Chapter

5

Safeguarding Children and Its Implications for the Anaesthetist

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Child protection and safeguarding children are integral to good medical practice.

Safeguarding is a broad concept and includes all actions that are taken to promote the welfare of children and protect them from harm. Safeguarding means:

- Protecting children from abuse and maltreatment
- Preventing harm to children's health or development
- Ensuring children grow up with the provision of safe and effective care
- Taking action to enable all children and young people to have the best outcomes

Child protection is part of the safeguarding process. It focuses on protecting individual children identified as suffering or likely to suffer significant harm. This includes child protection procedures which detail how to respond to concerns about a child.

Role of the Anaesthetist

Child maltreatment/abuse is not an uncommon problem. All National Health Service (NHS) and independent hospitals treating children should have safeguarding and child protection strategies in place. They must also ensure that all staff are adequately trained to identify the child at risk and deal with the situation appropriately. Anaesthetists need to be trained to a level commensurate with their level of responsibility and involvement with children. Anaesthetists should be aware of both national and local child protection policies:

- To act in the best interests of the child, which are always paramount
- To be aware of the child's rights to be protected
- To respect the rights of the child to confidentiality
- To contact a senior paediatrician for explicit advice or support when required (on-call consultant paediatrician, named or designated doctor/nurse)
- Where appropriate, to contribute to reports describing child protection/safeguarding concerns to relevant professionals, including social care
- To be aware of local child protection mechanisms
- To clearly document findings in association with paediatric colleagues
- To be aware of the rights of those with parental responsibility

In the United Kingdom, all practitioners should follow the principles of the Children Acts 1989 and 2004 and the 2014 Children and Families Act. These state that the welfare of children is paramount and that they are generally best looked after within their families, with their parents playing a full part in their lives, unless compulsory intervention in family life is necessary.

In this chapter, a child is defined as anyone who has not yet reached their 18th birthday.

The fact that an individual has reached 16 years of age, is living independently or is in further education, is a member of the armed forces or is in hospital or in custody does not change their status or entitlements to services or protection. 'Children', therefore, means 'children and young people' throughout this chapter. It's important to recognise that everyone who comes into contact with children and families has a role to play.

Anaesthetists need to be fully aware of safeguarding processes. Some examples where they may be involved include:

- When a baby or child is admitted as an emergency for resuscitation or surgery and the cause of the presenting illness is unclear, e.g. severe head injury
- When a baby or child is admitted for investigation of safeguarding concerns, such as when a child protection plan is in place

- When the baby or child is admitted for urgent or elective surgery and coincidental suspicious signs are noted that may be the result of abuse or neglect
- When a child, parent or carer discloses concerns that prompt a suspicion that there may be maltreatment or abuse within a family. In practice this is rarely reported to the anaesthetist but may be to another member of the theatre team so knowledge how to deal with this is important.

Growing numbers of young people are presenting to the acute hospital setting with self-harm and self-poisoning. Repeat attendances are common and a challenge. It is important to consider and discuss children with perplexing presentations or fabricated or induced illness with colleagues within the multi-disciplinary team. Consideration should be given to the drivers for childhood distress as these are often linked with deprivation, abuse, neglect, bullying or other adverse childhood experiences. Safeguarding concerns should be considered and discussed, if present, and responded to appropriately. The focus must be on the potential harm to the child rather than the perceived severity or type of caregiver motivations, actions and behaviours. In particular, one should always bear in mind that abuse does not need to be intentional on the part of the caregiver for it to constitute maltreatment.

High-Risk Groups

There are particular high-risk groups of children who are more vulnerable to abuse and neglect. This can be by nature of their socioeconomic, physical or mental health or because of pre-existing disability that makes them more vulnerable to all types of maltreatment. Child maltreatment occurs in all sectors of society and in all age groups.

It is worth considering the following high-risk groups in particular. These include children and young people who are:

- Looked after children (LAC)
- Refugee and unaccompanied children
- Children and young people with physical or intellectual disability

Looked after Children (LAC)

The Royal College of Paediatrics and Child Health reports that more than 93,000 children in the United Kingdom are in care, 70,000 in England. This term typically denotes children whose welfare is the responsibility of the state and therefore generally directly involves social care. Most are taken into care over fears of abuse or neglect. They are vulnerable to health inequalities and exhibit significantly higher rates of mental health issues, emotional disorders (anxiety and depression), hyperactivity and autistic spectrum disorder conditions.

This diverse group includes children under foster care and those in residential homes, though exact definitions vary between the four nations. It also includes unaccompanied asylum seekers and those accommodated compulsorily for their own protection or those around them (e.g. under the criminal justice system). Young people who have been under the care of the local authority for the period of 13 weeks that spans their 16th birthday are termed 'care leavers' and are also at higher risk of maltreatment.

What Is 'Abuse'?

Somebody may abuse or neglect a child by inflicting harm or by failing to act to prevent harm. Children may be abused by an adult or adults or another child or children. All are forms of maltreatment.

The broad types of maltreatment include physical, emotional and sexual abuse as well as neglect. It is not uncommon for several forms of maltreatment to coexist. Children may be vulnerable to neglect and abuse or exploitation from within their family and from individuals they come across in their day-to-day lives. Additional threats can include exploitation by criminal gangs and organised crime groups, trafficking, online abuse, sexual exploitation, female genital mutilation and the influences of extremism leading to radicalisation.

Physical Abuse

This form of abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

Emotional Abuse

Working Together to Safeguard Children 2015 defines emotional abuse as the persistent

emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying) causing children frequently to feel frightened or in danger or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur in isolation.

Online Abuse

Online abuse is any type of abuse that happens on the internet. It can happen across any device that's connected to the web, such as computers, tablets and mobile phones. It can happen anywhere online, including social media, text messages and messaging apps, emails, online chats, online gaming and live-streaming sites.

Children can be at risk of online abuse from people they know or from strangers. It might be part of other abuse which is taking place offline, like bullying or grooming. Or the abuse might only happen online.

Sexual Abuse

Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching the outside of clothing. They may also include non-contact activities, such as involving children in looking at or in the production of sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways or grooming a child in preparation for abuse. Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Grooming

Grooming is when someone builds an emotional connection with a child to gain their trust for the purposes of sexual abuse, sexual exploitation or trafficking. Children and young people can be groomed online or face to face, by a stranger or by someone they know – for example a family member, friend or professional.

Child Sexual Exploitation

Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity either in exchange for something the victim needs or wants and/or for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact.

Female Genital Mutilation (FGM)

The World Health Organisation (WHO) defines FGM as 'all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons'. FGM is recognised internationally as a violation of the human rights of girls and women. It is nearly always carried out on minors and is a violation of the rights of children. FGM has been illegal in the United Kingdom since 1985. In 2003 it also became illegal to take a British national or permanent resident overseas for FGM procedures to be carried out, or to help someone trying to do this. A mandatory reporting duty for FGM came into force on 31 October 2015 and requires regulated health and social care professionals and teachers to report to the police known cases of FGM in those under 18. Most professionals will only visually identify FGM as a secondary result of undertaking another action, when they are informed by a girl under 18 that an act of FGM has been carried out on her, or if they observe physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and they have no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth.

Neglect

Neglect has been defined in Working Together to Safeguard Children 2015 as 'the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development'. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- Provide adequate food, clothing and shelter (including exclusion from home or abandonment)
- Protect a child from physical and emotional harm or danger
- Ensure adequate supervision (including the use of inadequate caregivers)
- Ensure access to appropriate medical care or treatment

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Radicalisation

Radicalisation is the process through which a person comes to support or be involved in extremist beliefs or behaviour. This goes beyond terrorism, and those who seek to promote these beliefs target the vulnerable – including the young – by seeking to sow division between communities on the basis of race, faith or denomination. They may justify discrimination towards women and girls, persuade others that minorities are inferior or argue against the primacy of democracy and the rule of law in our society.

Whatever the form of abuse or neglect, practitioners should put the needs of children first when determining what action to take.

Child Trafficking

Child trafficking is defined by the United Nations as the 'recruitment, transportation, transfer, harbouring or receipt' of a child for the purpose of exploitation. In adults, the definition of trafficking also requires the threat or use of force or other forms of coercion. Child trafficking recognises that a child cannot give informed consent to their own exploitation, so protection applies even if a child agrees to travel or complies with their predicament.

What to Do When Concerns Arise

Anaesthetists may encounter abused children during resuscitation or the care of a sick or injured child, during routine perioperative care, preoperative assessment or (rarely) in the context of an ongoing consultation such as might occur in a pain clinic. The Royal College of Anaesthetists (RCoA), the Association of Paediatric Anaesthetists of Great Britain and Ireland (APAGBI) and the Royal College of Paediatrics and Child Health (RCPCH) have developed a flowchart to guide anaesthetists in the operating theatre if they have child protection concerns (Figure 5.1).

The Referral Process

Anaesthetic trainees and staff or associate specialist anaesthetists are generally advised to discuss safeguarding matters initially with a consultant anaesthetic colleague. Thereafter, it may be necessary to involve a senior paediatrician for advice or support or, when available, with the nominated or designated safeguarding consultant or nominated senior nurse. The emphasis should be on good communication using non-threatening terms. Unless there is risk of immediate, serious harm to the child's health or life, caregivers can be informed about the need to share information between different professionals involved in the child's life. Choice of language is important – it is helpful to think and speak about this in terms of getting a 'second opinion'.

The views of the child or young person should always be sought where possible. The anaesthetist will rarely make detailed follow-up enquiries, but anyone working with children should see and speak to the child, listen to what they say and take their views seriously. The role of the child health professional is to work with children and their families collaboratively when deciding how to support their needs. Special provision such as the use of play therapists or interpreters should be put in place to support conversations with children who have communication difficulties, unaccompanied children, refugees and those children who are victims of modern slavery and/or trafficking, where language difficulties may add additional complexities.

Anyone who has concerns about a child's welfare can make a referral to the local authority children's social care and should do so promptly if there is a concern that the child is suffering

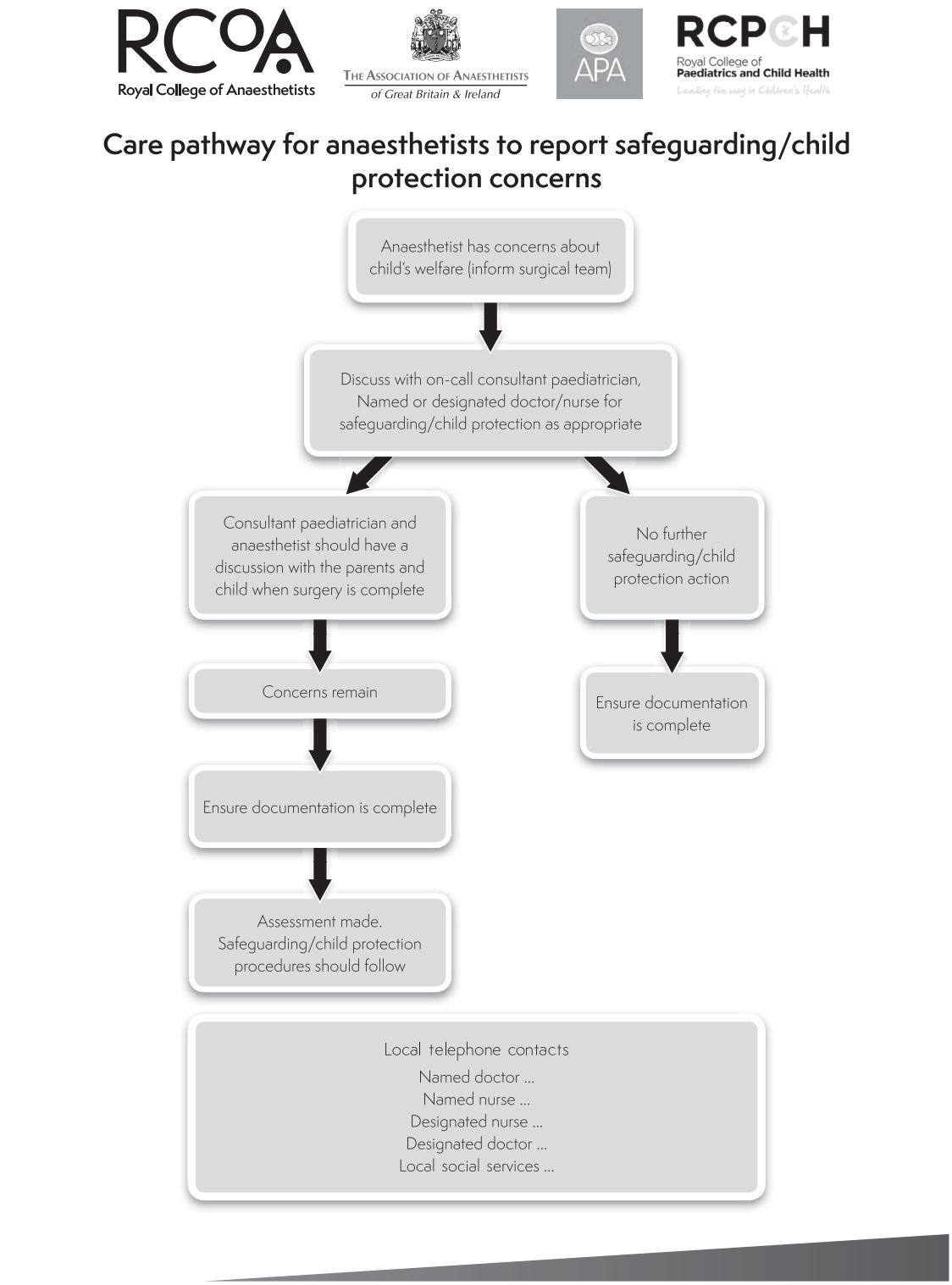

Figure 5.1 Flowchart explaining what should be done to safeguard children in the operating theatre.
Source: Produced jointly by the RCoA, RCPC and APA in 2007 and updated in 2014.

significant harm or is likely to do so. For anaesthetists, this will generally be in association with paediatric colleagues. Practitioners who make a referral should always follow up their concerns if they are not satisfied with the response.

A comprehensive record of any discussions held should be kept throughout, including decisions made, in line with standard safeguarding practice. Anaesthetists may be asked to add a note if they witnessed particular behaviours or had conversations that revealed abuse. In all instances, it is important to stick with fact and not stray into 'opinion'. This will include the circumstances surrounding the initial identification or disclosure of abuse and details of any safeguarding actions that were taken. The organisation's designated safeguarding lead must be updated as appropriate.

If practitioners have concerns that a child may be a potential victim of modern slavery or human trafficking, then a referral should be made to the National Referral Mechanism, as soon as possible.

In England, a local authority social worker should acknowledge receipt to the referrer within *one working day* of a referral being received and *make a decision* about next steps and the type of response required. This will include determining whether:

- The child requires immediate protection and urgent action is required
- The child is in need and should be assessed under Section 17 of the Children Act 1989
- There is reasonable cause to suspect that the child is suffering or likely to suffer significant harm, and whether enquiries must be made and the child assessed under Section 47 of the Children Act 1989
- Any services are required by the child and family and what type of services
- Further specialist assessments are required to help the local authority to decide what further action to take
- To see the child as soon as possible if the decision is made that the referral requires further assessment

Similar but not identical processes are in place in the four UK nations (see 'Further Reading').

When a Child Dies

In England, investigation of all child deaths follows a standardised path that includes immediate decision-making and notifications and a decision as to whether there is a need for a joint agency response. A designated rapid response team gathers information for unexpected deaths or, when otherwise required, to assist investigation and information gathering. A joint meeting will be convened at which professionals involved in the care of the child will be invited to attend.

These processes are described by the NHS England Child Death Review Statutory and Operational Guidance (2018) and are to be followed after the death of any child under the age of 18 who normally resides in England. This includes the death of any live born baby where a death certificate has been issued, but does not include stillbirths, late fetal loss or terminations of pregnancy. It builds on the statutory requirements set out in Working Together to Safeguard Children (2018) and clarifies how individual professionals and organisations across all sectors involved in the child death review should contribute to reviews. The process is designed to capture the expertise of professionals who were involved in the care of the child through the systematic collection of data to inform local and national learning via the Child Death Overview Process (CDOP) and National Child Mortality Database (NCMD). Child death review meetings need to be flexible and proportionate but must be held for all child deaths, not just unexpected deaths.

A set of notifications need to be made to the Child Death Overview Panel (CDOP) via a series of Notification Forms. A standardised dataset is collected for all children who die for the purposes of the NHS England National Child Mortality Database (NCMD).

Joint Agency Response (JAR)

This is multi-agency response which will be triggered if the death is due to external causes, when the death is sudden and there is no immediate apparent cause, when the death occurs in custody, where initial circumstances raise suspicions that the death may not have been natural and in the case of stillbirths where no health professional was in attendance.

A Joint Agency Response meeting is held within 48 hours of the death. A JAR should also be triggered if a child is brought into hospital in a moribund state, successfully resuscitated but then expected to die. This is a common scenario in

paediatric intensive care units, where the JAR should be initiated at the point of presentation in order to enable an accurate history of events to be taken, and if necessary so that a scene of collapse visit takes place.

Child Death Review Meeting (CDRM)

The Child Death Review Meeting is a multi-professional meeting where all matters relating to an individual child's death are discussed by professionals directly involved in the care of that child during life. The meeting is held within the hospital where the child died and chaired by a paediatrician with designated time in their job plan. The meeting should take place within three months of the child's death or as soon as results of investigations are available, for example postmortem examination. The guidance advocates that attempts are made to engage with other professionals, for example the paramedic, the local paediatrician and the local team, which might include an anaesthetist if relevant. In every case, an analysis form is completed and sent to the relevant child death overview panel.

The aim of the child death review process is to put bereaved families at the centre of the review process. A key worker is allocated to the family to make sure their questions are brought to the CDRM and so that their questions can be answered sensitively. This role is in addition to usual bereavement support services. The key worker is nominated by the lead paediatrician to act as the named point of contact throughout the process of the child death review.

Child Death Overview Panel Meeting (CDOP)

The statutory responsibilities of the CDOP are set out in Working Together to Safeguard Children (2018). The panel is required to conduct an anonymised secondary review of each child death. Meetings are attended by senior representatives across health, police, social services and other agencies as well as paediatricians.

The aim of the CDOP review is to:

- Identify the cause of death
- Provide support to families. Families should have an identified key worker to act as named point of contact throughout the process of the child death review.
- Identify modifiable/contributory factors
- Ensure statutory obligations are met
- Learn lessons that can be applied to promote the health and well-being of other children.

NHS England has published guidance for the bereaved 'When A Child Dies' (2007) as a guide for parents and carers, setting out the steps that follow the death of a child.

Medical Examiner

A new medical examiner system has been rolled out across England and Wales to provide greater scrutiny of deaths.

Medical examiners are senior medical doctors who are contracted for a number of sessions a week to undertake medical examiner duties outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification processes.

The national network of medical examiners was recommended by the Shipman Inquiry 2002–2005, the Mid-Staffordshire NHS Foundation Trust Public Enquiry 2013 and the Report of the Morecambe Bay Investigation 2015. In October 2017, Lord O'Shaughnessy, Parliamentary Under Secretary of State for Health, announced that a national system of medical examiners would be introduced in April 2019.

The purpose of the medical examiner system is to:

- Provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- Ensure the appropriate direction of deaths to the coroner
- Provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- Improve the quality of death certification
- Improve the quality of mortality data

The system will also offer a point of contact for bereaved families to raise concerns about the care provided prior to the death of a loved one.

Key Points

When considering safeguarding in children it is essential:

- To act in the best interests of the child, which are always paramount

- To be aware of the child's rights to be protected
- To respect the rights of the child to confidentiality
- To contact a paediatrician with experience of child protection for advice (on-call paediatrician for child protection, named or designated doctor/nurse)
- Where appropriate, to report child protection/safeguarding concerns to relevant professionals including social care
- To be aware of local child protection mechanisms
- To be aware of the statutory processes for reviewing deaths of children

Further Reading

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