Safeguarding for anaesthetists: working to protect children

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Abstract

An awareness of what may constitute neglect or ill treatment to children and young people is important for all healthcare staff, and prevention of harm is everyone's business. Whilst it is relatively unusual to see serious signs of abuse in a routine surgical context, anaesthetists also see children in many different settings and should be able clearly to communicate their concerns. Whilst there are differences in both relevant law and statutory advice in the various parts of the UK the message is basically the same. New recommendations potentially allow for a more meaningful and flexible approach to training.

Keywords Anaesthetist; child protection; competencies; safeguarding; training

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Learning objectives

After reading this article, you should be able to:

- describe the various types of child maltreatment and possess a knowledge of the process of raising concern with colleagues in paediatric practice
- know the recommendations on levels of training for anaesthetists
- possess a knowledge of the statutory guidance and relevant law in all areas of the UK

Introduction

Doctors play a crucial role in protecting children and young people from child abuse and neglect. In this article we will explain why the safeguarding agenda is important, what anaesthetists need to know and where to get assistance if you have concerns. We will provide useful additional references and an overview of relevant statutory advice and legislation.

The language in this speciality is changing, with 'child protection' generally signifying the protection of children from maltreatment and 'safeguarding' being generally the preferred broader term encompassing the need to make sure that children are growing up in circumstances which provide safe and effective care (i.e. safeguarding includes the need to prevent maltreatment).

The various types of abuse are briefly defined in Box 1. It should be stressed that Children and Young People (CAYP) often experience more than one type of abuse. Neglect is the most common form of abuse in the UK.

Why is it important?

Babies and children die each year as a result of abuse and generally at the hands of parents and carers. Many more suffer less extreme injuries, which may be repeated and serious and yet be undetected and lead to long-term physical and psychological damage.

Statistics

The latest statistics from the NSPCC in the UK[1] show that the number of children being killed as a result of abuse is gradually declining, but there is still an average of one child per week killed in the UK at the hands of another person each year. All four countries in the UK have seen the number of recorded sexual offences against children increase over recent years and there has been an increase in contacts to the NSPCC helpline and ChildLine about sexual abuse. The number of recorded sexual offences against children have also increased over the last year.

Types of abuse[10]

Physical

Physical 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.

Sexual

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. This may or may not include physical contact, e.g. inducing children to view pornographic images or encouraging children to act in sexually inappropriate ways. It also includes grooming a child for abuse and all forms of child sexual exploitation.

Emotional

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development.

Neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, (whether intentioned or not), which is likely to result in the serious impairment of the child's health or development. Summarised from the RCPCH Child Protection Companion 2013.

Box 1

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There are approximately 50,000 children and young people identified as requiring protection from abuse in the UK.[1] This is likely to be an underestimate of those at risk. A study published in 2011 reported that one in four adults in the UK say that they were severely maltreated in childhood.[2]

An important report commissioned and published by the WHO in 2013[3] showed that there were about 850 deaths per year as a result of child maltreatment in Europe. Seventy-one per cent occurred in low and middle income countries (LMIC) where the death rate was 2.4 times that in high income countries. Overall 60% of deaths were in boys and rates were consistently higher in the under 4s as compared with older children.[6]

What do I need to know?

In the UK it is expected that staff coming into contact with children and family members in an educational, health or social care context have the knowledge and ability to (at the least) seek appropriate advice and if sufficiently able, to intervene if they perceive that child abuse or neglect is a possibility.[4,7] Whilst there are differences in some terminology, legislation and statutory advice across the UK, basically the principle that the child must be protected is a key objective in all jurisdictions and involves a multidisciplinary approach. Education in child protection and safeguarding is a key priority and forms part of mandatory training across Health, Education and Social care.

IC (Intercollegiate) competencies

In the UK intercollegiate competencies for safeguarding training[5] describe 5 levels for all healthcare staff, with level 1 applying to purely administrative staff, and levels 4 and 5 for those with lead (clinical) responsibilities for organising and delivering safeguarding services within a hospital, or a wider region (e.g. Clinical leadership within the Local Safeguarding Children Board in England, Health Board in Scotland).

The 2014 revision of the intercollegiate document also includes details of the recommended competencies for hospital management boards, chief executives and commissioners, and expects that there will be appropriate leadership at this level.

The framework allows more flexibility in the acquisition of knowledge and skills, encourages relevant and multidisciplinary working and suggests that knowledge should be updated, and not simply repeated annually.[8] Most anaesthetists need to maintain level 2 competencies, as do all medical and trained nursing staff who should have gained these competencies in early stages of training. It may be provided in face-to-face sessions, relevant reading and e-learning. Dependent on specialization and practice it may be worthwhile to focus on particular areas of knowledge (e.g. for the obstetric anaesthetist it may be important to spend some time on the processes in place for the care of mothers and babies). Even if the anaesthetist has no paediatric practice it is important to stress that they still have safeguarding responsibilities as the adults they treat are also part of families which generally include children and young people. It is important that the scenarios used are both realistic and relevant to the audience. Training is often delivered by the designated or nominated professionals who may need to be carefully briefed to make this a worthwhile exercise. Some anaesthetists will act as safeguarding leads and will have extended ('core' level 3) knowledge.[6] They are in a good position to both coordinate training within a department, and act as a key contact for paediatric colleagues in dealing with difficult cases. However the responsibilities of the role should not extend to giving high-level advice on individual cases which still should rest with safeguarding professionals.

Statutory advice and relevant legislation across the UK

Terminology, statutory advice and procedures vary slightly across the UK and are outlined in Table 1.

In all parts of the UK there is a need for doctors to seek advice if they are unsure about maltreatment and neglect. In sharing of information it is important to recognize that the child's welfare is paramount and that whilst consent to disclose information to other agencies is ideally sought from the child/young person and their carers, this may not always be possible or in the child's best interests. Information may be shared if it is in the public interest and should be on a 'need to know' basis (i.e. to relevant senior professionals). Even if you are wrong about your concerns the assumption should be that the possible risk of harm was greater than the patient's right to privacy. You should take great care to document all communications with other professionals. These same professionals should advise you on what should be communicated to the child and parents if you need to do so without the assistance of a paediatrician. This should also be documented and ideally witnessed (e.g. by a trained member of nursing staff).

In cases of serious abuse including the death of a child there are case review processes in place ('Significant case review' in Scotland, and 'Case management reviews' in Northern Ireland). In all parts of the UK there are also reviews that follow a child's death from whatever cause, and whether or not there is a safeguarding element. These are under the auspices of the Child Death Overview panels which are the responsibility of the Local Safeguarding Children Boards (LSCB) in England and Wales, and the Safeguarding Board in Northern Ireland. In Scotland a statutory process for Child Death review is currently being actively considered. On occasion anaesthetists will be asked to provide information for these reviews and attendance as an observer is a suggested activity for those undertaking the safeguarding/child protection lead in anaesthesia.

If I have concerns – where can I get more help?

Anaesthetists may encounter child abuse and neglect in many situations, for example acute presentation of serious injuries, pre-assessment or chronic pain clinics and occasionally perioperatively. In all but the first situation they may be the first person who has recognized that there is a possible or real safeguarding issue. They are not expected to be experts but a reasonable working knowledge of what may or may not be normal (some of which relates to an awareness of normal childhood development), as well as patterns of abusive injury is an important part of training.

Good sources of reference are available and include websites such as that maintained by the Wales Child Protection Agency (www.core-info.cardiff.ac.uk).