Child Protection and the Anaesthetist: Safeguarding Children in the Operating Theatre

Intercollegiate Document

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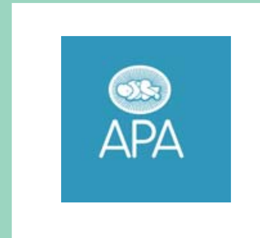

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Child Protection and the Anaesthetist - Detailed advice

Background

Anaesthetists may encounter abused children in a number of situations:

1. Resuscitation of a critically ill child who has sustained an injury under circumstances that cannot wholly be explained by natural circumstances or is consistent with intentional trauma or abuse.
2. In the paediatric intensive care unit e.g. following severe head injury, where the above needs to be considered.
3. When called upon to anaesthetise a child for a formal forensic examination, possibly involving colposcopy, sigmoidoscopy and the collection of specimens. This may also include medical photography/video records.
4. Rarely a child may tell the anaesthetist about abuse ("disclosure").
5. During the course of a routine pre-op examination or surgical procedure, the anaesthetist or surgeon notes unusual or unexplained signs which may be indicative of physical or sexual abuse.

In all these situations, it is essential that health care professionals, including the anaesthetist, act in the best interests of the child. **The safety of the child is paramount and over-rides all other duties.** In 2003 the DH published advice for all health care professionals in the form of a series of simple flow charts and an accompanying booklet[1]. The most recent Guidance issued by the RCoA on Provision of Paediatric Anaesthetic Services states that "Anaesthetists should be aware of legislation including the 1989 Children Act, rights of the child, child protection issues and the process of obtaining consent"[2]. The 2004 Children Act[3] further describes statutory guidance on making arrangements to safeguard and promote the welfare of children, and this is further outlined in the joint Chief Medical Officer's report "Safeguarding children"[4 5]. Specific and detailed advice needs to be provided for particular clinical groups and situations. The RCPCH have published comprehensive guidance[6], primarily for use by paediatricians. This is a valuable resource for other Health Care professionals. Anaesthetists should undertake child protection awareness training as part of their regular Clinical Governance programme. The primary aim of this document is to deal with the situation of what to do, if signs of abuse are manifest in the peri-operative period. It also deals with anaesthesia for formal examination when signs of child abuse are to be confirmed.

What might alert the anaesthetist to possible abuse?

There are occasions when a child is anaesthetised (for emergency or elective surgery) and concerns are noted about possible physical or sexual abuse e.g. on exposure of the child possible cigarette burns are seen. The interpretation of a flaccid or dilated anus is particularly difficult. This can be a normal finding in an anaesthetised patient[7] and especially where a caudal/epidural block has been performed[8, 9, 10]. Great care is required before raising suspicions about abuse in the child, as knowledge about what constitutes normal appearance is sparse. Physical signs can rarely be interpreted in isolation.

Clinical Features Which May Cause Concern or Suspicion

Suspicious signs which may be indicative of abuse (see also www.core-info.cf.ac.uk)

- Unusual or excessive bruising, particularly in the non ambulant baby/child.
- Cigarette burns.
- Bite marks.
- Unusual injuries in inaccessible places e.g. neck, ear, hands, feet & buttocks.
- Intra-oral trauma.
- Damage to intra-oral frena, or unexplained frenum injury in a non-ambulant child.
- Genital/ anal trauma (where no clear history of direct trauma is offered or part of the clinical presentation).
- Trauma without adequate history eg. Intra abdominal injury.

If anaesthetists have real concerns, they are advised to discuss these at an early stage with key child protection workers.

Who to consult

It is essential to involve personnel with special expertise in Child Protection. In the first instance, it may be appropriate to seek advice from the duty paediatric consultant, or for junior anaesthetists to consult a more senior colleague (see next section). In addition, all Trusts have access to specific child protection experts. These are the Named Doctors and Nurses, who usually work within the Trust, and Designated Doctors, who often work within the local area. It is crucial that all anaesthetic departments know who these people are and how to contact them (see page 8). If there are very serious concerns, Social Services need to be informed – this will generally be decided upon by the Named or Designated Doctor or Nurse.

How to manage concerns when abuse has not previously been suspected

If the anaesthetist becomes concerned about the possibility of abuse during a procedure for an unrelated condition, then contact with the child's paediatrician or the on call consultant for acute paediatrics is advised. If there is genuine uncertainty about whether signs are consistent with those caused by intentional harm, this should be discussed at an early stage with a senior paediatric or anaesthetic colleague who may attend and give advice. A visual inspection (e.g. of a skin lesion) is acceptable, but any additional or intimate / invasive examination requires additional consent. This should not result in the anaesthetic being markedly prolonged if a second opinion is not readily available. It should be emphasised that any member of the multi-professional team should be able to initiate the process.

Further management needs to be agreed with the paediatrician, surgeon and anaesthetist. Consideration needs to be given to:

- Informing the parents*

* There are rare circumstances where it is not in the best interests of the child to inform the parents. These include concerns about fabricated or factitious illness (FFI), or any other circumstances where the consulting team consider that informing the parents might further harm the child.

- Further assessment (including forensic samples and photographic record)
- Informing Social Services and/or police

The paediatrician should lead this process, but may well wish to discuss management with the on call child protection team. It is advisable that the parties present in any discussion with the parent(s) and child should be the consultant paediatrician (the local paediatrician on call, or the named child protection consultant) and the consultant anaesthetist. In cases where the surgeon has noted the abnormal finding, the anaesthetist might be replaced in these discussions by him / her. However, it would be both unwise and unnecessary to confront parent and child with a committee of 3 senior clinicians. Within this discussion, a reasonable explanation may be put forward. However, if there are continued concerns (on the part of any of the consultants involved), a formal referral to the Named or Designated personnel should be made by phone and followed up in writing. Both the parents and (where appropriate) the child should generally be informed as to why a second opinion has been 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 might be …

"Whilst James was asleep some unusual marks were noticed. We aren't sure what caused this and need to ask for a second opinion. Another doctor/nurse should take a look".

Documentation

Full documentation of this discussion should take place. Notes should be contemporaneous, written and signed by a consultant[11].

When dealing with a child in whom abuse has been recognised, who performs the examinations?

The paediatrician will carry out examinations when physical abuse is suspected. This might be the on call paediatrician or the Named Doctor.

When Child Sexual Abuse (CSA) is suspected - paediatricians with specific expertise in child sexual abuse, carry out these examinations. In some areas, Forensic Medical Examiners (police surgeons) may be the personnel with this expertise.

A Joint Statement by the Royal College of Paediatrics and Child Health and the Association of Forensic Examiners recommends that whoever examines the child should have knowledge and experience of managing both the paediatric examination and needs of the child, as well as having knowledge of the forensic aspects of care. On occasion two doctors may need to carry out this examination i.e. a paediatrician and a forensic specialist[12]. Colposcopy, photography and forensic sampling may form part of the examination.

Consent and Confidentiality

In the case of the child in whom signs of possible abuse are discovered in theatre, consent to anaesthetise and undertake surgery / investigation on the child will already have been obtained in the usual way. This does not allow for more detailed *examination* in relation to suspected child abuse.

If the child is subject to a child protection investigation, consent for any examination will usually be from the parent or carer. Where such a child is subject to an Interim or Full Care Order, parents retain responsibility, although the local authority becomes the senior partner, and it is then essential that permission for the anaesthetic and examination is given by Social Services and the Courts (Social Services are responsible for gaining the Court's permission).

Older children who are Gillick[13] competent can give permission in their own right, but the nature and implications of the examination must have been fully explained to, and understood by them. It is however generally advisable to also seek parental consent, unless in doing so you are over-riding the child's wish for confidentiality, or putting the child in danger (see footnote page 3). In Scotland competent children / young persons may consent in their own right[14, 15].

Lord Laming has stated that "*in cases that fall short of an immediately identifiable label, the seeking or refusal of parental permission must not restrict the initial information gathering and sharing*."[16]

Consent for formal Child Protection examinations will be obtained by the examining doctor and / or nurse and not the anaesthetist.

In the case of a forensic examination, consent should include the examination, photography and the production of all reports.

With respect to confidentiality the doctor must disclose information about the child if they feel that it is the child's best interest. In the GMC document "Confidentiality : Protecting and providing information[17] it is stated "If you believe a patient to be a victim of neglect or physical, sexual or emotional abuse and that the patient cannot give or withhold consent to disclosure, you must give information promptly to an appropriate responsible person or statutory agency, where you believe that the disclosure is in the patient's best interests".

More guidance may be obtained from the RCPCH document "Responsibilities of Doctors in Child Protection Cases with Regard to Confidentiality"[18].

Refusal to Give Consent

Where there are any concerns in undertaking specific examinations including parental refusal, or no-one with parental responsibility is available, then the team should consult the Trust's legal advisors and Child Protection specialists.

If the child requires urgent attention, or is at risk of harm. it may be necessary to consider emergency legal action, initiated by Social Services or the Police.

Child's Interests

It is essential that all clinicians respect the rights of the child with regard to protection from harm and to confidentiality. It may be necessary for a child to be detained in the hospital until a sexual abuse examination can be carried out. It is also important to consider the risk to other siblings within the family.

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 CP, Named or Designated Doctor/Nurse).
5. To be aware of the local Chid Protection mechanisms.
6. To be aware of the rights of those with parental responsibility.

Responsibilities of Trusts

It is the responsibility of any hospital providing services for children to ensure that appropriate procedures for child protection are in place and that these are disseminated 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. The Trust should make sure that Child Protection awareness training is available for all staff who work with children.

More information

- 'Child Protection Companion', RCPCH, April 2006, www.rcpch.ac.uk.
- 'Safeguarding Children', a Joint Chief inspector's report on arrangements to safeguard children, DH, 2005 (www.dh.gov.uk)
- Welsh Child Protection Systematic Review Group, www.core-info.cf.ac.uk
- See flow chart on page 8, which is available as a separate A4 laminate for reference in Operating Theatres. Copies are available from the Royal College of Anaesthetists.

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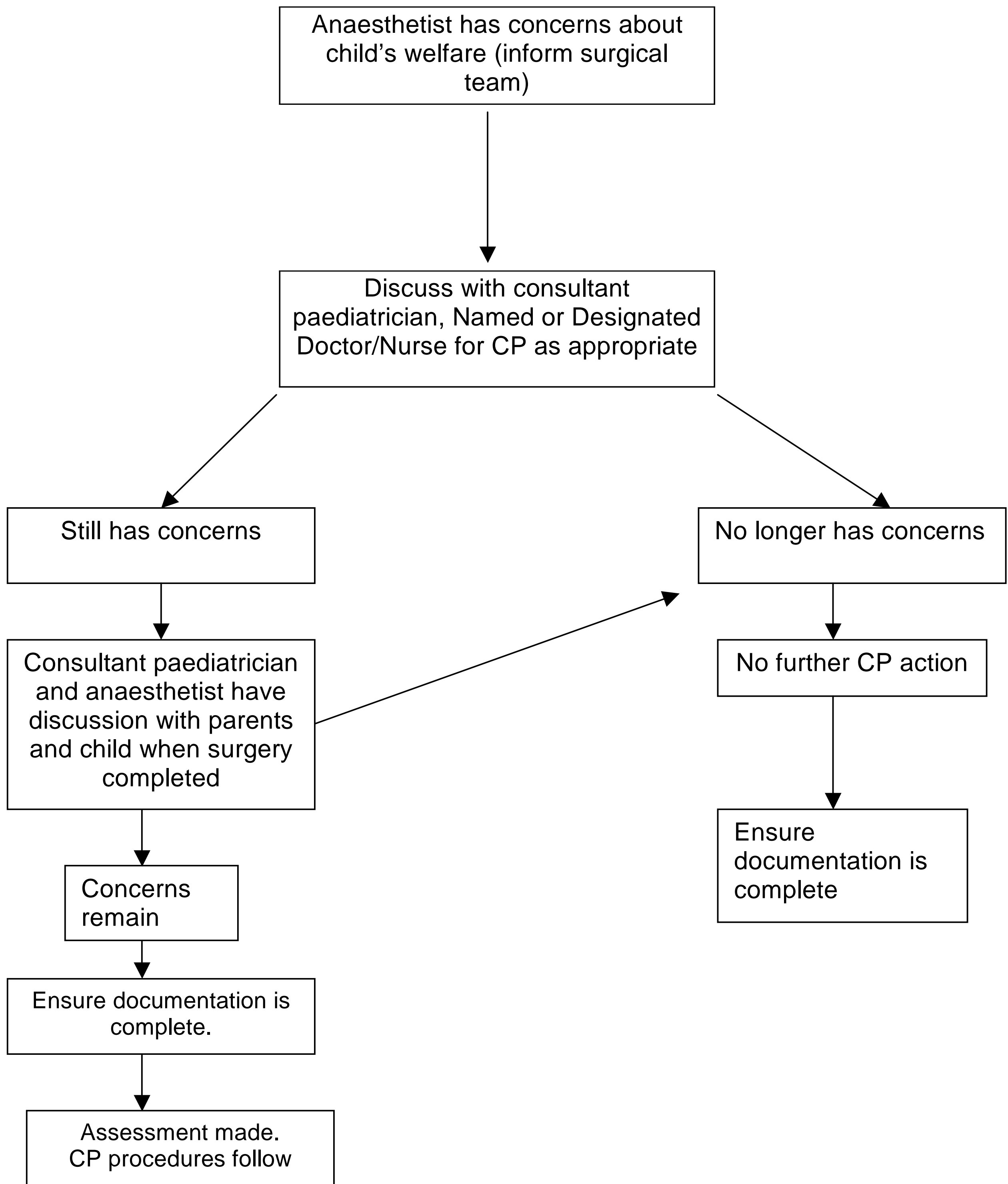

LOCAL TELEPHONE CONTACTS

Named Doctor…..
Named Nurse….
Designated Nurse…
Designated Doctor…
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Inside cover

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