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Hidden on the Ward: The Abuse of Children in Hospitals

Andrew Kendrick

PhD, MA(Hons)

Senior Lecturer

Department of Social Work

University of Dundee

Julie Taylor

RGN, MSc, BSc (Hons), RNT

Researcher/Lecturer

School of Nursing

University of Dundee

Address for correspondence:

Andrew Kendrick, Senior Lecturer, Department of Social Work, University of

Dundee, Dundee, DD1 4HN, Scotland, UK.

Telephone, 01382-344739. Fax, 01382-345573.

email, a.j.kendrick@dundee.ac.uk

SUMMARY

While there have been a small number of high profile cases of the abuse of children by hospital staff, there has been relatively little attention paid to the child protection issues for children staying in hospitals. Drawing on a conceptual framework from work on institutional abuse, we identify three types of abuse: physical and sexual abuse; programme abuse; and system abuse. Physical and sexual abuse can be perpetrated by medical professionals and hospital workers, it can be perpetrated by other children, or it can be perpetrated by the child's own parent(s). Research evidence from the United States suggests that the rate of abuse in hospitals is higher than in the family home. Programme abuse occurs when treatment and care falls below normally accepted standards. Recently, a tragic case of programme abuse concerned the unacceptably high death rate of babies undergoing heart surgery at Bristol Royal Infirmary. System abuse is the most difficult to define but concerns the way in which child health services fail to meet the needs of children. Recent reports have highlighted inadequate services for children and young people, lack of priority given to children's services, and geographical inequalities in the provision of services. Three crucial aspects in safeguarding children from abuse are highlighted: listening to children; the selection support and training of staff; and external systems of inspection, monitoring and standards. The recent government agenda which has placed quality at the centre of NHS service developments are discussed. Only by addressing the abuse of children in hospital openly and honestly will effective child protection be possible.

KEYWORDS: child protection; child abuse; hospital; institutional abuse; programme abuse; system abuse; selection; monitoring; standards.

INTRODUCTION

A large number of children spend time away from home in hospitals. In England and Wales, approximately 1.3 million completed hospital in-patient episodes involved children aged 18 and under in 1994/95. Approximately 41,000 of these episodes lasted for more than 15 days (Utting 1997). Hospitals should provide a safe and secure environment for the care of sick children. To what extent, however, do they prove to be the setting for the abuse of their vulnerable charges?

In social work, there has been increasing concern about the abuse of children in residential and foster care. High profile scandals have highlighted the systematic, physical and sexual abuse of children and young people in residential establishments. Abuse of children need not be perpetrated by staff and there has been a growing recognition of the risk posed by other children and young people. These concerns led to two recent government reviews of the measures to safeguard children living away from home (Kent 1997; Utting 1997). Importantly, these reviews did not confine themselves to residential care but looked at the situation of all children living away from home, including stays in hospital.

There has, however, been very little attention paid to the abuse of children that takes place in hospitals in the UK and a marked lack of empirical research (Kendrick 1997). The case of Beverley Allitt led to a review of many of the systems in place for the recruitment and appointment of nurses, and for security within paediatric units. Apart from such an extreme example, there is little to suggest that child abuse within hospital settings ever occurs. Occasionally a case of abuse by a health professional will reach the courts and be reported in the press. Anecdotal evidence from senior

nurses suggests that incidents of staff abusing children do happen, but such incidents are played down and hidden. Chesson and Chisholm (1995) note that, in contrast to children's residential homes, there have been few reports of patient abuse in child psychiatric units but highlight the lack of attention focused on such units.

This paper will review the literature on the abuse of children and young people in hospitals and will highlight the measures needed to protect children. It sets out a conceptual framework drawn from the literature on institutional abuse. Importantly, this framework does not just include the physical and sexual abuse of children by individual staff members; it also addresses the broader issues of programme abuse and system abuse.

A recent report has suggested that the elderly, disabled and children will continue to be abused in residential settings unless the 'culture of secrecy' is broken (Public Concern at Work 1997). We contend that even if the abuse of children in hospital is relatively infrequent, only by challenging the orthodoxy of secrecy around such events will effective child protection be possible.

DEFINITIONS OF INSTITUTIONAL ABUSE

A crucial issue in any discussion of abuse concerns the point at which acts of commission or omission are defined as abusive. A recent overview of child protection research highlighted that there is no absolute definition of abuse. While many definitions describe abusive *incidents* such as beating or sexual interference, an important aspect concerns the *context* in which they occur (Department of Health 1995). This issue of the threshold of abuse has been identified as creating major

problems in the identification of, and response to, abuse of children living away from home (Thomas 1995, Nunno & Motz 1988, Rindfleisch & Rabb 1984).

In this discussion of abuse in hospitals we have found it useful to use a framework of institutional abuse of children in out-of-home care developed by Gil (1982). This highlights the particular features of institutional abuse as:

... any system, program policy, procedure, or individual interaction with a child in placement that abuses, neglects, or is detrimental to the child's health, safety, or emotional and physical well-being or in any way exploits or violates the child's basic rights (Gil 1982 p.9)

Gil identifies three types of abuse: physical and sexual abuse, programme abuse and system abuse. This is summarised in Figure one.

(insert figure one here)

Physical and Sexual Abuse

Physical and sexual abuse can be perpetrated by medical professionals and hospital workers, it can be perpetrated by other children, or it can be perpetrated by the child's own parent(s). Much of the available literature concerns one high profile case of the abuse and harm of children in hospital. Between February and April 1991, three children died suddenly on Ward Four of Grantham and Kesteven General Hospital and a baby died shortly after discharge from the ward. Nine other babies and children

collapsed unexpectedly. Beverley Allitt was found guilty of four murders, three attempted murders and six instances of grievous bodily harm (Clothier 1994).

The Clothier Report identified only two previously reported cases of nurses attacking child patients. In 1980/81, there was a dramatic increase in the mortality rate in the cardiology ward of a Toronto children's hospital and investigation found that deaths were linked with digoxin poisoning. In the second case in Texas, USA, an unusual increase in the number of deaths and arrests in the paediatric intensive care unit of a large medical centre was found to be linked to the presence of one nurse (Clothier 1994).

Repper (1995) details five cases of children harmed by their carers which, she argues, share features of Munchausen Syndrome by Proxy, a form of abuse where factitious injury or manifestation of illness is inflicted on others. Nurses were involved in three of these cases.

Clothier, however, states that in nearly all cases of Munchausen Syndrome by Proxy the abuse has been perpetrated by mothers on their own children and while there have been cases involving others relatives or carers, none have involved nurses in a hospital setting. He goes on to argue that the confusion surrounding the meaning of Munchausen Syndrome by Proxy meant that it was not helpful in the context of the Allitt Inquiry (Clothier 1994).

Children and young people may also be sexually abused in hospital settings and Long (1992) describes the case of a registered nurse convicted of four counts of indecent

assault on two 13-year old boys and sentenced to two years in prison. The offences took place while Philip Donnelly was director of nursing services at Booth Hall Children's Hospital in Manchester and occurred both in his office and outwith the hospital (Long 1992).

Children and young people with disabilities are particularly vulnerable to abuse (Kelly 1992, Westcott 1991, Garbarino *et al.* 1987). This has been related partly to the fact that they are more likely to live away from home in residential establishments or hospitals at some point in their lives (Sullivan *et al.* 1991, Brookhouser *et al.* 1986). Westcott interviewed nine adults with learning disabilities and eight adults with physical disabilities about their experiences of abuse both as children and as adults. Many of them had spent long periods in hospitals, psychiatric institutions or special schools and they reported that many of the abusive incidents had occurred in these institutions (Westcott 1993).

One American study specifically compares the abuse and neglect of children in a range of institutional settings (Spencer & Knudsen 1992). They calculate a rate of maltreatment in various out-of-home care settings for the state of Indiana between 1984 and 1990. While the maltreatment rate in 'hospitals/other facilities' of 15.66 per 1,000 children was the second lowest rate, it was still higher than the maltreatment rate in the child's family home. Sexual abuse was the most frequent type of maltreatment in hospitals (8.54 per 1,000); followed by physical abuse (5.70 per 1,000); and neglect (1.42 per 1,000) (Spencer & Knudsen 1992).

There is increasing evidence of the problem of the sexual abuse of children by other residents in residential child care (Farmer & Pollock, 1998, Barter 1997). While there is anecdotal evidence that this is also a problem in hospitals, particularly in psychiatric units, very little research evidence is available. Carrey and Adams (1992) carried out an analysis of the patterns of sexual acting out in the psychiatric inpatient ward of the Pierre Janet hospital, Quebec, over a one year period. Sexual acting-out was defined as discrete episodes involving at least two children that consisted of 'either sexual intercourse, oral-genital contact, digital penetration, or touching of the other child's genitalia' (Carrey & Adams 1992, p.19). Twelve children were involved in seven episodes, committing a total of 32 acts. Spencer and Knudsen also found that in 10 out of 15 cases of sexual abuse in hospital settings, the perpetrator was another child rather than a staff member (Spencer & Knudsen 1992).

Finally, children in hospital can be abused by their own parents. Southall *et al.* (1997) describe the use of covert video surveillance in hospital settings to document life-threatening child abuse. The video surveillance revealed abuse in 33 of the 39 suspected cases; most involved intentional suffocation. While these 39 cases were specifically referred to hospitals for the investigation of apparent life-threatening events, this work does raise the more general issue that children may not be safe from abuse by their parents simply because they are in a hospital setting.

The Royal College of Nursing prepared guidance 'to raise awareness among nurses and their managers of the complex issues which need to be addressed in the light of recent cases where children have been harmed by nurses and other health care staff caring for them' (Royal College of Nursing 1996). While this is to be commended, it

is concerning that some commentaries focused more on the protection of staff from false allegations of abuse rather than the protection of children from abuse (Glasper & Powell 1996). False allegations do occur but they are not common (Wolkind 1994).

Programme Abuse

Programme abuse occurs when treatment and care in an establishment falls below normally accepted standards (Powers *et al.* 1990, Gil 1982). Gil includes in this: over-medication, inappropriate isolation, mechanical restraint, and disciplinary techniques. Robin (1982), discussing children and young people in psychiatric hospitals in the US, argued that they are abused in the normal course of treatment, through the use of locked doors, depersonalised rules and regulations, seclusion and isolation, and the use of drugs for the management of disruptive behaviour (Robin 1982).

Programme abuse may also occur because of a lack of understanding of the special needs of children. Pain control is one aspect of treatment where poor practice can potentially lead to the abuse of children. Twycross (1997) describes the continuing prevalence of misconceptions held by nurses and other health professionals which lead to children continuing to feel unnecessary pain. Latarjet and Choinère (1995) argue that pain in burned children remains too often underestimated and undertreated and Cross (1992) highlights inadequate pain control in relation to children with 'physical impairments' who suffer greatly from preventable pain because of the nature and relative frequency of surgery (see also Atkinson 1996, Cummings *et al* 1996, Liben 1996, Howard 1994). One third of all patients seen in Accident and Emergency departments are children, yet a survey in South West and Wessex regions

found that only one in five departments have a pain control policy for children (Simpson & Finlay 1998).

The fifth report of the House of Commons Health Committee (1997) has highlighted the fact that a large number of surgical interventions are being performed on children which are either ineffective or unnecessary (House of Commons Health Committee, 1997, p. xxix, see also Audit Commission 1993). Recently, a tragic case of programme abuse concerned the unacceptably high death rate of babies undergoing heart surgery at Bristol Royal Infirmary; in 53 operations, 29 children died and 4 were left brain damaged, even when it was known that too many children were dying (Dyer, 1998). The General Medical Council found two surgeons guilty of serious professional misconduct for disregarding warnings about the unacceptable death rates, and also found the former chief executive guilty for failing to stop the operations going ahead when the death rates were brought to his attention. Issues of the failure of wider systems to prevent the deaths of children at Bristol leads on to the third type of institutional abuse: system abuse.

System Abuse

Gil suggests that system abuse is the most difficult to define, acknowledge or correct. In relation to child welfare services Gil gives examples of the damaging effect of 'foster care drift' and multiple placements to highlight the abuse 'by the immense and complicated child care system, stretched beyond its limits and incapable of guaranteeing safety to all children in care' (Gil 1982, p.11). In relation to hospitals, we must examine the way in which child health services fail to meet the needs of children.

A shortage of resources is likely to compromise 'best' care. While acute bed shortages have occasionally been highlighted by the media, at times resulting in unnecessary delay and even death, these are relatively rare. Shortages of other essential resources are less likely to attract such headline-grabbing attention. Several recent reports, however, have highlighted inadequate services for children and young people, lack of priority given to children's services, and geographical inequalities in the provision of services (Association for Children with Life-threatening or Terminal Conditions and their Families and the Royal College of Paediatrics and Child Health 1997, House of Commons Health Committee 1997, Audit Commission 1993).

SAFEGUARDING CHILDREN FROM ABUSE IN HEALTH CARE SETTINGS

There are three crucial aspects in safeguarding children from abuse. It is essential that children are listened to and that mechanisms exist to make it easy for children to make abuse and potential abuse known. Staff and carers must be of the highest quality and this demands rigorous procedures in selection and assessment, and ongoing training and support. Finally, there must be external systems of inspection, monitoring and standards.

Listening to Children

A common feature in cases of abuse in residential and foster care is that children and young people are not believed (Kendrick, 1997). It is essential that there are easily accessible ways for children to voice their concerns. The reaction to complaints should not be a defensive one; there should be a culture which 'welcomes complaints for the positive contribution they can make to the development of services'

(Gulbenkian Foundation, 1993, p. 102). It is now a requirement for all health authority boards and trusts to establish a formal complaints procedure (Rodgers 1998). However, children and young people have difficulty expressing their concerns or grievances through formal procedures and other ways need to be explored (Aiers with Kettle 1998, Utting 1997). Children should have access to telephones and telephone helplines. Services such as ChildLine have found that children rarely make up allegations, but accessibility to such services whilst in hospital may be severely restricted. The organisation 'Action for Sick Children' has played an important role in improving standards and quality in child health services but there may be a place for the further development of posts equivalent to 'children's rights officers' for children in local authority care (Kent 1997, Utting 1997). At national level, there is an increasing demand for the role of Children's Commissioner to promote the welfare of children (Williams of Mostyn 1996)

Sinclair (1996) has emphasised that the right of children to participate is closely linked to their rights to protection. Fulton (1996) highlights the way that parents, rather than children, are seen as the consumers in relation to children's health care and that children rarely participate in the planning of services. Fulton goes on to emphasise the confusion and lack of precision around children's rights to consent to treatment. Alderson (1993) found wide variations in the practice of gaining the consent of children for surgery and stressed the importance of a 'cycle of consent' which helps surgeons and children 'make informed decisions about the purpose and value of treatment as well as the process' (Alderson 1993, p. 197)

Partnership and involvement with parents and families has increased markedly over recent years (Belson 1993). Family involvement itself is another important aspect of the protection of children (Utting 1997).

Selection, Training and Support

The quality of staff and carers is the second important factor in ensuring the safety of children. Selection and assessment procedures must prevent, as far as is possible, the entry of paedophiles and other unsuitable people into hospital services. Staff must also be supported and trained to ensure the highest quality of care.

As is the case with residential child care, the abuse of children in hospitals has highlighted inadequacies in recruitment practice (Repper 1995, Clothier 1994).

Rigorous selection procedures begin with good job descriptions and person profiles for posts. The selection process should make appropriate and considered use of written exercises, group exercises, aptitude tests and personality tests (Rae *et al.* 1997). Bowles (1995), for example, reviews the use of personality tests designed to assess factors such as: adaptation to stress; levels of autonomy; interpersonal skills; self-actualisation; and predisposition to caring. While acknowledging that identification of clear-cut selection criteria is likely to be highly problematic, Bowles calls for a nationally agreed measurement criteria and common instrumentation and protocols for psychological testing. The selection process should also explicitly address attitudes to the control and punishment of children and issues of power and sexuality.

Checks on criminal records are widely considered to help protect society against people who may seek to abuse positions of trust. They are not the sole answer as many abusers are not known to the police and have no previous convictions, but the checks can act as a deterrent. Other sources should be used for vetting potential employees. In its submission to the government review of the Nurses, Midwives and Health Visitors Act (1997), the UKCC calls for the mandatory confirmation of registration by employers of nurses, midwives and health visitors because of the current under-use of the confirmation service (UKCC 1997). References should be used to gain detailed information on a candidate's strengths and weaknesses and disciplinary history (Rae *et al.* 1997, Warner 1992). There is, however, a debate raging about checks on applicants' previous mental health. House (1997) argues that the link between mental health and dangerousness is 'tenuous' and there are issues concerning breach of the Disability Discrimination Act (House 1997, Naish 1997, Sandford 1997, Barker *et al* 1996).

No matter how intensive the selection, assessment and vetting procedures, it is unlikely that they will ever be able to effectively screen out all abusers (House 1997, Stark *et al* 1997). It is therefore essential that the possibility of abuse is always recognised and mechanisms to detect and investigate abuse are in place.

Stark *et al* (1997) suggest the best way to avoid harm to children is to avoid dangerous practice rather than attempt to screen out allegedly dangerous people. One way to address this would be emphasising the use of effective clinical supervision and the monitoring of practice (Naish 1997, Rae *et al* 1997, Repper 1995). Whitaker (1994) highlights the benefits of protecting patients by reducing mental ill health

among health service staff. Whitaker argues that managers should identify and correct situations which are likely to result in increased levels of mental ill health among their staff and should monitor and evaluate the health and safety performance of staff (Whitaker 1994).

The right of children to be cared for by appropriately educated and skilled staff who are aware of their physical, emotional and clinical has been often repeated in reports and inquiries. Children require specialist nurses who have different skills and knowledge. Yet the same reports have consistently shown gaps in specialist nursing for children. The House of Commons Health Committee regretted the failure of many hospitals to meet the DoH's standards for the numbers of nursing staff on children's departments and wards. It recommended that the increased numbers entering programmes leading to registration as a qualified children's nurse be maintained for at least five years (House of Commons Health Committee 1997). Specialist paediatric training is essential to provide high standards of medical, nursing and therapeutic care and to protect children's rights. It is also important that training should address issues of sexuality and power and the possibilities of the abuse of children in hospital settings.

Inspection, Monitoring and Standards

Children and young people in residential care are subject to statutory reviews (Kendrick & Mapstone, 1991) and the residential establishments themselves are subject to statutory inspection. Children's services in hospitals, however, are not uniformly inspected on a statutory basis. Utting stresses that the primary function of inspection is serving the public interest by providing an additional safeguard for

vulnerable people (Utting, 1997). Both Kent and Utting express concern at the complexity of the inspection systems and the fact that while some children's services are subject to several types of inspection, others are not subject to any regular inspection. They recommend that all services, including all health provision in which children are accommodated should be brought within the inspection system (Kent, 1997; Utting, 1997). The English National Board for Nursing, Midwifery and Health Visiting (ENB 1995) sees child protection education as the responsibility of all health and social care professionals and emphasises that all services should have a child protection strategy that is monitored and audited regularly.

There are approximately 650,000 nurses, midwives and health visitors on the UKCC's register but only 50 to 60 per year are removed for serious professional misconduct (Skyte 1996). In 1996 there were only 12 complaints of sexual abuse by nurses brought to the UKCC's attention and although they do not keep statistical details, it is likely that these mostly concerned adults (Shamash 1997a). Over the last 20 years, 188 doctors have been struck off for professional misconduct (Healy 1996). Skyte suggests that the low numbers of nurses removed from the register 'can only reflect the professionalism and good conduct of those on the register' (Skyte 1996 p. 20). In relation to the abuse of children, this is a dangerous assumption. Given the vulnerability of children, we would argue that many cases of abuse never become public.

There has been recent concern expressed by the UKCC at the disproportionate number of disciplinary cases involving female patients and male mental health nurses (Rae *et al* 1997). UKCC figures show that whilst 10% of nurses are men, they are

subject to 44% of its complaints (Shamash 1997a). As a result, the UKCC is currently re-evaluating its disciplinary procedures. The mental health nursing review team (Department of Health 1994) focused attention on sexual misconduct and controversial decisions made by the UKCC continue to highlight such cases. Rae et al (1997) offer the example of the male nurse who was restored to the UKCC register after being struck off for committing a second serious sexual assault and the letters pages of professional journals reinforce the clear outrage felt by most of the profession.

Paul Clarke, a trainee health visitor and qualified nurse, midwife and sick children's nurse, was arrested for taking indecent photographs of children in 1994, but it took the UKCC three years to remove him from the register (Shamash 1997b). Long (1992) castigates the UKCC Professional Conduct Committee for finding Phillip Donnelly guilty of professional misconduct but allowing him to remain on the register and continue in practice. Long concluded that the case showed that gross acts of indecency and misconduct will be tolerated by the profession and that 'the governing statutory body of nursing cannot be trusted to act responsibly to prioritise public safety before the career interests of an individual practitioner' (Long 1992 p. 9). The UKCC has called for broader measures for dealing with incompetent practitioners and for tighter controls for those restored to the register following removal for misconduct, or on grounds of ill health (UKCC 1997).

Whistleblowing

The fear of retaliation and dismissal is a real issue for health staff in reporting poor standards of care or abuse by colleagues (Fursland 1997, Public Concern at Work 1997, McHale 1992). The serious consequences of such a culture of defensiveness

was highlighted in by the deaths of children undergoing paediatric cardiac surgery at Bristol Royal Infirmary (Davidson 1998, Gulland 1998). Staff in all health care settings must be able to raise concerns in the confidence that genuine complaints will not have repercussions for them in their day to day work or their later careers (Public Concern at Work, 1997, Gulbenkian Foundation, 1993). Castledine (1997) suggests a number of steps in situations where it is suspected that a colleague's conduct, health or general performance is placing patients at risk. These include: writing down the concerns; consultation with colleagues; confronting the person concerned in a tactful and helpful manner. In the event of refusal of help, the concerns should be referred either to senior management or directly to the UKCC's health committee or professional conduct system (Castledine 1997). A major step forward has been made with enactment of the Public Interest Disclosure Act 1998. This legislation is intended to protect individuals who make certain disclosures of information in the public interest and to allow such individuals to bring action in respect of victimisation.

QUALITY IN THE NEW NHS

A number of the issues raised in relation to safeguarding children from abuse are integral to the Labour Government agenda of improving services in the NHS. Quality has been placed at the centre of the government's initiatives for change and development. Recognising serious, past failings, the same agenda has driven the Quality Protects Programme to provide safe, effective and high quality social services for children in need (Department of Health 1998a). NHS White Papers in England and Scotland have established models for setting, delivering and monitoring national standards to address unacceptable variations in performance and practice (Department

of Health 1998b, Scottish Office 1997). It is important that the following initiatives do not ignore the protection of children in hospital settings.

New organisational structures will promote clinical and cost effectiveness, advise on best practice, appraise new health interventions and advise on implementation. In England and Wales, the National Institute for Clinical Evidence (NICE) has been established. In Scotland, the structure of the Clinical Resource Audit Group (CRAG) has been revised with the establishment of the Clinical Effectiveness Strategy Group; the Clinical Effectiveness Programmes Subgroup; and the Implementation Subgroup. Work on setting national standards is being progressed through a rolling programme of National Service Frameworks in England and Wales and the Clinical Standards Board for Scotland (Department of Health 1998b, Scottish Office 1998).

Delivering quality standards is to be achieved through the system of clinical governance which will provide a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care (Department of Health 1998b, Scottish Office 1997). Alongside clinical governance, lifelong learning and Continuing Professional Development is stressed as a continuous process of updating and maintaining expertise to support the delivery of high quality and effective healthcare. Endorsing professional self-regulation, the government's agenda for quality calls for the modernisation of this framework in ensuring openness and public accountability.

In England and Wales, the Commission for Health Improvement will provide independent scrutiny of local efforts to improve quality and undertake a programme

of service reviews to monitor national implementation of the National Service Frameworks. In addition, a new National Framework for Assessing Performance will be established. This will focus on six main areas: health improvement; fair access to services; effective delivery of appropriate healthcare; efficiency; patient and carer experience; and health outcomes of NHS care. Finally, a New National Survey of Patient and User Experience has been introduced to provide systematic information on an annual basis (Department of Health 1998b).

CONCLUSION

The UN Convention on the Rights of the Child stresses in Article 19 that ‘states shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) *or any other person who has the care of the child...*’ (United Nations 1989, emphasis added). In Article 20, it goes on to state that a ‘child temporarily or permanently deprived of his or her family environment, or in whose best interests cannot be allowed to remain in that environment, shall be entitled to *special protection* and assistance provided by the State...’ (United Nations 1989, emphasis added).

Providing a safe and caring environment involves action at all levels; in day-to-day practice; in management and planning; and in politics and policy-making at local and national level. While we would be the first to praise the positive work of nurses, doctors and other medical staff in children’s health services, it is vitally important that the issue of the abuse of children in hospital settings is addressed openly and

honestly. It is crucial that an holistic and integrated approach to the care and protection of child and young people in hospital is adopted and the current agenda of quality care in the NHS must address the particular needs of children.

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Figure 1

Abuse of children within hospital settings

