

Debate

Some ethical issues surrounding covert video surveillance – a response

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Abstract

In a recent article in this journal (1) our unit was accused of a number of errors of judgment in applying covert video surveillance (CVS) to infants and children suspected of life-threatening abuse. The article implied, that on moving from the Royal Brompton Hospital in London to North Staffordshire Hospital, we failed to present our work to the Research Ethics Committee (REC). We did send our protocol to the REC though we did not consider that, after a total of 16 patients had been documented as being the subject of life-threatening abuse, this was research. The REC in Staffordshire agreed with us. We were also accused of undertaking work that should be pursued by the Police. We agree with this. However, unlike the Metropolitan Police the Staffordshire Police would not undertake CVS. We fail to agree that 'working together' with parents is necessarily practical or safe when trying to protect children from life-threatening abuse of this kind.

Introduction

In 1986, our unit first undertook, in collaboration with the Metropolitan Police in London, the CVS of a child with recurrent, unexplained, life-threatening episodes of collapse, which had resulted in cardio-pulmonary resuscitation and 'near death' on several occasions. CVS revealed that the mother was responsible. By 1992, prior to moving to Staffordshire 18 cases had undergone surveillance, 16 revealing intentional suffocation. In one, no abuse was identified under surveillance but subsequent court procedures agreed with the need to protect the child from abuse.

On arriving in Staffordshire, we presented the inter-agency protocol established with the child protection team in London including the Metropolitan Police to the local child protection team. Staffordshire Police stated they would be unable to undertake the surveillance. However, they confirmed that using nursing staff as observers would

not be illegal. Providing evidence was collected carefully, using methods similar to those of the Metropolitan Police, it would be admissible. Our concern, however, was not criminal issues but protection of the child. We considered the surveillance part of our work to be Police activity. At the Brompton Hospital we had included a registered mental nurse as part of the surveillance team, to support the Police officers in the stress of surveillance, and to observe the mother and ensure she was not developing any behaviour which could be dangerous, warranting immediate intervention. We considered that this methodology was the best for all involved, but unfortunately Staffordshire Police could not agree. Unless we provided trained nursing observers to undertake CVS, it could not continue. We discussed with our nursing staff the ethical implications and it was agreed that, although second-best, they should be trained and employed in CVS. We appraised the observer nurses of our publications (2–4) and showed them examples of video-recorded abuse. They were given every opportunity to withdraw and not to be involved.

A further 21 patients have undergone CVS in Staffordshire since August 1992, 16 demonstrating abuse. Thirteen were intentional suffocation, one involved a fracture of the arm and, one involved poisoning and the thrusting of a toothbrush down a child's throat to make her vomit. One involved physical and emotional abuse with unequivocal fabrication of data relating to the child's alleged apnoeic attacks.

The absence of Police during CVS had some negative effects. On one occasion, serious abuse was identified and while waiting for the Police to arrive, the mother attempted to take the baby from the hospital. We were attacked by the mother when we tried to restrain her, fearing further abuse to her child.

The ideal form of CVS involves, therefore, the Police, utilising a registered mental nurse to work with them.

On arriving in Staffordshire, we realised that, although there had been much previous debate in London, there were initial anxieties among the Staffordshire Child Protection Team about CVS.

Key words

Munchausen syndrome by proxy; covert video surveillance.

Although we considered it established clinical practice, we wanted to ensure that there was confidence in this work. We therefore referred our protocol to the REC, pointing out in the submission letter that, in our opinion, it was NOT research. Clearly if they felt it was research, they should address that question and decide whether it was ethical or not. After two meetings, the REC agreed it was not research but clinical practice. At this stage the results of CVS had been published in three medical journals (2–4) and presented at the British Paediatric Association. The developmental work had received approval from the Brompton Hospital REC. However, the Staffordshire REC did suggest a review of our work by a hospital ethics committee. When this committee was formed by the Hospital Trust, our protocol, established by excellent inter-agency collaboration between ourselves and Staffordshire Police, was presented, reviewed and approved.

We fail to understand how much more vigorous we could have been with respect to this and are surprised that Dr Evans did not take the trouble to find out all the facts before writing his paper. Many readers of the report in the *Journal of Medical Ethics* would have concluded that we had not submitted our protocol to the REC. This is not true. Despite this, *The Sunday Times* on 5 February, 1995 in an article criticising our activity, stated: 'Southall will be criticised in the *Journal of Medical Ethics* this month for his failure to seek approval to use video surveillance from his hospital's research ethics committee' (5). On a subsequent BBC radio programme in Staffordshire, Dr Evans stated the following: '... there is a large research element in this practice and as such it ought to have been referred to the local research ethics committee which is set up to protect the interests of research subjects' (6).

As a result of Dr Evans's campaign concerning what he perceives as our failure to involve ethics committees, we have received a lot of criticism from people who have not made themselves cognizant of the facts.

Could we have satisfactorily protected our patients by utilising existing child care proceedings under *Working Together*, the Department of Health guidelines on the management of child abuse? Before CVS is undertaken, a strategy meeting is held and chaired by a senior social worker in the child protection team. This meeting includes the referring paediatrician and child protection team, Staffordshire child protection team and ourselves. On the basis of discussed information, a decision is made by members, in particular the legal adviser to the social services department, as to whether there are sufficient grounds for proceeding to child protection procedures in the court. Since the potential abuse is life-threatening, protection would involve separation of the child from the

suspected parent. This is a serious activity and one which the *Working Together* document tries to avoid. According to the latter, every effort should be made to work with abusing parents, retaining the child within the family. In all of the strategy meetings undertaken to date, there has been unanimous agreement that child care proceedings, whilst they could be explored, had a high risk of failing to protect the child for any length of time should the reality be that a parent were responsible for the child's symptoms. The confrontational approach might work over the short period required for an Emergency Protection order or perhaps even for a few months while intense investigations are undertaken. However, in terms of longer term protection from a condition which is known to arise from a longstanding psychiatric and psychological disorder in the parent, this was not considered likely to be achievable. Considerable support for our concern was highlighted by the response of parents to confrontation after there was video evidence of abuse. Such parents refused, unanimously, to acknowledge their role in abuse, even, on occasion, after the video data had been described to them. *Working Together* assumes that the parents involved are functioning on a level at which you can trust them and that what they say to you is the truth. It is well known that parents who have fabricated and induced illness in their children are unable or unwilling to be truthful in their discussions with professionals in providing care for their child. In our view, 'working together' is an inappropriate concept with respect to the management of children whose parents suffer from factitious disorder.

In his article, Dr Evans suggests that *overt* video surveillance may be a more appropriate procedure. Common sense dictates that this is inappropriate. If the mother knows her child is being videoed, how likely is she to suffocate him? Mothers performing this abuse are devious and know that if detected they are likely to be prosecuted and lose care of their child.

Our protocol enrolls the concept that if the strategy meeting's opinion has been wrong and the parent isn't responsible for abusing the child but rather a natural, yet undetected mechanism is responsible, this will be detected by a combination of multi-channel physiological recording and video surveillance. For safety the child is also attached to an oxygen monitor which would alarm if the child's oxygen level fell, thus alerting observers and parents to respond. To date, however, only one child subject to CVS has been identified as having a natural mechanism for cyanotic-apnoeic episodes, and this was in addition to intentional suffocation.

In conclusion, Dr Evans's article contained some important criticisms of our work which we have addressed. However, it also contained extremely

As it turns out, the concept of responsibility to protects the legitimate interests of both parties in the physician-patient relationship.

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References and notes

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misleading statements suggesting that we had not presented our protocol to a research ethics committee. We consider Dr Evans should have researched this and found out from our hospital the truth of the situation before writing his paper or criticising our child protection work in the media.

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