Jeremy Gibson, Michelina Racioppi and Jasmine Nembhard-Francis

What makes a good-quality GP report for an Initial Child Protection Conference?

J Gibson, MRCGP, named GP for safeguarding children; **M Racioppi**, BSc, RGN, assistant director for safeguarding children/ lead designated nurse for safeguarding children, NHS Derby and Derbyshire Clinical Commissioning Group, Derby.
J Nembhard-Francis, DipSW, head of service for children quality assurance, Derby City Council, Derby.

Address for correspondence
Jeremy Gibson, NHS Derby and Derbyshire Clinical Commissioning Group, Cardinal Square, 10 Nottingham Road, Derby DE1 3QT, UK.
Email: jeremy.gibson@nhs.net

Submitted: 19 June 2019; **Editor's response:** 16 July 2019; **final acceptance:** 23 July 2019.

DOI: https://doi.org/10.3399/bjgp19X706529

INTRODUCTION

Under the Children Act 1989, when safeguarding concerns arise in England, local authorities (LAs) have a statutory responsibility to carry out a Section 47 Enquiry. This may lead to an Initial Child Protection Conference (ICPC), which relies on collating pertinent information from relevant agencies. Because GPs are a key health representative, who may hold crucial information in their records, they should be invited to submit a written report for and, if able, attend the ICPC. GPs have been poor attenders at ICPCs and locally it has been found that offering teleconferencing as an alternative to attending in person was not taken up.[1]

The General Medical Council (GMC) and the Royal College of General Practitioners (RCGP) both recognise that doctors have a professional responsibility to *'contribute to child protection procedures and provide relevant information to child protection meetings'*.[2] If they cannot attend, they should provide *'a comprehensive report … prior to the conference'*.[3] Because many factors can lead to a child being at risk of, or suffering, significant harm, it is essential that GP reports contribute intelligently to this process. Their reports should contain relevant health information (about the parents and the child) to help Children's Social Care protect the child from harm. Their reports should attempt to capture the voice of the child and to analyse critically any health issues in relation to the child and the impact parental health may have on the situation (Box 1).

IDENTIFY HEALTH-RELATED RISK FACTORS

The United States National Incidence Study (NIS) is a congressionally mandated, periodic effort to provide updated estimates of the incidence of child abuse and neglect. NIS-4, the most recently conducted (2010), reported the following.[4] Children with a disability were more likely to suffer from emotional abuse and girls were at greater risk of sexual abuse. Children living with two married biological parents had the lowest rate of overall maltreatment (6.8 per 1000), whereas those living with one parent who had an unmarried partner in the household had the highest incidence (57.2 per 1000). Perpetrators could have problems with alcohol and drug misuse and mental illness. Risk of maltreatment was higher in families with four or more children. Children aged ≥6 years, those from lower socioeconomic status groups, and those with unemployed parents were at highest risk of maltreatment. It was estimated that black children (24.0 per 1000) were nearly twice as likely as white children (12.6 per 1000) and 1.7 times more likely than Hispanic children (14.2 per 1000) to experience maltreatment. Although these are potential risk factors for abuse, it must be emphasised that *'children in all social classes can be maltreated, and physicians need to guard against biases toward low-income families'*.[5]

Although the child's social worker should establish their age and sex, and construct a straightforward genogram, it is the authors' recommendation that GP reports should detail which family members are registered at the practice and how many children live in the family home. Comment should be made on the biological and non-biological relation to the child of adults living there (for example, if they have parental responsibility), their employment status (if known), and whether they have problems with substance misuse or mental or physical illness that could impair their ability to look after the child.

Children and adolescents who live in homes where there is domestic abuse are at increased risk of experiencing emotional, physical, and sexual abuse, of developing emotional and behavioural problems, and have increased exposure to other life adversities. It has also been reported that children who are not brought to appointments are more likely to be on a child protection plan. These additional potential risk factors should also be considered.

REFERENCES

1. Gibson J, Nembhard-Francis J, Racioppi M, Evennett J. Communication, communication, communication: the key to improving general practitioner report submission for Initial Child Protection Conferences. *Child Abuse Rev* 2019; **28(4):** 310–311. DOI: 10.1002/car.2572.
2. General Medical Council. *Protecting children and young people: the responsibilities of all doctors*. 2012. https://www.gmc-uk.org/-/media/documents/Protecting_children_and_young_people___English_1015.pdf_48978248.pdf (accessed 24 Sep 2019).
3. Royal College of General Practitioners, National Society for the Prevention of Cruelty to Children. *Safeguarding children and young people: the RCGP/NSPCC safeguarding children toolkit for general practice*. 2014. https://www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/Files/CIRC/Safeguarding-Children-Toolkit-2014/RCGP-NSPCC-Safeguarding-Children-Toolkit.ashx (accessed 24 Sep 2019).
4. Sedlak AJ, Mettenburg J, Basena M, *et al*. *Fourth national incidence study of child abuse and neglect (NIS–4): report to Congress*. 2010. https://www.acf.hhs.gov/sites/default/files/opre/nis4_report_congress_full_pdf_jan2010.pdf (accessed 24 Sep 2019).
5. Dubowitz H, Bennett S. Physical abuse and neglect of children. *Lancet* 2007; **369(9576):** 1891–1899. DOI: 10.1016/S0140-6736(07)60856-3.
6. Ofsted. *The voice of the child: learning lessons from serious case reviews. A thematic report of Ofsted's evaluation of serious case reviews from 1 April to 30 September 2010*. No. 100224. 2011. http://www.bucks-lscb.org.uk/wp-content/uploads/Serious_Case_Reviews/Ofsted_Report_The_Voice_of_the_Child.pdf (accessed 24 Sep 2019).
7. HM Government. *Information sharing: advice for practitioners providing safeguarding services to children, young people, parents and carers*. 2018. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf (accessed 24 Sep 2019).

Provenance

Freely submitted; externally peer reviewed.

Competing interests

The authors have declared no competing interests.

Discuss this article

Contribute and read comments about this article: **bjgp.org/letters**

Box 1. Recommended minimal contents of GP ICPC report

Identify health-related risk factors		
Child's developmental needs	• How long has the child been registered with the practice? • Medical conditions (in lay language), indications for and concordance with treatments • Behavioural issues in the child • Physical or learning disability • Is there a history of abuse or neglect? • Are immunisations up-to-date or have they been delayed?	• When was the child last seen in the practice? • What is the frequency and appropriateness of the child's attendances at the GP surgery, emergency department, and NHS out-of-hours services? • Alcohol or substance misuse in the child
Family and environmental factors	• Which family members are registered with the practice? • Biological and non-biological link of household adults to child (for example, if they have parental responsibility)	• Ethnicity of child and family members • Parental employment status • Number of children in family home • Domestic abuse
Parenting capacity	• Substance misuse • Alcohol misuse • Mental illness	• If a parent has problems with substance misuse/alcohol misuse/mental illness, are they having treatment for this, and are they compliant with treatment? • Parental physical or learning disability • Child not brought to appointments
Capture the voice of the child. Clearly explain and critically analyse health information – THINK FAMILY. If safe to do so, has the GP shared the details of this report with the child's parents?		

CAPTURE THE VOICE OF THE CHILD AND CRITICALLY ANALYSE RELEVANT HEALTH INFORMATION

The United Nations recognises that children have the right to be involved in decisions that affect their lives and the Children Act 2004 places a statutory duty on LAs to involve children in child protection decision-making processes. Unfortunately, the view of children is often not represented in Child Protection Conferences. In one report of 67 serious case reviews evaluated by Ofsted between 1 April and 30 September 2010, it was felt that the children were not asked about their views and feelings.[6] Therefore, it is recommended that GP reports should attempt to capture the voice of the child. What was it like for the child to live in their family home?

Given that the ICPC is mostly attended by non-medical professionals, and parents, it is important for medical terminology to be explained in simple terms, including relevant critical analysis of that health information. For example, if a child was not brought to an annual asthma review they may suffer from increasing cough, wheeze, and shortness of breath. If they miss epilepsy reviews they could be experiencing undocumented seizures. Even if the GP has not seen the child recently they can still comment on these potential health issues. An immunisation history and medication list are unhelpful for the ICPC without explaining if the immunisations are up-to-date, what each medication is prescribed for, and whether it is believed to be taken regularly. GPs should also consider including details on how long the child has been registered at the practice, when were they last seen, and the frequency and appropriateness of their attendances at the GP surgery, emergency department, and NHS out-of-hours services.

Such critical analysis also applies to parental health issues. Does a parent with, for example, bipolar disease adhere to taking their prescribed medication? If not, how could their potential mood fluctuation affect their parenting capacity? From a health perspective, what does the GP feel are the strengths and weaknesses of the family? Do they have any additional concerns?

While *'information sharing is essential for effective safeguarding and promoting the welfare of children and young people'*, it is important to *'be open and honest with the individual (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so'*.[7] It is therefore suggested that, where possible, the details of the ICPC should be shared with parents before it is submitted.