

**GMC Call for evidence on doctors' roles and responsibilities in  
child protection  
September 2010  
Family Justice Council response**

The Family Justice Council is a Non Departmental Public Body sponsored by the Ministry of Justice. It was established in the summer of 2004, following a public consultation. Its main remit is to promote an interdisciplinary approach to the needs of family justice and through consultation and research to monitor the effectiveness of the system and advise on reforms necessary for continuous improvement. One of its main terms of reference is the provision of advice and the making of recommendations to Government on changes to legislation, practice and procedure, which will improve the workings of the family justice system. Its members and those of its committees and working groups are drawn from the professions involved in the family justice system and include lawyers, social workers, medical professionals and government officials.

***Consent and confidentiality***

Doctors who work to protect children must keep the interests and needs of the child at the heart of what they do. This means listening to children and giving them information in a way they can understand; and examining or treating children with their consent, parental consent or other legal authority. It may also involve doctors sharing information about the child and family with other agencies or when acting as a witness giving evidence to the court in order to provide services for the family or to protect a child from abuse or neglect. In these circumstances, the child and their family may have conflicting interests.

**Q1. What problems do you see in relation to consent and confidentiality when doctors work with children and their families where there are child protection concerns? If possible, please provide examples of good practice, or areas where problems commonly arise.**

**Q1 FJC Response**

Children and families caught up in the court process are often in considerable conflict and distress, and may have limited ability to negotiate or solve their own problems. Clear letters of instruction or orders from the court are essential to ensure that Doctors can contribute effectively to the protective process, as these instructions override the consent normally required to disclose medical information.

In pre-proceedings, the usual consents apply and the potential new legislation on transparency (although currently not planned for implementation) would have major implications for practice in gaining consent, as it would mean that the possibility that information gleaned from clinical consultations might be reported by journalists following court proceedings. Specific GMC and RCPCH guidance would be needed if this law was implemented (CSF Act part 2, 2010)

Clarity about accountability in child protection work is also necessary: it may be entirely legitimate for a Doctor in an incidental role (e.g. as a Named or Designated Doctor or as an opportunistic consultee) to identify child protection concerns and report them to the proper investigating authorities. It is clear from 'Working Together' guidance that the appropriate threshold for action is 'reasonable concern', not certainty. This may lead to some families being involved in child protection processes as 'false positives'. There should be a proper understanding at the GMC that this unfortunate situation is a by product of an effective child protection system. There should be no language of the nature of 'false accusation' – this is equivalent to saying that a doctor is 'falsely accusing' a child of having leukaemia if requesting blood investigations that turn out to be simple anaemia. Certainly all families caught up in the child protection process should be treated courteously and honestly. However, the negative feelings the families perceive are not all down to the medical staff – but the Doctor is liable to be perceived as ultimately responsible (RCPCH 2009 Understanding Parents information needs and experiences where professional concerns re NAI were not substantiated)

Good practice indicates that consent for medical examination should be gained for S47 medical examination, but if withheld, there may be a place for greater use of child assessment orders.

More widespread appreciation of how to undertake and document Gillick competence would also be valuable.

### ***Relationships with parents, carers and the wider family***

Doctors must ensure that a child's safety and welfare is paramount and takes priority over other considerations. But they should also ensure that the child's family members are treated with dignity and respect, take account of the rights of family members, for example to make decisions about their lives and lifestyle, and provide additional support or help they may need.

**Q2. Do you agree with this? If possible, please provide examples of circumstances where a child's and family's needs and rights have been met and respected in the context of child protection proceedings, or occasions where they have been in conflict and how this conflict was managed by doctors.**

### **Q2 FJC Response**

Please see combined response below to 2 and 5

### ***Doctors working in partnership***

Doctors are expected to work as part of a team alongside other health professionals when they provide treatment and care to a child or young person. Doctors are expected to cooperate with other agencies, such as services for children and young people and the police, where abuse or neglect of a child or young person is suspected or known. Doctors may also be asked to work with colleagues when

giving evidence to a court, for example when the court asks experts for all the parties on a case to advise the court on issues on which they agree or disagree.

**Q3. What are your views or experiences about how well doctors work with other doctors, professionals and agencies, when there is the possibility of harm to a child?**

**Q3 FJC Response**

Whilst it is clearly essential for Doctors to work with other agencies in safeguarding children, there are huge conflicts of priority and logistic difficulties in achieving appropriate levels of interprofessional working, as the NHS is simply not resourced for medical staff to be able to attend all case conferences. Clear interprofessional protocols between medical and nursing staff exist and work well in many areas, but need to be clearly agreed, and the accountabilities made explicit, and quality assured on a regular basis. The information from Serious Case Reviews should be used more widely as a learning resource, as valuable practice lessons can be gained quickly if messages are shared locally in a timely manner.

Organisations must bear their responsibility on child protection systems, and Laming Audit scores should be examined in conjunction with any assessment of a practitioner's performance. The example of the tragedy of Baby Peter in Haringey set alongside the OFSTED report on Social Services and the problems identified in the management of Medical services to the area should have been reflected in the Laming self audit scores for the period, an organisational background that would be very likely to impact on the performance of individual professionals.

**Q4. In your experience, what factors help or hinder clarity about who has what roles and responsibilities to protect children and young people? This might include, for example, local working arrangements, and apply to doctors working in different areas of practice, or the way doctors work with other professionals.**

**Q4 FJC Response**

There is considerable variability in the skills and expertise of doctors in different types of child protection concern. The management of chronic fatigue or of concerns about FII is variable across areas. It would be helpful to the child protection process if there were clearer guidance on management of the range of conditions seen. Nevertheless, recognising that even where NICE guidelines exist there may be considerable individual variation in clinical presentation and local resources, leading to variation in views in different parts of the country. It would be helpful to establish clear processes for gaining second opinions in difficult cases, instigated by families or professionals. In FII, a doctor may find themselves 'out of their depth' and wish to seek professional support or advice. However this may lead to a complaint from a family that the child was being referred without consent, and confidentiality breached. Guidance should deal specifically with this scenario, and reinforce good

practice, honesty and openness with parents whilst acknowledging that some cases are very complex, difficult and worrying as the child may be at considerable risk. Recent GMC judgements (Dr Ikuekwe, Baby Peter Connolly's GP) indicate that failing to act on child abuse concerns may constitute professional misconduct, so adherence to the agreed interagency Working Together process should be seen as essential. Time and resources are needed for this, as is a clear understanding and training for all GMC assessors, FTP and IOP panellists.

### ***Doctors' knowledge skills and experience***

The GMC's guidance requires doctors to keep their knowledge and skills up to date, recognise and work within the limits of their competence, and consult and take advice from colleagues where appropriate. These requirements apply to doctors' clinical knowledge and skills and to other professional activities, for example acting as a professional or expert witness in the family court. All doctors have some role in protecting children, but some have additional, specialised knowledge and skills to undertake specific tasks in protecting children.

**Q5. What training and other support do doctors need to undertake their particular roles in child protection, for example, in preparing and training to give evidence to the family court? If possible, please provide examples where doctors are (or are not) receiving appropriate training or other support.**

### **Q2 and Q5 FJC Response:**

Good practice requires excellent communication skills at all stages of the process, from pre-proceedings to completion. The potential conflict of interests between the child and the parents means that it is often necessary to establish a hierarchy of interests, and the child's rights to protection may be prioritised over other rights to family life. This is often articulated clearly in a court judgement such as a finding of fact in a care case (for example, see the anonymised reports published on BAILII <http://www.bailii.org/ew/cases/EWCC/Fam/2010/9.html>). These reports now provide an important resource for learning and training, and are already being incorporated into Local Family Justice Council (LFJC) training pilot schemes. Interprofessional training opportunities are key to the development of appropriate levels of medico legal skills in doctors who may be able to assist the court (including Paediatricians, Psychiatrists, Emergency Medicine Doctors and GPs).

The FJC is currently working to support LFJCs (via training days, discussions and mini pupillages) in developing a network of medical specialists to promote this work and ensure a better supply of medico legal expertise throughout England and Wales.

### ***Other issues of interest***

**Q6. Is there anything else you would like us to consider when deciding the scope and content of guidance we give to doctors about child protection issues? For example:**

**a. the factors that affect doctors' readiness to raise concerns of suspected child abuse or neglect or to act as a professional or expert witness.**

**b. any gaps or issues lacking clarity in existing guidance available to doctors on child protection issues, from the GMC or other professional and government bodies.**

### **Q6 FJC Response**

Where, for example, a Local Authority seeks a care order, particularly with a plan for adoption, perhaps in relation to a child which has been injured, parental emotions, understandably, run high. In their distress they sometimes do make complaints about everyone involved in the case: lawyers, judges, social workers, Cafcass officers and medical experts. Most professional complaints bodies operate a "screening process" whereby complaints which are plainly ill-founded are promptly dismissed. The GMC does not. Its response to any complaint is to investigate it on the criterion that, 'if the case were proven it would constitute professional misconduct'. There is no requirement to establish even the most rudimentary prima facie case. That is a deeply unhelpful approach. Where, for example, a doctor's evidence has been wholly accepted by a competent court and a parent's version rejected, it simply should not be open to the parent to pursue a complaint against that doctor based on the same facts. The absence of protection for the practitioner from mischievous complaints, particularly in the specific situation of child protection, where the patient is the child, whose interests may diverge from the interests of the parent is astonishing to other professionals involved in the family justice system.

For the courts to reach timely and appropriate decisions in relation to vulnerable children, medical and, specifically, paediatric expertise is sometimes critical. The FJC has become increasingly concerned that suitably qualified medical practitioners are reluctant to engage in child protection work. One of the reasons repeatedly given for that reluctance is fear of complaint to the GMC.

FJC members have received numerous reports from Doctors who have been in this situation, and have found that a live complaint to the GMC, even if not progressing as far as a FTP hearing, has a massive effect on their current clinical practice, employment prospects, mental health and future professional record. Doctors report feeling shamed and professionally undermined by this, and that these highly aversive experiences are a significant influence on their future practice.

This needs to be addressed urgently by the GMC itself. The function of an effective regulatory system is to promote the desired end point, so if the process of quality assuring doctors fails to help children to be better protected, then some part of the process needs to change.

