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## Symposium on covert video surveillance

# Covert video surveillance – an assessment of the Staffordshire protocol

Terry Thomas *Leeds Metropolitan University, Leeds*

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### Abstract

*An assessment of a protocol devised to guide practitioners thinking of using covert video surveillance. Such surveillance is particularly used to help identify cases of Munchausen's syndrome by proxy. The protocol in question has been written by staff at the Academic Department of Paediatrics, North Staffordshire Hospital, Stoke-on-Trent in association with their local Area Child Protection Committee and has been commended by the Department of Health to others wishing to implement covert video surveillance.*

The secret filming of parents visiting their children in hospital to try and secure evidence of ill-treatment and child abuse has been the subject of some criticism (1-4). The technique known as covert video surveillance (CVS) has been developed in particular to counter Munchausen's syndrome by proxy, at the Academic Department of Paediatrics, North Staffordshire Hospital, Stoke-on-Trent. Criticism has further been made that CVS is a form of research that has not been subject to review by any Local Research Ethics Committee (5). The purpose of this paper is to look at CVS as a form of child protection practice.

The Academic Department of Paediatrics of the North Staffordshire Hospital has prepared a protocol on how best to implement CVS (6). This twenty-one page document has been published by Staffordshire Area Child Protection Committee, the inter-disciplinary body charged with co-ordinating child protection matters in a given locality, which is made up of representatives of the local hospital authorities, social services departments, police, education department and any other agency involved with child care and likely to be involved in child protection matters. In turn the protocol has been commended by the Department of Health as guidance all authorities should follow if CVS is being attempted in any hospital (7). The Department of Health is

said to be looking into producing its own guidelines (8), although in response to a Parliamentary question asking what plans there were to introduce regulation of CVS, the Junior Health Minister, Tom Sackville, appears to have confused CVS with general video security in a hospital's grounds. He responded: 'The particular security measures which are appropriate to individual hospitals are the responsibility of local management' (9).

In the meantime what the Staffordshire protocol presents us with is a code to guide us on how CVS might be put into practice. The protocol has nine sections and four appendices. All subsequent references to paragraph numbers are from the protocol.

### 1) Introduction

The protocol provides 'a framework for the investigation of suspicions of abuse among children referred to hospital following apparent life-threatening episodes for which there seems no other probable cause' (para 1.1). This would seem to make it apply to any form of child abuse but in fact it has been written to help manage 'life-threatening cyanotic-apnoeic episodes' where the child is thought to have been intentionally suffocated by a parent or carer (para 1.3).

The introduction outlines its belief that 'children have the right to protection from abuse and ill-treatment'. As the *Cleveland Report* pointed out, however, putting children's rights first is not the same as ignoring parents' rights altogether. A balancing is needed and abusing parents should be 'given the same courtesy as the family of any other referred child' (10). When the evidence suggests a child is at risk the balance tips in favour of care to the child and the child's rights. If sufficiently strong evidence exists to justify the use of CVS it might be argued that it also exists to tip the balance in favour of action without recourse to CVS.

### 2) Principles of referral

When a child is found to be suffering unexplained injuries an initial 'strategy discussion' is organised.

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### Key words

Munchausen's syndrome by proxy; child protection; covert video surveillance.

The protocol suggests this should be organised by the referring authority (para 2.1). This appears to be in contrast to the Department of Health's guidance on child protection procedures where it is stated that it is the 'responsibility of the agency receiving the referral' to initiate a 'strategy discussion' (emphasis added) (11). The seeming contradiction may be cleared up if it is taken that hospitals offering CVS are more likely to be acting on a regional basis rather than for their immediate locality. An initial assessment, including a child protection conference will, therefore, already have been made by other child protection agencies, including police, hospitals, social services departments etc, who will have initially acted as the 'receiving agency'.

### 3) Pre-admission 'strategy discussions'

The pre-admission 'strategy discussion' is used to consider the existing evidence and whether or not it is sufficient or insufficient to institute care proceedings (para 3.3). If the latter, then the appropriateness of CVS may be considered. It is presumed at this stage that working voluntarily with parents, offering family support or general supervision have not been successful in resolving the child care concerns.

On the ward, staff are warned to watch for indicators that include 'parents who contentedly fit in with ward life and attention from staff' (para 3.6 (g)) and 'parents who are unusually knowledgeable about the illness and its repercussions' (para 3.6 (f)). Strategy meetings are to be held in secret and parents not informed of their existence (para 3.7).

### 4) The second strategy discussion

This meeting is to be convened by Staffordshire Social Services Department (para 4.1) and again 'it is essential that parents are not alerted by any breach of confidentiality' (para 4.3). It could be argued that we have here a re-working of the definition of 'confidentiality' that has previously been held to be the keeping of personal information about an identifiable person in conditions of confidence. Confidentiality implies a restriction of the circulation of that personal information in order to maintain the trust and working relationship essential to good practice between the health care professional and the patient. Confidentiality as used in the protocol is much more about keeping information secret within the professional staff group.

It could be said that as the child is the patient in this area of work, confidentiality does not extend to the parent as the non-patient. Alternatively it might be argued that the real patient actually is the adult carer concerned even though he or she has not presented for treatment. Proponents of CVS have agreed that attacks on the child are often due to 'longstanding psychiatric and psychological disorder in the parent' (12).

If we take the concept of 'personal information' as the central component of confidentiality, however, a different perspective can be applied. The 1990 Access to Personal Health Records Act, for example, states that normally parents have a right of access to all information held about their child (1990 Act s.4 (c)). In practice the 'withholding' provisions of the same Act would probably be applicable in a case of CVS (s.5). Within the protocol nurses are asked to keep contemporaneous notes during CVS (para 6.6), and the videotapes themselves can also be considered as part of the medical record.

There is also no mention in the protocol of why 'strategy discussions' take place rather than child protection conferences. The latter, of course, are more formal and there is an expectation that parents will be invited to attend – but again provisions to keep them from attending can be activated and proceedings are completely confidential (13). It would certainly be unheard of for health and social services personnel *not* to have a child protection conference in any other situation where there was an alleged life-threatening episode for a child or children. As only a child protection conference can place a child's name on a child protection register, it also means that these children considered in danger of their life never even get on to the local register, for any protection it might afford. If the 'strategy discussions' are seen as sufficient for the involvement of the CVS-providing hospital (possibly because they are geographically away from the referring agency (see above)), it always makes the 'discussions' rather marginal to the overall child protection procedures as envisaged in *Working Together* (14).

One of the suggested agenda items for this strategy meeting is seeking the leave of a court to set up CVS if care proceedings are already in process (para 4.4 (k)). If care proceedings are already in process, however, presumably the necessary evidence already exists to lay before the court. Use of CVS in these circumstances does seem unnecessary and does smack of what an unattributed *Lancet* editorial has called 'vindictiveness' (2). Local authorities (who initiate care proceedings) would rarely want to go before a court whilst still in the process of gathering evidence.

Another agenda item raises further concerns. If a child is removed from hospital during CVS and before an incident has been filmed – as a parent would have every right to do – the protocol, although recognising this might happen, is silent on what action should follow (para 4.4 (l)). Later it suggests 'the nurse in charge of the ward must be contacted immediately' (appendix 3, para 12) but again says nothing about what should be done. However much one would like to take action, it is contended that none is legally possible, without allegations of 'false imprisonment' being heard.

In fact this is really a crucial question with which any CVS arrangement must have some difficulty. If you can stop parents removing children without film

evidence you must already have enough evidence to take that action. If you cannot stop them and they refuse to consent to a re-admission the agencies concerned will have to consider alternative action that does not involve CVS.

### 5) Applying CVS

A cubicle is prepared with a secret camera (para 5.5) and nurses take up their surveillance stations, two at a time, for eight-hour shifts (para 5.8). All nurses are volunteers (appendix 2, para 3 (iii)) and receive special training. All equipment is checked out by hospital electronics staff (para 5.5 (e)). When CVS first started in the mid-80s the police, rather than nurses, took on this role (15). Why the police in Staffordshire are more reluctant to get involved in CVS remains uncertain. Police forces in England and Wales do have their own Home Office guidelines to follow when mounting covert surveillance operations and it is possible that these guidelines have been interpreted as being more prohibitive in terms of hospital-based CVS (16).

The protocol advises that 'child and parent must not move into the surveillance cubicle until all preparations required for CVS are completed' (para 5.4). There is no mention of what explanation parents are given for either the admission to hospital or a move from a shared ward to the private cubicle. Physiological monitoring would be an explanation, but clearly they are not told the complete truth and the question of how much 'deceit' is being practised on them here is another important ethical question.

The child is subject to physiological monitoring by attached equipment, as used for sleep studies (para 5.6). In the past it has been suggested that this equipment has also been useful in 'anchoring (the child) within the field of vision of the camera' (17). In practice, it is accepted that this is not as restrictive as it might sound. (This point was made by nursing staff from the North Staffordshire Hospital Trust at a workshop on CVS presented by Professor Southall at the conference, Munchausen's syndrome by proxy, which was held on the 5th of October, 1994 at Wakefield, West Yorkshire.)

During filming care must be taken not to film the parents on their own away from the child as this would be 'invasive of the parents' privacy' (appendix 4, para (a)). If an incident takes place staff have to intervene promptly to protect the child (appendix 3, para 6). A parent attempting to leave at this point with the child must be restrained using all possible personnel including, if necessary, porters (appendix 3, para 11). It is not fully clear what legal powers are being used here to detain a person who is actually not the patient, and before any orders exist on the child. Presumably staff would be covered by common law in protecting 'life and limb' of the child.

At the end of the process, whether or not they have been used, the video cassettes are retained by

the North Staffordshire Hospital (para 5.10). According to the protocol this is in accordance with the 'recommended practice regarding the video recording of children' (para 5.10). If this is a reference to the Home Office 'recommended practice' on child interviews on video where children are talking about the abuse they have suffered, (18) then the hospital is not strictly keeping to those guidelines.

There is, for example, no mention of destroying tapes when no longer required, as the Home Office guidance requires (19). The protocol further states that these tapes are later used for training purposes with nurses interested in taking up surveillance duties (appendix 2, para 1 (iii)), but the protocol makes no mention of the need for the consent of those in the video to do this, which is what the Home Office guidance requires. In the case of interviews the videotapes can only be used in training if 'specific and informed consent has been given for that purpose' by the child, or if he or she does not understand, after consultation with 'the adult who discharges the principal duty of care for the child' (20).

### 6) Management of surveillance staff

Nursing staff are volunteers who have been appropriately trained and who are given support for this very stressful work. Full notes have to be kept by observers.

The protocol does not say what happens if the team get it wrong and fail to intervene in time. Who would be responsible in any action for negligence – the people who set the CVS arrangements in place, or those who failed to act swiftly enough?

### 7) Talking to other family members

It is accepted that families may be in shock when told of what has happened. Initially, senior medical or nursing staff will approach the family. There is no suggestion that these family members be approached *before* CVS is used; presumably they could not be trusted to maintain confidentiality, ie not to tell the suspected abuser.

### 8) Staff support and feedback

The stress levels for nursing staff are recognised and appropriate support duly given.

### 9) Access to videotapes

Tapes are given to the police if there are criminal proceedings and to the social services if there are civil proceedings (paras 9.1 and 9.2). If there are no proceedings 'and no abuse is demonstrated during CVS' the hospital retains the tapes (para 9.3); there is no mention of whether parents are actually told their children have been secretly videoed when nothing has been found, or whether or not an

apology is offered. As we have already noted, tapes are returned to the Academic Department of Paediatrics after court proceedings and are used in training (see Section 7 above).

## Conclusions

The protocol is an important document of guidance in implementing CVS; it does, however, raise a number of questions that still need to be answered. The Department of Health will need to do a lot of work to iron out some of the contradictions and vagueness of the protocol. It will also need to place it fairly within the context of the Children Act 1989, which is the legal framework for all child protection work. The Department of Health's current guidance on the Act emphasises:

'the importance of professionals working in partnership with parents and other family members (and) ... fully involved from the outset in all stages of the child protection process, and (with) ... as much openness and honesty as possible between families and professionals' (21).

It may be that arguments revolve around the interpretation of the word 'possible', but it remains true that all children are covered by the Children Act 1989 and however dreadful the acts perpetrated by adults against children may be, there is not a category of children that falls outside the Act's jurisdiction.

*Terry Thomas, BA, is Senior Lecturer in Social Work at the Faculty of Health and Social Care, Leeds Metropolitan University, Leeds.*

## References

- (1) Anonymous. Diagnosing recurrent suffocation of children [editorial]. *Lancet* 1992; 340: 87.
- (2) Anonymous. Spying on mothers [editorial]. *Lancet* 1994; 343: 1373.
- (3) Foreman D M, Farsides C. Ethical use of covert videoing techniques in detecting Munchausen's syndrome by proxy. *Lancet* 1993; 307: 611.
- (4) Thomas T. Covert video surveillance. *New law journal* 1994; 144: 966.
- (5) Evans D. The investigation of life-threatening child abuse and Munchausen's Syndrome by Proxy. *Journal of medical ethics* 1995; 21: 9-13.
- (6) Staffordshire ACPC. *Guidelines for the multi-agency management of patients suspected or at risk of suffering from life-threatening abuse resulting in cyanotic-apnoeic episodes*. January, 1994.
- (7) Department of Health. Protocol on videoing children in hospital. *Children Act news* 1994; 12: 5.
- (8) Cervi B. Department of Health backs covert video in child abuse cases. *Community care* 1994; Feb 17: 1.
- (9) Hansard, 24 Oct 1994. PQ 5469 (1993-4).
- (10) The Cleveland Report. *Report of the Inquiry into Child Abuse in Cleveland, 1987*. Cm 412. London: HMSO, 1988: para 246.
- (11) Department of Health. *Working together*. London: HMSO, 1991: para 5.13.1.
- (12) Southall D P, Samuels M P. Some ethical issues surrounding covert video surveillance - a response. *Journal of medical ethics* 1995; 21: 104-105, 115.
- (13) See reference (11): para 6.1-6.35.
- (14) See reference (11): *passim*.
- (15) Samuels M P, McCloughlin W, Jacobsen R R, Poets C F, Southall D P. Fourteen cases of imposed upper airway obstruction. *Archives of disease in childhood* 1992; 67: 162-170.
- (16) Home Office. *Guidance on the use of equipment in police surveillance operations*. London: HMSO, 1984.
- (17) Southall D P, Stebbens V A, Rees S V, Lang M H, Warner J O, Shinebourne E A. Apnoeic episodes induced by smothering: two cases identified by covert video surveillance. *British medical journal* 1987; 294: 1637-1641.
- (18) Home Office/Department of Health. *Memorandum of good practice on video recorded interviews with child witnesses for criminal proceedings*. London: HMSO, 1992.
- (19) See reference (18): para 4.16.
- (20) See reference (18): para 4.17.
- (21) See reference (11): para 6.11.

## News and notes

### The XIVth International Conference on the Social Sciences and Medicine

This conference will be held at Peebles Hotel Hydro, Scotland from 2-6 September 1996.

Themes of the conference include: Behavioural changes in health-related behaviour: lessons from AIDS research; Beyond the orthodox: heresy in medicine and the social sciences; Causes of change in the health of populations; Child development: vulnerability and resilience in adversity; Comparative health care systems: recent

reforms, and Cultural problems of ageing - especially in relation to gender and intergenerational equity.

The registration fee is £120. Registrations will be accepted in the order of fees received, subject to a quota in favour of participants from the Third World.

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