Royal College of Anaesthetists

Royal College of Anaesthetists' response to the Independent Inquiry into Child Sexual Abuse's call for views for the planned Health Sector Seminars

About the Royal College of Anaesthetists

- The Royal College of Anaesthetists (RCoA) is the professional body which ensures the quality of patient care through the maintenance of standards in anaesthesia, critical care and pain medicine across the UK
- Anaesthesia is the UK's single largest hospital specialty, playing a critical role in the care of two-thirds of all hospital patients[1]
- With a combined membership of over 21,500 fellows and members, including our Faculties of Intensive Care Medicine and Pain Medicine, the RCoA is the third largest Medical Royal College by UK membership.

Introduction

The Royal College of Anaesthetists welcomes this review of a very serious and sensitive topic. We have sought expert opinion from our members particularly those working in the major Paediatric Centres across the UK and those with a special interest in providing education to anaesthetists in the sphere of Child Protection. The specialist society for paediatric anaesthesia in the UK, the Association of Paediatric Anaesthetists, has also contributed.

Our response to the consultation questions, in full, is provided below. Should you have any questions regarding this, please contact [redacted] at [redacted] or by phone on [redacted].

1. Please outline the steps your organisation has taken since 2015 to prevent children from being sexually abused in healthcare settings.

The Royal College of Anaesthetists has produced a suite of new web resources ("SafeguardingPlus") that will be launched in September 2017 and which include specific pages on both Child Sexual Abuse and Child Sexual Exploitation. These in turn include a link to the ongoing work of the IICSA. However, there are no materials that specifically draw attention to the problem of CSA in healthcare settings. As a college we will be highlighting the importance of education in this sphere to all of our members around the time of the launch and we are actively considering ways to encourage study of the material in such a way that colleagues can evidence its study in their portfolios prior to appraisal.

2. How well does the current legislative framework prevent the sexual abuse of children within healthcare settings?

There is an emphasis on Safeguarding training, recruitment and security but little or no emphasis on how more sophisticated abusers might be spotted and prevented from harming children and young people in healthcare settings. There are very high levels of security in paediatric areas but little or no attempt to explain to professionals why this is needed. Clear explanation of risk might lead to better compliance.
There is anecdotal evidence from some of our members that security in hospitals is not always at the level expected. Some Trusts have the same master codes for all secure doors to be used in case of medical emergencies. This is more of a problem in the older building stock that still remains in use.

Children are sometimes treated outside of the specialist paediatric environment in facilities that only regularly treat adult patients. For example, radiotherapy or interventional radiology

suites. These children are more vulnerable on these occasions as some of the staff they come in to contact with are not trained appropriately.

There is a strong emphasis on safe recruitment processes but little explanation about why this is important and there is a lack of a coherent joined up approach between organisations. Checks may be repeated for employees on multiple occasions (e.g. trainees moving around a city or region to receive specialist training within a very short time frame of weeks or months). Such checks are inconsistent, expensive and time inefficient and have not been shown to prevent harm. But at the same time it is impossible to know if visiting staff have been appropriately vetted before they treat children. Is there a place for a centralised unified vetting agency providing staff with a "children's care passport"?

Medical staff are sometimes not able to seek "chaperones" during routine examinations of patients of all ages as there are universally staff shortages in all areas of the acute hospital. This includes but is not limited to, pain and pre-op clinics, ward assessments and induction of anaesthesia.

3. To what extent do the sanctions available to regulatory bodies ensure that children receiving health care and treatment are protected from sexual abuse? This includes the regulators of both:

a) organisations providing healthcare services; and

b) professionals delivering care and treatment.

The General Medical Council can act swiftly via the MPTS to restrict medical practitioners having a license to treat children pending the investigation of a complaint. This is generally thought of as proportionate and effective by our members. However, the devastating effect that such a restriction can have if it goes on to be disproved should not be underestimated.

4. Are health professionals and health sector leaders provided with adequate training, support and guidance on the issue?

Almost certainly not. This topic is not covered in e.g. level 2 or 3 child SG training. Intercollegiate guidelines have since 2014 included specific training for Trusts and Boards but this is very basic and again there is no specific mention of competences that reference institutional CSA. There is to be a revision of the training guidelines in 2017 and this is an opportunity to include additional knowledge competences.

The results of the 2015 Lampard report on Savile for health care do not seem to have been widely disseminated. For example, it is possible that training for all health professionals should include a discussion around HR policy and risk assessments for screening and accompanying volunteers and VIP guests who are seeking to work on a regular and/or individual basis with children, young people and vulnerable adults.

5. How effectively are organisations and people held to account for the effective prevention of child sexual abuse in healthcare settings?

Many Trusts include some teaching about security at induction and during mandatory training updates. Also, there are ongoing reminders that staff should not allow individuals to "tailgate" them through security doors. However, there is no training as to how to challenge individuals without appearing to be rude and discourteous. Obviously it is extremely rare that someone will not have a bona-fide reason to gain access to a corridor or ward. The culture may need to change such that parents expect to be challenged in the same way that they now expect to see staff cleaning their hands.

6. To what extent do the responsibilities of health sector organisations to work with partner agencies help to prevent child sexual abuse in healthcare settings?

This is not an area that our members felt was appropriate for us to comment on.

7. What impact (if any) have reforms of the health sector in England and Wales over recent years had on the effective prevention of child sexual abuse in healthcare settings?

The concentration of expertise into fewer sites clearly has benefits for some but at the same time leaves other hospitals devoid of what little expertise they previously had. As a Royal College we are dealing with this issue in respect of the provision of paediatric anaesthesia and we are sure child protection cover is the same. We are aware of several hospitals receiving sick and injured children on a regular basis without onsite access to Paediatricians and the attendant gaps in providing swift informative child protection advice.

8. What do you see as being the major opportunities for organisations in the health sector to prevent the sexual abuse of children in healthcare settings?

One of the major opportunities would be to standardise and quality assure the training delivered in this area to all staff in the healthcare sector. Clear recording of compliance would allow staff working full-time with children confidence that visiting colleagues, commercial reps and locums were all aware of the risks, trained in their prevention and trusted to be on site.

9. What needs to happen to ensure that organisations in the health sector best protect children receiving health care and treatment from being sexually abused?

The risks identified by this consultation need to be considered and flagged as mandatory to Trusts and Boards with personal accountability placed on them. There should be quality education and training of staff. Raising of awareness to staff and parents of the potential risks should be widespread and, as stated previously, parents should expect to find access to wards difficult, they should expect to see visible security wherever their children are cared for.

10. Please describe the whistleblowing measures you have in place and how you assess their effectiveness.

No members commented on this. We were made aware of a situation involving a member of staff and their conduct on the internet in a large tertiary Children's Hospital. There was no formal process to follow within the Trust however; the situation was dealt with swiftly and fairly by the Chief Executive's Deputy.