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Debate

Covert video surveillance: the Staffordshire Protocol – a response to Dr Shinebourne

Terry Thomas *Leeds Metropolitan University, Leeds*

Abstract

This paper is a response to Dr Shinebourne's response to my recent paper assessing the relative merits of the Staffordshire Protocol on covert video surveillance. Dr Shinebourne does not take the opportunity to rebut the criticisms made of the text of the protocol. It is further suggested that judicial oversight of the use of CVS might accord the process a degree of proportionality.

In response to my paper[1] making a critical assessment of the protocol produced by the Academic Department of Paediatrics at the North Staffordshire Hospital to guide personnel implementing covert video surveillance (CVS), Dr Shinebourne suggests a number of "misrepresentations of fact" have been made.[2] These are threefold:

(a) I say CVS is to film parents at the bedside of children, when actually it is the children being filmed. This distinction seems overly semantic when the Staffordshire Protocol is replete with references to the need for secrecy from the parents, the need for a mental health nurse to be present if possible, the need for the swift entrance of nursing staff if an abusive incident is observed, etc etc.
(b) I say CVS was first used in Staffordshire when it was actually London. In fact I only said it had "been developed" at Staffordshire; in an earlier publication I unequivocally state that "CVS was introduced into the UK by consultants at the Royal Brompton Hospital in London".[3] One of the developments we did not see in London, has been the widespread publication of the protocol prepared in Staffordshire.
(c) I state that "CVS is a form of research that has not been subject to reviews by any local research ethics committee". The statement was based on Evans.[4] It is withdrawn as we now know "the protocol was presented to the research ethics committee of the Brompton Hospital, where after extensive debate it was approved".[2] The implication is that the Staffordshire Protocol and the Royal Brompton Hospital Protocol are essentially one and the same document; in fact we know this cannot be so because in London the police do the surveillance and in Staffordshire they do not. The protocols would need to reflect this major difference.

Key words

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

Shinebourne's decision "not (to) deal with textual details" in his response, means he loses an opportunity to comment on the protocol and its relationship to confidentiality, the Access to Health Records Act 1990, the use of strategy meetings rather than child protection conferences, the anomaly of using CVS whilst care proceedings are already in progress, the secure storage of videotapes and other matters all raised in my article. Why the opportunity was not taken is not known.

Shinebourne asks the question: "what possible harm is done to the parents" by CVS. Later he suggests "CVS is a diagnostic activity that causes no harm to the child".

The actual running of a video camera is no doubt harmless, much as a gun lying unused on a table is harmless. What makes CVS "harmful" is the elaborate arrangements, deception (acknowledged as a harm by Shinebourne) and breach of trust that is entered into. An operation so complex it requires a 21-page protocol to guide the personnel concerned and creates for them, what the protocol itself calls a "scenario of extreme emotional stress".

When I propose the possibility of "action" without CVS I am proposing the same action that takes place in the overwhelming majority of child protection work that does not use CVS. These are actions on a continuum from negotiated supervision through to care proceedings to gain a care order. Shinebourne's reference to "trial separation" of a mother and child as being "cruel and harmful for the child and the mother" is confusing. There is no concept of "trial separation" in the Children Act or any other UK child care legislation; the term can only refer to something that is voluntarily entered into by the parents. Clearly if that was "cruel and harmful" to the mother she would not consent to it.

Shinebourne suggests a positive aspect of CVS is the helping of parents to "refute allegations" and

prove their innocence. This would imply not only that innocent parents have in the past (in pre-CVS days) been wrongly accused, but also that there is almost an onus on parents to prove their innocence and "refute allegations".

Natural justice has traditionally been premised on the belief that people are innocent until proved guilty, with the onus being on the accuser making the charge or allegation, to prove his or her case. To suggest the accused must prove his innocence, makes it easier for the accusers to allege, and turns traditional justice on its head.

Finally Shinebourne suggests that "those who are not actively involved protecting ... children should perhaps be more reticent about criticising those who are endeavouring to do the best possible for the child even if that means making difficult ethical decisions".[2] This statement raises a number of points:

(a) the author does have 12 years' professional experience of child protection, including three years at the Leeds General Infirmary as a senior medical social worker, working with the paediatric department and the accident and emergency department.
(b) the protection of children is not solely a professional activity but one which should engage all citizens all of the time.
(c) those professionals charged with protecting children on behalf of the public, must expect the public to have a legitimate interest in scrutinising their work. Covert video surveillance may be (and often is) the start of judicial proceedings and "justice must be seen to be done". An open and public debate on CVS can only be helpful, both within the pages of academic journals such as this one and indeed on a wider front. And:
(d) the public could take over some of these "difficult ethical decisions" through the medium of the courts.

I have elsewhere argued that CVS might properly be the subject of judicial oversight.[5] Leave of the court could be sought *every time* CVS is being considered and not just when care proceedings have started, as the protocol currently requires. Applications could be "*ex parte*" to protect the secrecy; the court could be empowered to make other orders if it felt the evidence already existed without recourse to CVS. A court saying "no" to CVS would not be "criticising those who are endeavouring to do the best possible for the child" but simply adding a degree of detachment and proportionality to those "difficult ethical decisions" that have to be made.

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

References

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4 Evans D. The investigation of life-threatening child abuse and Munchausen's Syndrome by Proxy. *Journal of Medical Ethics* 1995; **21:** 9–13.
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News and notes

American Physicians' Poetry Association

The American Physicians' Poetry Association held its first meeting on June 16 this year in Farmington, Connecticut. The goals of the association are: To provide a forum for all physicians who love poetry; to foster the interactions of medicine and humanity; to allow physicians of similar aspirations to gather together and support each other through mututal enrichment.

APPA publishes a periodical approximately four times a year, where members may find room for their creations. APPA is a non-profit organisation currently supported only by membership fees ($25 annual fee) of its members.

All interested physicians should contact either Dr Rita Iovino or Dr Lodovico Balducci for more information.

Dr Balducci is Program Leader, Senior Adult Oncology Program, Division of Medical Oncology and Haemotology, Dept of Internal Medicine, USF College of Medicine, 12902 Magnolia Drive, Tampa, Florida 33612-9497 USA. Dr Iovino, the APPA Literary Editor, can be reached at: 34-1 Arnold Way, West Hartford, CT 06119 USA (860) 523-1100.