



**PAEDIATRICS**

# **A NATIONAL MODEL OF CARE FOR PAEDIATRIC HEALTHCARE SERVICES IN IRELAND**

## **CHAPTER 16: CHILD PROTECTION**



Féidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

Clinical Strategy and Programmes Division



**ROYAL  
COLLEGE OF  
PHYSICIANS  
OF IRELAND**

## TABLE OF CONTENTS

|      |   |    |
|------|---|----|
| 16.0 | Introduction  | 2  |
| 16.1 | Current Service Provision   | 3  |
|      | 16.1.1 Current services for children with inflicted injury/neglect/emotional abuse in Ireland | 3  |
|      | 16.1.2 Current Child Sexual Assault Services for Children in Ireland                          | 4  |
| 16.2 | Proposed Model of Care  | 6  |
|      | 16.2.1 Model of Care for Physical Abuse/Inflicted Injury/Neglect/Emotional Abuse              | 7  |
|      | 16.2.2 Model of Care for Historical Child Sexual Abuse  | 8  |
|      | 16.2.3 Model of Care for Acute Child Sexual Assault   | 8  |
|      | 16.2.4 Other Resources  | 9  |
|      | 16.2.5 Vulnerable Children and Serious Case Reviews   | 9  |
| 16.3 | Requirements for Successful Implementation of Model of Care                                   | 9  |
|      | 16.3.1 Organisation-level Requirements  | 9  |
|      | 16.3.2 Staffing Requirements  | 10 |
|      | 16.3.3 Governance   | 11 |
|      | 16.3.4 Education and Training   | 11 |
| 16.4 | Programme Metrics and Evaluation  | 11 |
| 16.5 | Summary   | 12 |
| 16.6 | Key Recommendations   | 12 |
| 16.7 | Abbreviations   | 12 |
| 16.8 | References  | 13 |

## 16.0 INTRODUCTION

All children and young people have a right to be protected from child abuse and neglect. Child protection is a very important aspect of paediatrics, and all doctors have a duty to protect children. However, the historical neglect of this area of paediatric health service development means that the service in Ireland is under-resourced and difficult to navigate, leaving the most vulnerable children in society at risk. Child protection is a complex and demanding area, which requires the involvement of many hospital, community health and non-health multidisciplinary agencies and services. A national strategy addressing the child protection needs of children who present with inflicted injury, neglect, emotional abuse or child sexual abuse is the cornerstone to improving the delivery of care to a level that reaches best practice standards. The formulation of this strategy will require consultation with the Health Service Executive (HSE) and Tusla, the Child and Family Agency.

*Child protection referrals to paediatricians have traditionally been divided into the following subtypes:*

- physical abuse/inflicted injury including head injuries, burns, and fractures
- neglect
- emotional abuse
- factitious or induced illness
- child sexual abuse

### Background – Informing Best Practice for Child Protection

It is internationally accepted that child abuse and neglect is a major public health issue. In 2012, there were 19,044 child protection and welfare referrals to social work departments in Ireland for initial assessment. The number of referrals had increased year on year from 2006, when there were 9,461 referrals (Tusla, 2014). A report by the Department of Children and Youth Affairs, State of the Nation's Children: Ireland 2012, revealed that at the end of 2012 there were over 6,300 children in the care of the state, 2,070 of whom entered into care that year (DCYA, 2012). In 2009, there were 2,500 reports of child sexual abuse to social work departments across Ireland (HSE, 2011). The 2002 Sexual Abuse and Violence in Ireland (SAVI) study of over 3,000 adults reported that one in four of those interviewed had experienced sexual abuse in childhood. Almost half (47%) reported that they had never previously disclosed the abuse to others, indicating that the figures may actually be much higher (McGee et al., 2001). Few suspected cases of child abuse result in criminal prosecution or a conviction.

The Irish Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* (IMC, 2009) states that all doctors should be aware of the national guidelines for the protection of children. It also states that any doctor who has concerns regarding alleged or suspected sexual, physical, emotional abuse or neglect of children must report this to An Garda Síochána (Withholding of Information on Offences Against Children and Vulnerable Persons Act 2012) and/or the relevant statutory agency (Tusla) without delay.

Tusla was established on 1 January 2014, and is responsible for improving the well-being of children and ensuring best possible outcomes for them.

*Children First: National Guidance for the Protection and Welfare of Children* was first published in 1999, and subsequently revised in 2011 (DCYA, 2011). This document promotes the protection of children from abuse and neglect, and outlines what different statutory and non-statutory bodies, and the general public, should do if they are concerned about a child's safety and welfare. Although Tusla and An Garda Síochána are the two bodies with statutory responsibility for child protection and welfare, the document outlines the significant role that paediatricians play in protecting children. It also emphasises the importance of multidisciplinary and interagency working in which paediatricians play a vital role.

In 2012, the Health Information and Quality Authority (HIQA) developed the *National Standards for the Protection and Welfare of Children* to support continuous improvements in the care and protection of children in receipt of HSE child protection and welfare. The Standards recommend that children should be supported through the provision of accessible information and services, including timely action to protect children at risk of harm. Timely assessment by paediatricians is essential, in order to comply with this recommendation (HIQA, 2012).

*The Children First Bill, 2014*, which is due to be enacted in 2015, will place Children First guidelines on a statutory basis. Paediatricians and all medical doctors will be mandated to report suspected and known cases of child abuse to Tusla. The Act will require mandated persons to assist Tusla in the assessment of risk, including preparing verbal or written reports and attending meetings. The new legislation will inevitably lead to an increase in child protection assessments and this will require increased paediatric manpower (Medical Workforce Planning: Interim Project Report, HSE, 2014).

The provisions of the Children First Bill are in line with international guidance on child protection. In the United Kingdom, Working Together to Safeguard Children (HM Government 2013) states that:

- Safeguarding children is everyone's responsibility, including paediatricians.
- For services to be effective, each professional and organisation should play their full part.
- A child-centred approach should be adopted, based on a clear understanding of the needs and views of children.

Recent initiatives have seen the development of the Joint Children's Hospitals Child Protection Guidelines by the three Dublin children's hospitals, which provide algorithms and guidance for all staff dealing with child protection issues (Our Lady's Children's Hospital, Crumlin, 2015). A joint multidisciplinary child protection committee has been established, which convenes quarterly, and includes representatives from Tusla and HSE Children First Office.

The vision for the paediatric model of care for child protection in Ireland is that all paediatricians should be competent to assess and manage the majority of child protection cases. Specialist support from paediatricians with additional training and experience should be available for paediatricians when they require it. In relation to child sexual abuse services, there needs to be a national coordinated network of children's sexual assault treatment units (CSATUs), comparable to the existing network of adult sexual assault treatment units (SATUs).

## 16.1 CURRENT SERVICE PROVISION

### 16.1.1 Current services for children with inflicted injury/neglect/emotional abuse in Ireland

There are 19 paediatric units in Ireland. All paediatricians in these units have a responsibility to manage child protection cases that present to them. Paediatricians with a special interest in community child health, and other paediatricians, may have additional training and/or experience in the area of child protection and often take a supportive role in difficult cases. All consultant paediatricians with a special interest in community child health are joint appointments, with a large commitment (usually 50%) to hospital-based general paediatrics and neonatology. As a result, they have little time to devote to service and governance developments, or to contribute to national committees who are developing policy. There are too few consultant general paediatricians in Ireland and, of these, there are too few with a special interest in community child health nationally, the number being just 11.75 whole-time equivalent (WTE) as shown in Table #.1 (HSE, 2014).

Table 16.1: Consultant paediatricians with a special interest in community child health (July 2014)

| HSE Area            | Hospital      | Population (0-19 years) 2011 census | Consultant Community Child Health WTE |
|---------------------|---------------|-------------------------------------|---------------------------------------|
| Dublin Mid-Leinster | Crumlin       | 1,319,754                           | 1.0                                   |
|                     | Tallaght      |                                     | 1.0                                   |
|                     | Portlaoise    |                                     | 0.5                                   |
|                     | Mullingar     |                                     | 0.5                                   |
| Dublin Northeast    | Temple Street | 1,019,658                           | 0                                     |
|                     | Drogheda      |                                     | 1.0                                   |
|                     | Cavan         |                                     | 0.5                                   |
| South               | Kilkenny      | 1,162,112                           | 0.5                                   |
|                     | Wexford       |                                     | 0.5                                   |
|                     | Waterford     |                                     | 0                                     |
|                     | Clonmel       |                                     | 0.5                                   |
|                     | Cork          |                                     | 1.25                                  |
|                     | Tralee        |                                     | 0.5                                   |
| West                | Limerick      | 1,086,728                           | 0.5                                   |
|                     | Galway        |                                     | 1.0                                   |
|                     | Ballinasloe   |                                     | 0.5                                   |
|                     | Castlebar     |                                     | 0.5                                   |
|                     | Sligo         |                                     | 1.0                                   |
|                     | Letterkenny   |                                     | 0.5                                   |
| TOTAL               |               | 4,588,252                           | 11.75                                 |

### 16.1.2 Current Child Sexual Assault Services for Children in Ireland

There are two types of assessment required for child sexual abuse:

- acute forensic examination, which involves the identification and management of acute injury and the collection of forensic samples which, ideally, needs to be done within 72 hours of the abuse
- clinical assessment of a child who has alleged historical sexual abuse

#### Dublin

At present, there is no formal arrangement for the provision of acute child sexual abuse assessments in the Dublin/ Greater Dublin region, resulting in difficulties for patients, their families, and referring agencies. Currently, there is an ad hoc service based on the goodwill of paediatricians, with no dedicated time allocated for these assessments.

These assessments are highly time-consuming involving examination, reporting and court cases. There is an immediate need to address the medical service deficit in the Dublin/Greater Dublin region.

#### Waterford

Forensic, acute and planned medical examinations are provided at the Community Child Centre (CCC), the regional child sexual abuse assessment centre for the Southeast region, based at University Hospital Waterford (UHW). This centre was established in 1988 as the regional child sexual abuse assessment centre for the then South Eastern Health Board. An average of 95 assessments was carried out each year between 1989 and 2011.

The CCC is staffed by a multidisciplinary team (MDT) from psychology, social work, nursing and medicine with administrative support from 9am to 5pm Monday to Friday. Diagnostic or therapeutic assessments are provided in suspected or alleged child sexual abuse cases for children aged up to 18 years. Referrals for medical examinations come directly from medical personnel, e.g. paediatric emergency departments or GPs, An Garda Síochána, social workers and others.

Medical examinations are carried out in a dedicated room at the CCC by a community medical officer/senior medical officer grade with forensic training, and may include video colposcopy, sexually transmitted infection screening and prophylaxis, post-coital contraception, follow-up and onward referral, if required. Nursing cover for medical examinations is provided by the Public Health Nursing Department. The CCC has been part of Tusla since January 2014, and maintains close links with the adult sexual assault treatment unit at UHW. The medical officer assigned to the CCC retired in February 2012, but has continued to work on a half-time temporary basis pending recruitment of a permanent replacement. There is an immediate need to address the medical service deficit in the South East.

### *Cork*

Medical and forensic, acute and non-acute, examinations of children who have alleged sexual abuse are provided at the Family Centre, St Finbarr's Hospital, Cork. The centre is staffed by social workers, a part-time clinical nurse manager, and a psychologist (post currently vacant). Up to December 2009, a full-time senior medical officer was employed to carry out the medical examinations in this centre. However, since her retirement in 2009, there has been a drastic reduction in the medical service provision from 1.0 WTE to the current level of 0.1875 WTE, representing more than an 80% reduction in this resource.

Currently, there are around 100 referrals per year to the Family Centre from local social services departments and An Garda Síochána, most reporting historical abuse. However, a significant number are cases of acute or recent abuse referred directly from local hospital emergency departments or paediatric wards. All historical referrals are offered a medical examination as part of the overall multi-interview assessment.

The medical examinations at the Family Centre in Cork are carried out by one of three consultant paediatricians, each of whom provides a very small weekly sessional commitment to the child sexual abuse service. The combined commitment comes to 1.875 sessions each week (0.1875 WTE). The service in Cork is provided from 9am to 5pm Monday to Friday. Outside of these hours, the on-call consultant paediatrician is responsible for assessing and managing children who report sexual abuse. As child sexual abuse presentations are, by their nature, unscheduled this service is limited, and is supported by the goodwill of the clinicians involved. The service is supported by one half-time nurse specialist. However, as she covers both Cork and Kerry, her availability for examinations is limited. There is an immediate need to address the medical service deficit in the Southern region.

### *Galway*

The Child and Adolescent Sexual Assault Treatment Service (CASATS) in Galway is based in premises shared with the Adult Sexual Assault Treatment Unit (SATU). The service provides an integrated forensic medical service for children aged under 14 years who are victims of sexual assault or suspected child sexual abuse. The service also accommodates adolescents aged between 14 and 18 years who allege historical child sexual abuse (>7 days previously). During the past four years, the average number of children seen each year for assessment was 60.

Currently, children from counties Galway, Mayo, Roscommon, Donegal, North Tipperary, Clare and Limerick who are victims of acute sexual assault are referred to CASATS in Galway. This service currently has two consultant paediatricians and one general practitioner, all of whom have completed comprehensive forensic training. The current rota of one in three is unsustainable in the long term. There is shared access (with the adult unit) to one clinical nurse specialist, 22 on-call support nurses, and one manager who provides administrative support. The service operates 24 hours a day, 365 days a year for patients who report an assault to the Gardaí or social services.

### Sligo

The two paediatricians with a special interest in community child health in Sligo offer assessment of children in their catchment area who have disclosed a history of sexual abuse. Approximately 12 cases are seen each year. Cases are referred mainly from social services, and the vast majority relate to historical abuse. Examinations take place in the colposcopy suite in Sligo Regional Hospital, with the support of the clinical nurse manager 2 (CNM2). Since 2010, both paediatricians perform the assessment jointly. Historically, photo-documentation was used, but in the recent past the use of video-documentation has been explored.

### Tralee

The community paediatrician in Tralee sees approximately eight referrals per year.

### North East (Cavan/Meath and Louth)

Approximately 30 children are seen for child sexual assault (CSA) assessment in the North East each year where there are three paediatricians with a special interest in community child health.

## 16.2 PROPOSED MODEL OF CARE

*The child protection service should satisfy the following criteria:*

- Meet the needs of children and provide appropriate and timely medical assessment, management and aftercare by consultant paediatricians in cases of child maltreatment.
- Involve multidisciplinary collaboration with specialist nursing colleagues, social services departments in hospitals and in the community, radiology departments, laboratory and microbiology departments, ophthalmology departments, other agencies such as An Garda Síochána, and therapeutic services, e.g. counselling, which children who have been abused may require.
- Be accessible and have clear referral pathways.
- Meet best practice international standards.
- Provide clinicians with dedicated time to perform this complex work effectively

It is proposed that a number of dedicated consultant paediatricians be appointed in each hospital group to guide the development of a child protection service. In the United Kingdom (UK) model there are both “designated” (trust-wide) and “named” (hospital-based) doctors for child protection (Royal College of Paediatrics and Child Health, 2014). These consultants are members of, and have close links with, Local Safeguarding Children Boards. They also support other consultant paediatricians by providing assistance and expertise in more difficult or complex child protection cases, and they usually undertake specialist child sexual abuse medical assessment and management. In the UK, these consultants usually have a commitment of 16-20 hours per week for child protection activity within their roles. A similar model could be developed in Ireland, with the appointment of consultants with a specific sessional commitment for child protection work.

The role of specialist child protection nurses also needs to be developed to enable them to fulfil essential functions such as nurse training, mentoring and providing support, along with co-working with the medical staff.

Every hospital that treats children requires a medical social work presence to assess child protection concerns in conjunction with the MDT.

### **16.2.1 Model of Care for Physical Abuse/Inflicted Injury/Neglect/Emotional Abuse**

- All clinicians who work with children must develop and maintain their skills in the recognition and management of children who present with child protection concerns and child abuse.
- All paediatricians are obliged to be knowledgeable about Children First guidelines and processes and the Children First Bill 2014 and to carry out their obligations according to the guidelines and the Act.
- Children or young persons referred for evaluation of a child protection concern are likely to be referred by Gardaí, social workers, primary care, community doctors and/or emergency department staff.
- Clear guidelines should be developed with social work departments within the hospitals, Tusla and with the Gardaí as to when a medical assessment is required and the urgency of that assessment. The Children First Bill 2014 outlines there should be coordinated working arrangements between children and family services and local hospitals.
- The consultant paediatrician under whose care a child/young person is registered (either as an outpatient or inpatient) will retain responsibility for the clinical management of the child or young person.
- When a doctor requests a paediatric consultation in relation to child abuse, it is necessary that the requesting doctor remain involved in the clinical care of the child. They should contribute to the child protection report and attend child protection meetings regarding that case as required.
- Consultant paediatricians with additional training in child protection, appointed to each region and/or institution that treats children, should provide specialist knowledge, expertise and support to colleagues in the area of child protection.
- In certain circumstances, a child who is critically ill as a result of injuries sustained, may need to be transferred to a regional centre for specialist clinical assessment and management. The referring clinician should remain involved in child protection proceedings and provide clinical follow-up.
- There need to be clear pathways to access expertise in fields such as radiology, ophthalmology, neurosurgery and orthopaedics.
- There should be clear national guidelines for comprehensive medical child protection assessment, based on best practice and international standards, e.g. required investigations in cases of fractures/bruises.
- There must also be clear guidelines relating to the follow-up arrangements and onward referral to other relevant agencies, as outlined in the Children First guidelines (DCYA, 2011) and the Child Protection and Welfare Practice Handbook (HSE, 2011).
- Ready access to structured peer review is an essential component of work in this field.



### 16.2.2 Model of Care for Historical Child Sexual Abuse

The majority of children only disclose child sexual abuse sometime after the abuse has occurred, and too late for the collection of forensic samples. In these cases the assessment is not urgent. It is anticipated that some of these children will continue to be seen in their local facility and some will be referred to the regional centre depending on the expertise and facilities available locally.

### 16.2.3 Model of Care for Acute Child Sexual Assault

The model proposed is informed by the recommendations of the Ferns 4 report and the National Review of Sexual Abuse Services for Children and Young People (HSE, 2011). The report of the Ferns 4 National Steering Committee 2014 sets out a national model for sexual abuse services for children, young people and their families providing a roadmap for development of an integrated approach by the key stakeholders (Ferns 4 Steering Committee, 2014). There is an immediate issue with regard to the provision of medical/forensic examination in the country. It is recommended that three Child Sexual Assault Treatment Units (CSATUs) are established nationwide as a matter of urgency.

These proposed regional centres of excellence, would be 'one-stop-shops' providing medical/forensic examination, interview assessment, therapy, child protection liaison and Garda liaison as core components for children referred for assessment after acute child sexual assault.

Each CSATU will coordinate, train, support and supervise the work of clinicians in the clinical network for the region.

*The CSATU must be able to provide the following medical care:*

- first aid for minor injuries
- emergency contraception with an appropriate care pathway
- pregnancy testing with an appropriate care pathway
- prophylaxis for sexually transmitted infections with an appropriate care pathway and follow-up
- provision of, or referral for, hepatitis B immunoglobulin and/or vaccination with appropriate follow-up and care pathway
- provision of, or referral for, post-exposure HIV prophylaxis with appropriate follow-up and care pathway
- screening for sexually transmitted infections when appropriate, e.g. when examining suspected historic sexual assault/abuse

All services require the appointment of a number of consultant paediatricians with a special interest in child protection, and dedicated time within their posts to lead and provide the service. They also require an adequate number of specialist nurses. Some of the existing general paediatricians and consultant paediatricians with a special interest in community child health may become involved in the rota for acute sexual abuse assessment in the regional units in Ireland. Accommodating this additional commitment would require alterations to their current job description and workload.

*Recommendations for Medical Child Sexual Abuse Assessment*

- All doctors who see children should be competent to take a brief history of a sexual abuse concern or allegation.
- Access to expert advice on whether a child needs an acute forensic assessment should be readily available via telephone 24 hours a day, seven days a week.

- Children referred for assessment following sexual assault should have ready access to a medical assessment by a trained and competent clinician, with appropriate equipment including magnification and dynamic photo-documentation and forensically clean examination facilities, where required. It is recognised that children examined in a CSATU are more likely to have injuries documented correctly and to receive sexually transmitted infection screening (Girardet et al., 2011).
- There is evidence that forensic assessment in children under 10 years old should ideally be carried out within 72 hours, but is more likely to yield positive findings if conducted within 24 hours of the acute assault (Walsh et al., 2007).
- Clinicians should engage in regular, structured peer review.
- Clinicians should carry out a minimum annual number of CSA assessments in order to maintain their clinical skills; the Royal College of Physicians Faculty of Forensic & Legal Medicine in the UK recommends 20 per year per practitioner (FFLM, 2014).
- Staffing resources should be provided to allow for joint (i.e. two-consultant) examinations where required.

#### 16.2.4 Other Resources

Children and families should be provided with written documentation explaining their likely journey through the service. This information should be readily available to Gardaí, GPs, Tusla social workers and any other likely referral source or multi-agency participant in the delivery of child protection and safeguarding services.

#### 16.2.5 Vulnerable Children and Serious Case Reviews

Clinical staff should be alert to the increased risk of harm being suffered by children with disabilities and those living in special circumstances.

Organisations involved in the management of child deaths must be familiar with the relevant policies and procedures, and must respond accordingly. Clinicians should be involved in these multi-agency reviews. HSE staff must cooperate with Tusla when a serious case review is being undertaken.

## 16.3 REQUIREMENTS FOR SUCCESSFUL IMPLEMENTATION OF MODEL OF CARE

A national paediatric strategy, including workforce planning, needs to be developed for child protection. This document will support the development of such a strategy. Each region should have comprehensive child protection policies that are in line with national guidance, and that take account of guidance from any relevant professional body. A national strategy must include the formal training of all health personnel who treat children, as well as a coherent pathway of care from the moment children present to health services through to a comprehensive assessment and reporting to Tusla. Specific services for child sexual abuse need to be established. A supportive clinical service needs to be developed for children and young people in the care of the State.

#### 16.3.1 Organisation-level Requirements

The new Children First Bill 2014 specifically provides that any child availing of the child protection service is safe from harm while availing of that service. When commenced, services will also be required to produce a child safeguarding statement (Children First Bill, 2014). The key organisational features for an effective child protection service are:

- All healthcare staff should understand their role and responsibility in protecting and safeguarding children. Every healthcare staff member plays a critical role.

- There must be a clear commitment to, and understanding of, the importance of the role of the paediatrician in safeguarding children (child protection) and promoting children's welfare, by senior management of the HSE and by Tusla.
- A clear commitment is required to develop child protection services to acceptable international standards as soon as possible, informed, where appropriate, by the views of children and families.
- Clear lines of accountability, which include all staff within each medical and non-medical organisation that works to safeguard or promote the welfare of children, are necessary.
- There should be a lead senior team, including management, which is informed about, and which takes responsibility for, the actions of its staff in child protection and promoting the welfare of children.
- Training on the safeguarding of children for all staff who work with, or are in contact with, children and families is essential. When the Children First Bill 2014 is commenced, all mandated persons will have to undertake a Children First foundation training course, which will be provided by the Children First Office.
- There must be safe staff recruitment procedures in place.
- Policies and arrangements should be in place to provide staff with supervision and support in order to:
  - enable them to manage stress within their work
  - promote good practice and quality assurance of the services they provide
  - ensure that staff use effective systems to record their work
  - follow local multi-agency policy and procedures
- All services should have an MDT in place with overall responsibility for:
  - ensuring that the organisation has procedures for dealing with allegations against staff
  - provision of advice and liaison
  - ensuring that cases are dealt with as quickly as possible
- There must be appropriate governance at national and regional level (see Governance section below).

### **16.3.2 Staffing Requirements**

The number of general paediatricians and paediatricians with a special interest in community child health in Ireland needs to be increased urgently. The requirement for community child health has been calculated as outlined in detail in the Royal College of Physicians and Child Health Medical Workforce Planning Paediatrics document January 2014. The current model, whereby appointments are joint general paediatrics and community child health, should be maintained. A total of 65 WTE consultants are required to provide the disability (42 WTE) and child protection (23 WTE) services. Given the 50% time commitment to general paediatrics, this equates to a requirement for 130 consultants. This is the minimum requirement based on international standards.

Specialist second opinion is often required in inflicted injury cases, particularly in abusive head trauma and where there are multiple fractures. This opinion would be provided by paediatricians with a special interest in child protection. These paediatricians would have additional training/expertise in child abuse and, in addition to supporting colleagues by providing a second opinion, they would also develop child protection guidelines and clinical pathways. In addition, these clinicians would retain responsibility for the assessment of children with historical (non-acute) allegations or disclosures of child sexual abuse. If geography allows, regional leads for child protection would participate in the assessment of acute cases of child sexual assault at the CSATU.

Based on the child population (aged 0-17 years) in Ireland of 1,148,687 in 2011 (Central Statistics Office, 2011), the national requirement for paediatricians in child protection is nine WTE hospital-based ("named doctors") and 11 WTE regional-based ("designated doctors"). The Ferns 4 Implementation group recommends three regional centres for the medical and forensic assessment of child sexual abuse, which would require three clinical directors (three WTEs) in addition to the above. Child protection services therefore requires the appointment of 23 WTE consultant paediatricians, and with a 50/50 division of time with general paediatrics, 46 consultant posts are required.

### 16.3.3 Governance

A national governance structure in relation to child abuse and neglect is essential. In relation to child sexual abuse, Ferns 4 recommended “the establishment of a national steering committee with a mandate to manage and coordinate assessment and therapy services throughout the country; and to have governance oversight of these services”. A national group has been established, representing the major stakeholder agencies – Child and Family Support Agency (CFSA), HSE, integrated services, An Garda Síochána, the CARI Foundation and paediatric consultant representation. This group will provide national governance oversight, interagency coordination and policy development for the national sexual abuse service.

The HSE Children First Implementation Plan requires each community health organisation and hospital group to have a Children First Implementation Committee in place.

### 16.3.4 Education and Training

- All doctors who have contact with children including emergency, orthopaedics and surgical doctors, both at junior and senior levels, need specific training in child protection.
- Recommended basic training for paediatricians is the Child Protection: Recognition & Response course (Royal College of Physicians of Ireland), which is mandatory for paediatric basic specialist trainees in Ireland.
- Children First foundation training is already available for all HSE designated officers.
- Child-protection awareness training has been developed across the three Dublin children’s hospitals.
- General paediatricians and paediatricians with a special interest in child protection require specific training. There are courses available through the Royal College of Paediatrics and Child Health (RCPCH) in the UK and an annual child maltreatment meeting is held in the United States each year.
- The core skills for competence in a paediatric forensic medical examiner for child sexual abuse are detailed in Quality Standards for Doctors undertaking Paediatric Sexual Offence Medicine (FFLM, 2014). Recommended qualifications for new examiners include the Certificate in Sexual Assault Forensic Examination (UCD) and/or the Diploma in the Forensic and Clinical Aspects of Sexual Assault (FFLM, UK)
- All health organisations that treat children should have a training policy covering all staff, which details required skills and competencies commensurate with their role and responsibilities, and a training strategy that details how this will be achieved. The HSE Children First Training Strategy identifies the relevant training programmes for each HSE staff member.
- Such organisations should also have training programmes that are appropriate to staff roles, ensure that staff are released to attend relevant training, and provide updated staff training on a regular basis.
- In the UK, the RCPCH has outlined the roles and competencies for all healthcare staff (RCPCH, 2014). The HSE needs to produce a similar document for healthcare workers in Ireland.

## 16.4 PROGRAMME METRICS AND EVALUATION

The collection of data by the paediatric services on the frequency and nature of child abuse is currently poor. However, these data are critical to planning a child protection service and informing clinical practice in this area.

A local and national database is necessary to record information regarding referrals, patient demographics, and outcomes. Activity must be recorded and regularly audited against standards of care to inform ongoing development of the service. Outcomes should be clearly defined, e.g. referral source, type of abuse, time to assessment following referral, numbers returning for follow-up (can be particularly low in this cohort of patients), referral to Tusla and/

or Gardaí, and health outcomes. The patient experience should also be incorporated into outcome measures, e.g. feedback on service quality and satisfaction from the patient's perspective. Feedback should also be sought from other agencies that access the service. A culture of feedback, reflection, and continuous learning and development needs to be engendered in the service from the outset.

Recent developments that will assist are the development of the e-reporting system for HSE staff by the HSE Children First Oversight Committee and the development of the new childcare information system, which will greatly enhance data on referrals and assessments.

## 16.5 SUMMARY

The important role of the paediatrician in child protection has been underestimated and, to date, child protection is an under-resourced and underdeveloped area of paediatric practice in Ireland. Paediatricians are uniquely positioned to identify and act on child protection concerns, as they are often the first point of contact for children and their families. They have an ethical duty (soon to become a legal obligation) to protect children and report any concerns. As advocates for children, paediatricians have developed this model of care to inform the development of a national strategy addressing the child protection needs of children who present with inflicted injury, neglect, emotional abuse or child sexual abuse. It is hoped that the recommendations made in this document will be taken forward and implemented to finally give the most vulnerable children the child protection service that they deserve.

## 16.6 KEY RECOMMENDATIONS

- The number of general paediatricians and paediatricians with a special interest in community child health in Ireland needs to be increased.
- A number of consultant paediatricians with a special interest in child protection need to be appointed in each hospital group to develop and lead the clinical aspect of the service and develop robust links with other agencies delivering this multidisciplinary service.
- There is an urgent need to provide a national clinical forensic service for children who have been victims of acute sexual assault. Three Child Sexual Assault Treatment Units (CSATU) should be developed nationwide.
- Each CSATU will require consultant paediatricians with a special interest in child protection with dedicated time within their posts to lead and provide the service.

## 16.7 ABBREVIATIONS

|        |   |
|--------|---|
| BACCH  | British Association of Community Child Health         |
| CASATS | Child and Adolescent Sexual Assault Treatment Service |
| CCC    | Community Child Centre                                |
| CFSA   | Child and Family Support Agency                       |
| CNM    | clinical nurse manager                                |
| CSO    | Central Statistics Office                             |

|       |  |
|-------|--|
| DCYA  | Department of Children and Youth affairs |
| HIQA  | Health Information and Quality Authority |
| HSE   | Health Service Executive                 |
| IMC   | Irish Medical Council                    |
| SARC  | Sexual Assault Referral Centre           |
| SATU  | Sexual Assault Treatment Unit            |
| SAVI  | Sexual Abuse and Violence in Ireland     |
| CSA   | child sexual assault                     |
| CSATU | Children's Sexual Assault Treatment Unit |
| UHW   | University Hospital Waterford            |
| UK    | United Kingdom                           |
| WTE   | whole-time equivalent                    |

## 16.8 REFERENCES

Central Statistics Office (CSO) (2011) This is Ireland – Highlights from Census 2011 Part 1 Dublin: Stationery Office. Available at: <http://www.cso.ie/en/media/csoie/census/documents/census2011pdr/Census,2011,Highlights,Part,1,web,72dpi.pdf> [Accessed 5 October 2015].

Department of Children and Youth Affairs (DCYA) (2011) Children First: National Guidance for the Protection and Welfare of Children. Dublin: DYCA. Available at: <http://www.dcy.gov.ie/documents/Publications/ChildrenFirst.pdf> [Accessed 5 October 2015].

Department of Children and Youth Affairs (DCYA) (2012) State of the Nation's Children: Ireland 2012. Dublin: DYCA. Available at: <http://www.dcy.gov.ie/documents/research/StateoftheNationsChildren2012.pdf> [Accessed 5 October 2015].

Faculty of Forensic & Legal Medicine (FFLM) (2014) Quality Standards for Doctors undertaking Paediatric Sexual Offence Medicine. London: FFLM. Available at: <http://fflm.ac.uk/upload/documents/1393326841.pdf> [Accessed 5 October 2015].

Ferns 4 Steering Committee (2014) Report of Ferns 4 Steering Committee, 2014.

Girardet, R., Bolton, K., Lahoti, S., Mowbray, H., Giardino, A., Isaac, R., Arnold, W., Mead, B. and Paes, N. (2011) 'Collection of forensic evidence from pediatric victims of sexual assault' *Pediatrics*, 128(2), pp. 233–8. Available at: <http://pediatrics.aappublications.org/content/128/2/233.long> [Accessed 5 October 2015].

Government of Ireland (2014) Children First Bill 2014. Dublin: Stationery Office. Available at: [www.oireachtas.ie/documents/bills28/bills/2014/3014/b3014d.pdf](http://www.oireachtas.ie/documents/bills28/bills/2014/3014/b3014d.pdf) [Accessed 5 October 2015].

Health Information and Quality Authority (HIQA) (2012) National Standards for the Protection and Welfare of Children. Dublin: HIQA. Available at: [www.hiqa.ie/system/files/Child-Protection-Welfare-Standards.pdf](http://www.hiqa.ie/system/files/Child-Protection-Welfare-Standards.pdf) [Accessed 5 October 2015].

Health Service Executive (HSE) (2011) Child Protection and Welfare Practice Handbook. Dublin: HSE. Available at: [http://www.tusla.ie/uploads/content/CF\\_WelfarePracticehandbook.pdf](http://www.tusla.ie/uploads/content/CF_WelfarePracticehandbook.pdf) [Accessed 5 October 2015].

Health Service Executive (HSE) (2011) National Review of Sexual Abuse Services for Children and Young People. Dublin: HSE. Available at: <http://www.hse.ie/eng/services/Publications/corporate/sexualabuseservices.pdf> [Accessed 5 October 2015].

Health Service Executive (HSE) (2014) Medical Workforce Planning: Interim Project Report. Dublin: HSE. Available at: [http://www.hse.ie/eng/staff/Leadership\\_Education\\_Development/MET/plan/Interrep.pdf](http://www.hse.ie/eng/staff/Leadership_Education_Development/MET/plan/Interrep.pdf) [Accessed 5 October 2015].

HM Government (2013) Working Together to Safeguard Children. London: HM Government. Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/419595/Working\\_Together\\_to\\_Safeguard\\_Children.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf) [Accessed 5 October 2015].

Irish Medical Council (IMC) (2009) Guide to Professional Conduct and Ethics for Registered Medical Practitioners (7th edn.). Dublin: IMC. Available at: <http://www.medicalcouncil.ie/News-and-Publications/Publications/Information-for-Doctors/Guide-to-Professional-Conduct-and-Ethics-for-Registered-Medical-Practitioners.pdf> [Accessed 5 October 2015].

McGee, H., Garavan, R., deBarra, M., Byrne, J. and Conroy, J. (2001) The SAVI report: Sexual Abuse and Violence in Ireland. Dublin: Dublin Rape Crisis Centre. Available at: <http://www.drcc.ie/wp-content/uploads/2011/03/savi.pdf> [Accessed 5 October 2015].

Our Lady's Children's Hospital, Crumlin (OLCHC) (2015) Child Protection at OLCHC. Available at: <http://www.olchc.ie/About-Us/Child-Protection/> [Accessed 5 October 2015].

Royal College of Paediatrics and Child Health (RCPCH) (2014) Safeguarding children and young people: roles and competences for health care staff (3rd edn.). London: RCPCH. Available at: [http://www.rcpch.ac.uk/sites/default/files/page/Safeguarding Children - Roles and Competences for Healthcare Staff %20\(3\)\\_0.pdf](http://www.rcpch.ac.uk/sites/default/files/page/Safeguarding%20Children%20-%20Roles%20and%20Competences%20for%20Healthcare%20Staff%20(3)%20.pdf) [Accessed 5 October 2015].

Tusla (2014) Review of Adequacy for HSE Children and Family Services 2012. Dublin: Tusla. Available at: <http://www.tusla.ie/news/review-of-adequacy-for-hse-children-and-family-services-2012> [Accessed 5 October 2015].