Child Protection and the role of the Medical Profession

GMC Oral Evidence Sessions held in January 2011
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Introduction

The GMC’s Working Group on Child Protection was set up in July 2010 to gather evidence about doctors’ roles and responsibilities in child protection work and to make recommendations about updating the guidance the GMC provides for doctors on child protection issues. The new guidance should help doctors to understand and apply the standards of professional conduct and performance expected of them when they work in this complex and challenging area.

The GMC has undertaken an evidence gathering process to help inform the drafting of the new guidance. The work started with a call for written evidence, which ran from July to September 2010, and is supplemented by information from oral evidence sessions, informal meetings and commissioned reports. Ipsos MORI was commissioned by the GMC to carry out an analysis of the oral evidence based on the transcripts made of each session. This report sets out the findings from that process.

The views reported here reflect the comments and opinions of those who gave oral evidence. They do not represent the views of the GMC or Ipsos MORI.

Background

The GMC held 24 oral evidence sessions to explore with key individuals and organisations the important issues and themes that emerged from the written call for evidence.

The evidence sessions took place on 11-13th January 2011 and 25-27th January 2011. The sessions were held in private, in order to encourage candour on sensitive topics and to provide a level of privacy for those participating as individuals. The sessions were facilitated by three panellists - at least one medical and one lay – all members of the Working Group on Child Protection. The panel heard from 37 organisations and 13 individuals including members of the public, individual doctors and a psychologist. A full list of the organisations that attended an evidence session is set out in Appendix A. Questions for the sessions were framed around 10 core questions (Appendix B), modified as appropriate to reflect the interests of those attending. A verbatim record of the discussion at each session was made and transcribed for the purpose of analysis. As the sessions were not open to the public, this report does not name any individuals who gave evidence.

Analysis method

In order to produce this report a systematic analysis of the transcripts took place to ensure that the data was fully mined and explored from multiple perspectives. Four researchers split the transcripts between them and each transcript was searched on key words and phrases, and relevant information coded in relation to the key themes and questions agreed with the GMC.
The coded information was then drawn from each transcript and put into a pre-designed and pre-agreed spreadsheet under the key chapter headings, putting all the relevant information in each section. This information was then drawn together to create the first draft of the report.

Once the shape of the report was agreed, transcripts were then reviewed further by different members of the project team to mine the data for clearer views on which key points and arguments were held by whom, and to identify any potential areas of disagreement between categories of participant. The final report does not attempt to include every comment but rather to reflect the key points and arguments made. It includes points made by only one or two individuals where these seem important to the subject being explored. Verbatim comments were selected to represent different points of view, and we have tried to indicate throughout this report the strength with which those views are held.
Executive Summary
Executive summary

Where child abuse or neglect is a concern, tackling these concerns can be challenging, emotionally distressing and complicated by uncertainty. This is true for doctors, children and their parents or carers and others involved in the child protection process. Doctors face a number of challenges, from the initial stages of identifying risk to a child; later decisions about sharing information with other agencies; and the procedures involved when a case goes to court.

Factors supporting or discouraging engagement with child protection

There are a number of factors which may discourage some doctors from engaging with child protection processes, but there are also factors that weigh in favour of doctors involvement, and a range of support and advice available (or that might be put in place) to help doctors play an effective role.

The challenges identified include:

- Understanding the risk factors and recognising the signs that suggest a child or young person has suffered or may be at risk of abuse or neglect.

- Knowing when and with whom confidential information should be shared, especially in situations where there is uncertainty about whether it is reasonable to suspect abuse or neglect or there are only ‘niggling concerns’.

- The risk of being complained about (to their employer, the GMC or the courts) and of being made the focus of media criticism.

- The additional demands placed on doctors’ time and resources by the need for longer term involvement in a case, including case conferences, court proceedings and case reviews.

There are a range of factors identified as supportive of doctors’ involvement:

- Agreement across all groups that doctors play a key role in protecting children and young people from abuse and neglect and should have access to advice that supports them to meet these responsibilities.

- Many of those commenting consider that through regular attendance at child protection courses, doctors will have the knowledge and skill to be proactive in identifying children and young people who may be in need of protection; to work effectively with local agencies; and to be able to handle difficult conversations with the parents or carers of a child where abuse or neglect is suspected.

- There is a general view that, prompt access to clear advice and support, from the earliest stage when a concern arises about possible abuse or neglect, is a key factor in helping doctors to reach a view about individual cases and make sound decisions about what should be shared with other agencies.

- There is general recognition that guidance from the GMC and others does not require
doctors to be absolutely certain before sharing their concerns and referring a case to child protection colleagues.

- All professionals acknowledge the need for more flexible ways of working that take account of the demands that involvement in child protection case conferences, reviews and court cases place on GPs and other doctors.

**Working with the whole family**

- All groups consider that doctors who work with families can play a key role in safeguarding vulnerable children, as well as protecting them from abuse or neglect.

- It is generally recognised that doctors who work with families can face competing priorities between the interests of family members, which is a particular challenge for GPs who do not wish to compromise their relationship with a child’s family. But it is also agreed that children’s interests must be given priority where abuse or neglect is an issue.

- There is a view across all groups that open, honest, clear communication with a child’s parent/carers from the outset when child protection concerns arise, and working to maintain the relationship as the process continues, can help to reduce the distress and mistrust that parents/carers might feel.

- A number of areas are flagged where doctors’ communication skills could be improved, to help parents understand better what is being done and why and what support may be available to them. This includes improving ‘cultural competency’ so doctors are better placed to meet the needs of families and children in those groups often identified as ‘hard to reach’, such as traveller communities and asylum seekers.

- Some medical professionals and family rights groups raise a question about how doctors can best deal with situations where a parent or carer refuses consent to an examination of a child or a young person refuses consent to a forensic examination. There is broad agreement that in seeking consent it is important that there is clear, open communication about what will be done and why; what might follow as a result; and discussion about the views or concerns of the parent/carer, the child or young person. Guidelines and training can be helpful in handling cases where questions arise about whether a young person is competent to refusing, particularly if seeking consent from those who have communication or learning difficulties.

- Many professionals identify adults who have problems with mental health, substance abuse or domestic violence as patient groups where there is a strong link with child maltreatment, but where the risks may not be identified or shared at an early enough stage. Doctors working with these groups of patients may need access to informal advice and support, as well as some reassurance that raising a concern about their adult patient need not inevitably lead to child protection proceedings.

**Inter-agency working and information sharing**

- The importance of constructive interagency working is acknowledged by almost all participants. It is seen as a key factor in helping to clarify concerns; make sound judgements about referring individual cases; and providing reassurance that sharing concerns does not lead inevitably to child protection proceedings.
All agree that doctors play a crucial role in child protection cases, and can bring a unique perspective where they have a close relationship with the family. But they also feel that it can be difficult to engage doctors in the more time consuming and complex inter-agency work, such as case conferences and court proceedings.

There is agreement across the board that if there is a concern about potential risk to a child or young person the default position should be to share information - there would have to be a strong reason not to do so. However, it is widely believed that threshold levels for information sharing vary amongst professionals.

A key challenge for doctors is obtaining consent to share information. Parents and carers have very different assumptions about how confidential information might be shared, and doctors may be concerned about damaging their relationship with family members. Family rights, legal and medical professionals stress the importance of doctors being clear, explicit and open about why they are seeking consent and how the information will be used. On the whole participants felt that parents/carers want information to be shared between agencies so they can get the help they need.

In the case of children, advocacy organisations say that children and young people are very protective of their rights to confidentiality. However they accept the idea of information sharing when it is necessary to protect them from significant harm or provide them with a significant health or other benefit.

**Training and support**

- The role of training is described as vital by almost all participants, and whilst there is felt to be plenty on offer from a variety of sources, some describe the quality as variable and others describe the need for doctors to be more proactive in accessing what is available and keeping themselves up to date.

- Most participants take the view that doctors should see child protection training as a basic requirement to practice effectively, starting at undergraduate level and going on throughout their career. Training also needs to be tailored to the needs of particular specialties; and more and better quality training is needed to support doctors who act as expert witnesses.

- There is a great deal of support and advice available from designated doctors, informal networks, and the help-lines of medical defence bodies and professional associations. The designated doctor role was highlighted as particularly valuable in providing an opportunity to talk things through and alleviating doctors’ concern that asking for advice might lead to unnecessary escalation of a case.

- Some social workers suggest that ‘outreach’ work with local doctors can help to build doctors’ confidence to be more proactive, but outreach is not a requirement of their role. Doctors suggest that local peer review of cases is another way of building confidence about their approach to child protection decisions.

**Suggestions for guidance**

- Medical participants say that there is a wide range of good guidance available from a number of sources, and there are many positive comments from all professionals about the clarity of existing GMC guidance where the confidentiality issues are said to
be dealt with effectively.

- Some professionals from a range of fields suggest there is too much guidance and question whether doctors are following it; rather than more guidance the need may be for synthesis and distillation of current guidance to make it more accessible.

- Some participants feel there is a lack of clarity amongst professionals involved in child protection about each others’ roles and remit and it might be helpful to refer to these roles within the guidance.

- A number of participants suggest case studies as a useful tool to support the guidance, and raise the possibility of developing more tailored (complementary) guidance for particular professionals.

- A number of specific suggestions for GMC guidance content are described in this chapter. But there is also acknowledgement that the guidance cannot, and should not try to deal with everything in one place.
1. Factors supporting or discouraging engagement with child protection
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Overview

Where child abuse or neglect is a concern, tackling these concerns can be challenging, emotionally distressing and complicated by uncertainty. These and other factors may discourage some doctors from engaging with child protection processes, but there are also factors that weigh in favour of doctors involvement, and a range of support and advice available to them. The challenges identified include:

- Understanding the risk factors and recognising the signs that suggest a child or young person has suffered or may be at risk of abuse or neglect. Some doctors, particularly GPs, may not have much exposure to cases of children and young people who are at risk of abuse or neglect and may be less knowledgeable about what are seen as potential warning signs. Doctors may be over- or under-reporting potential cases of abuse or neglect, where they do not have up-to-date training or information about safeguarding practice.

- Knowing when and with whom confidential information should be shared, especially in situations where there is uncertainty about whether it is reasonable to suspect abuse or neglect or there are only 'niggling concerns'. There is a perception that different professionals (medical, police, social care) have different interpretations of when confidential information should be shared. Some doctors may be hesitant about sharing information outside the healthcare team at an early stage because they fear that this might quickly and unintentionally escalate into formal child protection procedures. In some cases there may be a lack of clarity about the roles that doctors and other practitioners are expected to play in child protection cases.

- The risk of being complained about (to their employer, the GMC or the courts) and being made the focus of media criticism. For some doctors, the risk of professional repercussions from pursuing child protection concerns may discourage them from taking a proactive approach.

- The additional demands placed on doctors’ time and resources by longer term involvement in a child protection case. GPs in particular may find it difficult to attend case conferences or serious case reviews held at short notice or in surgery time. Doctors called on to act as a witness in a court case may not have enough knowledge about court proceedings and the different roles of ‘expert witness’ and ‘witness of fact’.

There are many supportive factors:

- Agreement across all groups that doctors play a key role in protecting children and young people from abuse and neglect. It is thought that they can bring an important perspective about other family members, and a proactive approach on their part can help to lower the risk to a particular child or young person.

- Many of those commenting consider that where doctors keep up to date by attending child protection courses they will have the knowledge and skill to be proactive in identifying children and young people who may be in need of protection. They will be
better placed to work effectively with local agencies, and they will develop their ability to manage conversations with a child's parents and carers in a way that reduces the risk of later complaints.

- There is a general view that, prompt access to clear advice and support, from the earliest stage when a concern arises about possible abuse or neglect, is a key factor in helping doctors to reach a view about individual cases and make decisions about what should be shared with other agencies. The availability of local designated doctors is highlighted as a key source of help and advice, and many report positive feedback about the benefits of their role.

- There is general recognition that guidance from the GMC and others does not require doctors to be absolutely certain before sharing their concerns and referring a case to child protection colleagues. The guidance is seen as reassuring about ‘good faith’ disclosure of concerns which are not later substantiated (although some consider that more should be done to address concerns about professional repercussions).

- All professionals acknowledge the need to take account of the demands that involvement in child protection case conferences, reviews and court cases place on GPs and other doctors. They are generally sympathetic to any proposals for improving doctors’ capacity and availability to carry out this work.
1.1 What supports or discourages engagement?

‘Engagement’ with child protection for doctors happens on a number of levels, each with its own barriers and encouragements for involvement, from taking the decision to have an informal preliminary discussion with other professionals about a case, through to making a referral and subsequently engaging with social work and perhaps court proceedings.

It is most helpful if we approach this in terms of where doctors currently say they face, or are felt to face barriers to taking action at these different levels, a number of which are picked up in the remaining chapters of this report, and at the same time look at how these may be overcome, as these suggestions often also represent ways of encouraging greater doctor involvement.

It should also be noted that underpinning many of these barriers are some common themes. Lack of time and resources, lack of skills and experience, lack (or perceived lack) of support, varied interpretations of responsibilities, and fear of professional repercussions are cited by practitioners across all organisations – not just the medical profession - and are picked up throughout this report, providing a backdrop to some of the more specific challenges discussed here.

At the simplest level, some in the social work and medical profession believe that doctors can sometimes be unsure whether their initial opinion that a child is at risk is valid or that their level of concern is enough that they should be able to share informally information about that case, which can sometimes lead to them keeping concerns to themselves.

“When doctors make the decision to do anything which is going to raise confidentiality because they may be concerned, they have already taken a very very wide step because we are drilled in believing parents.” (Medical Representative)

The importance of informal networks is discussed in more detail in Interagency Working but the strength of these networks of professionals in the child protection field is cited by almost all professionals as a source of great support when doctors have concerns but are merely uncertain, and unwilling to start any formal proceedings.

“We see networks as generally useful for delivering high quality care for children...this is about how you develop support for professionals, increasing expertise, and people sharing information and working together is always good for that” (Government body)

A few participants from a social work or other non-medical background mention the fact that GPs in particular may often not have had much exposure to children and young people at risk, and are therefore not so easily able to identify some of the triggers and indicators of child abuse and neglect, which might warrant further discussion, for example non-attendance at clinic or not being available for home visits.

“GPs knowledge, experience and competency in identifying and reporting child protection concerns is variable...others say that (some GPs) have very little awareness of child protection issues or maybe even direct work with children” (Social Services)

“...when people do not attend appointments, like this particular family, they are not chased up and there is an assumption that maybe the family do not need the service any more, or if you do not attend for three appointments you are bumped off the
waiting list. Often these are the families that need the service the most and should be chased more” (Regulatory body)

The importance of doctors keeping up to date with safeguarding practice and familiarity with the literature around this is cited by almost all professionals, and is discussed in more detail in the chapters on training and guidance.

“All practitioners should be supported and people work together...to identify the triggers and indicators that would support active intervention or some further action” (Nursing organisation)

The balance between maintaining patient confidentiality and sharing information is mentioned by almost all participants across the professions, and there is no doubt that there is consensus on the view that if sharing information is in the best interests of a child then that is where the balance should lie. However, doctors may not be clear about when and with whom information may be shared and this can create a number of challenges. For example family rights organisations express the view that doctors need to exercise discretion and only share the appropriate amount of relevant information, particularly with a third party, say a social worker asking for greater disclosure. There is some feeling amongst the medical profession that differing interpretations of when information should be shared and past experiences with third parties can often cloud the handling of cases.

"GPs would be put off by one or two bad experiences. They may make a referral and not feel that it is well received, which goes back again to skills and competencies and confidence" (Government body)

The importance of advice and support at this stage of early concern is stressed by medical professionals and those who represent them. Medical defence unions cite the importance of their role in directing doctors with initial concerns to the appropriate guidance, information and if necessary further support.

Almost all clinical professionals consider that being able to engage with designated doctors is very encouraging as they are felt to be a strong point of support and expert advice at the pre referral stage. Equally designated doctors report that they have had positive feedback about the benefits of their role. They provide a counter to the perception held amongst some doctors that they will be setting in motion a train of events the conclusion of which is uncertain.

"It is very helpful [being advised to report to a designated doctor within health] because it is within your culture, it is within your comfort zone rather than something you feel is automatically going to get taken out of your hands and snowball and there is this big black hole.” (Medical Representative)

However even amongst some health professionals there is a feeling that raising concerns just to other healthcare professionals limits the sharing of information that may be very useful at the preliminary stage. Doctors and social workers express worry that keeping concerns within the profession may preclude doctors from potentially valuable data sharing with police and social services, and overall, almost all professionals agree that sharing relevant information is paramount.

"Whether we consider a preliminary discussion within health, that already happens, but always at the back of my mind is you are not going to know what social services may have on the family, what the police may have in terms of domestic violence call
Whilst there is general agreement about the importance of sharing information with other agencies, some doctors report the fear that once a child protection issue has been reported out of the profession there can be an escalation of the process, and police and social services quickly become involved. In some cases the view amongst a small number of doctors – notably those with direct experience - is that there is no chance to discuss these issues with interagency colleagues without setting off a whole chain of events with perhaps unintended consequences; this could to some degree be countered by greater shared understanding and interpretations between the agencies of how and when information can be used.

"Some colleagues have told me that once they start going outside health, they find it difficult to 'stop the juggernaut.'" (Medical Representative)

At this level of reporting concerns on an official basis, almost all medical professionals mention on some level the need for them to feel confident that they can raise child protection issues without fear of professional repercussions; challenges described range from irate parents, to wrongful accusation of malpractice and, at the extreme end, the fear cited by a small number of individual medical practitioners, one or two with direct experience, of being reported to or investigated by the GMC.

"If you have concern about child protection matters then there are going to be occasions when your concerns are ultimately not borne out as a result of a multi-agency investigation. We do not want to see doctors who have reported things and then are complained about by parents to end up being subject to repeat investigations and hearings with a threat to their registration, careers, livelihoods because this is not helpful." (Medical Representative)

“One of our members felt there was some concern from GPs that there had been some well-publicised cases with people referring to their practitioners and saying they had broken confidentiality, and because hearings too quite a long time and looking at their own professional position that sometimes made people more cautious” (Children’s Advocate)

This represents the worst case scenario for doctors. Paediatricians with strategic national and local level involvement in child protection, say that there is a perception among some doctors (perhaps partly due to high profile cases in the courts and at the GMC) that becoming involved in child protection cases can sometimes lead to high profile professional damage, as the public often has an automatic instinct to blame professionals without question if something goes wrong.

“The public somehow adopts an all-or-nothing swing to blaming professionals for when things go wrong but, as those of you who are experts in the field know, as do the Panel, safeguarding concerns are all too common, though fortunately child deaths remain relatively rare, although always very high profile, and there are things we can learn from them” (Government body)

“...there is a kind of professional anxiety behind which some practitioners may hide, inspired perhaps by the fear of legal action, perhaps the fear of uncomfortable scrutiny from professional bodies or within the courts” (Police body)
In relation to professional and legal repercussions, it is agreed across the medical profession that doctors need to feel confident in the decision they are making (either to share information or to refer a case) and that they have clear guidelines and support; this is partly an issue of doctors themselves being aware of their own roles and responsibilities and a couple of medical organisations make the point that the information and guidance is there, but that doctors need to ensure their own familiarity with it.

All health professionals agree that there is no requirement for absolute certainty on the part of doctors before reporting a concern – one organisation expressed the view that if 100% certainty were required, nothing would ever be reported - and it is seen as helpful that the GMC is quite clear on the duty on doctors to raise reasonable concerns. This helps to allay doctors fears of being complained about for potential ‘over reporting’ – erring on the side of referring a child where there are concerns but no clear evidence.

“You do not have to be right. In fact, the GMC does not require you to make that diagnosis and that is helpful. I also reassure people that just because you have picked up the phone and made a referral it does not mean that the child is going to be taken away because it is the interagency discussion that decides.” (Medical Representative)

A few participants point out however, that for some doctors there may be an unwillingness to potentially put themselves in the position of not being right – which in turn will affect the level of their engagement - and this may partly reflect a lack of clarity about the roles that various practitioners and indeed they themselves may be expected to play in child protection cases.

“The lack of GPs availability…is a common theme that comes up….it was felt that there is something about status…but that is an issue for us when it comes to holding our own and challenging other professionals” (Social Services)

“Often doctors do not like saying that they do not know, and therefore they get drawn into areas that perhaps they should not be commenting on” (Medical College/Specialist Group)

Whilst a small number of doctors may have concerns about over reporting, and indeed a small number of representatives of families who have first hand experience also express this concern, the view amongst many professionals from a medical background is that there is more to be feared from under reporting, and doctors must feel able to voice concerns knowing that they will be professionally supported.

“I appreciate damage can be done by over-reporting or overacting, but I encourage other doctors to seek my advice, particularly if they were thinking of doing nothing” (Medical College/Specialist Group)

“We know that there is a huge amount of under reporting there. I think if we did our jobs better, there would be more children in the child protection system. In a way, there is a kind of created tension here between the objectives of the social care system to prevent it and, if the whole system works better, the objectives of doctors and the GMC actually ought to be the other way, to identify more children.” (Medical Representative)

Paediatricians expressing a view suggest that The GMC needs to provide that reassurance, although it is also recognised by them and others that the range of existing guidance in this area including that of the GMC is felt to be good.
"I think the guidance that has been produced by the College, by the GMC and by the chief medical officers over the last ten years has been hugely helpful" (Medical Representative)

"I think that doctors need that level of reassurance from the GMC that if they are genuinely concerned and their concern is not unreasonable, that they have nothing to fear." (Medical Representative)

"Very often it is a matter of reassuring doctors that the action that they are about to take or have taken is consistent with GMC guidance and other guidance." (Medical Representative)

There are also challenges when doctors are asked to become involved in more longstanding processes, such as attending case conferences, review meetings and court proceedings, which require time and resources to facilitate. All professionals acknowledge the demands placed on doctors' time, particularly if taking them away from seeing patients.

"If you are invited to a meeting that is going to last two hours at very short notice, and you have a full surgery and a lot of demands – and we must remember that demands have gone up in primary as well as secondary care – then thinking ‘do I go?’ is something people do" (Government body)

"We have to accept the fact that if there are a small number of paediatric radiologists in a centre they have a lot of demand for their NHS work alongside the request for them to be an expert witness"

Despite this, many professionals are of the view that doctors need to be more encouraged to participate in child protection conferences. The ensuing need for perhaps locum doctors and further administration is recognised certainly by the legal profession as difficult for GPs in particular. However, senior medical professionals with a child protection remit express the view that these things should be considered by doctors as part of their job. The provision of guidance and further training is cited by almost all organisations in terms of clarifying doctors' obligations.

Guidance and training is also important to doctors who are asked to become involved in court proceedings as an expert or professional witness. Many respondents cite the crucial role that doctors can play but there is some comment from the legal and medical professions that many don't have the skills or experience to know what is expected of them.

"How do we make it clearer to them that there is an expectation that you should be able to write a good factual report …there is anxiety about what going to court might mean and be about" (Government body)

This is also covered in the chapter on Training but the issue is mentioned mainly from the perspective of doctors being aware of their own limitations in court, and not stepping into ground that they are not confident with.

The term 'expert witness' itself is described by one medical professional as sometimes inappropriate as not everyone is actually an expert, and this expectation can be off-putting. Also, experts can be brought in from outside the UK and be under no regulation; this suggests there needs to be more detailed suggestions of what competencies an expert witness needs.

"The GMC needs to be clear what kind of experts you are regulating and what the
minimum standards are" (Medical Representative)

These challenges have led to a perceived dearth of expert witness, particularly by the legal profession, and it is described by many across the legal and medical professions as important that training and clear guidance again can help here in terms of developing the right skills and providing advice and support.

Notwithstanding all of the above, one or two respondents point out that the whole field of child protection work is often in itself very unappealing.

“This is unpleasant work, it’s emotionally challenging, the rewards are elusive and uneven...it is difficult, unpopular and unpalatable work.” (Police body)

1.2 Managing risk

Managing risk occurs in two areas; managing risk to a child or young person, and managing professional risk.

With regard to managing risk to children and young people, there is a need for care both ways, acknowledged by all professionals, for doctors to be proactive but also to consider the implications of in particular sharing information; whilst there are naturally concerns about missing the signals which may indicate child abuse or neglect, there is an equal problem of potentially being oversensitive to what may or may not be indicators, and alleging or reporting abuse or neglect where there is in fact none. However, without exception professionals in all fields agree that the risk of harm to a child or young person must outweigh any other. The clear point here again is the very fine balancing act that must be performed, reflected in discussion with the range of organisations.

"Whilst we have seen the effects of failure to either recognise these conditions [child abuse / neglect] or deal appropriately in the timely fashion with them, we have also seen the ill effects which could be considered no less severe when over-assiduous or an appropriately low threshold of suspicion is issues of child neglect has occurred." (Government body)

The unique contribution of GPs to protecting children and young people from abuse and neglect is highlighted in particular by those with a social work or family rights background. They often know other family members in a particular case, not just the child and this contact on an ongoing basis can bring a useful perspective in assessing risk.

“They do have a long history (with the family). Often they have known them for a long time and they can talk about the strengths as well as the issue that has led to the inquiry” (Parent/carer/patient advocate)

Proactiveness and early intervention by being able to identify potential signs are described as being important in helping families where children or young people are being abused or neglected; there is also a feeling amongst health and social work professionals that greater proactiveness on behalf of doctors more generally can lower the risk of abuse taking place in the first instance, and that early interventions when problems have been identified is the best way to prevent escalation. This view is echoed by those who do outreach work within communities.

"The best way to work with families is when there is a low level risk and you do not want statutory services to intervene". (Nursing organisation)
This can be summed up by this description of the weighing up of the balance between risk to the child and the risk of bringing families into the child protection arena incorrectly.

“I think the risk to the child is that if we miss things, of continued significant abuse and harm... often we cannot assess what the risks are until we have done the examination. Unfortunately that means that some people in families will be sucked into the child protection arena when there is no problem.” (Medical College/Specialist Group)

This touches on a proposition that has been made in the current Munro review, that the fewer families in the child protection system the better. This is mentioned in about a third of the evidence sessions, mainly by medical professionals, and there are two responses to this suggestion. Some medical professionals interpret this as meaning that early interventions are more effective and would lead to fewer referrals into the child protection process. The majority of those expressing a view, however, felt that this could be interpreted as proposing higher thresholds for identifying risk to children or young people that would warrant referral, and express concern that this would present challenges for doctors in assessing risk.

There is also the opinion from a member of the legal profession that risk to the child or young person is rarely a consideration by the time matters are within the criminal justice process, as it then becomes about looking at past events rather than the future. However, during the sentencing process where doctors are involved, there are considerations around the Mental Health Act, or other general considerations around a defendants health, how a sentence will affect them, or how a child may be affected by the imprisonment of a parent which should be factored in when considering risk.

"It is important that where a doctor’s opinion as to future risk may be determinative of the sentence and has great reliance placed on it by a judge, it should not be made in ignorance of the judge’s criteria that he has to impose under the sentencing provisions - they are a minefield in terms of assessment of risk..." (Legal body)

Professional risk is also cited by participants in all professions as a potential concern for doctors, from dealing with accusations by parents of over-reporting or malpractice and dealing with a complaint to their employer or the GMC. It is suggested that this may be an area where training and guidance can be effective in helping doctors manage the risk.

A medical representative body raised questions about situations where parental consent to examine a child or young person is not given person and how to proceed in these cases. For example, if a doctor suspects that a child might be in physical danger, but the parent refuses consent, then the child cannot be examined without the doctor laying him or herself open to a charge of assault. This should be considered in relation to the view of most professionals that doctors need to be clear that they should err on the side of acting when they are balancing out the risk to the child or young person against their own professional risk.

"My experience has been that the bulk of complaints about doctors has been over exposure of potential children at risk. We would certainly always encourage doctors to err on the side of taking the risk of being complained about as opposed to not declaring a child to be at risk” (Medical Representative)

“We say 'you do not have to be 100% sure, if you have a worry pass it on and let other people make the joint decision with you” (Social Services)
On a broader level, and discussed in more detail in Working with the whole family, is the issue of how the relationship and communication with the family can have an impact on how any intervention is perceived, and therefore also the risk of complaint. The importance of clear and open communication with families is cited across the board as key to avoiding potential conflict. There is concern that the focus on over reporting is just conscientiousness on the part of doctors that may be perceived as over reporting because of the way that the doctor handles the issue with the family. If communications are not handled sensitively and appropriately parents and carers can become defensive and potentially uncooperative.

"I wonder whether some of what is perceived as over reporting is actually appropriate raising of a concern which perhaps has not been dealt with in a sensitive way with this family." (Medical Representative)
2. Working with the whole family
2. Working with the whole family

Overview

All groups consider that doctors who work with families can play a key role in safeguarding vulnerable children, as well as protecting them from abuse or neglect. For example, for children who are looked-after by people other than their parents their doctor may be the most stable relationship that they have with a professional and may be in a position to identify risks to the child at an early stage.

It is generally recognised that doctors who work with families can face competing priorities between the interests of family members, particularly GPs who do not wish to compromise their relationship with a child’s family. But it is also agreed that children’s interests must be given priority when abuse or neglect is an issue, even where this might impact on the therapeutic relationship a doctor has with an adult patient.

There is a view across all groups that open, honest, clear communication with a child’s parent/carers from the outset when child protection concerns arise, and working to maintain the relationship as the process continues, can help to reduce the distress and mistrust that parents/carers might feel. This is particularly stressed by family rights groups who say that parents lose trust in doctors where they feel they are being kept in the dark, or given too short notice, and have no control over what seems like a ‘roller coaster’ process.

A number of areas are flagged where doctors’ communication with family members could be improved. From the perspective of individuals who have experienced the child protection process, doctors need to bear in mind that, for example, parents and carers may not understand the terminology being used, and they will need advice about where they can go to get help. Doctors need to keep an open mind about parent’s explanations, and when a case is ‘closed’ to make sure the parents/carers are informed and feel that they will continue to be supported. On the other hand, some medical and social work participants stress the importance of doctors being willing to adopt a position of ‘respectful cynicism’ and dig deeper when considering the explanations given by parents/carers.

All groups highlight the need for doctors to improve their ‘cultural competency’ to understand how cultural factors can impact on communication and the particular needs of families and children in groups often identified as ‘hard to reach’, for example some ethnic minorities, traveller communities and asylum seekers.

Some participants raise concerns about situations where a doctor needs consent to examine a child or young person, but the parent/carer refuses. Medical professionals are also concerned about cases where a young person refuses a forensic examination. Almost all participants agree that clear, open communication about the nature and purpose of an examination and how the findings might be used, and taking account of the parent/carer or young person’s views, can be helpful in gaining consent and reducing the scope for conflict.

Some professionals identify adults who have problems with mental health, substance abuse or domestic violence as patient groups where there is a strong link with child maltreatment, but where the risks may not be identified or shared at an early enough stage. This may be because their doctors may not be thinking about the wider implications for safeguarding and protecting children, or they may be uncertain about the point at which the interests of their adult patient is outweighed by the need to protect the interests of the child.
2.1 Working with the whole family

It is acknowledged across the board that doctors generally, but GPs in particular can be faced with difficulty when managing competing priorities whilst working with the whole family:

"As paediatricians we are very clear that the child is our patient, but it is almost easier for us. For GPs they have the whole family and sometimes they cannot have thought through clearly "The child is my patient, my responsibility and that is what I have to do". (Government body)

It is broadly acknowledged by all participants that children's rights must be given priority, even when there is a danger that this might interfere with the doctors’ therapeutic relationship with an adult patient; it is clear that GPs do not wish to compromise their relationship with family members and indeed the lynchpin role that doctors can have precisely because of these wider relationships is cited by many professionals in positive terms.

“GPs are often the first port of call for families and their role amongst doctors and paediatricians is extremely crucial” (Regulatory body)

All participants express the importance of honest and clear communication with families from the outset, whether that is being open about concerns that a young patient is themselves at risk, or that there is a potential risk to a child from a patient; doctors need to be able to see the bigger picture and their role within families can enable this.

It is a broad view across professionals that working in partnership with parents and carers can often mitigate distress to families when child protection concerns are raised. Indeed this call from a family rights group reflects the widely cited need for greater openness and transparency between doctors and parents or carers as soon as there are child protection concerns, even if this might upset or anger them.

"As soon as things start happening behind closed doors/people are whispering/papers are shoved away when parents are present. That is when the distrust starts and the whole thing spirals out of control." (Parent/carer/patient advocate)

Doctors are often reliant on parents and carers to tell them what is wrong with children, particularly very young children, so good communication is paramount. However, some participants with a social work and medical background felt that doctors can often be too reliant on what parents and carers say, and are more likely than some other professionals to take what they say at face value when perhaps they should dig more deeply.

"Unlike social workers who deal with child protection day in day out, the majority of people who come to see a doctor are telling the truth about what has happened and doctors rely on parents to tell them the truth...It is harder for doctors to have that respectful cynicism that you may need in order to identify when somebody is being truthful and to question" (Regulatory body)

However family rights groups and the few individual participants with first hand experience state the counter need for parents’ explanations to be recognised in cases where there may be an alternative diagnosis. These same organisations express the view that an unwillingness or inability to tell whether parents are telling the truth can sometimes lead to presumption of guilt. This was particularly referred to by two participants in the case of alternative rare genetic diagnoses that can be perhaps misunderstood or dismissed by doctors.
Parents and family rights organisations mention the need for families to find closure once cases are finished, and this again highlights the need for doctors to keep up good communication with families and demonstrate their maintained interest.

“Families can be left in the lurch and do not know if it is finished; what is happening...if doctors can give closure in cases where this is appropriate that truly is beneficial but there are so many cases where people are left in fear” (Parent/carer/patient advocate)

In particular it is suggested that this lack of closure and feeling of being left in the dark can prevent families from engaging with professionals in the future.

Another challenge is in working with those families who are often identified as hard to reach. This is mentioned by parent/carer advocates, those in the medical profession with experience in the field, and some from a social work background who also cite the need to consider the ethnic or cultural background of families.

These representatives express the view that for some doctors there may be issues around cultural awareness, cultural norms and so on, which may impact on communication, issues around understanding and consent, or understanding what concerns are being expressed and why. One participant cites this as an issue for traveller communities while a few more discuss this in relation to families from an ethnic minority background or those seeking asylum.

“Often it is said by members of the communities the way they are perceived when they take their children to A&E, for example, is often different to the way if someone from the dominant community attends A&E” (Children’s Advocate)

According to research done by one charity, for example, some GPs apparently do not know what BME stands for. This can be a problem with the terminology itself but this also highlights the need to look at the issue of ‘cultural competency’ and cultural awareness training, an issue which is raised by many of those working in family and child support roles.

“Often there is a reliance on one or two specific individuals within the healthcare team who have access” (Children’s Advocate)

A few respondents from a family rights perspective suggest that there is a "roller coaster phenomenon" once a concern that a child may have been abused or neglected has been raised, if doctors start off with the assumption that parents or carers are guilty.

"Once xx came into A&E a senior house officer diagnosed he was 98% certain that [xx] had been shaken without having examined [xx]. He had not performed a neurological examination but once that label had been applied it became a juggernaut out of control" (Parent/carer/patient advocate)

They also explained that when parents and carers are involved in child protection procedures they are not always able to understand the process or what will happen next, and can sometimes feel "ambushed" with an allegation.

“So what they said was "Well if you do not mind, we will just take some observations..." I did not understand within that setting that they were actually saying that they had serious concerns, that they had already referred the case to Social Services, that they had contacted the police.”
"Parents are ambushed ... on a Friday afternoon and told that, for example the court hearing will be on Monday, so essentially they have a weekend to find legal defence" (Parent/carer/patient advocate)

A small number of respondents in this context also highlight the need for doctors to be aware of, and able to signpost parents to, places where they can go for support, or help-lines that they can call if they find themselves in such a situation.

One educational body said it is important, in situations where there is likely to be conflict, that doctors as well as patients are supported, and this view is reflected generally across health professionals.

"Some practitioners, not just doctors, find it extremely difficult to deal with conflict and part of that is about training, both as individual professionals, but also as a multi-disciplinary team....a team working to provide support to the child and the family so that no one individual professional can be 'singled out' for potential targeting." (Nursing body)

Overall the view amongst most participants across all areas is that the best interests of the child should always prevail, and training and guidance can help doctors with how they might override an adult patient's right to confidentiality in circumstances where a child or young person is at risk whilst at the same time avoiding causing distress to family members, and balancing concerns that families may make a complaint against them if they do take action to protect a child.

"If one is guided by the possibility that one is going to upset the parents and possibly be subject to a complaint by the parent, that actually is not necessarily going to be in the best interests of the child …GPs and a lot of paediatricians always worry about damaging their relationship with the family" (Medical Representative)

Another difficult area raised by a children’s advocacy organisation is in relation to safeguarding children who are looked-after by people other than their parents or carers. It is pointed out that these children and young people often have a range of changing professionals in their lives and doctors can often be the most stable relationship they have with a professional. It is also described as important, by a medical representative body, that extra safeguards and checks are put in place by doctors when children or young people in care are considered to be at risk.

“...children in care are likely to have experienced a number of different placements, different moves, changes of social worker, changes of school...and breaks in continuity which can also be breaks in records” (Children’s Advocate)

“You very quickly get into the question of who is the (child’s) representative…children regularly raise problems of decisions being referred back...because a foster carer or member of staff feels they are too small a cog...to make decisions on behalf of a looked-after child, they feel they have to go to a social worker, and the more urgent the decision the bigger it is, and the more people start to get involved” (Children’s Advocate)
2.2 Safeguarding children whilst working with adult patients

A small number of examples are cited of cases where a doctor needs to gain consent from a parent or carer to examine a child or young person, and they have not willingly given it. This is discussed in the context of open and clear communications between doctors and patients and carers about why consent is being sought and what will then follow.

“It is incredibly important that the doctor is clear about issues of consent, why they are doing a report, who asked them to do it, where it is going and do they agree” (Parent/carer/patient advocate)

This is connected with the challenge raised by some medical professionals of young people not giving their consent to forensic examinations, partly due to lack of clarity around competencies and partly communication on the part of other professionals.

“One of the concerns is that social services colleagues actually manage to transmit the impression that the examination is traumatic.” (Medical Representative)

Almost all participants agree that with clear and open communication about what is being done and why, and taking on board the young persons point of view where possible, this can largely be mitigated against.

Consent is naturally a more challenging issue when seeking it from those who have communication or learning difficulties particularly where consent is being sought from the young person themselves. Many medical professional are of the view that interpretation of Gillick standards of competency can be very subjective and highlight the role that guidance and training can play in enhancing practice in obtaining consent.

“There could be some more guidance on the doctors response if the child is reluctant or refuses examination…and dealing with this issue of the child’s right to refuse…I guess this is most likely to be important around the Gillick competent age but most difficult in a child who is on that borderline” (Medical Representative)

One of the issues arising from the evidence of many medical, legal and social work professionals is the relationship between child protection practice and adult mental health, where there is a strong link identified between parents or carers with mental health issues and child maltreatment. This is described by some as being a particularly challenging area for doctors in terms of knowing when to share information about their patient if that person is potentially placing a child or young person at risk.

“There is, despite enormous efforts ..., some complexity about the disclosure of information about adult subjects who may have mental health issues from the mental health service where there are children involved, and this may be pre the involvement of other agencies. There does still seem to be some confusion … about the point at which a child’s interest should outweigh the confidentiality issues for adults.. perhaps secondary interest in the welfare of children, and perhaps not always the same kind of alertness that those of us who work primarily in this area would have.” (Children’s Advocate)

There may be situations where a GP sees a parent or carer who may be known to have, for example, drug-related or mental health issues; the ability to cross reference this with other members of the family might help to identify children or young people at risk earlier. However, according to one information specialist, current systems do not allow GPs to note concerns against all the family members. As well as this, for a range of reasons patients
sometimes rarely see the same GP twice and in some cases family members might not share the same name, so it may not always be possible to make these connections.

“Clinicians need to be aware of this complex arrangement and where they believe a child is residing with an adult who has particular health issues which may put a child at risk they need to take relevant steps to record that within the child’s record.” (Government body)

Although there are deemed to have been improvements across the professions in regard to shifting the balance in favour of breaking a patient’s confidentiality if there is concern, psychiatrists and in some cases GPs are mentioned by senior paediatricians in particular as needing to be able to think about the wider implications for safeguarding children if they are treating someone they feel may present a risk.

“Many GPs are extremely reluctant to share information about parents and particularly mental health seems to be a completely isolated area of medicine” (Medical Representative)

Another example cited by a medical association is that of parents or carers carrying blood borne viruses. Often, tests can be performed on both children and adults for these, but parents and carers can demonstrate a wish not to find out about the results. Therefore, the doctor needs to make a judgement call as to whether it is in the family’s best interests for the parents or carers to know what the test results are.

“Clearly the child needs to know and be treated. The question is, can you force the parents to know? You can certainly try to encourage the parents to be prepared to listen to the results....At the moment, adults cannot be forced to know, but we do everything we can to encourage them to be prepared to know.” (Medical Representative)

One representative of a children’s rights organisation strongly stresses the need to, where possible, take on board the child’s point of view in decisions about what happens to them when it is their parent or carer who is the main focus. Notwithstanding the point made elsewhere around interpretations of competency standards, the view here is that children and young people by and large understand what is in their best interests and the potential risks to them are more likely to be mitigated if they feel more able to be open about their wishes in any given set of circumstances. This view is echoed by an individual with experience of being at the centre of child protection proceedings.

The kind of tools doctors have at their disposal to help them manage their processes can also be useful in helping them to identify potential risk to a child or young person from family/carers with health problems. One medical association, for example, has tried to help doctors develop assessment templates, discharge summary templates, and to educate them as to the types of risks that patients with mental health issues can pose.

However, there is an alternative view expressed by at least one medical practitioner that it is possible to get too bogged down by using such tools, and that they leave no room for professional intuition or judgement on the part of doctors; being able to use such judgement where things are not clear cut is felt to be important by most medical professionals, notwithstanding the need for solid guidance to support their decisions.
3. Interagency working and information sharing
3. Interagency working and information sharing

Overview

The importance of constructive interagency working is acknowledged by almost all participants. It is seen as a key factor in managing uncertainty and making sound judgements in individual cases; the most successful outcomes are usually achieved where there are well defined partnership working processes.

Most professionals agree that where a doctor has doubts about a child, s/he should have discussions with other agencies to help clarify concerns, and this is where there is a need for doctors to feel confident that sharing concerns will not result in the ‘runaway train’ approach that some fear (see earlier chapters). There are areas where there is a good relationship between agencies through, for example, regular informal and formal discussions between designated safeguarding professionals. Some also cite interagency training as a positive way to achieve effective interagency working.

All agree that doctors play a crucial role in child protection cases, and can bring a unique perspective where they have a close relationship with the family. But participants feel that it can be difficult to engage doctors in the more time consuming inter-agency work, such as case conferences and court proceedings. A range of causes are suggested in particular the time and financial constraints on doctors, and a lack of flexibility in other agencies’ response to these constraints. Legal professionals stress the need for doctors to make a strong contribution to court processes, but they and some advocacy organisations question whether doctors have the right skills or training to do so. There is a general view that more should be done to facilitate doctors’ involvement in these processes.

There is agreement across the board that if there is a concern about potential risk to a child or young person the default position should be to share - there would have to be a strong reason not to do so. However, there is a widely held view that threshold levels for information sharing vary amongst professionals. There is also a perception that some health professionals are less effective at sharing or knowing when and with whom information should be shared. This may be a particular problem where doctors work in relative isolation and are not aware of local sources of informal advice. Arrangements for interagency working in Scotland are cited as an example of good practice that supports a focus on prevention.

A key challenge for doctors is obtaining consent to share information, as parents and carers have very different assumptions about how confidential information might be shared, and doctors may be concerned about damaging their relationship with family members. Family rights, legal and medical professionals stress the importance of doctors being clear, explicit and open about why they are seeking consent and how the information will be used. This should be done with sensitivity and cultural awareness, and a proper record of the doctor’s thinking should be made, bearing in mind the role that records play in any court proceedings. On the whole, participants felt that most parents/carers want information to be shared between agencies so they can get the help they need, but they would want only relevant information to be disclosed.
Children’s advocacy organisations say that children and young people are very protective of their rights to confidentiality. However they accept the idea of information sharing when it is necessary to protect them from significant harm or provide them with a significant health or other benefit. Doctors should seek and take their views seriously – even young children can be more capable of understanding tricky situations and the balances that have to be struck, than many adults believe.

### 3.1 Inter-agency working

The importance of constructive inter-agency working is acknowledged by all professionals, albeit with acknowledgement of potential tensions and competing priorities between practitioners in different fields outlined later on in this section. It is seen as a key factor in both managing uncertainty (when an individual doctor may have concerns but is not sure what to do) and enabling earlier prevention by ensuring that the full picture is obtained on any case in which there is doubt, as well as ensuring an effective process past referral.

It is acknowledged by almost all participants that it is important to have a range of professionals involved in the decision making process, as a range of professional views is more likely to produce a sound judgement than any one individual.

> "I am very concerned when the opinion of a single clinician is the linchpin for decision making around the outcome of the child. I think it is important that everybody produces the information that is required together to make a safe judgement. I think the worst errors have occurred when it has been around the credibility of single individuals." (Medical Representative)

One participant from the medical profession was of the view that a single clinician with the requisite skills should make any final judgement, but the strongest view by far amongst the range of professionals is that where a doctor is in doubt he or she should seek to have discussions with others just in case; the presence of doubt itself should be enough to warrant it. This is where there is a need for reassurance for doctors that simply sharing concerns with other professionals will not result in the ‘runaway train’ described elsewhere in this report.

> "I am not aware of any public inquiry that has been held because of doctors sharing too much information. There have been several held over many years where information has not been shared to the detriment of the child and we have to err on the cautious side. It is a very fine balance" (Medical College/Specialist Group)

Overall it is acknowledged that the best outcomes are usually achieved in those areas where there are good relationships between agencies and numerous examples are cited of this where for example there are designated safeguarding teams who communicate regularly both informally and formally and the role of doctors is important in this.

> "I think there are some areas where they have a system...where families move in they have a connection with the health centres, so they pick up new registrations to try and engage them. They try and build in some kind of communication that links the children’s’ centre to the GP because they are still the hub of accessing health services” (Nursing organisation)
“It is about raising people’s thinking about how local systems - there are a lot of professional involved in child protection - can work together. It is not right that initial child protection concerns…can process, for example, without the medical practitioner because of other professional responsibilities” (Regulatory body)

Interagency training is described as a positive step on the road to more effective interagency working by a few participants in the medical and legal profession, with the view that this will lay the foundations for more collaborative approaches in the future.

“People who train together are much more able to work together in the operational environment.” (Police body)

It is acknowledged by practitioners in all fields that whilst doctors can have a crucial role to play, it can be difficult to engage them in the more complex inter-agency processes, for example attending conferences and discussions, and a number of reasons for this are discussed.

"People accept that doctors do not come to child protection conferences, and they accept they do not submit written reports. There might be a sense of frustration but nobody thinks through systematically what can be done to affect that, particularly in cases where doctors are central to the safeguarding or protection of that child." (Regulatory body)

Whilst the constraints on doctors are widely recognised in terms of time, cost and practicality, a few participants from a local authority and regulatory background expressed this view, that the system often works against this kind of engagement and there is a need to think differently about how doctors can make the most effective contribution.

"We recognise both the critical input but also the time constraints they have to work under...I think we need to be more flexible and creative around how we engage doctors" (Social Services)

It is recognised by almost all that GPs have a key role to play in interagency working as they have an intimate relationship not only with the child but with their family and wider social circle, and can bring a unique perspective that needs to be facilitated rather than hindered.

There are a number of barriers to effective interagency working, some of which have been highlighted earlier. One of these cited by a small number of participants from each profession is a mutual lack of faith and respect. Some in the medical profession cite doctors' need to feel that they are dealing with professionals of equivalent skills and expertise, and that this not sometimes how younger professionals particularly within social work are seen.

“GP’s believe the only thing that works is them...somehow we have to be convinced that this social worker is not just a jumped up thing just out of college” (Medical College/Specialist group)

"The practitioner [might have] a lack of confidence in social care, the police or whatever". (Regulatory body)

This is reflected in the view of some in the medical and legal professions that doctors are unwilling to engage when they don't feel their views will be treated with respect by fellow professionals.
“Even working as an expert exposes doctors to a level of challenge and discourtesy that they are not generally used to in other parts of their working lives” (Children’s Advocate)

The opposite view is also expressed however, that doctors need to have more faith that other professionals are also able to do their job effectively.

It is also acknowledged from within the medical profession that all areas are different and some just do not have the local resources for effective partnership working and doctors may be withdrawing from child protection proceedings early.

“It does not happen in all areas though because it depends on the expertise locally in the way these are run, and they are tending to hand over very much to paediatricians or social workers” (Medical College/Specialist Group)

Close contact, including co-location, between professionals can help this and one or two examples are cited of good practice.

“They have paediatricians sitting in the same building with social workers and the health visitors and a police officer and they all communicate very well. Because they sit in the same building they become aware of issues at an earlier stage but those individuals filter the information back to their organisations, and so good communication ripples out across the organisations.” (Regulatory body)

Doctors need to make a strong contribution to interagency working in particular during the investigative procedures and potential court processes that follow a referral. More specifically, health professionals are described by those from the legal profession as needing to co-operate more with the legal justice system in order to have a sustainable process, whether this is in relation to providing adequate notes and reports, to appearing at conferences or in court. As mentioned earlier, there are some barriers to this level of involvement by doctors, in particular the demands made of GPs in attending court can be problematic in terms of time and cost, for example to need to pay for a locum doctor or to complete extra administrative work.

“Sometimes you give an opinion and are drawn into the court process and have to give evidence. As I said, most of this work is unplanned; you cannot predict that. Therefore, it is quite a drain on your own personal resources” (Medical Representative)

On top of this, a number of participants, in particular legal and family and child support professionals question whether some doctors have the right skills for courtroom proceedings, if it is not something they are specifically trained in; this can lead to a lack of clarity about what is expected of them.

“I think a lot of doctors get confused about, if you like, the professional roles and the expert roles. Quite often when you are in court you are asked expert questions when you are a professional witness, and often doctors do not like saying that they do not know and therefore they get drawn into areas that possibly they should not be commenting on. That is a problem with the court system, essentially.” (Medical College/Specialist Group)
Equally some doctors cite the concern that other doctors may be unwilling to engage at this level as they don’t like the challenges or questions around their professionalism that may occur in court and the potential for professional harm can be a worry. The court system is described by a number of respondents as adversarial and one medical association points out that doctors can be exposed to more hostility than they would perhaps expect in other professional circumstances.

However some of those in the legal profession acknowledge the need for strong medical expertise in court, and reflect the view that this is getting harder to come by.

“The last fifteen years has caused some doctors to be reluctant…it leads to less good quality decisions because you cannot get any expert at all, or you can get one who is an expert at proclaiming their expertise and being paid for it, because we have not made the progress in the sphere of experts that we have been trying to achieve” (Children’s Advocate)

It is also acknowledged in the same context that the best experts do not necessarily make the best court performers, and this is another area where training in court proceedings generally and specifically on a medical professional’s role in court can help.

Somewhat related to this is the view expressed by a handful of medical professionals and those from a legal and social work background that it is not uncommon these days for doctors, in particular GPs to bill for their time. Whilst it is recognised that doctors involvement in proceedings can present logistical and financial challenges, the general view where this is discussed is that this is perhaps not in the best spirit of interagency working, and that GPs need to reflect on their own role as part of the safeguarding team rather than acting as a paid consultant.

In terms of best practice, current child protection practice in Scotland is cited by one or two Scottish professionals as having improved greatly in regard to interagency working, under the Getting it Right for Every Child guidelines, due to an acknowledged government push towards prevention and the avoidance of crisis situations. Implementation of this interagency framework is something that all agencies are working towards and health representatives are described as becoming more committed to this approach.

“The child protection landscape has changed considerably over the last couple of years. There is a real government push towards prevention. The implementation of [GIRFEC] is something that all agencies involved in …child protection…are working towards” (Police body)

Under the Scottish guidelines decisions are always three ways between the paediatrician, social workers and police, which is described as reassuring to GPs that the health perspective is strongly featured during the decision making process and that therefore their input and information is treated seriously, and they themselves treated with respect.

“The paediatrician sits at the table with the police and social workers to determine what is going to happen…I think that should give GPs some level of assurance that health is very much at the decision making table” (Police body)

### 3.2 Consent and Information sharing

There is no disagreement amongst professionals across the board that if there is uncertainty about a child or young person on the part of a doctor then the sharing of information should
be the natural step and the current GMC guidance is seen to be very clear on this. A key challenge cited by many professionals, and discussed previously, is for doctors to feel able to discuss initial concerns informally with other professionals without feeling that it will lead to an official referral, and guidance and strong networks can help support this.

Whilst there is a clear agreement that yes, information should indeed be shared, there is a perceived difference between how effective different types of health professionals are at sharing information and in knowing who the appropriate people are with whom they should share information. Concerns may arise particularly in areas where practitioners may operate in relative isolation from other professionals, and are not aware of informal networks of professionals that may be open to them.

"What I am concerned about is whenever you have practitioners of whatever professional, operating not so much in isolation but when they are separate from the main thrust...it can be more difficult to go forward" (Regulatory body)

"It is part of medicine to discuss with people. Some people find that difficult because they are isolated. Some people do not have access. Some people cannot find the expertise" (Medical College/Specialist Group)

"We have to make those informal links work, it is expected we do talk to these people but we just do not have the time or informal contacts any more so we have to make a more formal arrangement" (Medical College/Specialist Group)

It is also mentioned by two or three participants with long experience of working in the local authority or medical fields that informal information is much harder to get now that professionals are less able to talk to each other or less willing to risk breaches of confidentiality if they share information.

"Many years ago as a social worker putting together a chronology you could speak to the health visitor and go and read their records so you had a good covering, not just social services but health and education...It does not happen any more. For about the last eight to ten years a health visitor would say “it is confidential, you cannot read our records” (Social Services)

As discussed in the previous section stronger partnership working both formally and informally and both geographically and practically, is described as facilitating more effective information sharing whilst mitigating against concerns.

As discussed earlier, explaining to parents and carers clearly and honestly why information needs to be shared with other professionals is important to engage them willingly in the process. Doctors need to be aware of and acknowledge the difficulties some parents and carers may have in understanding why sharing information is important, be they language or other communication skills, and aim to counter these.

In this context it is described as being the doctor's duty to gather as much information as possible about why disclosure is requested or needed to avoid making inappropriate disclosures and to make sure they are aware of all the relevant information.

"There is an expectation... that sometimes the mere mention that "It is a child protection investigation and we need the records of the following patients" will be met with an immediate disclosure" (Medical Representative)

The amount of information going within an individual’s shared GP records needs to be
considered carefully, and needs to be balanced against the right of individuals to have their medical information kept confidential, as illustrated by the following two points made by respondents from medical defence groups

"I think any information that is relevant to the clinical care of the patient – and we would see that in the very broad sense of being social care and general welfare issues – should certainly be part of the clinical record, if it is relevant" Medical Defence Society

"It is the principle of simply not allowing carte blanche access to people’s health records in relation to a child protection issue." (Medical Representative)

For paediatricians, with their focus on advocating for children and young people, the decision about when to share information may be easier than for GPs.

"It is easier for a paediatrician who has the child at the centre of their work, to put together an understanding of what other people, the parents, the carers in the child’s environment are contributing" (Medical College/Specialist Group)

As previously discussed they might be concerned about their relationship with parents or carers and family members who are also their patients, and there is recognition that a GP’s benchmark of when something is in the best interests of a child's may not be the same as a paediatrician’s.

"One of the problems is that, although the GMC advises to share information, sometimes it is only a doubt that is shared" (Medical College/Specialist Group)

One of the challenges of information sharing and disclosure is in relation to consent to do so, and can result from different interpretations of what it means in practice; this is connected with the widely held view that threshold levels for information sharing can vary amongst professionals, and that parents and carers have differing assumptions about confidentiality.

For example some people will assume that information given to doctors is always confidential, and the doctor may not be explicit enough about why they are asking for consent to share.

"They have a general notion that the doctor they see will treat things as confidential, unless they have had a bad experience. It is incredibly important that the doctor is therefore very clear about issues of consent, why they are doing the report, who has asked them to do the report, where it is going, what it is for and do they agree" (Parent/carer/patient advocate)

From a legal point of view doctors need to be explicit about the potential consequences of disclosure and how information will be used.

"One has experience of patients signing a blanket consent for disclosure of medical records, simply not understanding that those records will be seen not only by the police, the prosecuting lawyers, but may well be disclosed to the defence team and to the defendant themselves and may well be used in a public setting in a trial “ (Legal body)

There is also the suggestion in this context that doctors needs to apply greater discretion when considering what information is relevant to be passed on, but an understanding that this is sometimes out of their control.
“Doctors should also be astute to understand the scope of the documents that are being requested. One often gets blanket consent forms, as I say, requesting the entirety of a child’s medical records. Frankly, that is, in some sense, laziness on the part of the people requesting it.” (Legal body)

Looking at the issue from children’s point of view, a children’s representative organization advises that young people can be very protective of their rights to confidentiality, especially those in care or ‘looked after’ given the large number of professionals who may come into their lives over time.

"Quite a few children in my own remit feel that various professionals, particularly people like social workers have a kind of freedom to roam through files of information about them." (Children’s Advocate)

They accept that sharing information may be necessary to protect them from significant harm or to provide them with a significant health or other benefit, but they feel that a need-to-know only approach should be applied. This organisation suggests an holistic approach to working with children – having a 360 degree view of them as an individual - and taking their opinions seriously. Children can be far more insightful and capable of understanding tricky situations and balances than many adults give them credit for. Pre-school age children can very often express a consistent feeling or reaction to a situation, even one verbally presented.

“Please ask the child, if it is feasible…before passing on information so you have their views and their feelings. It does not necessarily mean you do not have to pass it on anyway, but do take into account their feelings and their views…even if they cannot understand the situation and the decision making manner. ” (Children’s Advocate)

A number of key points were reported as being important to children when professionals are thinking about whether to share information about them with third parties. These include:

- Assess the amount of benefit and the risk that comes with transmitting the information.
- Assess the seriousness of the harm that might be prevented and the likelihood that transmitting the information will prevent that harm.
- Beware of transmitting rumour and assumptions, and letting past history prejudice current care.
- Pass on only what is relevant and that the other person needs to know.
- If you are the person receiving information passed on in confidence, you must apply the same criteria in deciding whether to share the information with others. Only keep the information as long as it is needed.

It is a balancing act for doctors to know how much of the information that they hold is relevant, and in many cases they may have records going back for many years, which arguably may have no bearing on any proceedings. From a legal point of view this interface between the legal and medical professionals can sometimes be problematic.

“It can sadly become quite confrontational in the sense of the doctor trying to protect the confidentiality of their patients’ record and the lawyers trying to get access as part of the criminal process.” (Legal body)
Medical defence organisations and those offering support and advice to doctors report this as a common problem and there is a view that doctors often need to seek advice on what to do in this situation.

“There are those times where there is an immediate concern on a child protection issue where you are weighted towards disclosure, and I do not think that poses a huge amount of problems to the practitioner. There is then, the second issue of when disclosure is requested regarding an incident or an event after the waters have settled and is part of an investigation or inquiry. That becomes more challenging on the basis of what information is requested and from whom.” (Medical Representative)

From a legal point of view it would be beneficial if doctors considered the competing interests in more detail and make proper records of their thinking and bore in mind the role that records might play in criminal court processes arising from their disclosure.

The importance of keeping detailed records on cases means that, as pointed out by a couple of lawyers, doctors must consider ‘what is likely to happen in terms of the information that he passes on and not to make those disclosures unless absolutely necessary in the best interests of the child’. “It is important in making a disclosure that it is made accurately and if to another agency, in writing so that there could be no subsequent complaint or discrepancy about what exactly had been disclosed and why”.

One lawyer also suggests there is a ‘fear that [doctors] may be unleashing a runaway train’ that may be disproportionate to their initial anxiety, which could lead some doctors to err on the side of caution and not disclose relevant information.

Whilst there is little disagreement amongst respondents across the board that information should be shared if there is any concern of risk to a child or young person, a few medical professionals feel that some GPs need to have it stressed more clearly to them that there must be a strong reason not to share and that the default should be to share.

“At the moment the way [the guidance] is interpreted by GPs is you do not share information unless there is a clear reason to do so. I think we need to be very clear in an upfront statement that the imperative is to share information unless there is a very clear indication not to.” (Medical Representative)

Linked to this is the view that in some cases doctors are uncomfortable sharing information despite the clear guidance on the issue.

“There is still a lack of clarity and a lot of nervousness out there about what people should be sharing despite guidance.” (Designated Doctor)

On balance, most respondents’ views on information sharing are reflected in this comment:

“Without collaboration and shared information there is no way in which children’s interests can be properly safeguarded” (Children’s Advocate)

Naturally professionals from all backgrounds report the need to tread with caution when sharing information, and some children’s rights and legal professionals highlight the need for doctors in particular to be wary of blanket disclosures but many medical professionals are of the view that on the whole families want information to be shared as it indicates they will be getting the support they need.
“For most families there is not a problem because most families actually want us to work with other agencies” (Medical College/Specialist Group)

The need for sensitivity and cultural awareness is raised by a few participants working in child and family support roles, and explanations and openness are also described as important to ensure that if consent is given it is fully informed.

“He got their consent. Once someone had sat down and explained it to them in their own language, taking time to explain terminology, the families were in a position where they could ask questions to somebody who spoke their own language from their own culture and community and could also put the issues within a cultural context as well, but also looking at what their needs were.” (Children’s Advocate)

In those cases where there is no consent, doctors must look for very strong public interest arguments for disclosing medical information, for example if there were serious risks to either the individual or a third party.
4. Training and support
4. Training and support

Overview

The role of training is described as vital by almost all participants, and whilst there is felt to be plenty on offer from a variety of sources, some describe the quality as variable and others describe the need for doctors to be more proactive in accessing what is available and keeping themselves up to date.

Most participants took the view that doctors should see child protection training as a basic requirement to practice effectively, starting at undergraduate level and going on throughout their career. Training should focus on the range of concerns already identified (see previous chapters); on enabling doctors to deal with conflict and challenging relationships over a sustained period; and in the view of family advocates it should include firsthand accounts of parents/carers perspectives.

There is a general view that training needs to be tailored to meet the needs of particular specialties such as psychiatry and general practice. Legal professionals would like to see more and better quality training for doctors who will be acting as ‘expert’ witnesses, to help them manage their dealings with the court and with lawyers more effectively.

Most medical participants say that, aside from training, there is a great deal of support and advice available from designated doctors, informal networks, and the help-lines of medical defence bodies and professional associations. Access to these sources of support is described, by almost all professionals, as providing an important opportunity to talk things through ‘off the record’ which can alleviate doctors’ concern that asking for advice may lead to unnecessary escalation of a case. The designated doctor role was highlighted as particularly valuable in this regard.

It is suggested by some social workers that ‘outreach’ work with local doctors would help to build doctors’ confidence to be more proactive in their approach to child protection. But there is no requirement on social workers to do outreach of this kind. Medical professionals felt that local peer review of cases could also be helpful in building doctors’ confidence and providing reassurance about their practice.

4.1 Training and support

The importance of training and support in encouraging and enabling doctors to get more involved in child protection cannot be overstated.

"Training is a big issue, because via training is how we raise the profile of safeguarding children among doctors" (Medical College/Specialist Group)

Almost every participant referred to training at some point and whilst it is felt by a few to be of variable quality, there is a strong view across the medical profession that there is a lot of training available, through the Royal Colleges and other organisations, notwithstanding concern that some doctors are not proactive enough in accessing it.

The importance of child protection needs to be stressed to doctors as soon as possible both in undergraduate and postgraduate education and training; they need to see child protection training as a requirement for them to practise effectively, and they need to develop the skills
and understanding needed on an ongoing basis.

"...we concentrate on the first ten years of a doctor's career in terms of filling them with information and skills and then neglect them for the last 30 years..." (Government body)

Training needs cover a number of areas for doctors working on child protection issues; these are cited by all professionals and representative bodies as including:

- better awareness of risk indicators
- clearer understanding of their roles and responsibilities after raising a concern or making a complaint
- understanding how best to communicate with parents or carers, particularly when there is conflict, and how to manage their professional involvement in cases to minimise risk.

In terms of the legal process, more training for doctors in understanding court processes and the role of legal professionals is described by a few legal professionals as necessary to avoid potential conflict over competing priorities. For example, some doctors have been on training courses about becoming expert witnesses which are described as being variable in quality. To be properly effective these courses need to address the differences between the roles and responsibilities of professionals and help doctors to manage their expectations of lawyers.

"We have experience of doctors expecting us to coach them on what to say or what opinions to express...I think that is borne out of mistaken preconceptions...about our professional limitations and the distinction between barristers and solicitors...there is case law about witness training which doctors need to be aware of." (Legal body)

This is echoed in the view that doctors could be better trained to manage their dealings with court more effectively.

"We think it is important that doctors who do this work should not only have training in courtroom skills, but in witness statement writing because if you write a good statement that will often prevent you having to go to court to give evidence" (Medical College/Specialist Group)

This could help to counter some of the issues discussed earlier around the time consuming and complex nature of the work and the challenges this presents for doctors.

From parents’ and carers perspective there is a need to ensure that doctors have first hand experience of hearing from them about their experiences, and that this is incorporated into their training.

"It would be very helpful if the child protection training that doctors receive about thresholds and the law and the rest of it, could also contain a component which is delivered by service users, patients, to explain what it is like to be in the receiving end” (Parent/carer/patient advocate)

This is echoed by the view that this would help prepare them for dealing with potentially challenging situations and relationships.
“I think there is a major training issue for many practitioners in terms of not just handling conflict but handling face to face interaction over a sustained time” (Nursing organisation)

On a related note two or three representatives of family rights organisations raise the issue of training in cultural awareness and other issues relating to harder to reach groups such as language and cultural differences.

Whilst it is seen as important to support practitioners, it is also felt that practitioners need to be proactive and keep themselves up to date, and there is recognition that whilst some training and guidance can be generic, where necessary this needs to be tailored to the needs to different medical practitioners:

"What is needed for a child psychiatrist will be different from a GP and from a paediatrician…and the surgeons, the anaesthetists, the radiologists" (Government body)

However, another medical view is expressed that the expectation that so many people can be expert enough in any given field may not be the best approach, and that more high level and specific training, but for fewer people, would be the better scenario. There is a suggestion from this participant that there should be a sub speciality for doctors who specialise in child protection as in the US.

"Perhaps creating a sub-speciality, where paediatricians who do this kind of work are recognised first and foremost as people who are trained and experienced and some sort of expert. For example, in the United States since 2006 the American Academy of Paediatrics has recognised child abuse and paediatrics as a sub-speciality … but I do have to say that clinical supervision amongst career grade doctors is a hit or a miss." (Medical Representative)

As well as doctors it is also mentioned that it is worth considering the role of practice managers when thinking about training professionals in child protection; this role is likely to become more significant as GP practices become consortia in that it may be that they take on a greater range of responsibilities.

Underpinning this is the need for evaluation of training, mentioned by a couple of medical professionals, to ensure that it is reaching the appropriate targets and creating the desired outcomes and one participant suggests that not enough is being done in this area.

On a more general note, there is a call for more regional and national events for all relevant professionals in safeguarding practice, as well as the suggestion that interagency training where it happens is beneficial, and would help ensure that those advising doctors can be as effective as possible.

“Something that caters for the more complex areas, particularly inter agency training, because often we are the people who are advising…doctors on the ground” (Medical College/Specialist Group)

There is seen by most medical respondents to be great deal of support and advice available, aside from training, ranging from informal networks, to help-lines run by medical defence or legal organisations and indeed from the well praised role of Designated Doctor. Indeed one respondent argues that this role could be strengthened to a more consultative role within local networks to provide a first port of call for support. The challenge here is also seen to be
the wide dispersal of sources of advice and support and sometimes conflicting advice that doctors say they can receive.

4.2 Peer review and seeking advice

It is generally agreed within the medical profession that individual doctors definitely need access to advice, and they need the opportunity to talk through things anonymously and discuss sensitive information. There is a need for 'off the record' advice to be available which would alleviate concerns that the act of asking for advice may lead to an unnecessary escalation. Informal networks are described by almost all practitioners as providing an important sounding board in this regard.

“Individuals need people to turn to for advice, not necessarily ‘should I do X or Y?’ but to talk through the case in a truly anonymised form and say ‘in the following circumstances, is my judgement right?’ A useful touchstone, somebody who is an expert” (Medical Representative)

This reflects the feeling amongst many participants that doctors may need to feel better supported when presented with a child protection case, recognising the view from legal and family support organisations that some doctors may not have the requisite skills and support. "We wonder whether or not the procedures could be refined to ensure that at the point of a child protection presentation there is a greater emphasis placed on support for the doctor at that stage to assist in management of the situation." (Legal body)

Where the peer review system was discussed, it was felt to work well and is felt to be something that should be encouraged as part of good practice. A number of medical professional cited the reassurance factor provided by the confidence of ones peers and how this kind of process can help to minimise risk on both a child protection and professional level as well as providing a valuable source of information and support.

"All the examinations that we do ... are peer reviewed within, I would say, the next two months.” (Medical Representative)

The designated doctor role was described as particularly valuable in this regard, in terms of offering peer support, in that a doctor raising concerns can seek professional reassurance from someone within their profession with the requisite knowledge.

It was suggested by one or two social work professionals that outreach work to build confidence among doctors is important to counter what is sometimes seen as a passive approach to child protection. However there is a question around who is actually reached in this way as there is no actual requirement for outreach, and where it does happen, those doctors who are willing to proactively engage are likely to benefit the most, and those who are not so proactive perhaps missing out on important information and skills development.

There is also a suggestion from a medical professional that doctors need a 24 hour source of confidential advice, but defence organisations some medical practitioners in particular say there is a wide range of such advice available.

This illustrates the balance between offering simply advice and support to those who want it, and systematically delivering training and teaching throughout the profession. Overall there appear to be two prevailing views. Some consider that the existence of designated doctors and specialist support networks should mean that most doctors need only a general understanding of child protection issues and knowledge of who to contact for specialist advice and support within their locality. Others consider that all doctors, whatever their area of practice, will need ongoing training in child protection issues, with some requiring higher
levels of competency to match their role.
5. Suggestions for guidance
5. Suggestions for guidance

Overview

Medical participants say that there is a wide range of good guidance available from a number of sources, and there are many positive comments from all professionals about the clarity of existing GMC guidance where the confidentiality issues are said to be dealt with effectively.

Some professionals from a range of fields suggest there is too much guidance and question whether doctors are following it; rather than more guidance the need may be for synthesis and distillation of current guidance to make it more accessible.

Some participants feel there is a lack of clarity amongst professionals involved in child protection about each others’ roles and remit and it might be helpful to refer to these roles within the guidance.

A number of participants suggest case studies as a useful tool to support the guidance, and raise the possibility of developing more tailored (complementary) guidance for particular professionals.

A number of specific suggestions for GMC guidance content are described in this chapter. But there is also acknowledgement that the guidance cannot, and should not try to deal with everything in one place.

5.1 Suggestions for Guidance

As with training and support, the general view amongst medical practitioners is that there is a wide range of available guidance from a number of sources; the challenge is that for some participants there is seen to be too much guidance, and too widely dispersed, to be easily understood.

There are many positive comments from all professionals about the clarity and reach of the current GMC guidance, particularly in the area of information sharing and working with other agencies.

“I think your guidance is pretty good, I think you have gone as far as you can in making it clear for practitioners” (Medical College/Specialist Group)

This is reflected in the view across most of the discussions that one of the key issues for doctors – handling confidentiality issues – is dealt with thoroughly and well by current guidance.

“You have come very close in your guidance on your confidentiality. I think this section is written in such a way I think it does support and enable doctors through a number of ways – I think the guidance is actually very helpful. It seems to have the balance that you need in the guidance…I think the guidance is very well written in terms of confidentiality.” (Social Services)

“I certainly have found, and other advisors have found that the GMC guidance is perfectly adequate and works” (Medical Representative)
However, a small number of professionals from a range of fields are echoed in this view from a legal professional that

“The issue is doctors following it, not the quality of the guidance” (Legal body)

Equally, from a medical and regulatory perspective there is perhaps not a need for any more detailed guidance, and the focus needs to be on ensuring that doctors can use it to carry out their roles effectively.

“I would agree the guidance is pretty clear now and sets out what needs to be done. What we need to focus on is supporting doctors to carry out their statutory responsibilities where it is required, particularly within those services which do not directly relate to children” (Regulatory body)

This is echoed by the view that it may be more a case of making the existing guidance in general including that of the GMC more accessible and easier to find, supported by the suggestion from within the medical profession that many GPs are not familiar with the guidance, particularly in terms of sharing information.

“It’s partly to do with there being good GMC guidance, but a lot of GPs do not seem to be familiar with it” (Medical College/Specialist Group)

“There is a limit to what the GMC can do to send out very clear and helpful signals to doctors about what it is they should or should not do” (Children’s Advocate)

A contrasting view is given by one medical union, however, in that doctors are said to have reported the opposite experience

“Our experience in a number of cases has been that although the doctors are often aware of the GMC guidance… many other professionals or agencies are not; they do not know about the GMC's guidance about weighing public interest against the patient's right to confidentiality and trying to seek consent if it is possible in these circumstances. That, I think, is where friction tends to arise between the doctor who is trying to comply with his GMC obligations and other parties who, for the very noblest of reasons, have a different approach.” (Medical Representative)

One or two doctors also said that they are more aware of responsibilities of other professionals than the other way round and this highlights the need for stronger guidance about the roles of all the relevant professionals in child protection cases.

The danger of information overload is highlighted by a few, in that doctors can be likely to turn off if there is a large array of guidance that they should be up to date with.

“One of the bigger anxieties is the more guidance the more muddling and the less people will read it” (Medical Representative)

From a medical perspective also there is also a view that some doctors may be put off by the sheer amount of guidance available and the fact that it is currently in a number of different places.

"I think that the guidance that has been produced by the college, by the GMC and by the Chief Medical Officers over the last ten years has been hugely helpful, but one of the difficulties remains that they are separate pieces of guidance. What we most hope from the GMC is that we will now get a single distilled piece of guidance which
people can refer to without having to look at hundreds of other documents which give them a very clear steer on what they should do, and if they are not clear what they should do and where they would seek advice from." (Medical Representative)

This was mentioned a number of times particularly from a medical and legal perspective, and there is felt to be a strong need for the guidance to be synthesised

"Perhaps one of the real problems is that there is too much guidance in too many different places and I very much hope that this exercise that you are engaged in now will achieve a situation where there will be, if you like, a gold standard by which issues can be addressed in the future." (Legal body)

This is reflected in the broad acknowledgement of the need to make sure in all cases that guidance stays up to date and incorporates new thinking.

"I think all you can do is to keep reviewing it as cases change the way the law is interpreted." (Children's Advocate)

This is highlighted in particular in relation to how families and children can best be supported, which is connected to the suggestion that the guidance may need to incorporate, as well as practical issues, thoughts on dealing with communications and relationships with a wide range of people in any given scenario.

“I think we would like our advice to be referenced in the guidance because it would be really useful…then it is open to every doctor to access it and for the GMC to be responsible for distributing it…that would then lead to an awful lot of parents having a route to get independent free advice" (Parent/carer/patient advocate)

Supporting this view is that of a number of legal and medical professionals and representatives of children's and family rights organisations which suggests that case studies can be useful tools to incorporate into the guidance which could illustrate a number of different scenarios – such as dealing with conflict, or responding to a challenging question around disclosure. These could not only provide doctors with help to work out what they should be doing but, and particularly this is raised by family representatives, enable them to see what the reality is like for those at the centre of child protection cases.

Notwithstanding this however, there is also the opinion that the GMC guidance needs to be consistent with other guidance and incorporate the views of other organisations

“If the guidance could be made to come into line with guidance issued to other professionals ... so that they knew the constraints under which doctors must operate, I think that would go a long way to helping to iron out some of the tensions and occasional frictions that do occur” (Medical Representative)

“One of the things I would like to suggest is that some of the sections on serious case reviews and internal management reviews need to be strengthened. I think internal management reviews are incredibly difficult to do if you have never done them before.” (Social Services)

It is also acknowledged however that with the broad scope of the guidance generally, different professionals with varying remits may need tailored information and that not all guidance will be relevant to all practitioners so there is a need to work out....

“… what can be generic, what needs to be bespoke, and what (else) is available"
In terms of specific elements that may be incorporated, suggestions from individuals and small numbers of participants include

- tackling the issue for doctors of how to deal with information that comes to light not from the child but from the parent or carer; existing GMC guidance does is described by one participant as not addressing that.
- providing a greater degree of specificity in terms of who should be contacted for advice when doctors have initial child protection concerns.
- providing more detailed information about the value of managed clinical networks for child protection.
- providing further emphasis on the value of psychiatrists with adult clients participating in local Safeguarding boards.
- providing more detailed information about, and encouragement to engage with, local preventative and early intervention services for children and families at risk.
- the need to clearly express the balance of duties amongst the range of involved professionals in directive language.
- strengthening the recognition of the validity of parental testimony as there is a suggestion from parents and carers that this can sometimes be marginalised.
- Strengthening the recognition that violence in families may impact on a parent as well as their child, and the some parents are vulnerable adults themselves.
- strengthening advice on dealing with consent when working with young people aged 18 or under, alongside further advice on dealing with young people who do not give consent for examination.
- stressing the need for basic skills and competencies in child protection practice.
- stressing the need for the engagement of designated doctors in critical areas of commissioning.
- Encouraging the use of audit regimes where there is a risk of under reporting.
- placing more emphasis on sharing information; ‘a lot of protocols emphasise what you can’t do and not what you can do, and there is a need to reverse that’
- generating shared understanding of the data protection act and its implications.
- encouraging doctors to make themselves aware of population level data.
- acknowledging opportunities for working with new GPs consortia as they may have more engagement at a local level than Primary Care Trusts.

However there is recognition that guidance (any guidance) will not be able to deal with
everything and a connected concern about over reliance on it.

“Guidance can go so far in setting principles, but there is an element - and this is where the GMC’s Good Medical Practice comes in - about where those relationships conclude…from the consultation I sensed that there were some parts of the profession where there are differences of understanding what the roles of different professions are”.

“In 1998 when the guidance was last done it was called interagency guidance - I think we are very conscious of some of the facts that professor Munro made in her first report for child protection, that we have an over-guidance culture in some respects and we need to be careful about what we are recommending professionals use” (Government body)

Finally, whilst the issue cannot be addressed specifically in the guidance, in discussion on this area there is a view from the medical profession that there needs to somehow be an emphasis on the fact that there is support from the GMC for doctors making reports, and thus try and reduce the fear factor they believe is responsible for much under reporting, which links to the point made earlier in this report about the importance of the GMC offering more reassurances.

"I would like the GMC to come out with some support for the doctor who has done it in good faith. When you focus on the complaint from a wrongly accused parent, you are shifting the focus from protecting the child to protecting the parent and investigating the doctor." (Medical Professional)
Appendix A: Organisations taking part in panel discussions

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38. Designated/Named Doctors
Appendix B: Core questions for oral evidence session

1. What factors affect doctors’ willingness to work in, or engage with, child protection? What can be done to address barriers to doctors’ involvement?

2. Doctors’ primary duty is to the child; but how can doctors also fulfil their obligations to other family members?

3. What is the proper balance between doctors’ duty to provide a confidential service for children, young people and adults and their duty to share information with other agencies involved in safeguarding children and young people?

4. What challenges arise in seeking consent to examine children and young people in the context of child protection? How can these be overcome?

5. How should uncertainty, and consequent risk to the child and doctor of under- or over-reporting child protection concerns, be managed? What can the GMC do to help doctors manage risk better?

6. The Munro Review (First Report) suggests that ‘keeping more families out of the child protection system’ would reduce distress to families, give social workers more time to deal with high risk cases and reduce cost. Do you agree with this objective, and how can GPs and other doctors help to meet it?

7. How well do you think doctors who work with adult patients recognise, and act on, their role in safeguarding children and young people? Can you provide any examples of good practice?

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

9. What are the gaps and opportunities for access to training and support in child protection work?