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Child Protection Guidelines

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Samantha Davey asks if they are Good Practice or a case of Guilty Until Proven Innocent

There is no doubt that protecting children is a role which hospitals must now accept. Tragedies such as Victoria Climbié[1] and Baby P[2] highlight the need for inter-agency communication and coordination throughout the child protection process. Hospitals are at the heart of this approach so as to ensure that concerns about babies and children at risk of significant harm or 'in need' are identified as early as possible.

Once concerns have been raised, Working Together 2000 and Southend, Essex & Thurrock Guidelines suggest that there should be appropriate intervention ranging from provision of support for parents to a 'partnership' between parents and Social Services.

Recently, AIMS requested a copy of the Good Practice Guidelines for Staff in the North East Essex Health Trusts. Close scrutiny of the Guidelines reveals that an unnecessarily interventionist approach towards child protection appears to be encouraged in this region. This article explains the troubling aspects of the Guidelines and the implications not only for new parents but for future inter-agency cooperation between North Essex hospitals and Social Services.

The mantra that 'Child protection is everybody's business'[3] makes it clear that any professional who has child protection concerns has a duty to act. However, the Guidelines indicate that parents are under hospital scrutiny from the moment of their child's birth. The Guidelines inform health professionals that: 'All staff coming into contact with children therefore needs to keep the possibility of abuse in mind and ensure they are adequately trained in its recognition.'[4]

At birth, and on every subsequent hospital visit, health care professionals such as doctors and nurses are empowered to assess 'parenting capacity.'[5]

It is unclear what this involves and which parents will have sufficient parenting capacity and which will not. It is suggested that this could be wide in scope and may encompass any number of features of parenting, including rejection of aspects of orthodox medicine such as routine vaccinations. It therefore provides medical professionals with the ability to strongly influence parental choices about medical treatment.

Although looking out for obvious examples of parental inadequacy is common sense, the emphasis placed on assessing the ability to parent is unwarranted. If health care professionals think that a mother has

insufficient skills to look after her baby, the next step could be a professional assessment from safeguarding nurses that the baby is at 'significant risk of harm.'[6]

The consequences of this are likely to be a referral to Social Services. Once Social Services become involved, actions could range from 'support' to removal of the baby from its mother. The approach taken towards subsequent visits to hospital facilities after birth demonstrates a reversal of the burden of proof. Although health care professionals must not close their eyes to the possibility of neglect or abuse, they should not be actively looking for it. The Guidelines refer to the duty of 'screening'[7] all children attending Emergency Departments and Drop-In Centres. It is unclear what is meant by 'screening' but it does seem to suggest that any visit should be considered to give rise to the possibility of neglect/abuse. This means that health care professionals could be actively on the lookout for abuse and may adopt a defensive approach in respect of care. If a doctor or nurse is of the opinion that a child has been abused, significant weight will be attached to such an assessment, despite the fact that there may be no evidence to support it. Parents will then find themselves in the position where they have to prove a negative; that they have not abused their child.

It is more troubling if a baby needs to be taken to hospital. The Guidelines indicate that the younger the child is, the greater the need to be on the lookout for possible signs of abuse. Although health care professionals must be vigilant in ensuring that infants and young children are protected, the Guidelines appear to assume that certain injuries must be caused by abuse and it is for the parent to prove otherwise. They provide a thorough explanation of different fractures a young child may receive and the likelihood that such fractures are caused by abuse. It states that: 'The presence of a fracture in an infant frequently indicates more severe abuse'[8] and also that: 'The younger the child the greater the likelihood of abuse. One or more fractures in a child less than 1 year is highly suggestive of abuse.[9]

This means that should a baby sustain one accidental fracture, it is likely to be assumed that the parents have abused the child rather than presumed innocent unless there are other warning signs. As a consequence, parents may find it difficult to take their baby home unless they can provide an explanation which satisfies health care professionals. Guidelines like this increase the likelihood of parents being treated as guilty until proven innocent, with possible Social Services involvement placing strain on the whole family.

The Guidelines about fractures are based solely on two studies from 1984 and 1999. The Guidelines suggest that spiral fractures are 'unusual' and raise concerns about abuse.[10]

Cage and Salus (2010), for example, suggest that spiral fractures can be caused by accidents, for example babies getting their feet caught in crib slats, and do not always suggest that abuse has taken place.[11,12,13]

It is crucial that more recent academic literature should be used for support considering the likelihood of Social Services involvement under the circumstances.

It might also be wise for the Guidelines to place a greater emphasis on observation of other features

coupled with a fracture which might be suggestive of abuse, e.g. the demeanour of the child, the nature of the bruising in conjunction with the fracture or the provision of a version of events which is inconsistent with the nature of the injuries. This and a consideration of possibilities other than abuse, such as bone disorders, would make the Guidelines much more effective.

The most alarming feature of these Guidelines is that once Social Services have decided not to accept a referral from the hospital, one might be forgiven for thinking that beyond passing on concerns to the family GP, that would be the end of the matter. This is not the case. The Guidelines state: 'DO NOT GIVE UP if your referral was not accepted, you are free to raise your concerns again.'14

This means that even if Social Services are satisfied that a child is not being neglected or abused, further action is encouraged in spite of it.

So not only may parents be treated as guilty until proven innocent but once they believe that their innocence has been 'proven,' health care professionals have carte blanche to continue to pursue parents. This aspect of the Guidelines does not reasonably strike a balance between protecting babies and children versus protecting the interests of the family as a whole. If anything, in this author's opinion, these Guidelines may encourage some health care professionals to engage in their own abuse of parents.

Furthermore, the Guidelines fail to emphasise the notion of 'partnership' in the child protection process. Health care professionals should attempt, to the extent that it is possible, to work with parents. This means that they should explain their concerns and try to resolve matters without conflict, rather than place families under unnecessary stress and put parents on the defensive. The Guidelines may indirectly encourage health care professionals to threaten involvement of Social Services if parents fail to comply with their suggested treatment plans.

The lack of 'partnership' between parents and health professionals and the injustice that can be caused by these Guidelines are apparent. It is necessary to strike a balance so that children are protected without, in the case of blameless parents, harm being caused to the well- being of families as a whole. The danger of unnecessary intervention of health care professionals is demonstrated acutely by the Cleveland Crisis,15 where a number of families were torn apart because of the work of Marietta Higgs, which was later discredited.

As Jean Robinson has pointed out, even short-term unnecessary intervention can be extremely harmful to families.16 This is of particular importance when considering a newborn baby, as the more vulnerable the child is, the greater the perceived need for intervention. Unfortunately, unnecessary and excessive state involvement can be especially harmful to new mothers who may lose important opportunities for bonding, breastfeeding and happy memories of a special time.16

New parents who have had an unpleasant brush with health care professionals and Social Services may fear 'punitive' measures in the future. Therefore, as Jean Robinson has suggested, women may conceal mental health problems, postnatal depression, rape or any other traumatic life event in case their children are taken away. Parents might even avoid orthodox medicine altogether to avoid even the

slightest possibility that they might be parted from their children.16

The Guidelines may also have implications for the working relationship that the NHS has with Social Services. If a hospital makes a large number of referrals despite concerns being dismissed by Social Services, it could become apathetic towards genuine concerns. The little boy who cried wolf comes to mind here; if a hospital makes numerous groundless referrals, Social Services may be less inclined to take referrals from specific health care professionals seriously. The last review of these Guidelines apparently took place in February 2007. In this writer's opinion, these Child Protection Guidelines are cause for 'concern' which should be addressed and amended as soon as possible, for the Guidelines introduce much more potential for abuse than they are likely to prevent.

References

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