CPHVA RESPONSE TO SAFEGUARDING CHILDREN IN WHOM ILLNESS IS FABRICATED BY CARERS WITH PARENTING RESPONSIBILITIES CONSULTATION DOCUMENT

The Community Practitioners' and Health Visitors' Association is an autonomous section of the MSF Trade Union with 18,000 members. It is the third largest professional nursing union and is the only union which has public health at its heart. We welcome the opportunity give feedback on this document and would comment as follows:-

Q1. Are there changes to the guidance which would further strengthen the way in which it promotes effective inter-agency practice which keeps a clear focus on securing good outcomes for children in whom illness have been fabricated or induced?

We feel it is important to stress that the designated professionals must be informed as well as the named professionals. This will ensure that all issues with regard to the case are covered. Experience shows that named professionals are not always aware of the degree of co-ordination that needs to occur. Also, where there is conflict in a case, they may become less objective. The designated professional being kept informed will help this, as their independence across the health sector will enhance the planning for the safeguarding of the child.

Q2. Are the roles and responsibilities set out clearly and correctly?

We are happy with the content of this section. However, we would like to suggest that the chapter entitled "Roles and Responsibilities" be placed before the chapter "Handling Individual Cases". This would seem to be a

more logical sequence and would be comparable to the way that a training session may run. This will also help to stress the accountability that practitioners have before considering individual cases.

Again, designated professionals should be included within as well as named professionals in “Roles and Responsibilities”.

Q3. Are there any elements of the guidance where greater clarity, or more detail, is needed?

The document is quite comprehensive. However, it may be useful to highlight in more detail the likelihood of disabled children being involved in this form of abuse from both parents and professionals.

With reference to “Complaints Procedures” (6.47), in the last sentence we would suggest rather than “it may be *helpful* to involve ...”, it says “it is ***essential*** to involve ...”

With regards to complex strategy meetings, designated professionals should be invited.

There should be an acknowledgement that parents do not always consent willingly to psychiatric assessments and clear advice should be given as to how this situation should be handled.

With regards to covert video surveillance, if this is used to obtain police evidence, consideration must be given as to where and how it is carried out.

Pre-birth child protection conferences should include the evidence based practice that these are best held early on in the pregnancy, preferably before the end of the second trimester.

In the relevant chapter discussing the health authority, it would be more helpful to set this in the context of PCGs and PCTs, as these are the organisations that practitioners relate to.

Q4. Has anything important been left out which should be included?

There should be a strong reminder for caution regarding employment of agency nurses when planning for observation of these children in the ward environment. Any member of staff not trained and briefed on the process should not be placed in a situation of monitoring children under any circumstances.

Should there be a mention of 'abuse on contact' in domestic violence cases, when for example the poisoning of a child is deliberately done to exercise power and control over the mother resulting in accusations of poor parenting/neglect?

The sections on information sharing should be clearer and more prescriptive about how and when information should be shared regarding adult medical histories. There is still confusion about how confidentiality may be breached in order to protect a child. Doctors seem to find this particularly difficult. Disability teams would benefit from child protection training with this area of concern added as a separate module. Caldicott Guardians should be aware of the issues, as should the legal departments of the various health providers.

Private school nurses are professionally accountable to their professional body, not to the head teacher or their employers. This may be worth stating to assist colleagues in those circumstances.

Q5. The guidance includes material from *Working Together to Safeguard Children* and *The Framework for the Assessment of Children in Need and their Families*. Do you consider there is too much, too little or the correct amount of cross-reference to these publications in the document?

We feel that this is satisfactory.

Q6. What needs to be done, and by whom, to implement the new guidance? How might Government most helpfully support implementation?

ACPCs need to implement the guidance as an attachment to their ACPC guidelines. Consistency in approach must be the standard, as variations lead to conflict and allows parents to manipulate the situation. ACPCs must back the guidance with training managed in part by the designated nurse and doctor to ensure that the medical content is clear.

This response does not have to remain confidential.