

PART 23

**GUIDANCE - CHILD PROTECTION
AND
BLOOD BORNE VIRUSES**

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Child Protection and Blood Borne Viruses

1. Blood borne viruses are infectious agents that some people carry persistently in their blood. The person may be unwell as a result, or be a carrier of the virus and be symptom free. The virus can be passed onto another person whether the infected person is symptomatic or not. It is possible for someone to be unaware that they are a carrier.
2. The blood borne infections of particular concern are:
 - Human Immunodeficiency Virus (HIV) which can cause Acquired Immunodeficiency Syndrome (AIDS) affecting the body's immune system, and
 - Hepatitis B virus (HBV) and Hepatitis C virus (HCV), which affect the liver and which can lead to cirrhosis and cancer.

Transmission

3. The blood borne viruses are transmitted by direct contact with infected blood. However semen, vaginal secretions and breast milk may also be infectious. Other bodily fluids such as saliva, sputum, sweat, tears and vomit are not infectious unless contaminated with infected blood; which is not always obvious to the naked eye.

HIV

4. The main routes of spread of HIV are:
 - Sexual intercourse with an infected person without using a condom. ie unprotected sex.
 - Sharing needles or other drug injecting equipment, contaminated with infected blood.
 - Mother to child transmission during pregnancy, delivery or breast feeding.

Hepatitis B

5. The main routes of spread of Hepatitis B are:
 - Transmission from an infected mother to her baby during delivery.

Although in adults, 1 in 20 persons affected become chronic carriers, 9 out of 10 children become chronic carriers if infected at birth and 1 in 4 if infected between the ages of 1 and 10 years. 1 in 5 infected children go on to suffer cirrhosis or primary liver cancer, both of which are life threatening conditions.

- Unprotected sex with an infected person.

- Sharing contaminated needles or other injecting equipment by drug users.

Hepatitis C

6. The main route of spread of Hepatitis C is through the sharing of contaminated needles and other injecting equipment by drug users.
7. Before the screening of donated blood, blood transfusion with infected blood was the main transmission route.
8. Hepatitis C can be transmitted from mother to child during pregnancy and childbirth, although the risk is lower than for HIV and Hepatitis B.

Child Protection Issues

9. The main child protection issues that are likely to arise with the blood borne viruses are:
 - When a mother, who is known to be HIV positive, refuses to accept treatment for her in pregnancy and /or the baby post delivery.

The risk of HIV transmission from an HIV positive mother to her baby can be reduced from around 1 in 4 to 1 in 50 by anti-retroviral treatment for the pregnant mother; anti-retroviral treatment for the baby during the first few weeks of life; elective caesarean section and avoidance of breast feeding.

- When a mother who is known to be HIV positive insists on breast feeding her baby against medical advice. Breast feeding nearly doubles the risk of transmission from mother to child.
- When a child is thought to have a blood borne disease and his/her parents refuse to agree to medical testing and/ or treatment.
- Where a child is on the appropriate treatment but medication is given inconsistently or stopped altogether and there is danger of resistance developing.
- Where a child has been sexually abused and the perpetrator is thought to be infected with a blood borne disease.
- Where a child has been exposed to contaminated needles and syringes.

Responding to the Risks

10. In circumstances where children or parents have concerns about HIV, or other blood borne viruses, the reasons for their concerns should be explored in a sensitive manner. A child's concerns may arise from suffering abuse and they may need time to make a full disclosure. The decision regarding testing for HIV should only be made following the

appropriate counselling. It may be necessary to take advice from the local department of genito-urinary medicine.

11. Where a professional is concerned that a child may have been placed a risk of HIV, or Hepatitis B or C, an informed decision must be made about whether to raise the concern with the child and/or parents.
12. Post-Exposure Prophylaxis treatment (PEP) may be available to children who have been exposed to HIV or Hepatitis B through sexual assault or needle stick injury. PEP reduces the risk of infection but must be initiated within hours of the child being placed at risk. Urgent specialist advice should be sought. The British Association for Sexual Health and HIV (BASHH) guidelines provide recommendations for the use of PEP following potential sexual exposure to HIV.

Testing and Treatment

13. Antibodies to HIV take around 3 months to develop following infection with HIV. The 'HIV test' tests for these antibodies. Tests are also available for Hepatitis B and C.
14. A child aged 18 months or more who has been infected with HIV will have developed their own antibodies. For children under 18 months specialist tests are required to determine whether the child is infected or whether the antibodies are maternal. In the majority of cases where a child is found to be HIV positive, the mother is also infected.
15. When an HIV test is being considered, the local paediatricians, preferably with specialist knowledge of HIV, should be involved. Similarly, specialist advice should be sought regarding the testing for Hepatitis B and C. In the case of the older sexually active child it may be more appropriate to involve staff from the department of genito-urinary medicine.
16. The child and family must be given full information and counselling before testing.
17. Knowledge of disease status is valuable as early treatment can improve quality of life and prolong life.
18. Information should be both written and verbal. The need to provide the information in the first language of the family should be considered where the first language is not English.
19. Valid consent for testing is the same as consent for any other form of medical treatment. Particular consideration must be given as to whether a child under 16 years old is Gillick (Fraser ruling) competent.
20. The testing of any perpetrator requires his/her consent.

21. In the situation where the views of the parents are in apparent conflict with the health needs of the child, the parents' views should be considered fully and wherever possible every effort should be made to work in partnership. Due respect must be given to cultural and religious differences.

The welfare of the child is paramount and the duty of care is to the child and not the parents. If the parents ignore medical advice or refuse treatment, it may be necessary to seek legal advice. Legal action may be considered if the child is felt to be at risk of significant harm.

Confidentiality

22. Agencies have the duty to ensure the confidentiality of all parties.

23. However information can be shared with other agencies if:

- Disclosure of information would be in the best interests of the child or to protect an individual at risk of infection, and
- The professionals are aware of the confidential nature of the information and are able to maintain the confidence.

24. The child's and/or family's wishes regarding confidentiality may be overruled if:

- The child is at risk of significant harm if disclosure is not made.
- There is a legal requirement for information to be disclosed.
- 'Public interest' requires disclosure to prevent others being put at risk. Schools and foster carers are not entitled to be informed under the 'public interest' reason.

25. If it is considered necessary to go against the wishes of the child or parents, the social worker must:

- Consult with his/her manager and the legal department.
- Have the decision authorised by the service manager
- Provide the child and/or family with full written explanation of the reasons for overruling their wishes.

26. On extremely rare occasions a perpetrator may be known to be HIV, Hepatitis B or C positive. It may be appropriate to share this information, in the best interests of the child, even if consent is not given. In such situations specialist medical and legal advice must be sought, whilst maintaining confidentiality regarding the person concerned.

27. If the final decision is made to reveal the person's status, for the welfare of the child, a full written explanation must be given to the perpetrator detailing what information will be shared and why.

Support, Advice and Guidance

28. Support, advice and guidance should be available for all agencies through the lead officers for individual agencies. The local paediatricians, particularly those with a special interest in blood borne viruses, and the department of genito-urinary medicine are useful sources of advice and support.

29. Our thanks go to the London Safeguarding Children Board who gave permission to use their Child Protection Procedures regarding blood borne viruses, in the preparation of this document.

Useful documents

Children in Need and Blood Borne Viruses: HIV and Hepatitis (DoH 2004)

UK National Guideline for the use of post-exposure prophylaxis for HIV following sexual exposure (BASHH 2006)

Final Draft January 2008