General Medical Council Call for Evidence on Doctors Working in Child Protection

Response by Family Rights Group

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About Family Rights Group

Family Rights Group advises and supports parents and wider family members who are involved with their local authority children's services department about the needs, care and protection of their children (i.e. public law cases).

We advocate for the involvement and support of family members in making safe plans for their children which will promote their welfare. We campaign to challenge injustice, to improve access to effective services, and to increase the voice children and families have over decisions affecting their lives. Our free telephone and email advice service advises 6,500 parents and relatives per year about their legal rights and the options open to them:

- Within the local authority decision-making processes for supporting and safeguarding vulnerable children, particularly before care proceedings are issued and when children are looked after in the care system; and
- When a court application is made by the local authority for an emergency protection order, care order or placement order.

We also:

- Publish a wide range of advice sheets on all aspects of child care law and practice which can be downloaded from our website at www.frg.org.uk/advice_sheets.html;

- Run a web-based electronic discussion board and set up support groups for family and friends carers, including grandparents who are raising children unable to live with their parents;

- Convene the Kinship Care Alliance and national Family Group Conference Network;

- Run training courses on a regular basis for child care professionals including Independent Reviewing Officers;

- Run action research programmes, for example on working with fathers and lobby for improvements in childcare law and practice.

In this submission we have drawn on our extensive experience of working with parents and wider family members whose children are at risk of harm. Consequently we have focussed particularly on what works in terms of working with parents whose children are at risk of harm. We have set out in red the GMC questions and in black print our response.

We agree to this response to be published.

We would like to be contacted about the GMC's public consultation the new guidance in 2011.

Consent and confidentiality

Doctors working to protect children must keep the interests and needs of the child at the heart of what they do. This will involve listening to children and giving them information in a way they can understand; and examining or treating children with their consent, parental consent or other legal authority. It may also involve sharing information about the child and family with other agencies or as a witness in giving evidence to the court in order to provide services for the family or to protect a child from abuse or neglect. There may be conflicts of interest between the child and the family.

Q1. What problems arise in relation to consent and confidentiality when doctors work with children and their families? If possible, please provide examples of good practice, or areas where problems commonly arise.

- **Young people, consent and involving their parents**:
  When young people are 16 they can obviously consent to their own medial treatment and examination. However problems arise when they are under that age and do not necessarily have the maturity and understanding to give such consent. Particularly worrying is when they are estranged from their parents, either because they have been voluntarily accommodated under section 20 or because they've run away from home. Some of the children we are referring to are as young as12 or 13. There tends to be little work with the parents/family to try to restore relationships in these circumstances which makes it difficult for the parents to exercise their parental responsibility and support their child. Yet there is normally no-one else who has such responsibility of legal authority for the child.

  Doctors therefore need to be mindful of the importance of trying to involve parents and help to restore relationships in these circumstances, making appropriate referrals for other interventions such as family therapy and family mediation as appropriate.

  When it comes to consenting to examination and treatment of younger children who are not competent to give such consent, the consent of one person with parental responsibility, typically a parent is legally required. Where this is not forthcoming, unless it is a life-threatening situation, doctors need to discuss the need to apply to the court for a child assessment or other appropriate order with the local authority. The examination/treatment should not proceed without such consent/order. Parents/others with parental responsibility should be referred to relevant sources of advice and support in these circumstances – see question 2 below.

- **Referrals to local authority Children's Services where there are concerns**
  When doctors have concerns about the care being provided to a child and suspect that s/he may be suffering or likely to suffer significant harm, they must refer the matter to local authority Children's Services departments for enquiries to be made. However, some doctors are anxious about making such referrals in case their concerns are not substantiated and a complaint from the parents is subsequently made. Averting such complaints being made may be impossible, but various measures can be taken to reduce the likelihood such a complaint being upheld:

  i) Doctors should receive training on the legal and practice framework surrounding such referrals as set out in s. 47 Children Act 1989 and Working Together to Safeguard Children so that they are clear about when and how to refer and what their subsequent contribution to the child protection process will be;
  ii)Doctors need to be open with parents/carers the wider family as to the course of action they are taking and why, and how they may obtain independent advice; they then need to confirm this to them **in writing**. Not only does this give the family the

opportunity to digest and reflect on the situation but also it will help them to know where to go to get independent advice – this is discussed further under question 2 below;
iii) Doctors including family GPs should be expected to participate in any multi-agency child protection work that may follow the referral including contributing to and attending any child protection (CP) conference to report both on the family's strengths as well as any concerns, unless there are exceptional reasons to justify not doing so – this is discussed further below under Q3;
iv) Others also administering GMC Fitness to Practice procedures need to be trained on and conversant with the legal and practice framework for child protection so that they can make an informed decision about what is an appropriate referral even if the concerns later turn out to be unsubstantiated.

- **Need for openness/consent when reporting on a parent's psychiatric state**
  It is not uncommon for a parent to be asked to submit to a psychiatric assessment, or for a psychiatrist to be asked to give an opinion about a parent's psychiatric state and its impact on their ability to care for their child by the local authority in the course of child protection enquiries or care proceedings. Unless a breach of confidentiality is required to secure the child's immediate safety, a parent's consent is required for such a report to be prepared. When this is not explicitly discussed with the parent it can lead to them feeling very distrustful and that their confidentiality has been breached. Again, doctors therefore need to be open with the parent as to the course of action they are proposing and why, referring them to relevant sources of independent advice (as discussed further under question 2 below).

Relationships with parents[1] and carers and the wider family

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

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

- It is well established that the engagement of families is key to keeping children who are at risk of harm safe when they are subject to child protection plans[2]. This makes sense practically because 93% children who are subject to a child protection plan live at home[3] hence their families need to engage with and commit to implementing the plan if the child is to be safe. Whilst the Baby Peter case demonstrates that seeming co-operation isn't sufficient on its own for children's social care services to be confident that a child is protected, the absence of partnership working between the family and the social care agency is an important indicator of serious concern. A lack of parental cooperation is a key factor as to why some cases end up in proceedings.

[1] References to 'Parents' means anyone holding parental responsibility. For example, if a child is 'looked after' parents share parental responsibility with a local authority. A foster carer does not hold parental responsibility if a child is placed with them under a fostering arrangement but they do if they are a child's special guardian or hold a residence order. For further details about who can hold parental responsibility please refer to appendix 2 of *0-18 years: guidance for all doctors.* You can access this at www.gmc-uk.org/guidance/ethical_guidance/children_guidance_appendix_2.asp

[2] DoH, 1995, Child Protection: Messages from Research TSO

[3] DCSF: Referrals, assessment and children and young people who are the subject of a child protection plan, England - Year ending 31 March 2009

- Yet it is often difficult for families to understand local authority concerns and to engage during s.47 child protection enquiries because–
    - They are often unclear about the totality of the concerns and the reasons for them – they may be given information in a series of different conversations and/or local authority social workers are often unclear themselves about the nature of the underlying problems that need to be addressed and at times may give contradictory views.
    - The fear that the child may be removed by the local authority makes it hard for them to trust and work openly with the social workers to reach agreement about how their child should be kept safe,
    - They are frightened, angry and confused which prevents them from hearing what is being said by the local authority, and they don't know who to turn to for advice,
    - Only a minority of fathers involved with their children are routinely invited to child protection conferences

- So what works?

Independent advice and advocacy for parents/ carers in child protection cases:

Research has found that independent advocacy for parents in child protection processes can have a very positive impact, enabling the parent to hear the concerns, to engage in the child protection conference, and to focus upon the child's needs rather than be caught up in hostilities with the local authority. Key is that the advocate has specialised knowledge of child care law and practice, is non-confrontational, works to a reporting threshold and is independent of the local authority[4].

Further a recent independent evaluation of Family Rights Group's Advice Service[5] found that 88% of family members who had called the advice line felt it had helped them to cope with their situation, with 90% feeling more confident in their dealings with social workers/professionals and 60% reporting that the advice they received had helped the family to stay together. Respondents reported that as a result of their call they had acquired more understanding of their situation (88%). This was linked to a reduction in abnormal psychological functioning, that research suggests is linked to improved parental functioning.

Doctors are in a very good position to refer parents and relatives to sources of independent advice and advocacy and other relevant sources of support when there is any concern about the care being provided to, or safety, of a child, with GP surgeries and health clinics well placed to display advice posters and information materials . Although there is as yet no national provision of family advocacy services, the following sources of advice may be relevant:

- Family Rights Group (FRG) runs a free, independent, confidential national advice service for parents and wider family members who are involved with social care services about the care and protection of their children (tel 0808 801 0366) which is open every weekday 10-3.30. We also provide email advice and have extensive written advice materials on their website (including one on their rights within the child protection [process which can be downloaded for free and given to families – see http://www.frg.org.uk/advice_sheets.html]. Advice posters and leaflets are available from ckanow@frg.org.uk.
- Some local advocacy services have the requisite specialist knowledge to provide advocacy services to parents and relatives in child protection cases. Others which do

[4] Lindley, B, Richards M & Freeman, P, 2001, 'Advice and advocacy for parents in child protection cases – what's happening in current practice? [2001] *Child and Family Law Quarterly* 13:2 at p.167; and Lindley, B, Richards,M and Freeman, P, 'Advice and Advocacy for parents in Child Protection Cases: an exploration of conceptual and policy issues, ethical dilemmas and future directions', *Child and Family Law Quarterly*, 13:3, p1

[5] Ritchie C (forthcoming) Evaluation of Family Rights Group's Advice Service

not have such knowledge, but may be specialists in another relevant areas, for example in adult mental health or learning difficulties, may be able to provide local support whilst accessing specialist advice from FRG to help them effectively support such parents and relatives retaining a focus on the child and without giving them false expectations.

- Ø Solicitors specialising in child care law can also provide advice (subject to funding being available which will depend on the individual's means and the nature and stage that a case has reached) in these circumstances.

Parents need written information about the concerns

Parents and relatives often find it impossible to understand the full implications of the concerns because they are required to piece together what is alleged to be wrong with their care of their child and what they need to do to put it right from a series of different conversations with the range of professionals involved. Our case work experience shows that it is therefore helpful for them and for those advising and supporting them if the **concerns can be set out in writing** with clear information about the processes which are being invoked and the legal position, what is expected of them to address the concerns satisfactorily, the consequences of them not doing so and where they can get independent advice.

Government guidance[6] to local authorities requires that the local authority should send such a letter to parents where care proceedings are being considered. However, its use is patchy and it is often sent so late in the process that there is no time for parents/wider family members to address the concerns satisfactorily before care proceedings commence.

Doctors should be in a good position through their participation in multiagency child protection decision making to check that families are being referred to sources of independent advice, that child protection concerns are explained to them clearly in writing and that the local authority send a letter before proceedings precipitately as soon as there is a possibility of care proceedings.

Child Protection – signs of safety

A new way of professionals working positively with families in child protection has been established in Gateshead, following the 'signs of safety model'. This is a strengths based approach which can inform best practice[7]

Involving fathers as well as mothers in child protection cases

Typically, the focus of the assessment, and indeed any subsequent social work intervention in child protection work, is on the mother and those in her household, failing to assess non-resident fathers and paternal family as a risk and/or resource[8]. Whilst the lead agency conducting the child protection enquiries is the local authority, doctors may also be very involved either because there is a medical concern or because they have long term knowledge about the family. They are therefore in a good position to influence the conduct of the enquiries including the importance of involving the father and the paternal family, both in terms of any risk they may pose and any potential resource they may provide for the child's future care.

Exploring family and friends care for children who cannot remain with their parents:

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[6] Vol 1 Guidance: Children Act 1989 Regulations and Guidance, Volume 1 Court Orders http://www.justice.gov.uk/guidance/careproceedings.htm

[7] Turnell, A & Edwards S, 1999, Signs of Safety: A Solution and Safety orientated Approach to Child Protection Casework, see http://www.signsofsafety.net/

[8] Roskill, C, 2008, Fathers Matters 2, Family Rights Group, London www.frg.org.uk

Where the professional view is that it is not safe for a child to remain in or return to the parents' care at least in the short term, whether for medical or social care reasons, the local authority, working closely with the medical staff, take legal advice on whether there are grounds to apply to court to remove the child either under an emergency protection order or in care proceedings. Typically, partnership working between the family and the professionals becomes strained and adversarial at this point. It is the time when the parents tend to feel most confused, frightened and disempowered; at times it leads to irrational and aggressive behaviour and they find it hard to hear what is being said.

In addition to being referred to sources of independent advice which is crucial at this stage, it's important that all options are explored to enable the child to remain safely within the family network, such as grandparents with whom they have a loving, established relationship. This can be achieved by the family being offered a family group conference.

Family Group Conferences (FGCs) FGCs originate from New Zealand and support families (included extended family members) to take the lead in planning to keep the child safe and promote his/her well-being. The plan is constructed by the family but must address the safeguarding concerns[9]. FGCs are proven to:

- Result in extended family members stepping in to support struggling parents and when necessary to take on the care of the child if s/he cannot remain with their parents;
- Engage fathers and paternal relatives;
- Give children a voice;
- Improve outcomes for children at risk; and
- Be cost effective in preventing children being unnecessarily subject to care proceedings or removed into care. For example, a recent sample of 4 local FGC projects reported that they have prevented 159 children becoming looked after in the last year, including avoidance of proceedings for 87 children, at a saving of approximately £6.76 million

Doctors may come across, or could even negotiate with the local authority, that the family be offered a family group conference. As FGC become more widely used, doctors may also occasionally be invited to attend the first stage of the FGC to provide key information about the child, to inform the parameters of the family's subsequent plan. They therefore need to receive training/information to make appropriate referrals and to be information givers.

[9] Information about the FGC approach, and research evidence on its efficacy, can be found in a Protocol, endorsed by the Family Justice Council and CAFCASS, on the Use of FGCs for children who are or may become subject to care proceedings – see http://www.frg.org.uk/pdfs/FINAL+FGCs+and+courts.pdf

Doctors working in partnership

Doctors are expected to work as a team with other health professionals when they provide treatment and care to a child or young person. Doctors are expected to cooperate with other agencies, such as Local Authority Children and Young People's Services, the police and child protection teams, where abuse or neglect of a child or young person is suspected or known. They may also be asked to work with colleagues when appointed as a 'single expert', or where the court asks experts to discuss issues and advise the court on issues where they agree or disagree.

Q3a: What are your views or experiences about how well doctors work with other doctors, professionals and agencies, when there is the possibility of harm to a child?

- The importance of doctors being open with patients if they propose to breach confidentiality are expressed under Q1 above.
- We are also aware from casework that doctors often don't attend child protection conferences even though they are routinely invited. This means that the information they hold, both about alleged harm to the child and any strengths they are aware of in the family, will only be available, at best, in writing to inform the conference discussions and any resulting plan. We consider that there should be an expectation that GPs/doctors attend CP conferences unless there are exceptional reasons to justify not doing and that they should receive basic training/information on the relevant legal framework.

Q3b: In your experience, do local working arrangements or other factors create confusion, about who has what role and responsibility for acting to protect children and young people, between doctors working in different areas of practice or between doctors and other professionals, when concerns arise about possible neglect or abuse of a child?

Doctors' knowledge skills and experience

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

Q4. What training and other support do doctors need to undertake their particular role in child protection, including preparation and training for giving evidence to the family court? If possible, please provide examples where doctors are (or are not) receiving appropriate training or other support.

See question 1 above