

# GMC response to the Home Office consultation on mandatory reporting of child sexual abuse.

**Question 1.** Your name

Mark Swindells

**Question 2.** Address and postcode

General Medical Council

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London

NW1 3JN

**Question 3.** To help us analyse our responses, could you please tell us in what capacity you are responding to this consultation.

- Inspector or regulator

**Question 4.** If you are responding on behalf of a group or organisation, what is your role within that organisation?

- Senior leader (director, chief executive) If other, please let us know more about your role.

**Question 5.** If you are a representative of a group or organisation, please tell us its name and give a summary of the people or organisations that you represent.

Diversity

We know that we deliver better services when we receive feedback from a full range of backgrounds and experiences in the society we serve. We would be grateful if you could complete the following diversity questions. You can select 'prefer not to disclose' if you would rather not answer any question.

**Question 6.** What is your sex?

- Male

**Question 7.** What is your ethnic origin?

(Please delete the responses which don't apply.)

- White-English

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The mandatory reporting duty

**Question 8.** In sharing findings from this consultation, may we quote from your response?

- Yes – attribute to my organisation

**Question 9.** In addition to the definition of ‘regulated activity in relation to children’ provided by the Independent Inquiry, the government is proposing to set out a list of specific roles which should be subject to the mandatory reporting duty. Which roles do you consider to be essential to this list:

We note that, following the call for evidence, the proposal is to proceed with a new mandatory reporting duty on those who carry out ‘regulated activity in relation to children, with a specific list of roles that should be subject to the new duty.

We do not have suggestions about other roles that should be added to the list. However, we want to clarify whether the new duty is intended to apply to organisations that carry out ‘regulated activity in relation to the children’ as well as individuals.

In the consultation document you explain that organisations would be expected to inform their staff or volunteers about their new duty and support them to comply. It isn’t clear if you intend to create a requirement on organisations to do this, by means of a new legal duty or some form of statutory guidance.

Both the IICSA report, and the current consultation document highlight the importance of reducing the likelihood of institutional cover-ups through systems that ensure greater accountability for organisations. An organisational duty to report, or to support employees and volunteers to report, would seem important to tackling the type of organisational leadership and culture which can act as a barrier to action by employees and volunteers who have concerns (please see our response to the call for evidence). If the duty is taken forward only in relation to individuals, we believe it will be necessary to support it with statutory guidance which sets out the expectations on organisations to support individuals in carrying out their duty.

**Question 10.** What would be the most appropriate way to ensure reporters are protected from personal detriment when making a report under the duty in good faith; or raising that a report as required under the duty has not been made?

We understand and support the aim of protecting reporters from personal detriment when making a report under the duty in good faith.

The consultation proposal mentions an intention to provide clarity on the ability of reporters to share information to protect a child from sexual abuse, irrespective of other legal constraints on sharing relevant information. As we understand it, this means the duty to report would override any barriers in data protection and other confidentiality laws. It would also mean that reports made under the duty do not breach any common law duty of confidence owed to the person

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whose information is being shared, or any other restriction on the disclosure of personal information.

We know that the laws around protecting and sharing confidential information, including personal information, can be difficult to navigate when it comes to responding to concerns about protecting children and young people from harm. We can see that it might be helpful to provide reassurance to people who make mandatory reports in good faith, that they will not face criticism or legal action for what might otherwise be a breach of another legal duty. However, we think it will be important to provide clarity that the protection offered in the case of mandatory reporting of child sexual abuse does not alter the legal and professional duties of confidentiality that are owed, in other circumstances, to people who access health services.

As we have highlighted previously, access to confidential healthcare services is an important public good. It builds trust which gives people confidence to engage with healthcare professionals in an open and honest way. In any statutory or good practice guidance that supports implementation of the new duty, we would want to see a clear restatement of the importance of the confidentiality duties that healthcare practitioners owe to children and young people and their families.

In addition to confidentiality matters, we have previously explained that we consider the protections should be similar to the 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.

**Question 11. In addition to the exception for consensual peer relationships, are there any other circumstances in which you believe individuals should be exempt from reporting an incident under the duty?**

In our current guidance on [Protecting children and young people](#), we don't require doctors to report instances of consensual sexual activity. However, in our broader guidance on [0-18yrs](#), we do emphasise that doctors must act to protect children or young people when they are involved in abusive or seriously harmful sexual activity. They must consider each case on its merits, taking account of the child or young person's behaviour, living circumstances, maturity, serious learning disabilities and other factors that might make them vulnerable (see 0-18yrs, [paragraphs 57-62](#)). We therefore support the intention to prevent reports being made about consensual relationships.

We have previously outlined the difficulties of an age-based exemption for mandatory reporting, when it comes to older teenagers, and adults who have decision-making impairments or learning disabilities which affect their capacity to engage in consensual sexual relationships. We would

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reiterate the difficulty in practice for professionals to distinguish between a consensual peer relationship and sexual abuse.

The stated intention of the proposals in the consultation is to ensure consensual, noncoercive relationships between young people are not considered child sexual abuse and therefore subject to mandatory reporting under the new duty. However, our understanding is that the definition of child sexual abuse which has been used to give shape to the exemption, in practice would include these consensual relationships. In defining child sexual abuse as any act that would be an offence under the Sexual Offences Act 2003, those aged 18 or over commit an offence if they engage in sexual activity with someone who is under 16 (where the adult doesn't have a reasonable belief that they are 16 or over), or someone who is under 13. It seems to us that, in practice this would mean, for example, that a consensual sexual relationship between a child of 15 and someone who is 18 would be regarded as an instance of child sexual abuse and therefore not exempt from the mandatory reporting duty. However, this seems contrary to the stated aims of the exemption.

In addition, factoring the proposed age boundaries (with a difference of 3 years or more triggering a report) into the decisions practitioners will need to make about whether a relationship is consensual and non-abusive, adds further complexity to these judgements. This complexity may lead to situations where some consensual relationships are treated differently by different practitioners, resulting in inconsistent local decisions, which may then impact on children and young people's willingness to share the sort of personal information that might alert healthcare or other practitioners to the need to take safeguarding action.

We think that, if healthcare professionals (and other practitioners) find that there is confusion or ambiguity about what sort of relationship is exempt from mandatory reporting, it is likely that they would err on the side of reporting. Since 'good faith' reports will be protected from criticism and legal action. If this led to a significant increase in reporting of consensual relationships, the increased pressure on local authority children's services and other agencies may work against the aim of delivering more timely and effective action to tackle instances of child sexual abuse.

A lack of clarity about exemptions might also impact on whether children and young people choose to continue to access sexual health advice and care. We understand concern about confidentiality is the biggest deterrent to young people seeking sexual health advice, and this is worrying because of the opportunity that their engagement with sexual health services presents for health care practitioners to get to know their circumstances and identify signs of abuse or exploitation.

We believe that further consideration needs to be given to how consensual relationships are defined, either in the legislation or through supporting statutory guidance for practitioners.

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**Question 12. We are proposing that there would be criminal sanctions where deliberate actions have been taken to obstruct a report being made under the duty. What form of criminal sanction would you consider most appropriate?**

In our response to the Call for Evidence, we raised some concerns about the impact of criminal sanctions attaching to a failure to make a report. It would be helpful to know what actions might be taken to mitigate against the possible impact on healthcare professionals, if criminal sanctions and custodial sentences are attached to the mandatory duty.

**Question 13. Should situations where a reporter has been obstructed due to active indifference or negligence also be subject to these sanctions?**

We do not have a view on whether sanctions are appropriate in these instances. It is not clear what is meant by active indifference or negligence on the part of others and therefore how this would prevent a person from reporting. In addition, it is not clear if the intention here is to sanction the reporter who has been obstructed (which would seem counterproductive), or those who obstruct the reporter. We wonder if this would be clearer, if there was a specific pathway for reporting.

Our current understanding from the consultation document is that ‘reports should be made to either local authority children’s services or the police as soon as reasonably practicable.’ This isn’t sufficiently clear in terms of who (i.e. which roles) within local authority and police services reports must be made to, and who then is responsible for acting on the report. We believe that it’s important for reporters to have a single known point of contact for reporting purposes, in order to make it easy for reports to be made, recorded, and acted on, and for there to be an audit trail to support accountability, and access to data that supports learning across the whole child protection system. Although we don’t have a specific recommendation, we do note that mandatory reporting duties for female genital mutilation (FGM) must be made to the police as the central point of contact, and they in turn have responsibilities to make appropriate referrals to children’s social services and other agencies.

**Question 14. We would like to test the view that professional and barring measures apply to those who fail to make an appropriate report under the duty. Do you agree with this approach? Would different situations merit different levels or types of penalty?**

We do not agree with the Government proposal that professional regulatory measures and barring measures should apply to breaches of the new duty as a means to enforce the duty.

We have previously stated in the response to the Call for Evidence that GMC fitness to practise processes are not an appropriate mechanism for enforcing a new legal duty. 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

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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 i.e. 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.

**Question 16. In the light of the proposals outlined in this paper, what are the key implementation challenges and solutions reporters and organisations will face?**

We have highlighted a number of concerns in response to questions 9-14.

The consultation document also states it is expected that the new mandatory reporting duty will help those working with children to be better trained to respond to child sexual abuse ‘by incentivising organisations and professional bodies to ensure those they regulate and/or employ have the knowledge and skills to comply.’ We want to understand what the intentions of this proposal are for regulatory bodies.

We have specific powers set out in the Medical Act 1983 to set the outcomes for UK medical graduates and approve curricula for postgraduate training of doctors. At both the undergraduate and postgraduate level we set out the broad skills and knowledge required of doctors, including key themes on safeguarding for children and young people. However, we don’t specify the detail of curricula and don’t possess the powers to direct specific content. Individual medical schools determine how the outcomes we set are included, with oversight from the Medical Schools Council. At the postgraduate level Royal Colleges develop curricula, as well as the UK Foundation Programme Office. There are limits on the action we can take as a regulatory body to ensure that those we regulate have the knowledge and skills to comply with the duty.

How to respond Please email this response as an attachment to: [mr\\_csa@homeoffice.gov.uk](mailto:mr_csa@homeoffice.gov.uk)