General Medical Council

General Medical Council response: Home Office call for evidence – mandatory reporting duty for child sexual abuse and exploitation.

We are grateful for the opportunity to respond to the call for evidence.

We were fortunate to be invited to give evidence to the Independent Inquiry into Child Sexual Abuse, and to take part in the seminars that considered the evidence base around mandatory reporting. As the regulator for doctors (and in future Physician associates and Anaesthesia Associates), we are keen to share our perspective. We would also want to work with the Department of Health and Social care, and others in the healthcare sector, to consider how we can collectively support change in this area.

We are responding to questions 6, 10, 12-14, 17-19, 22-25, 27-28 and 32. Other questions fall outside our remit and expertise.

Q1: We are replying as an organisation.

The General Medical Council (GMC) is an independent organisation that helps to protect patients and improve medical education and practice across the UK.

- We decide which doctors are qualified to work here and we oversee all stages of UK medical education and training;
- We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers;
- We take action to prevent a doctor from putting the safety of patients, or the public's confidence in doctors, at risk.

Every patient should receive a high standard of care. Our role is to help achieve that by working closely with doctors, their employers and patients, to make sure that the trust patients have in their doctors is fully justified. We are independent of government and accountable to Parliament. Our powers are given to us by Parliament through the Medical Act 1983.

Q4: You may quote from our response.

Section 1: Who the duty should apply to

Q6 At what level should mandatory reporting apply?

- Only at an individual level

- Only at an organisational level (bodies, institutions or groups)
- Both individual and organisational level
- General duty on adult population
- Don't know.

GMC response

We want to start by making clear that, we strongly support initiatives that help health professionals and others to understand and meet their responsibilities for supporting children and young people and protecting them from abuse and neglect. Our professional standards for doctors, and the requirements we set for medical education and training, play an important part in driving good practice in this area.

We agree with the Inquiry that greater priority should be given to preventing child abuse and exploitation. We also agree that more should be done to tackle the systemic issues that influence the way that organisations, and the individuals associated with them, respond to child sexual abuse.

We have closely followed the work of the Independent Inquiry into Child Sexual Abuse (IICSA), and considered their analysis of the complex evidence base about, and differing views on, the benefits and drawbacks of introducing statutory duties to report concerns about child sexual abuse. We note IICSA recommends that a mandatory reporting duty should be placed on individuals in regulated professions and other positions of trust, with criminal sanctions attached to a failure to report. However, we are struck by the extensive evidence in IICSA's final report about the ways in which an organisation's leaders and the institutional culture that they create can act as serious barriers to employees, contractors or volunteers feeling able to raise or to follow up on concerns about suspected or known abuse of a child or young person. (For example, see Section A, paras 44-46; Section C, paras 3, 7, 20-24 and 27; and Section F4.) If a mandatory reporting duty is being introduced, we would argue that it should be set at the organisational level.

Our own experience suggests that leadership behaviours and an organisation's culture can be critical factors in enabling individuals to feel safe to speak up, make reports and continue to pursue their concerns. We believe that, facing the risk of a criminal conviction, for the judgements they may make in what IICSA describes as the complex challenges of recognising and acting on child sexual abuse, would not help to create the sort of supportive speaking up culture that IICSA identify as important to improving child protection practice.

Certainly, within healthcare, setting the duty at the organisational level would link to and support compliance with relevant professional duties, as set out in our guidance on Protecting children and young people (and similar duties established by the other health and care regulators). There is precedent for this approach in relation to the statutory Duty of Candour (in England and Wales) which applies to errors and serious incidents affecting the safety and efficacy of services provided to patients. The organisational Duty of Candour is helping to drive culture change, and to support leadership commitment to creating and maintaining workplace environments that support

individuals to comply with their professional duties (see the National Data Guardian 2021 freedom to speak up index report*). It's our view that the organisational Duty of Candour and regulators' professional duty of candour are mutually reinforcing, in terms of achieving improved reporting and a greater focus on patient safety and service improvement.

We have commented previously on proposals to introduce statutory reporting duties, aimed at improving the way that organisations and individuals respond when a child, young person or adult is at risk of serious harm. We shared our concerns about the likely negative impacts, on individual healthcare professionals and on their relationships with patients, if they are subject to a mandatory reporting duty accompanied by criminal sanctions for failure to report. We give more details about these concerns in response to questions 10-14.

Section 2: Scope of the duty

Q10 Should a MRD go beyond the IICSA scope and cover other/all types of abuse and neglect – yes/no/don't know.

We note that IICSA concluded, after detailed scrutiny of the issues, that a MRD should apply only to child sexual abuse and exploitation. We are not aware of additional evidence, outside of that reviewed by the Inquiry, that supports going beyond the IICSA recommendations.

However, we have concerns about the possible impact of the proposed IICSA duty on how professionals and services respond to other serious child protection concerns. And we believe that further thought should be given to the possible impact of a much wider duty, on a professional's ability to effectively support children and their families around less serious, but equally important welfare concerns.

(a) Doctors' professional duties, to report and act on child protection and welfare concerns, cover a wide spectrum of issues. They exist along a continuum, from the most serious matters of sexual abuse and all forms of violence and exploitation (which require urgent safeguarding action), through to lower-level concerns about a child's general welfare that require supportive interventions with the cooperation of their parent(s) or carers. This is recognised in IICSA's report at section C2, paragraphs 6-10 in particular.

There is a risk that, a MRD that applies only to sexual abuse and exploitation would have the effect of creating an artificial hierarchy for child protection work. Diverting safeguarding resources and services, which are currently under considerable strain, away from tackling these other areas of concern in order to prioritise those matters where a

* NHS National Guardian (2021) *Freedom to Speak Up index report 2021*. Available online.

failure to report would result in criminal prosecutions. This was identified as a risk in the IICSA evidence sessions around how MRDs have operated in other countries, where we note it was suggested that MRDs need to be accompanied by increased investment in support services for children and families as well as an expansion in the safeguarding workforce.

(b) We set demanding standards for doctors' child protection practice across the spectrum, and we are clear that if they fail to meet our standards they face the possibility of disciplinary action including removal of their right to practise. Introducing a MRD for individual professionals accompanied by criminal sanctions would mark a significant change in the regulatory and legal risks that doctors face when dealing with children and their parents/carers. This may act to discourage some individuals from entering areas of medical practice or taking up roles where they would be particularly exposed to a risk of criminal prosecution.

(c) One effect of a MRD is to override a patient's right to confidentiality in a particular area. However, provision of a confidential health service is key to the relationship of trust which gives people confidence to engage with healthcare professionals in an open and honest way. There are currently very few mandatory duties on health professionals to disclose confidential information, and none that carry criminal sanctions. Governments have been cautious about introducing proposals that set aside professional obligations to protect confidential health information. However, the MRD as recommended by IICSA would apply much more widely than any existing MRD. In effect, it would apply in every healthcare setting where concerns about a child or young person might arise; in multiple interactions between a child and health professionals and/or between their parent(s) and professionals; and in interactions with adult patients who are in a position of trust or a regulated profession.

Based on these considerations, it seems to us that a MRD that applies to all types of abuse and neglect would have significant drawbacks. These might have implications for the positive role that healthcare services and staff currently play, in terms of providing a supportive space and relationship of trust that creates the opportunity for vulnerable children to make disclosures and seek help.

Q12 What impacts (positive or negative) would MR have on:

- Children
- Individuals in scope of duty
- Organisations
- Individuals/organisations outside scope of duty
- Agencies in safeguarding system required to respond to reports of abuse
- General public

In previous consultations on different forms of mandatory reporting duties we have outlined the importance within healthcare of building and maintaining relationships of trust between doctors, children and young people, and their parents and carers. We have explained how statutory duties to make disclosures, even when narrowly targeted, can undermine trust in the confidentiality of doctor-patient relationships more broadly. (See also our response to question 10.)

In terms of the practical impact on healthcare professionals, past experience suggests that implementing a new mandatory duty requires:

- Considerable investment in awareness raising programmes amongst the professionals who are subject to the duty or would be impacted by an organisational duty
- Clear pathways for making reports and following up on concerns
- availability of relevant education and training (and access to the supporting evidence base) to ensure that those who are subject to the duty have the necessary knowledge and skills to meet their responsibilities
- availability of up-to-date national guidance and other supporting resources for organisations and/or individuals who are subject to the duty
- information for children, parents and carers, and the wider community. They need to be aware of how the duty may impact their interactions with different services, and need to understand the processes for reporting and follow up if they find themselves involved in anyway.

These practical considerations would be even more important, if implementing a new duty which has criminal sanctions attached. In particular, it is important that healthcare professionals have a clear understanding of what is expected of them at each stage. For example, it is essential that they understand the behaviours or other signs indicating abuse or exploitation which should trigger a report, in their particular area of practice; and that they are clear on the process for escalation if the reporting duty sits at the organisation level.

Clarity about professional expectations can in turn provide clarity for children and their parents and carers about the reporting requirement and how it might impact on them. Transparency and openness of this kind is a crucial element of good patient care, and it is a strong expectation in our existing guidance on Protecting children and young people. We make clear that doctors must (with some limitations) tell children, young people, and their parents when they have concerns about abuse or neglect, how they will act on them, what information has been shared, with whom, why and how it will be used. We have heard directly from health professionals working in child safeguarding roles that transparency of this kind can help to maintain patient engagement with health services, in circumstances where child protection processes are initiated and understandably create concern even fear on the part of the child, young person, and their parents.

We wonder how introducing a MRD for child sexual abuse might affect the priority that's given to tackling sexual abuse, domestic violence, and other serious crimes against adults in the

community. We are clear that medical professionals have similar duties to act on concerns about adult patients who are at risk of serious harm. It would be important to reinforce the need for attention to responsibilities in this area, as well as the responsibilities to support and protect children and young people.

Q13 At what level of knowledge should MRD apply? Known incidents, suspected and known.

We are not in a position to offer a view on what should be the threshold or trigger point for making a report, in terms of a person's level of knowledge or suspicion. We wonder how this would relate to IICSA's suggestion (in their final report) that something that would constitute an offence under the 2003 Sexual Offences Act should be the threshold for reporting.

Any definition of the threshold or trigger point when the reporting duty applies will need to consider how it would be understood and operate in practice in different sectors. For example, if there is a link with the Sexual Offences Act what would be put in place to ensure that healthcare professionals or organisational leaders would be able to judge whether the Act is engaged in a particular case?

Thresholds or trigger points would also need to be clear to health professionals at different stages along the career pathway. For example, undergraduate medical students on clinical placements may have a very different knowledge base to experienced clinicians in the same setting.

It may be important to consider the potential for inconsistent decisions, across different sectors, about whether to make a referral.

Bearing this in mind, whatever decision might be taken about the level of knowledge or suspicion of abuse that would trigger a mandatory reporting duty, it would be essential that sufficient training is available to help professionals understand what is expected of them..

Q14 What should be considered a disclosure of abuse?

We understand the question as concerning what a professional who is subject to a mandatory reporting duty should see as a disclosure to them.

We are not in a position to offer a view. However, we know that medical professionals attach importance to being able to access up-to-date evidence and guidance to inform their judgements about individual patients. For example, guidance on recognising the signs and symptoms of abuse is currently available from NICE https://www.nice.org.uk/guidance/ng76 and extensive guidance and supporting resources are available from the RCPCH https://www.rcpch.ac.uk/key-topics/child-protection.

If a MRD with criminal sanctions is introduced, it may be helpful in terms of consistent decision-making across different sectors, to provide access to a shared evidence base and technical

guidance, to support professional judgement.

Section 3: Sanctions

Q17 What is your view on the Inquiry's proposal that a breach of the mandatory reporting duty should constitute a criminal offence?

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don't know

Our answers to questions 6, 10 and 12 partly cover this point. In addition, see our answer to Question 18. In short, we do not support the attachment of criminal sanctions to a mandatory reporting duty.

Q18 Do you believe other types of sanction should apply to breaches (for example professional disqualification for individuals, or regulatory action in respect of organisations?) yes/no.

We believe a breach of the proposed duty could raise professional regulation concerns which we would want to be able to consider. However, we don't believe that professional regulation should be used as an enforcement mechanism for statutory failures by individuals to report. The GMC's fitness to practise process involves an assessment of whether there is current or ongoing risk to public protection and would not necessarily lead to regulatory action being taken by the GMC, as it involves considering factors such as seriousness and context. It would not therefore be appropriate for the fitness to practise process to be used as the enforcement mechanism ie. deciding what the law means and whether a breach occurred, but rather as a parallel regulatory process. We would suggest that any enforcement should form part of the mandatory reporting scheme which is being proposed and not sit in professional regulation.

Q19 What is your view on the exception to the duty described

(consensual peer relationships)

Our response to this question takes account of Q20 about difficulties with the exception and Q21 about other possible exceptions.

We understand that this is a difficult and contentious area, in part because of the evidence suggesting that sexual abuse and exploitation between young people under 16yrs old is much more common and perhaps less reported than previously understood.

An age-based exemption may be problematic in some areas of medical practice where a patient may still qualify to be treated as a young person up to the age of 25yrs. In addition, it would not recognise the situation of older teenagers or adults who have learning disabilities or certain decision-making impairments which affect their capacity to engage in consensual sexual relationships.

If an exception to mandatory reporting is made for 'consensual' relationships between young people, it would be important to provide professionals with clear guidance on what factors are relevant in determining whether a peer relationship is consensual, how to distinguish between this and abuse to be able to make a defensible judgment about whether the reporting duty is triggered in a particular case.

We are aware of the NSPCC's guidance Responding to children who display sexualised behaviour (nspcc.org.uk) which includes content on informed consent and categorises behaviours into three broad types. It may be helpful to seek feedback on how professionals are using this sort of guidance in practice.

Section 4: How to ensure successful implementation.

Q22 Can you foresee any overlap or tension with your or others' existing duties or professional requirements which may be introduced by a MRD

Please see our answer to Question 18.

In addition, we have highlighted that mandatory reporting duties override a person's right to confidentiality and described the impact that this can have within healthcare where professionals are subject to the common law duty of privacy and ethical duty to protect patient confidentiality. (See our response to Question 10.) It would be important, as part of the work to craft a new duty and plan its implementation, that the interaction with privacy laws is made clear in the legislation or supporting statutory guide, and that government works with us and other regulatory bodies to provide clear guidance on how the duty aligns with expected professional standards.

Q23 EDI considerations

We know that doctors who trained outside the UK (international medical graduates or IMGs), during the early months of their practice, can be at a disadvantage in terms of knowledge of the UK legal framework that impacts their area of work. If a MRD with criminal sanctions is introduced, it would be unfair if IMG doctors were more exposed to a risk of criminal sanction for non-reporting, because of a lack of knowledge, training, or relevant experience. Consideration should be given to funding relevant training programmes.

Q24 What protections need to be in place to ensure individuals making reports in good faith don't suffer personal detriment as a result?

We support protections to ensure individuals making reports in good faith don't suffer personal detriment as a result. We consider the protections should be similar to protections in place where professionals have other statutory duties to disclose information. However, this protection should not include immunity from regulatory scrutiny as we are an independent regulator and we must be able to consider any current or ongoing risk to public protection. We would also be concerned about circumstances in which organisations and employers tried to take punitive action against those professionals making reports in good faith by raising complaints with us.

Q25 What other reforms are needed to ensure MR protects children?

See our response to Question 10.

Q27 IICSA recommended that reports should be made as soon as practicable – should timescales be defined more specifically? Yes/no/maybe/don't know.

The timings of disclosures are important, but we do not have a view about defining specific timelines.

In our guidance on Protecting children and young people, we say that where doctors have a concern about potential abuse and neglect, but they are unsure whether this is likely to be the case, they are not required to make an immediate safeguarding disclosure. They should take prompt action to get advice, as sharing more limited pieces of information with others can help to build a wider picture, and identify the right course of action for that particular child.

We are aware that older children and teenagers can be particularly concerned about confidentiality, and may want to have some control over the timing of disclosure to children's

services or the police and other statutory agencies. Our guidance emphasises the importance of sharing information promptly, with scope in these cases for doctors to use their judgment to manage the pace and extent of disclosure. Using professional judgement in this way, can enable a young person to make disclosures by supporting them to go at their own pace.

Q28 Would your organisation need to make any changes in order to ensure the successful implementation of a mandatory reporting duty?

This depends on the nature and scope of the duty. Please see our response to Questions 18 and 24. It is possible that we would need to make changes to our professional standards, and to our standards for medical education and training (for example in relation to the expected outcomes for undergraduates).

Q32 What other approaches apart from MR could improve disclosures, reporting, investigation, prosecution?

It might be beneficial to establish more explicit links between the professional standards set by regulators and the standards and inspection framework applied by the system regulators. The aim would be to ensure that system regulators (CQC in England) use their inspection models to establish how organisations are working to support the regulated professionals they employ to comply with expected professional standards. Some work is already happening along these lines, and it may be helpful to build on this.

Feedback from health professionals working in safeguarding roles, points to the need to demystify the child protection pathway and provide greater transparency for children and families and the wider public, so communities have a better understanding of:

- the trigger points or criteria for making referrals to the local authority, police or other statutory agencies
- what actions are taken, or interventions made, at different stages in the process
- the different professional roles, and the part that may be played by family members and other carers
- the control that children and young people may or may not have over the decisions which are made at different points along the pathway.

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