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RADIOGRAPHERS



RADIOGRAPHY

The Child and the Law: The Roles and Responsibilities of the Radiographer

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RADIOGRAPHERS





R A D I O G R A P H Y

The Child and the Law: The Roles and Responsibilities of the Radiographer

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Foreword

“ Whether a nurse, doctor, dentist or allied health professional, manager or administrator or clerical worker, the contribution of all health service workers to the protection of children is crucial”

(Barker & Hodes 2004) ¹

Articles related to the safety and protection of children are currently prominent in the media in the UK and elsewhere as a result of, and following on from, many high profile cases including the Climbie inquiry and the more recent Jackson trial. The Society and College of Radiographers 1995 document entitled *The Implications for Radiographers of the Children Act 1989* was limited to issues surrounding child consent for imaging and radiotherapy examinations. This present policy document has gone further and refers to the legal framework as applied to the child and has examined the evidence in relationship to consent, non-accidental injury, and immobilisation of the child. In addition, it includes a section on the important issue of looking after the children of patients whilst they are in the department.

This present document provides advice and guidance to the individual radiographer and recommendations related to education and training. It also outlines the requirement by managers to draw up referral guidelines for Non Accidental Imaging (NAI).

Radiographers who wish to highlight the need for policy guidance and education and training in child protection procedures and containment, may wish to forward a copy of this document to named executive directors on their employing authority board or governing body (additional copies available from Professional Support).

The Society and College of Radiographers is grateful to Val Challen, Radiographer and formerly Director of the Centre for the Development of Learning & Teaching, St Martin's College Lancaster for all her hard work in developing this advice document for the profession. Val would like to thank Michaela Davis JP, Lecturer in Radiography, University College Dublin, for the generous provision of her time and her considerable expertise and experience in child protection matters which has informed this document. Grateful thanks must also be given to Judith Hardwick, Paediatric Radiographer, formerly Superintendent Radiographer, Great Ormond Street Hospital for Children, London and to Liz Murphy, Superintendent Radiographer, Therapy Clinical Specialist for Paediatrics, Northern Centre for Cancer Treatment (NCCT), Newcastle General Hospital, Newcastle upon Tyne, for their very helpful and timely advice and guidance on a number of paediatric issues.

Executive summary

Please refer to content sections and sub sections for details.

- *Radiographers have personal and professional responsibilities and duties in respect of their dealings with children. (Section 1 subsections 1.7; 1.12; 1.15; 1.18)*
- *It is important for all radiographers who come into contact with children that they are familiar with the statutory proceedings which are in place for the care and protection of children. (Section 1 subsections 1.1; 1.2; 1.3; 1.10; 1.11; 1.16; 1.17)*
- *Where there is concern that a child may be at risk of abuse and neglect, it is important that radiographers act in accordance with the guidance provided in this document and with other local and national protocols, The best interests of the child are paramount and it is incumbent upon the radiographer to ensure that the correct procedures are carried out. (Section 3 subsections 3.3; 3.5; 3.8; 3.10; 3.13)*
- *The radiographer may be the first person to suspect a case of non-accidental injury and s/he must ensure that such concerns are raised with the appropriate persons. (Section 1 subsection 1.7 and Section 3 subsections 3.2; 3.3; 3.4; 3.8; 3.10)*
- *Any diagnostic images produced by the radiographer may form part of the significant evidential documentation which may be presented in a court of law. Other documentation includes written reports which may include child disclosures and events which happened during the examination. (Section 3 subsection 3.14 and Section 5 subsections 5.2; 5.3)*
- *Radiographers must familiarise themselves with current legislation affecting their practice. (Section 1 and Section 4 subsection 4.1)*
- *Advice concerning the imaging of children who are suspected of having been abused should be sought from such agencies as the British Society of Paediatric Radiologists (BSPR) and the Senior Nurse in Child Protection. (Section 5 subsection 5.11; 5.17; 5.18 and Section 1 subsection 1.14)*
- *Local protocols for the imaging of children must be adhered to. Managers are required to draw up local referral guidelines for imaging for Non Accidental Injury (NAI)(Section 5 subsections 5.1; 5.2; 5.7; 5.11; 5.12; 5.13; 5.14)*
- *The radiographer is advised to seek verbal affirmation of consent to any procedure they undertake on a patient. (Section 4 subsections 4.11; 4.12)*
- *Radiation dose reduction to children should not be at the expense of obtaining incontrovertible evidence of child abuse. (Section 5 subsection 5.15 and Section 6 subsection 6.12)*
- *Immobilisation and restraint techniques on children should be used sparingly; distraction techniques and play therapy should be attempted first. (Section 6 subsections 6.3; 6.8)*
- *Pre registration curricula should include child psychology, child development, child protection and legal frameworks. (Section 7 subsections 7.3; 7.4)*
- *Child protection training for radiographers should be part of an induction programme on appointment and be included as part of regular updates. (Section 7 subsection 7.2)*
- *Radiographers and students should be aware of the implications of minding the children of patients. (Section 8 subsections 8.6; 8.7; 8.10)*

1. The legal framework

- 1.1 *The Children Act 1989*² is a key piece of legislation applicable to England and Wales dealing with the responsibilities of the state and of individuals to ensure the welfare of children and young people. It introduces orders which apply when children are at risk of 'significant harm' and states that the welfare of the child is paramount (See appendix 1 for the main principles of the *Children Act 1989*.)
- 1.2 In Scotland the *Children (Scotland) Act 1995*³ is the appropriate legislation and in Northern Ireland the *Children (Northern Ireland) Order 1995*⁴. There are some differences between the Acts in relationship to approaches to child protection and radiographers are advised to ensure they are familiar with the legislation appropriate to the country in which they work.
- 1.3 The concept of 'significant harm'⁵ is the threshold that justifies compulsory intervention in child protection cases in the best interests of the child. Under section 31 (9) of the Children Act 1989 'harm' means ill-treatment or the impairment of health or development. There are, however, no criteria for judging what constitutes significant harm. It can be a single traumatic act such as a violent assault, suffocation, shaking or poisoning, or it could be an accumulation of events such as neglect, emotional, physical or sexual abuse that has the effect of damaging the child's psychological and/or physical development.
- 1.4 In January 2003 the Victoria Climbié inquiry report by Lord Laming noted the serious shortcomings in communication between health professionals and between agencies involved in child protection despite the guidance provided in the 1999 national framework for child protection practice *Working together to safeguard children: a guide to interagency working to safeguard and promote the welfare of children*.⁶
- 1.5 The Climbié inquiry emphasised the importance of professions and others working together and sharing information in order to keep children safe from harm⁷. Four broad categories of abuse defined in *Working Together* are physical abuse, emotional abuse, sexual abuse and neglect. (See appendix 2 for an explanation of the four broad categories.)
- 1.6 As a result of the Climbié inquiry, the government published revised guidance for all professionals directly involved in child protection. This document *What to do if you are worried a child is being abused*⁸ provides a condensed version of the *Working Together* document to assist professionals working in the front line to respond appropriately if they suspect child abuse and/or neglect.
- 1.7 *What to do if you are worried a child is being abused* is also a valuable resource for all health practitioners including radiographers who come into contact with children and families in their everyday work and who thus have a duty to safeguard and promote the welfare of children. It provides guidance (later reflected in this present document) for those practitioners, such as radiographers, who do not have a direct specific role in relation to child protection but do play a role in the protection of children.
- 1.8 The Scottish equivalents of some of these documents are the Scottish Office *Protecting Children. A Shared Responsibility: guidance on interagency cooperation 1998*⁹ and the Scottish Executive *Protecting Children. A Shared Responsibility: guidance for health professionals 2000*¹⁰.
- 1.9 Prompted by both the Climbié inquiry and the Bristol Royal Infirmary inquiry, in September 2003 the government published the Green Paper *Every Child Matters*¹¹ which called for a radical improvement in the opportunities and outcomes for children to be driven by changes in the delivery of children's services in order to maximise opportunities and minimise risk for every child¹².

- 1.10 The government introduced The Children Bill into the House of Lords in March 2004 to provide the legislative framework for taking forward the Green Paper *Every Child Matters*. This Bill received Royal Assent on 15 November 2004 and is now the *Children Act 2004*¹³. Under this Act, there is a statutory duty for agencies to work together. Please note that it is not a rewrite of the *Children Act 1989*. The overall aim of the 2004 Act is to encourage integrated planning, commissioning and delivery of services as well as improve multi-disciplinary working, remove duplication, increase accountability and improve the co-ordination of individual and joint inspections in local authorities¹⁴.
- 1.11 The *Children Act 2004* places a new statutory duty on those agencies providing services to children, including NHS bodies, to establish Local Safeguarding Children Boards (LSCBs) to replace by April 2006 the voluntary Area Child Protection Committees (ACPCs), which are, at this time of writing, in place.
- 1.12 Radiographers should ensure they understand under Section 11 of the *Children Act 2004* that their employing authority has a duty to safeguard and promote the welfare of children and that, as employees and as professionals, they must play this important part too.
- 1.13 The responsibility for child protection services across all health service providers lies with the Primary Care Trusts (PCTs) in England who appoint a designated doctor and nurse to take the strategic lead in all aspects of the health service contribution to safeguarding children, including child protection matters. They represent the health service on the local ACPCs/LSCPs.
- 1.14 In addition, each NHS Trust, including PCTs, must appoint a named doctor and a named nurse to take the professional lead on child protection issues within their respective trusts. They are the principal points of contact for advice and opinion for health staff members who may have suspicions or concerns. They also organise and run training and information sessions for members of staff.
- 1.15 Radiography managers must make it very clear that the professional responsibilities of radiographers with regard to children make it imperative that they attend child protection training sessions on a regular basis, both on initial appointment as part of an induction programme and later as part of their routine (preferably annual) updates. (See also section 7.)
- 1.16 The UK ratified the *UN Convention on the Rights of the Child* in 1991¹⁵. The Convention sets out standards that should be reflected in health care and particularly in Article 3 which states that “*any decision or action affecting children.....should be focused on their best interests*”.
- 1.17 Radiographers should bear in mind that the rights of children and their parents under the *Human Rights Act 1998*¹⁶ will have a bearing on child protection issues. The Articles which may have a bearing are Article 2, the right to life, Article 3, the prohibition of torture, inhuman or degrading treatment or punishment, Article 6, right to a fair trial and Article 8, respect for private and family life.
- 1.18 Because child protection is everyone’s responsibility, this important area has to come within the remit of every radiographer’s personal and professional duties.

2. Radiographic background

- 2.1 It is now some 10 years since the Society and College of Radiographers (SCoR) published a guidance leaflet *The Implications for Radiographers of the Children Act 1989*¹⁷ which dealt mainly with consent issues. This present guidance is designed to cover wider issues and the responsibilities of every radiographer.
- 2.2 Both Hancock et al in 1997¹⁸ and Sudbery et al 1994¹⁹ have emphasised the importance for radiographers to have knowledge of the *Children Act 1989* and that radiographers require knowledge of not only the technical and radiological elements, but also the social, emotional and legal contexts of child abuse.
- 2.3 Several radiographers and others (notably Brown & Henwood 1997²⁰; Hogg et al 1999²¹; Drummond & York 2001²²; Dimond 2002²³; Rigney & Davis 2004²⁴; Davis & Reeves 2004²⁵; Hardwick & Gyll 2004²⁶); have written extensively on issues related to radiography, child abuse and non-accidental injury and have provided a number of recommendations for radiographers working with children. Many of these recommendations have informed this present guidance document.
- 2.4 In 1999 the SCoR published guidelines on aspects of forensic radiography in the *Guidance for the Provision of Forensic Radiography Services*. Forensic medicine refers to the application of medical knowledge in the collection of evidence [including radiographic evidence] which may be called upon to be used in a court of law. See section 5 of this present document for further reference to the SCoR guidelines in relation to imaging in cases of suspected non-accidental injury.

3. Initial Concerns: Where a radiographer during normal daily work may have concerns about a child in his/her care

- 3.1 Research undertaken by the NSPCC shows that a significant minority of children in the UK suffer serious abuse and neglect with 16 per cent of children experiencing serious maltreatment by parents²⁷. Figures from 2003 showed that in that year there were 32,700 children on child protection registers in the UK²⁸.
- 3.2 Figures like this mean that radiographers may come across potential or actual instances of child abuse and neglect in their normal daily work. When carrying out any examinations on children radiographers must be cognisant of the possibility and must be vigilant. Radiographers should familiarise themselves with local procedures for safeguarding the welfare of children. They should find out where they are kept in the department and ensure that they have read them.
- 3.3. The child protection responsibilities of the radiographer are defined into two distinct categories:
- 3.3.1. Personal and professional protection of the child
3.3.2. Undertaking imaging for diagnostic, clinical and evidential purposes.
- Under either category the main priority is the child's safety²¹.
- 3.4 As part of the routine care of children, radiographers (therapeutic and diagnostic) are often well placed to detect the possible signs of physical abuse where suspicions may be aroused both from appearances in the images produced and from marks on the child's body, eg bruising, cigarette burns, strap/belt marks. The younger the child, the more they are at risk from physical harm and, in this age range, injuries to the head, eyes, ears and mouth should be viewed with suspicion.
- 3.5 The diagnostic radiographer is also in a position to ascertain whether the radiographic appearance of any injury is consistent with the explanation provided by the child, the parent or the carer. Previous x-ray images taken at the hospital should be sought. Any concerns/suspicions must be drawn to the attention of the appropriate persons (see 3.8). The radiographer should not assume that other health care workers might have reported such; it is better that two (or more) persons voice suspicions than none.
- 3.6 Also, if the radiographer has concerns/suspicions that the sibling of a child being examined or the child of one of her/his patients is being abused s/he must draw these concerns to the attention of appropriate persons (see section 3.8). The radiographer should not assume that other health care workers might have reported such; again it is better that two (or more) persons voice suspicions than none.
- 3.7 If the radiographer has any concerns (see sections 3.4 and 3.5) s/he should understand that the hospital trust has child protection procedures which must be followed (see section 1.14). The Climbié inquiry emphasised the importance of professionals sharing information in order to keep children safe from harm.
- 3.8 In the event of any concerns, the radiographer must:
- 3.8.1. Discuss immediately any concerns initially with a senior member of staff. In the event of working single handed that staff member may be outside the clinical department.
- 3.8.2. Immediately make a detailed record of the observations leading to suspicion and the action taken. This record must show timings, be dated, signed and witnessed and a copy kept in safe keeping in the department.
- 3.8.3. Contact one of the named persons identified as a member of the NHS Trust child protection team (or equivalent in the private sector) and provide them with a copy of the record made.

- 3.9 In addition, the radiographer may have concerns raised by the behaviour of the child during the examination or through the words spoken by the child either with a parent/carer in attendance or more usually when s/he is alone with the radiographer.
- 3.10 If the child does confide in the radiographer s/he must be careful to avoid asking questions of the child as, should the case go to litigation, they might be construed as leading questions and might complicate early investigations with the police. The radiographer should listen carefully and record verbatim the whole discourse as soon as possible; notes should also be recorded of the child's demeanor during the discourse. Davis²⁹ recommends that a child disclosing any information must not be stopped and the radiographer should not promise to keep secret the information. The radiographer must listen carefully and not make assumptions about or interpret what the child is saying. The record, which must be in a clear and comprehensible format, must show timings, be dated, signed and witnessed and signed by another professional as soon as practicable. The radiographer should then discuss the event with a senior member of staff to let them know what has occurred and then contact one of the named persons identified as a member of the employing authority's child protection team.
- 3.11 At this point, the role of the radiographer has been fulfilled. It is not the responsibility of the radiographers to inform parents or carers of suspected abuse nor is it their responsibility to investigate. The child protection team member will decide whether Social Services need be contacted.
- 3.12 The radiographer should, however, expect feedback from the child protection team and investigate the extent to which his/her report has been acted upon. Service managers should assist the radiographer in this respect.
- 3.13 Radiographers should be mindful of the fact that students must be supervised at all times. In the event of any situation where a student radiographer undertaking a procedure suspects abuse, the procedure should be halted and the student report any suspicions to the supervising radiographer who should then relieve the student from the examination and ask the student to withdraw. The radiographer should follow the procedure as outlined in section 3.8. In addition, the student should complete a separate signed statement of his/her suspicions and the action taken. This statement must be appended to the radiographer's report.
- 3.14 The images produced as a result of the examination and the signed record form part of what Hancock et al 1997¹⁸ terms the **significant evidential documents**. Such documentation may also be supplemented by further images forming part of a skeletal survey examination (see section 5 of this present document).
- 3.15 The awareness by the radiographer of the child protection procedures which are in place cannot be stressed too much as the safety and protection of children must be the first priority.
- 3.16 Radiographers will, of course, be anxious about disclosures and worry about what would happen if they were wrong about their suspicion of child abuse. On 21 April 2005 the House of Lords delivered judgment in a test case brought by parents who had been suspected of inflicting non-accidental injury, sexual abuse and Munchausen's Syndrome by Proxy (*JD [FC] v. East Berkshire Community Hospital NHS Trust and Others 2005*). The House of Lords has ruled that parents wrongly accused of abusing a child cannot sue doctors or social workers. They ruled that in raising such a suspicion the doctor's sole concern should be the welfare of the child. The health professional's common law duty of care is to the child and not to the parent. The above is also relevant to radiographers.
- 3.17 Usually, radiographers would not have access to the Child Protection register but, if suspicious of abuse, the radiographer should make efforts to find out if the child has been x-rayed previously perhaps under another name or date of birth and to routinely review any previous images for possible radiographic signs which may lead to suspected non accidental injury.

4. Consent and Confidentiality

- 4.1 The legal framework upholding consent and confidentiality issues as far as children is concerned is complex but this should not be a barrier to radiographers becoming aware of where their professional responsibilities lie and acting upon them. In addition, it is the duty of any health care practitioner to keep him/herself informed of any legal developments that may impact on their practice. This is what being a professional means and distinguishes the professional from the non-professional.
- 4.2 Patient confidentiality is a fundamental feature of professional practice. Where the child is concerned, and in particular when in relation to child protection, the key feature surrounding confidentiality is that the interests of the child in question are paramount and may supercede all other considerations (*Children Act 1989*).
- 4.3 The Health Professions Council (HPC) document '*Standards of conduct, performance and ethics*'³⁰ which applies to all registered members of the HPC, indicates that it is possible to release personal or confidential information to anyone entitled to it and that information about a patient must only be used to continue to care for that person. Indeed, the *Children Act 1989* makes it clear that in any situation, the child's welfare is paramount.
- 4.4 All NHS Trusts, PCTs and health authorities and their employees have a statutory duty to assist Social Services making enquiries under the *Children Act 1989* [or *Children (Scotland) Act 1995* or *Children (Northern Ireland) Order 1995*].
- 4.5 Conducting such enquiries requires relevant information about the child. Consent to disclosure should³¹ be obtained but disclosure without consent should be restricted to the minimum that will serve the purpose, disclosed only to someone who holds a similar duty of confidentiality on a need to know basis.
- 4.6 The Department of Health 2001 documentation³² states that "*Obtaining consent before providing care is both a fundamental part of good practice and is a legal requirement*".
- 4.7 The principle of consent to an examination carried out by a health professional is the right of patients to determine what happens to their bodies and the radiographer (in common with all other healthcare professionals) who does not respect this principle is liable to both legal action by the patient and action by the HPC.
- 4.8 For consent to be valid and legal, three elements must be satisfied
- i) The patient must be legally competent;
 - ii) The consent must be freely given;
 - iii) The person consenting must be suitably informed³³.
- 4.9 Valid legal consent to treatment or examination can be express consent (oral or written) or implied consent. The radiographer must gain the consent of a patient to the procedure they will undertake.
- 4.10 Express consent is needed for treatments and investigative procedures which carry any risks; this must, by definition, include radiological/radiotherapeutic procedures. The law, however, does not require consent to be in written form, verbal consent is acceptable so long as the three elements above (see section 4.8) have been satisfied.

- 4.11 Implied consent is an agreement signaled by the behaviour of an informed patient, who may not express him/herself verbally but does as requested by the radiographer. The giving of information to the patient distinguishes implied consent from compliance with a request (eg lying on an x-ray couch or presenting an arm for an injection). The radiographer, like the nurse, is well advised to seek the verbal affirmation of a patient prior to undertaking any procedure³⁴.
- 4.12 If children are competent to give consent for themselves for either an examination or a disclosure, the radiographer should seek consent directly from them. The legal position on competence is different for children under 16 years of age and for those over 16.
- 4.13 Legally a child is a person who has not yet attained the age of 18 years, but by virtue of Section 8 of the *Family Law Reform Act 1969*³⁵ children aged 16 - 17 years are deemed capable and therefore competent to give consent in the same way as an adult. It is however prudent for the radiographer to encourage children of this age to involve their families in the decision making process unless the radiographer believes that it not in the best interests of the child to do so.
- 4.14 For children under the age of 16 years, competence to consent may not be presumed; a child under 16 will be competent to give valid consent if they have “*sufficient understanding and intelligence to enable him/her to understand fully what is proposed*”³⁶ (known as either Gillick competence or Fraser ruling competence).
- 4.15 Criteria for judging Gillick competence and the lower age range are not clear and radiographers are advised that “*legal capacity by a child varies according to the particular matter and maturity and understanding of the particular young person*”³⁷. Although there is no clear legal guidance, it would appear to be unlikely that the courts would consider children of 13 years and under to be Gillick competent³⁸. This however may well depend on the nature of the procedure to be undertaken. It is important, therefore, for radiographers to recognise that they must exercise professional judgement in this regard each time they carry out a diagnostic examination or treatment procedure.
- 4.16 Gillick ruling does not apply in Scotland. Young people in Scotland have a statutory right to give their own consent to treatment. Section 2 (4) of the *Age of Legal Capacity (Scotland) Act 1991*³⁹ allows a young person with no specified age range to consent on his or her own behalf to a medical procedure provided that, in the opinion of a qualified medical practitioner, s/he is capable of understanding the nature and possible consequences of the treatment and is owed the same duty of confidentiality as an adult unless the doctor suspects abuse⁴⁰.
- 4.17 If a Gillick (Fraser) competent child consents to a procedure, a parent cannot over ride that consent, however a parent can consent to a procedure should a Gillick (Fraser) competent child refuse.
- 4.18 In relation to examinations of a child there are several issues that the radiographer must address, consent to an examination of suspected non accidental injury (NAI) and consent to disclosure of information gained by the radiographer in the course of his/her professional activity. Disclosure of information relates to confidentiality principles and is a potential source of worry for all professionals. Technically, disclosure can be construed as a professional breach of confidentiality (see section 4.3) but in cases of suspected child abuse it can be justified, allowing disclosure to the appropriate person or agency (see *Children Act 1989*).

- 4.19 Radiographers may be concerned about disclosing any information gained by them about a child during a diagnostic imaging/radiotherapy treatment. They are not alone; nursing research carried out in Northern Ireland in 2003/04 found that health professionals are failing to report suspicious physical child abuse due to the fear of litigation, misdiagnosis and a lack of knowledge about the procedures of reporting⁴¹. These anxieties should be dealt with through thorough, appropriate and timely education and training, as well as professional support.
- 4.20 Consent to disclosure should normally be sought from a competent child and parent/carer, unless so doing would place that child, or indeed a sibling, at greater risk.
- 4.21 The radiographer should disclose information about a non-competent child if s/he feels that failure to do so may place the child at risk of death or serious harm or where the information would help to prevent, detect or prosecute a serious crime.
- 4.22 The radiographer should always record when, what and why information has been shared and with whom, in order that they are able to justify their decision at a later date.
- 4.23 In the event of a suspected NAI, a skeletal survey may be requested by a paediatrician. The parent/carer or competent child would need to know the reasons behind the request. A paediatrician or a paediatric radiologist should be the person explaining the request and seeking consent. Thus, it is not the role of the radiographer to seek initial consent for the examination, but the radiographer should always reaffirm consent on contact with the child and parent/carer.
- 4.24 In the event of a parent/carer or competent child subsequently refusing consent to the examination once in the clinical imaging department, the radiographer will need to liaise with the requesting physician. If further discussion with the persons holding parental responsibility does not lead to consent then it is likely that the local authority would ultimately make an application for a court order under the *Children Act 1989* for the procedure to be carried out in the best interests of the child.

5. Non-accidental injury and skeletal survey

- 5.1 Radiographers should note that usually, referrals to the clinical imaging department for a skeletal survey should only be accepted from a paediatrician or a radiologist usually after admission of the child.
- 5.2 Images produced may form part of the documentary diagnostic evidence in child protection cases, criminal proceedings and other forms of litigation ⁴².
- 5.3 Radiographers must be aware that the diagnostic images produced in cases of non accidental injury examinations form part of the so-called forensic evidence. The 1999 SCoR document '*Guidance for the Provision of Forensic Radiography Services*' ⁴³ clearly outlines the medico-legal aspects related to admissible evidence and provides a number of guidelines for radiographers to ensure the authentication and continuity of such evidence. Radiographers should familiarise themselves with Section 10 of the 1999 document.
- 5.4 Radiographic markers must be photographed onto the image in order for an image to be regarded as a legal document ²⁵. Date and time of the examination, initials/name of radiographer and witness (usually 2nd radiographer) and appropriate markers must also be recorded on the image at the time of the examination ⁴³.
- 5.5 Images may also provide information that points to alternative diagnoses, eg osteogenesis imperfecta or temporary brittle bone disease (TBBD).
- 5.6 Hardwick & Gyll (2004) advise that skeletal surveys should ideally be carried out by a radiographer trained in radiographic paediatric procedures²⁶, but this may not always be possible.
- 5.7 In order to reduce the emotional impact on the child, the parent/carer and the radiographer, the time allocation and the place where the skeletal survey is to be undertaken must be carefully managed. The procedure should never be rushed.
- 5.8 It has been indicated that most child abuse imaging protocols now require that the procedure be carried out by two radiographers to, not least, act as witnesses for one another ²⁵. Should this not be possible, the radiographer should be accompanied at all times by a second professional, eg a nurse who may have accompanied the child and the parent/carer to the department or a social worker.
- 5.9 The radiographer(s) undertaking the examination may also be sought as potential witnesses to the absence of certain physical [or if appropriate to their role, image-identifiable] injuries should the matter be attested in court. The radiographer(s) should, as a matter of routine, record what they observe of the child's body including, if appropriate, the absence of any physical signs of injury ²⁵.
- 5.10 The radiographer should note that the child may be accompanied by a parent or carer during the imaging procedure [unless it is not in the best interests of the child]. The radiographer must avoid any judgmental approach in either words or deeds towards parents/carers.
- 5.11 Please see section 3.10 above on how to react should the child start talking about the background to his/her injuries. It is not appropriate to promise the child to keep any information confidential.

- 5.12 The British Society of Paediatric Radiologists (BSPR) has produced guidelines in the form of standards for skeletal surveys in suspected NAI. These are available via their website⁴². The guidelines include technical standards for technique, procedural standards, targets for outcome and image protocols.
- 5.13 The Society & College of Radiographers expects each department in the UK to draw up clear referral guidelines for NAI and that such guidelines be available and easily accessible by radiographers. Managers are advised to use the BSPR standards and guidelines as a starting point. It is a managerial responsibility for the development and publication of these departmental guidelines.
- 5.14 Kleinman et al (2004)⁴⁴ in the USA and others in the UK [James et al (2003)⁴⁵; Offiah & Hall (2003)⁴⁶; Carty (2003)⁴⁷] have all noted that in hospitals imaging protocols for suspected NAI vary considerably as does, even more importantly, the diagnostic quality of the images.
- 5.15 Brown & Henwood (1997) warn that failure to follow protocols laid down by hospitals may cause any images produced to be inadmissible should the case be heard in a court of law²⁰.
- 5.16 A so called "Babygram" (imaging that encompasses the whole child on 1 or 2 radiographic exposures) plays no role in the imaging of children as it does not provide the requisite information about the specific and subtle abnormalities in cases of suspected abuse. [Carty identifies that the total effective dose from a BSPR recommended survey is 0.22mSv for a maximum of 22 exposures⁴⁷].
- 5.17 The balance of the importance between retaining acceptable diagnostic image quality, whilst at the same time keeping the dose as low as reasonably practicable must be considered by the radiographer. It is preferable that a set of good quality images be produced through the administration of a sufficient dose of radiation than the diagnosis be uncertain and the child returned to a high risk environment.
- 5.18 Doses must be within published diagnostic reference levels (DRLs) for children but dose reduction must not be at the expense of providing incontrovertible evidence of child abuse. The radiographer should record the exposure settings making a clinical evaluation of the outcome of the exposures.
- 5.19 The BSPR recommend that computed radiography (CR) or direct digital radiography systems may be used provided that dedicated paediatric software is available⁴².
- 5.20 The Society & College of Radiographers recommends that hard copies be created at the same time as those of digitally stored images. This will help prevent the possibility of the creation of manipulated images being used in evidence. The valid images will then be the hard copy images which must be authenticated in the normal way⁴³.

6. Co-operation, distraction and immobilisation

- 6.1 Children are often unable to fully co-operate with health professionals during diagnostic imaging or radiotherapy treatment. This may be due to their age, their lack of understanding of what is required of them, the type of procedure, the degree of urgency in carrying out the procedure and fear of the unknown and of the equipment and of the staff ⁴⁸.
- 6.2 Restraining children from moving or restricting their movement in order to carry out a diagnostic examination should be carefully considered by the radiographer. The radiographer should weigh up the situation and anticipate the possible need for the person in attendance [preferably a parent] to hold the child still for the procedure whilst at the same time give consideration of ways to prevent the need to restrain.
- 6.3 The need for restraint can be prevented through giving clear information, through encouragement of the child and the parent and gaining their confidence, through the use of distraction techniques ⁴⁹ appropriate to the age of the child and through constructive play. Restraint must be the last resort and in the best interests of the child ²⁶. Distraction is always preferable.
- 6.4 Distractions will be different dependent upon the age of the child, although the ability of a child to think and develop cannot always be understood outside the social & cultural contexts in which the child exists ⁵⁰. This may make it difficult for the radiographer to understand the viewpoint of the child.
- 6.5 The radiographer should be cognisant of the language s/he uses to describe the radiographic process as children make literal interpretations of words such as film, cassette, slice and cut in connection with diagnostic examinations and tattoo and fields with regard to therapeutic procedures.
- 6.6 Radiographers undertaking diagnostic examinations on children are advised to enlist the assistance of play specialists employed by the hospital who will be able to provide support if sufficient notice of their attendance is provided. This is especially important for NAI examinations.
- 6.7 For therapeutic procedures involving children, the National Institute for Health and Clinical Excellence (NICE) report *Service guidance for improving outcomes in children and young people with cancer* ⁵¹ recommends the involvement of play specialists during the planning stages which may later prevent the need for anaesthesia during the treatment stages.
- 6.8 Should immobilisation be the only way forward, consent to immobilisation should be sought from both the child, if competent to understand, and from the parent/carer. The proposed method of immobilisation must be fully discussed in non-technical language with the parent/carer and the opportunity for questions from them must be provided. The radiographer should familiarise him/herself regarding local restraint policies.
- 6.9 The radiographer must be aware that any child may exhibit distress when immobilisation is applied but that a child who may have been at the receiving end of physical abuse may experience 'flashbacks' which may be psychologically damaging.
- 6.10 Gentle, protective restriction of the child with pads and other devices to maintain the correct position is acceptable so long as the radiographer prepares both the child and the parent/carer.
- 6.11 Hardy & Armitage 2002 caution healthcare professionals to '*familiarise themselves with the legal and ethical implications of restraining or immobilising children and develop a systematic approach to this aspect of practice*' ⁵².
- 6.12 Correct positioning of children is difficult in order to provide the quality of image to detect often subtle signs of injury. The fact that the image was taken from a non-cooperative child is no excuse for the production of an inferior quality film ⁵³.

7. Education and training

- 7.1 It would appear from the research carried out by Davis and others that radiographers are often omitted from child protection training sessions carried out in their place of employment. This must be urgently addressed. The Royal College of Nursing (RCN) argues that there should be mandatory child protection training for all health care workers who come into contact with children and young people, this must include ancillary and office staff ⁵⁴.
- 7.2 Child protection training for radiographers, and other members of staff appointed to the radiology/radiotherapy department, should be provided as part of an induction programme on appointment and updated on a regular basis.
- 7.3 Issues surrounding child protection should be integrated into the curriculum in all pre registration radiography programmes. Assistant practitioner courses should ensure that learners on such courses attend the child protection training provided by their employer.
- 7.4 Pre registration curricula should include issues surrounding child psychology and social psychology, including child development.
- 7.5 The identification of the external physical signs and the subtle radiographic signs of non-accidental injury must be part of the pre registration curriculum. Pre registration curricula should also include imaging protocols and the issues surrounding the collection of evidence.
- 7.6 Radiographers who undertake forensic radiography examinations, including NAI cases, must be educated and trained in all aspects of medico-legal issues relating to the admissibility of evidence. Regular updating must form part of the radiographer's continuing professional development ⁴³.
- 7.7 Good report writing is a requirement of any professional and report writing skills should feature in all pre-registration curricula. Where a report is likely to be used for litigation purposes, however, radiographers should have access to local specific guidance on the structuring of such reports.
- 7.8 Diagnostic imaging examinations on children and radiotherapy treatments of children should only be carried out by a registered radiographer and by undergraduate students strictly supervised by a qualified radiographer.
- 7.9 Assistant practitioners should never carry out any examinations on children under the age of 18 years as they have neither the professional background nor statutory requirements of practice.

8. Looking after the children of patients

- 8.1 Recent correspondence (2005) in *Synergy News* has raised the issue of child minding by staff whilst a patient is undergoing diagnostic imaging examinations. The SCoR is mindful of the potential problematic nature of requests from patients to mind children and is offering the following advice and guidance which may help radiographers to develop policies, practices and educational events in their workplace in conjunction with other disciplines.
- 8.2 Clements⁵⁵ has identified risks to staff members associated with the practice of looking after patients' children as being legal issues of 'duty of care'; lack of training and vulnerability to accusations of abuse by a child who is unable to be in close contact with the parent/carer during a procedure.
- 8.3 Some hospitals in the UK have a free child minding service for children whose parent/carer is attending an outpatient clinic; this facility does not appear to be widespread and often will not cover emergency department attendance. Appointment letters to patients should indicate whether a hospital wide child minding facility is available to patients attending diagnostic imaging examinations or radiotherapy treatment sessions.
- 8.4 In the event of a hospital wide child minding service not being available, it is advised that all appointment letters should stress that older children (of school age) may accompany the patient provided they will be able to remain unattended in the waiting area for the duration of the procedure; but that younger children [or school aged children not able to remain unattended] cannot be looked after by departmental staff and that the patient will need to make alternative arrangements for child care.
- 8.5 For procedures not necessitating an appointment, the situation needs to be addressed on a case by case basis in line with hospital and departmental policies. Clearly, it is not in the best interests of care and management or of patient rights that a patient accompanied by a child or children is refused an examination unless independent child care is provided. Neither, in order to adhere to radiation protection principles, is it advisable that the child of a patient be in a controlled area.
- 8.6 A member of staff who has voluntarily decided to take charge of the child or children for the duration of the procedure should agree with the parent/carer on the most appropriate distraction techniques to use with the child [or children]. (see section 6.3 and Appendix 3)
- 8.7 In the event that distraction techniques do not work and physical restraint becomes necessary, the member of staff needs to be familiar with their employing authority's policies and thus have had prior education and training. Policies on restraining and containment should include when and how it is used and the reporting and recording of incidents (See section 6.8).
- 8.8 At the end of the procedure undertaken on the patient, the member of staff caring for the child (or children) should debrief the patient on the nature of the care provided and record this on the patient's request card. If deemed necessary, it may be appropriate for both the staff member and the patient to sign the record and to have it witnessed.
- 8.9 Any member of staff caring for children and for the children of patients should be aware of the legal framework governing the care of children including the *Children Act 1989*, the *Children Act 2004*, and, if appropriate, the *Children (Scotland) Act 1995* or the *Children (Northern Ireland) Order 1995* and the policies of their employing authority.
- 8.10 Radiographers should not use their authority to ask students to mind the children of patients. Students should be informed that in their role as student radiographers, they are not obligated to undertake tasks such as this. However, should a student voluntarily decide to mind a child(ren), s/he must be informed by the radiographer of the implications in so doing (see sections 8.6 and 8.7 above).

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10. Appendices

Appendix 1

Main principles of the Children Act 1989

- Welfare of the child is paramount
- The best place for a child to be brought up and cared for is within their own family, wherever possible
- Agencies should work in partnership with parents in so far as this does not prejudice the welfare of the child
- Children in danger should be kept safe and protected by effective intervention
- Delays in decisions affecting children are likely to prejudice their welfare. Courts should ensure that delay is avoided and make an order only if to do so is better than not
- Children should be informed about what is happening to them, participate in decisions about their future and have their wishes and feelings taken into account
- Parents continue to have parental responsibility in relation to their children, even if their children are no longer living with them.

(The Child in Mind 2004)

Appendix 2

Four Broad Categories of Child Abuse

● Physical abuse

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 feigns the symptoms of, or deliberately causes ill health to a child whom they are looking after. This situation is commonly described using terms such as factitious illness by proxy or Munchausen Syndrome by proxy.

● Emotional abuse

Emotional abuse is the persistent emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate or valued only in so far as they meet the needs of another person. It may involve 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 ill-treatment of a child, though it may occur alone.

● Sexual abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic, material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

● Neglect

Neglect is the persistent failure to meet a child's basic physical or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter or clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

(DH *Working together to safeguard children: a guide to interagency working to safeguard and promote the welfare of children* London: TSO 1999)

Appendix 3

Distraction Techniques - providing distractions

● Infants

- Encourage sucking
- Touch in a soothing way
- Sing
- Hold and rock
- Dangle a toy

● Toddlers

- Touch in a soothing way
- Sing
- Hold and rock
- Hold favourite personal items, eg blanket/toy
- Blow bubbles
- Read a book

● Preschool and school age children

- Hold hands
- Hold on lap
- Blow bubbles
- Explain what they see and hear
- Hold favourite personal item
- Massage
- Read a book
- Ask child to do a job like holding a bandage/letting you know when the light goes off

● Adolescents

- Talk
- Play music
- Massage
- Do deep breathing exercises
- Focus attention on pictures

● At all times

- Reassure
- Encourage
- Talk calmly
- Praise

*Based on 'helping your child during a medical procedure' Golisano Children's Hospital USA
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