CHILD PROTECTION AND THE ANAESTHETIST

SAFEGUARDING CHILDREN IN THE OPERATING THEATRE

July 2014

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BACKGROUND

The primary aim of this guidance is to assist anaesthetists and theatre personnel if concerns are raised during the course of a routine anaesthetic or perioperative care that suggest a child may have been deliberately harmed, or that a child or other children in the family may be the victim of harm or neglect in the future. The second part of the document (Appendix 1) deals with the process that surrounds a planned anaesthetic for a formal ('forensic') examination, when signs of possible child sexual abuse are to be investigated. This is a rare event but we believe that since the anaesthetist and theatre team are very much involved with process, they must have appropriate knowledge of the procedures involved. All guidance should be used in conjunction with your local child protection procedures in order that the correct lines of communication are followed. Anaesthetists may care for children and young people who have been abused or neglected in other situations, e.g. resuscitation or anaesthesia in an injured child. Rarely, a child may divulge information to an anaesthetist about maltreatment in the setting of the ward or clinic, i.e. make an allegation of abuse. In both these situations the anaesthetist is generally working as part of the paediatric team outside the operating theatre and access to advice should be more straightforward.

In any event where there are safeguarding/child protection concerns,† it is essential that healthcare professionals act in the best interests of the child.[1] **The safety of the child is paramount and overrides all other duties**. Within the four countries of the UK there is statutory guidance that should inform organisations and individual healthcare professionals of the relevant procedures. The GMC guidance: 'Protecting children and young people: the responsibilities of all doctors' places a duty on all doctors to protect and promote the health and well-being of children and young people. This means all doctors must act on any concerns they have about the safety or welfare of a child or young person. There are agreed national intercollegiate competences for all healthcare staff which should be regularly updated as part of mandatory training.[1] Local safeguarding children/child protection training updates may be delivered as part of a regular annual Clinical Governance Programme. All doctors are required to have and maintain level 2 competences. Departments should also have at least one anaesthetist with level 3 competences who provides leadership.[2,3] This role does not extend to providing expert advice in individual cases.

† Whilst we recognise that there are differences across the UK in the use of the terms 'safeguarding children' and 'child protection', for the purposes of this document they are used synonymously in relation to the processes for managing suspected or actual neglect or harm inflicted upon children and young people.

WHAT MIGHT ALERT THE ANAESTHETIST TO POSSIBLE ABUSE?

A full description of the different types of abuse and neglect is beyond the scope of this document and is provided elsewhere (see references and further reading). In particular, the 2009 NICE guideline[4] is helpful in providing a framework that describes when to 'consider' or 'suspect' abuse. 'Consider' refers to a situation when maltreatment is the possible explanation for the alerting feature or is included in the differential diagnosis. 'Suspect' is a more serious level of concern about the possibility of maltreatment but is not proof of it.

Clinical features that may lead to suspicion of physical, sexual or emotional abuse in the perioperative period

- Unusual bruising – both the pattern and the extent of the bruising is important, particularly in the non-ambulant baby/child.
- Unexplained thermal injury, for example, cigarette burns.
- Bite marks.
- Unusual injuries in inaccessible places, e.g. neck, ears, hands, feet and buttocks.
- Unexplained intra-oral injury in a non-ambulant child.
- Unexplained anogenital injury.
- Unusual ano-genital signs/appearance (where there is no clear history of direct trauma or infection as part of the history or clinical presentation). *NB Physical signs can rarely be interpreted in isolation, and there is poor evidence about what is abnormal in this context.*
- Other trauma without an adequate history, e.g. intra-abdominal injury.
- Very poor quality parent/child relationship, e.g. the parent seems oblivious to the emotional needs of the child, or is verbally abusive to the child.
- Parental risk factors such as parents with mental health or substance misuse issues, and living in a home where domestic violence takes place.

HOW TO MANAGE CONCERNS WHEN SIGNS OR SUSPICIONS OF ABUSE ARE NOTED

Please also see the care pathway on page 11.

If an anaesthetist becomes concerned about the possibility of abuse during a procedure for an unrelated condition, then contact with the child's consultant paediatrician (if known to have one), the on-call consultant paediatrician or the Safeguarding Team is advised, accepting that local systems may vary. If there is uncertainty about whether signs are consistent with those caused by abuse, this should be discussed at an early stage with a senior paediatric or anaesthetic colleague. Trainee or SAS grade anaesthetists are advised to also inform a supervising consultant anaesthetic colleague. Many anaesthetic departments now have lead anaesthetists for safeguarding, and whilst they may be able to advise when available, their main role is in providing information on training and not in dealing with an individual case.

Such consultations should not result in the anaesthetic being markedly prolonged if a second opinion/advice is not readily available. It must be remembered that consent has not been obtained for a safeguarding medical examination and in most instances there is no urgency in seeking an immediate referral while the child is still in theatre. It should be noted that intimate examinations or additional investigations and/or photography are not justified in this situation. If the anaesthetist has concerns prior to the anaesthetic that there may be a need to take advice about safeguarding issues, discussions should have occurred before the child arrives in theatre so that appropriate questions can be asked and the correct process is followed.

Before referral, it is important to ascertain some basic details about the family and social situation, e.g. who else is in the family? Do the medical notes identify previous or ongoing safeguarding concerns?

Any member of the multi-professional theatre team should be able to initiate the process. Further management needs to be agreed with the paediatrician and/or safeguarding professional and the anaesthetist (if they have initiated the referral). Other key professionals should be informed at an early stage, e.g. the operating surgeon and senior theatre nurse/ODP. Thereafter, if a consultant paediatrician is leading the process, they may wish to discuss the next steps with the Safeguarding/Child Protection Team or may direct the theatre team to do so.

All hospitals have access to specific child protection experts who may be involved in giving initial advice or in the subsequent escalation process. General or community paediatricians will be able to advise on the next steps 24/7. In England and Wales, expert advice can be obtained from the Named doctors and nurses for safeguarding children, who work within the health organisation, and Designated doctors, who often work in a wider geographical area, but will not generally be called upon to offer advice for an acute problem.

It will generally be the consultant paediatrician's responsibility to decide upon the following:

- Paediatric assessment including taking a history from the child and carer, the examination and consideration of forensic samples and obtaining a photographic record.
- Informing Social Care and/or the police.
- Whether it is reasonable for the child to go home at the normal time after surgery/anaesthesia.

It is advisable that the parties present in any discussion with the parent(s)/ person with parental responsibility and the child should be a consultant paediatrician (the local paediatrician on call, or the named safeguarding children/child protection consultant) and a consultant anaesthetist. In cases where the surgeon has noted the abnormal finding, the anaesthetist might be replaced in these discussions. However, it would be both unwise and unnecessary to confront a parent and child with a committee of three senior clinicians. Within this discussion, a reasonable explanation may be put forward by the parent(s). However, if there are continued concerns (on the part of any of the consultants involved) or a need for a second opinion, a referral should be made to Social Care. The referral involves an initial telephone call, which is followed up in writing according to local procedures. This is generally the responsibility of the consultant paediatrician. In very occasional circumstances the anaesthetist may be expected to make these referrals, e.g. when they believe there is a danger that a child protection concern is not otherwise being escalated.

Consideration needs to be given to consulting with/informing the parents (it would be most unusual not to do so at this stage). The parent and the child (where appropriate) should generally be informed as to why a second opinion and/or social care referral will be sought, how the situation will be managed, and how quickly and where any interview and/or examination is likely to occur.

A suggested form of words if there is a need for a further referral:

> **'We aren't sure what caused this and need to ask for a second opinion. I'd like another doctor/nurse to take a look'**

If a referral to Social Care is required:

> **'In these sorts of situations we have a duty to discuss our concerns with a social worker who will want to speak with you'**

SHARING INFORMATION

The advice within the 2012 GMC document[1] is helpful and considers the issues around consent, particularly when information needs to be shared between agencies, e.g. between healthcare staff and Social Care. In general, it is always good practice to ask for consent before sharing confidential information, unless there is a compelling reason not to do so.[‡] You should also seek to inform, and when appropriate, seek the agreement of the child/young person before sharing information. In doing so you should explain what information you will share, who you will share it with, and how any information will be used. If there is a delay in sharing information this should be justified and documented.

If consent is denied, it is important to document this fact but child protection concerns should be shared and the parent and child/young person told that this will occur.

CHILD'S INTERESTS

Healthcare professionals may come across obstacles in the process of identifying child maltreatment, e.g. discomfort in believing, thinking or wrongly blaming a parent or carer, but this should not prevent them from taking the appropriate course of action. It is essential that all clinicians respect the rights of the child with regard to protection from harm. It may be necessary for a child to be detained in the hospital until a further examination can be carried out. It is also important to consider the risk to other siblings within the family.

‡ There are rare circumstances where it may not be in the best interests of the child to inform a parent. These include concerns about the possibility of fabricated or induced illness (FII), or any other circumstances where the consulting team consider that informing the parents might result in direct harm to the child.

DOCUMENTATION

Full documentation of all discussions should take place. Notes should be contemporaneous, written and signed by both the paediatrician assisting with the referral (be it the consultant paediatrician on call or the Named doctor) and the consultant anaesthetist. The report should concentrate on facts not opinion, record what was said as accurately as possible and include relevant illustrations, e.g. body maps.

IN SUMMARY

Duties of the anaesthetist

1. To act in the best interests of the child, which are always paramount.
2. To be aware of the child's rights to be protected.
3. To respect the rights of the child to confidentiality.
4. To contact a paediatrician with experience of child protection for advice (on-call paediatrician for child protection, Named or Designated doctor/nurse).
5. Where appropriate, to report child protection/safeguarding concerns to relevant professionals including Social Care.§
6. To be aware of local child protection mechanisms.
7. To clearly document findings in association with paediatric colleagues.
8. To be aware of the rights of those with parental responsibility.

Responsibilities of Health Organisations

It is the responsibility of any hospital providing services for children to ensure that appropriate procedures for safeguarding/child protection are in place and that details of these are readily available to all staff involved in the care of children, including the names and contacts of the Named and Designated doctor and nurse for child protection (or equivalent). The CEO of each healthcare provider organisation also has a responsibility to ensure that their staff attain the appropriate training for their level; provide strategic leadership promoting a culture of supporting good practice with regard to safeguarding/child protection, and to promote collaborative working with other agencies.[2]

§ Inter-agency referral is generally the responsibility of a paediatrician or lead safeguarding professional but the responsibility lies with the individual clinician if they feel that appropriate referrals have not been made.

REFERENCES

1 Protecting children and young people. The responsibilities of all doctors. *GMC*, London 2012 (http://bit.ly/1qnMces).

2 Safeguarding children and young people: roles and competences for healthcare staff. Intercollegiate document (3rd Editon). *RCPCH*, London 2014 (http://bit.ly/1qnLtKx).

3 Lead anaesthetist for child protection/safeguarding. *RCoA* and *APAGBI*, London 2010 (www.rcoa.ac.uk/node/7126).

4 When to suspect child maltreatment (CG89). *NICE*, London 2009 (http://bit.ly/10g8FHB).

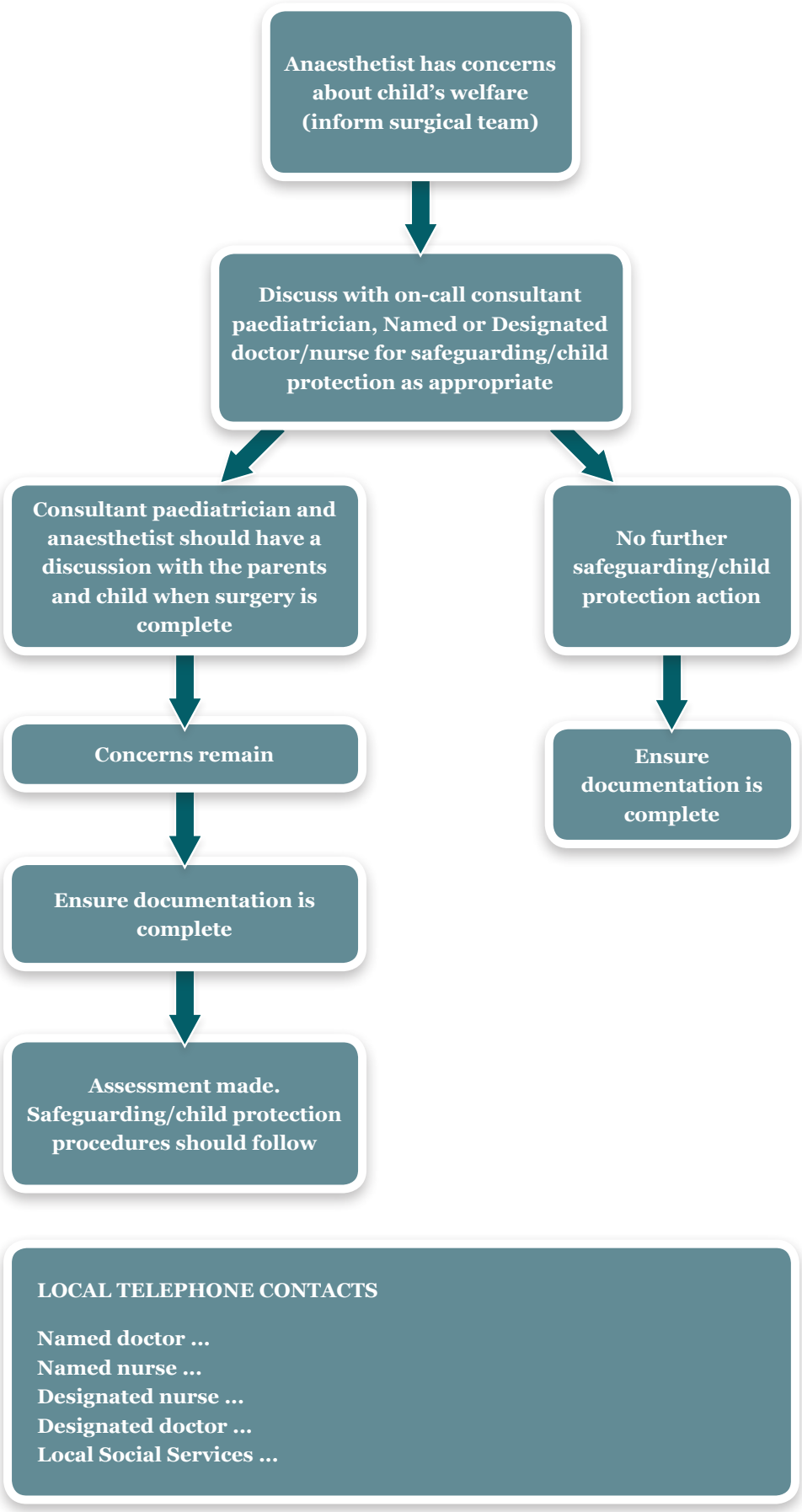
Additional information/resources

The 2014 Intercollegiate document[2] provides a detailed list of references relevant to all parts of the UK.

Web resources

- Child Protection Companion (CPC) (2nd Edition). Subscription required. *RCPCH*, London 2013 (http://bit.ly/1qnPz59).
- Cardiff Child Protection Systematic Reviews (www.core-info.cf.ac.uk).
- Association of Paediatric Anaesthetists of Great Britain and Ireland (APAGBI) (http://bit.ly/1qnRcjt).
- Safeguarding children and young people. Modules for Level 2 and 3. *e-LfH*, London (http://bit.ly/1qnRKWy).

CARE PATHWAY FOR ANAESTHETISTS TO REPORT SAFEGUARDING/CHILD PROTECTION CONCERNS



APPENDIX 1

Forensic examination under general anaesthesia for children and young people as part of safeguarding/child protection procedures

Background

There will be an occasional requirement for paediatricians, paediatric surgeons and gynaecologists to carry out relatively urgent examinations of children and young people under general anaesthesia for both diagnostic and therapeutic purposes and for the purposes of clear documentation. This forms part of safeguarding investigations and is generally in the context of suspected sexual abuse. The forensic examination of the perineum (possibly including colposcopy and sigmoidoscopy), may include taking specimens and swabs, medical photography as part of record keeping, as well as the need for treatment/surgical repair according to injuries. These procedures cannot always be reliably carried out in a child or young person while they are awake and/or may cause distress without general anaesthesia. Some centres in the UK are now designated to provide this service and receive referrals from other parts of a region. In England these are known as Sexual Abuse Referral Centres (SARC).

This diagnostic and therapeutic procedure generally involves a team of professionals including; forensic medical examiners, paediatricians, paediatric gynaecologists and/or paediatric surgeons, as well as members of the safeguarding medical and nursing team. When a request for such an examination is received, it is important that anaesthetists and theatre personnel are properly prepared, including having a shared understanding of the importance of the correct procedures and the respective responsibilities of team members. Senior anaesthetists are often able to coordinate and facilitate good practice, and are key members of the team in this process.

Points to consider in preparation for a forensic examination in theatre

- Coordination of a large multidisciplinary team who may be unfamiliar with the hospital site and/or theatre environment and procedures.
- The examination may be required out of hours in an emergency theatre.
- Procedures can be relatively time consuming and therefore, it is important that all the team appreciates this and that the examination is not performed until all equipment and professionals with the appropriate competences are available.
- The smooth running of the procedure may be greatly facilitated by a detailed WHO check[†] involving all team members that should occur at the usual points in time, both before and during the procedure.

† World Health Organization (WHO) Surigcal Safety Checklist. *NPSA*, London 2009 (http://bit.ly/WdSOCR).

- The need for samples to be securely transported and processed by the laboratory that may or may not be on site following a chain of evidence.‡
- Concerns and questions of all team members should be clearly acknowledged. Staff may have important concerns around confidentiality and the level of their expected involvement in any subsequent investigation. They may wish to be briefed as to what happens next.
- The need for all practitioners to be aware of the possibility of sexually transmitted infections (STIs). The appropriate infection control measures must be taken, as is usual with all such examinations.
- The need for normal procedures to be carried out, e.g. pre-operative 'nil by mouth' for the usual safe period. It is also vitally important to ensure that parents and carers are dealt with sensitively during the examination, with usual practices generally being in place, e.g. recovery room access for parents while the child is waking from anaesthesia.

Recommendations

- Paediatricians/paediatric surgeons should liaise directly with senior theatre staff and anaesthetists when there is an expected need for a forensic examination of a child under general anaesthesia and provide details of the expected procedure, including the number and specialty of additional personnel who will be in attendance, and approximate timings.
- Clearly take consent for and document the expected medical procedures including photography.
- It is essential that the usual full WHO pre-procedure safety checks are performed with all personnel present for a structured pre-anaesthesia discussion. This will greatly assist in identifying the role of key team members, and the necessary equipment required. The need for photography, and particular microbiology/virology requirements must also be established before the patient arrives in the operating theatre suite.
- Specifically and as a part of WHO pre-procedure checks:
  - The theatre team should be adequately briefed as to the nature of, and the need for the procedure and any confidentiality issues should be ratified.
  - Arrangements for where carers will wait, and their access to the child in the recovery room should be clarified before the child/young person arrives in theatre, as theatre staff may be unclear about whether a different process needs to be followed. Generally these should not differ from normal procedures.
  - Infection control measures to be ratified, e.g. is there a need for additional protective measures if HIV, Hep C suspected?

‡ The 'chain of evidence' is a process intended to protect specimens from any contamination. For more information see References.

- Arrangements for the correct collection and transfer of specimens to be discussed including use of transfer media etc.
- Arrangements for the use of confidential medical photography to be ratified and consent documented.

In recognition that this is a relatively unusual event, local teams may wish to discuss this scenario in advance of need and in particular, encourage senior theatre staff to have sight of and comment upon guidance. This might usefully occur during joint annual safeguarding/child protection training updates.

Key references

- Guidelines on paediatric forensic examination in relation to possible child sexual abuse. *RCPCH* and *FFLM*, London 2012 (http://bit.ly/1qnUymt).
- Guidance for best practice for the management of intimate images that may become evidence in court. *FFLM*, *RCPCH* and *ACPO*, London 2010 (http://bit.ly/1ogbto6).

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