and hard copy (six departments), duty social worker and computer copy (4), duty social worker, hard copy and computer copy (5), duty social worker and police (4) and duty social worker and "phone a nearby A&E" (1). "Other" means of access were via a dedicated social services telephone line (3), paediatrics (1), police (1) and joint consultancy child protection team (1). One department had no access to the child protection register.

Table 2 shows the level of satisfaction expressed by responding departments with their mode of access to the child protection register. There was a significant difference between the proportion satisfied with computer and social worker access (difference 32%, 95% confidence intervals 15% to 49%). The differences in satisfaction for hard copy versus duty social worker and computer versus hard copy did not attain statistical significance. The differences (95% confidence intervals) were 16% (−5% to 37%) and 16% (−3% to 35%) respectively.

The main reasons for dissatisfaction with social worker access were that it was time consuming, problematic outside office hours and it afforded no automatic check on children.

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Table 2 Levels of satisfaction with mode of access to the child protection register, ranked in order of most satisfied

Mode of access	Numbers (%) satisfied
Computerised copy	27 (82)
Hard copy	21 (66)
Duty social worker	45 (50)
Combination	14 (50)
Other	4 (50)

Problems common to computer and hard copy access were the provision of local information only, often out of date. In addition, hard copy allowed no automatic check and computer systems required training and could "go down".

Overall, 57 (30%) responding departments checked all patients routinely against the register, 112 (59%) checked children with specified risk factors and 40 (21%) used other criteria such as "staff suspicion, concern or hunches". There was some overlap in the latter two groups giving an apparent total greater than 100%. No departments using the duty social worker checked all patients routinely compared with 23 (72%) for hard copy, 22 (67%) for computer copy and 12 (44%) for departments using a combination of modes of access.

DISCUSSION

The child protection register is a centrally held list of all children resident in each area covered by a social services department who are considered to be at continuing risk of significant harm, and for whom there is a child protection plan. As stated in *Working together to safeguard children*, "the principal purpose of the register is to make agencies and professionals aware of those children who are judged to be at continuing risk of significant harm and in need of active safeguarding. Consequently, it is important that agencies and professionals who have concerns about a child are able to make enquiries of the register".[3]

This survey has shown that there is no uniformity of the way in which UK A&E departments make such enquiries. Contacting the duty social worker is the commonest mode of access, but it compares unfavourably with both computer and hard copy access in terms of satisfaction, principally because it takes so long. The Children Act charges an identified person within each social services department with custody and management of the register and it emphasises the need for confidentiality. This may explain the reluctance of some social services departments to "release" the child protection register as either a hard copy or in computerised form.[4]

A&E department satisfaction aside, an important finding of this survey is the suggestion that the way in an A&E department accesses the register seems to influence the department's criteria for checking the register. Most departments who can check all children against the register (that is, those with a hard or computer copy) tend to do so. An alternative interpretation is that those departments who feel it is important to check all children have put in place a level of access that allows them to do just that. There is no clear evidence which approach serves children best. Checking all children against the register is clearly impossible if access is through the duty social worker and the limitations of this "screening test" have been noted.[5] It is neither sensitive (many children with non-accidental injury will not be on the register) nor specific (many children on the register will attend with accidental injury). On the other hand, follow up studies have shown an appreciable re-injury rate (6.9% re-injury rate in the year following registration in 1982).[6] It has been argued that A&E departments will probably only detect a small proportion of cases of non-accidental injury and therefore the means should be in place to at least protect those already on the register.[4] Research evidence would be useful to carry this debate forward, for example comparing referral and detection rates between departments using different criteria for checking the register.

Whatever the mode of access and irrespective of the criteria for checking the register, the cornerstone of detecting child abuse remains the clinical judgement of a well educated and vigilant A&E staff.

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Contributors

Gareth Quin carried out the survey, collected and analysed the data and wrote the paper. Rupert Evans generated the core idea, edited the paper and is the guarantor of the paper.

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See sample questionnaire on emjonline.com

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