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.

**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.
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”.

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 to the child protection register, with computer access being the next most common. However, computer access is much less likely to be satisfied than hard copy access. This is likely to reflect the fact that people trained to access the register are often not trained to access computer systems, and may find it difficult to use the computer in the workplace without training. Furthermore, the use of computer systems to access the register may have implications for confidentiality, which may be important to agencies and professionals who have concerns about a child.

A&E department satisfaction aside, an important finding of this survey is that the way in which A&E departments access 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. 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).

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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REFERENCES
3 Department of Health. Working together to safeguard children. (www.doh.gov.uk/quality5.htm)
4 Porter JE. Checks on children in Southend have to be via a social worker. BMJ 1998;316:775.

See sample questionnaire on emjonline.com