

**Responsibilities of  
Doctors in  
Child Protection Cases  
with regard to  
Confidentiality**

**February 2004**





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Royal College of Paediatrics and Child Health  
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# Foreword

*Confidential – Spoken, written in confidence: entrusted with secrets*

– O.E.D.

Patient confidentiality is one of the key features of all medical practice. Where child protection is concerned the issues surrounding confidentiality seem to be more complicated than in other areas. In reality it should not be more difficult if we recognise that the needs of the child are paramount. There has been new legislation and legal precedent over the past few years which has left paediatricians, and indeed other professionals, confused. This document is an attempt to bring some clarity to the area and is based on wide discussions with relevant bodies and is as up to date, to February 2004, as it can be. It is important for us to understand the professional and legal framework in which we practise. There is a need for clarity about the rights and roles of children, parents, professionals and agencies.

That there is confusion is manifestly evident when Serious Case Reviews (Part 8 Reviews) are considered. In many cases the fundamental problems seem to be around information sharing and this is caused by a lack of clarity and understanding about confidentiality.

The legal situation is not the same throughout the UK. Scotland in particular has a different legal system. Where appropriate these variations are highlighted.

We hope that this short report which brings together the best current advice will give paediatricians the confidence to do what is necessary to protect children.

We must remember that if in doubt, the child's needs come first.

**Professor Alan Craft**  
**RCPCH President**

6th February 2004



## **Executive Summary**

1. The doctor's primary duty is to act in the child's best interest. If there is conflict between doctor and parents or parents and child, then the child's needs are paramount.
2. Where there are reasonable grounds to believe a child is at risk of significant harm the facts should be reported to social services (England & Wales).
3. In Scotland the key test for reporting to the Reporter to the Children's Panel is a perceived need for compulsory measures of supervision.
4. PCTs, NHS Trusts, health authorities and their employees have a statutory duty to assist Social Service departments making enquiries under the Children Act.
5. Conducting these enquiries requires access to relevant information about the child and possibly other family members. Consent to disclosure should normally be sought from a competent child and carer, unless doing so would place the child or a sibling at greater risk or hinder enquiries by provoking interference with verbal evidence.
6. You should disclose information about a non-competent child if you can justify doing so as essential to their medical interest.
7. You should always disclose information without consent where failure to do so may place a child at risk of death or serious harm or where the information would help prevent, detect or prosecute a serious crime.
8. Where you are uncertain whether 7 above applies but an apparently competent child or a parent refuses permission for disclosure, we have no doubt that where a child is in danger the doctor is obliged to act. This is also the case where the child's refusal results from duress or fear.
9. When deciding how much information to disclose, the key is to ask yourself how providing the information would assist further inquiries and failing to provide it would hinder investigations.
10. You should document thoroughly all decisions and the reasoning behind them, explicitly separating facts from speculation.
11. Familiarise yourself with Sections 17, 27, and 47 of the Children Act (or 93, 53, and 22 of the Children(Scotland) Act or articles 17,18, and 66 of the Children (Northern Ireland) Order 1995.)

12. A child in need who is not receiving services may be at risk of significant harm (E&W) (Section 17)
13. Psychiatrists primarily responsible for adults should always consider whether a parent or other adult's mental illness significantly adversely affects a child's health or development. Where they have reasonable grounds for concluding this is the case their obligations to inform social services departments are as detailed above.
14. Doctors providing sexual health services must balance child protection issues against the young person's right of confidentiality and need for a sexual health service. Young people may not use a service they perceive as not confidential and they may not disclose abuse or exploitation.
15. The GUM guidelines recommend using a risk assessment proforma to identify abuse and ensure there is follow-up when immediate disclosure is not made.
16. Children's need for protection does not diminish the importance of gaining their agreement to sharing information when practicable and time should be allowed to do so where the risk is not immediate.
17. Abuse should always be considered in those under 16 who are sexually active but anyone under 18 may be subject to protection procedures if they are being exploited. Very careful consideration must be given to those under 13 who are sexually active. Sharing information without parental consent may be necessary - particularly as the young people usually self-refer to sexual health services.
18. Young persons' refusal for photodocumentation should be respected
19. Whenever possible informed consent should be obtained to include patients in a research project and where this is impracticable, application should be made to the Patient Information Advisory Group.
20. Courts will take into account the views of a REC but will not necessarily concur. Having data anonymised independently may help but the GMC advise that consent is also needed to supply notes to the anonymiser.

## **1 Introduction**

- 1.1** Amongst the many concerns of doctors dealing with child protection is the tension between the need to share information and the rules governing confidentiality.
- 1.2** Several factors contribute to these concerns. Doctors may be uncertain where their legal duties lie when the interests of the child and parents do not coincide. They may be uncertain to what extent confidentiality may be sacrificed in the public interest. Some doctors have been targeted by dissatisfied patients and by pressure groups, who use allegations of breach of confidentiality as an entrée to the NHS complaints procedure or to the performance procedures of the General Medical Council.
- 1.3** Some paediatricians have expressed their special anxiety about third party information contained within medical notes shared with social service departments. The latter may be requested by the young person when he or she achieves majority or, **in Scotland**, when he or she has a general understanding of their right to have access to information (which is presumed from age 12).
- 1.4** Obtaining information about parents which may be relevant to protecting a child can be more difficult and contentious than sharing information about a child assessed as in need.
- 1.5** There are particular difficulties when the therapeutic alliance is challenged, for example when dealing with the initial investigation of suspected fabricated or induced illness (FII). Doctors may consider they need to obtain information held by others to aid in the differential diagnosis but are uncertain whether - at such a preliminary stage - they are justified in invoking formal child protection procedures.
- 1.6** Doctors providing contraception and genitourinary medicine services see many sexually active young people who appear not to be 'at risk' other than from pregnancy or sexually transmitted infections. Proposed new legislation (in England and Wales) may produce specific problems for doctors involved in providing sexual health services. At the time of writing it seems that when the sexual offences bill becomes law, it may be that any sexual activity between an adult aged over 18 with a child under 13 will be an offence carrying a maximum sentence of 14 years imprisonment upon conviction. We scarcely need to spell out the potential conflicts between the young people's expectations, the doctor's duty of confidentiality and the demands of the criminal law.
- 1.7** As a result of these and many other concerns expressed by practitioners working with abused children, the Royal College of Paediatrics & Child Health set up a multidisciplinary working

group with the following terms of reference:

- To examine statutory instruments, guidance and other advice with regard to patient confidentiality
- To analyse how these should be interpreted with regard to child protection
- To produce a position statement on confidentiality issues when they deal with a child protection problem

This document should be seen as a framework for developing policies locally.

## **2: Good practice: moral and ethical responsibilities**

**2.1** All published guidance on the moral responsibilities of doctors reaffirms their fundamental duty to act in their patients' best interests. The scope of a doctor's duty is wider than the simple consideration of whether or not a given intervention is clinically more beneficial than harmful. It also includes:

- preserving life, restoring health and preventing illness
- listening to children and respecting their autonomy
- respecting human rights and dignity
- performing these duties justly, fairly and to an acceptable standard

**2.2** Adults are regarded as having the capacity to decide what constitutes their best interests and the rights of children, in this respect, are becoming increasingly recognised. Parents normally have the moral and legal obligations to make decisions for their child, but the rights associated with this are coterminous with the child's best interests. Where it is clear that the parent is not or is not proposing to act in the child's best interests the courts will intervene.

**2.3** Some doctors find they have conflicts of interest: paediatricians know that their prime duty is to the child. General practitioners may have both child and parents as their patients; adult psychiatrists owe a duty primarily to the parent, even though children may be affected adversely by their carer's mental health problems.

**2.4** The doctor-parent-child relationship is pivotal and must be founded on mutual trust and respect, as well as a common aim to benefit the child. Where the child presents with symptoms or signs suggesting he or she has been subject to abuse it may be no longer possible to regard parent and child as a single unit - "the patient."<sup>1</sup> In a recent case where parents alleged that the doctors owed them a duty not to entertain a diagnosis of non-accidental injury, or factitious and induced injury, the Court of Appeal rejected the claim, saying that the interest of the child and the parent were 'poles apart.' Where such conflict exists, we consider the moral duty of the doctor is to act in the best interests of the child as he or she reasonably assesses and perceives them.

**2.5** When applying the above principles of fairness, justice and respect for autonomy doctors must be prepared to provide reasoned justification for their opinions and actions to those who have a right to such information. The moral justification for acting contrary to parents' wishes is that it is necessary to prevent harm to the child. In turn, this demands that the doctor has

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<sup>1</sup> But see the GMC guidance *Confidentiality: Protecting and Providing Information* p2-3: 'Glossary: This defines the terms used within this document...Patients: Competent patients and parents of, or those with parental responsibility for, children who lack maturity to make decisions for themselves...'

separated likely facts from speculation in making his or her judgement and has the duty of explaining to parents the reasons for any suspicion and the proposed action, provided that doing so does not increase the risk of harm to a child.

**2.6** We recognise that such situations are uncomfortable, stressful and, at times, dangerous to all concerned. Nonetheless this must not compromise the duty to take action where needed. It may be easier to avoid confrontation but it may not be fair or just.

**2.7** When this happens, the doctor has a duty to share information with those agencies with a statutory duty to investigate possible child abuse. Seeking parental consent to share information is generally a requirement of good practice. Where practical, parents should be involved in this process and their agreement sought<sup>2</sup> unless there are overwhelming reasons to the contrary, for example that it would increase the risk of the child (or a sibling, the practitioner or other professionals) coming to harm; or that the child's verbal evidence may be interfered with by the parent. Fairness requires that parents are then informed of the doctor's intention, but if you decide that you may be in personal danger, or a parent may be suicidal or the child or a sibling at risk of harm or their verbal evidence interfered with, it is reasonable to delay until the child has been protected.

**2.8** A major difficulty is that the doctor may have incomplete information so that gauging the risk may be impossible until information has been shared. The key is to be prepared to provide a reasoned justification for the action, whether you initiate it or are asked to do so by another. Doctors might sensibly ask themselves whether the child would be likely to consent if old enough to decide. The Department of Health Best Practice Guidance (May 2003) *What to do if you're worried a child is being abused* puts it in these terms (Appendix 3):

*“A decision whether to disclose information may be particularly difficult if you think it may damage the trust between you and your patient or client. Wherever possible you should explain the problem, seek agreement and explain the reasons if you decide to act against a parent or child's wishes.”*

**2.9** We should all be conscious of our level of competence. A sensible safeguard, before dispensing with parental consent is to seek advice and a further opinion from a more experienced colleague and, if appropriate, your Caldicott Guardian.

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<sup>2</sup> A form of words might be: “I'm worried about your child and I think I need to refer him to social services - I hope you agree with that.”

**KEY MESSAGE**

The doctor's primary duty is to act in the child's best interest. This includes the protection of weak and vulnerable subjects who are unable to protect themselves. If there is conflict between doctor and parents or parents and child, then the child's needs are paramount.

### 3. The regulatory framework

3.1 Doctors registered with the General Medical Council have certain duties and responsibilities detailed in four booklets produced by that organisation:

- *Good Medical Practice* May 2001
- *Confidentiality: Protecting and Providing Information* September 2000
- *Seeking Patients' Consent: The Ethical Considerations* November 1998
- *Research: The role and responsibilities of doctors*

3.2 The first of these includes the standards the GMC expects doctors to follow. They include duties to:

- respect patients' dignity and privacy
- listen to patients and respect their views
- respect the rights of patients to be fully involved in decisions about their care
- respect and protect confidential information.

3.3 The principles expounded in respect of confidentiality are:

- seek patients' consent to disclosure of information wherever possible, whether or not you judge that patients can be identified from the disclosure
- anonymise data where unidentifiable data will serve the purpose
- keep disclosures to the minimum necessary.

3.4 Overall doctors are told they must always be prepared to justify their decisions in accordance with GMC guidance. The **Confidentiality** booklet details exceptions, including implied consent to share material within a health care team, disclosure for education, research and epidemiology, public interest exceptions and situations in which doctors have dual responsibilities.

3.5 At first sight, GMC guidance on confidentiality may seem ambiguous because of its glossary definition of 'Patients' as including parents, thereby ignoring the situation that may pertain in child protection cases of a conflict of interest between a child patient and his or her parent(s). However, paragraph 38 permits doctors to disclose information about a non-competent child who has refused permission - namely that you may do so if it is essential in their medical interests, you have told the patient in advance and you have considered the carer's views and documented your actions thoroughly. For example, this would apply to such matters as contraceptive advice.

3.6 Paragraph 39 deals specifically with child protection. It states:

*"If you believe a patient to be a victim of neglect or physical, sexual or emotional abuse and that the patient cannot give or withhold consent*

*to disclosure, you should give information promptly to an appropriate responsible person or statutory agency, where you believe that the disclosure is in the patient's best interests. You should usually inform the patient that you intend to disclose the information before doing so. Such circumstances may arise in relation to children, where concerns about possible abuse need to be shared with other agencies such as social services. Where appropriate you should inform those with parental responsibility about the disclosure. If for any reason you believe the disclosure of information is not in the best interests of an abused or neglected patient, you must still be prepared to justify your decision."*

- 3.7** It is apparent that the GMC offers advice for the (unusual) situation in which a child refuses permission for disclosure but is silent about how to act when a parent refuses. Doctors may be protected by paragraph 36, which deals with disclosure without consent where failure to do so may expose the patient to risk of death or serious harm, or paragraph 37 which allows disclosure to assist in the prevention, detection or prosecution of a serious crime. It appears that doctors would be left to justify their decision by demonstrating that the 'significant risk of harm' as defined in Working Together is equivalent to the GMC's 'death or serious harm.
- 3.8** Guidance from the **Scottish Executive** for health professionals (1999) states that: 'when a concern relating to the welfare of a child is raised, whether this is a clear allegation of physical or sexual abuse or a more general concern about the possibility of neglect or emotional abuse, professionals must share information with other agencies involved with the child (police, social work and education) before deciding what further action to take).
- 3.9** Issues of consent are also relevant. In *Seeking patients' consent: the ethical considerations*, the GMC reminds doctors of their duty to assess children's capacity to decide whether to consent to or refuse investigations. You should bear in mind that at age 16 a young person can be treated as an adult and can be presumed to have such capacity. Under 16 they may have capacity depending on their ability to understand (Fraser or Gillick competence).
- 3.10** **In Scotland**, the Age of Legal Capacity (Scotland) Act 1991 states that a child under 16 may consent (or refuse) his or her medical treatment if, in the opinion of the medical practitioner, he or she is capable of understanding the nature and consequences of the treatment.

### **KEY MESSAGES**

You should disclose confidential information about a non-competent child if you can justify doing so as being essential to their medical interest

You should disclose information, without consent, where failure to do so may expose the patient to risk of death or serious harm

You should disclose information to help prevent, detect or prosecute a serious crime

You must tell the patient in advance, consider the carer's views and document your reasons unless doing so places the child at risk or would interfere with their verbal evidence

Although GMC guidance may appear ambiguous about permissible action when a competent child or a parent refuses permission for disclosure, we are in no doubt that where a child is in danger the doctor is obliged to act. Doctors should seek justification on the basis of the legal framework relating to child protection (see next chapter)

Thorough documentation, separating facts from speculation, and explaining your decisions is essential

## 4: The statutory framework

- 4.1** In balancing one's duty of confidentiality with that of sharing information to protect a child, doctors need to be aware of the legal framework.
- 4.2** The Children Act 1989 applies to England and Wales whereas the Children (Scotland) Act 1995 applies to **Scotland**. The two acts contain major differences in the approach to child protection. Guidance in **Scotland** is issued by the **Scottish Executive**. Department of Health (and now DfES) guidance does not apply to Scotland, though may be helpful.
- 4.3** The Children Act 1989 places the responsibility for taking action to investigate or enquire into child protection and the safeguarding and promoting the welfare of children in need with the local authority providing social services. The authority, through its social services department, has the power to call on other agencies, including health care trusts to provide assistance. Those trusts have a duty to assist.
- 4.4** Doctors employed by those Trusts have two major roles: firstly, if they recognise the possibility that a child might need protecting or be 'In Need' they must raise their concerns by informing the lead agency - social services. The second role is to make their skills available during the subsequent stages of the process. This may be primarily reactive, responding to requests or may be part of a continuing therapeutic relationship with the child.
- 4.5** We advise that all doctors who might become involved in dealing with child protection in England & Wales, even if they are neither a named or designated doctor, should become familiar with three primary provisions - Sections 47, 27 and 17 of the Children Act. **In Scotland** the relevant sections are 53, 22 and 93.
- 4.6** Section 47 of the 1989 Act requires social service departments to enquire, or cause enquiries to be made, under certain circumstances - including where the local authority has:

*“reasonable cause to suspect that a child...is suffering or likely to suffer significant harm” (s47(1)(b))*

- 4.7** Some doctors have expressed their concern to us about what degree of harm might justify the term 'significant,' especially in view of the GMC's preferred adjective 'serious.' We advise quoting the Oxford English and Chambers dictionaries, which define significant as: *noteworthy, having or conveying meaning, full of meaning, worthy of consideration, indicative.*

**4.8** However, it is important for all parties to consider the possibility that any form of harm, including emotional harm, may be significant in any seriously abusive relationship with a child. This is irrespective of whether the child is at the time suffering or seems likely to suffer significant physical injury in the immediate future (given that an abusive relationship may suddenly ‘spin out of control’)

**4.9** Once suspicion has been raised - often by a doctor - the local authority’s enquiries must be sufficiently thorough

*“to enable them to decide whether they should take any action to safeguard or promote the child’s welfare” s47(1)*

**4.10 In Scotland**, section 53 of the Children (Scotland) Act 1995 states that where the local authority has information suggesting that compulsory measures of supervision may be necessary, it has:

- a duty to investigate
- a duty to refer the information to the Reporter to the Children’s Panel, if it appears that such measures may be necessary.

This section also states that any person who thinks that compulsory measures of supervision may be necessary may give information to the Reporter to the Children’s Panel. It is not necessary to identify significant harm in order to start child protection procedures.

**4.11 In England & Wales**, Section 17 appears in part III of the Children Act 1989; it requires social service departments to safeguard and promote the welfare of children in need. Such a child is defined as one

- who is unlikely to, or have the opportunity to achieve or maintain a reasonable standard of health or development or,
- whose health or development is likely to be significantly impaired or further impaired without services or,
- who is disabled.

**4.12 In Scotland**, section 93 of the Children (Scotland) Act 1995 defines child in need and the definition is wider than in England & Wales:

- s/he is unlikely to achieve or maintain a reasonable standard of health or development unless services are provided
- his/her health or development is likely to be significantly impaired or further impaired, unless services are provided

- s/he is disabled
- s/he is affected adversely by the disability of another family member

Section 22 places a duty on the local authority to safeguard and promote the welfare of children in need.

**4.13** We believe it is vital for doctors to be aware that this concept of need is far wider than that underlying non-accidental injury. For example, some have looked at Sections 17 and 47 as somehow independent of each other, designed for quite different child populations. In his enquiry into the case of Victoria Climbié, Lord Laming criticised this approach as ‘dangerous.’ For doctors, concerned with issues of confidentiality, Lord Laming’s statements are of fundamental importance. We believe they could be of great assistance in helping doctors decide upon the reasonableness of their proposed actions so quote pertinent ones below.

**4.14** In essence, a child who, without services, is unlikely to achieve a reasonable standard of health or development or whose health or development is likely to be significantly impaired *is suffering or likely to suffer significant harm if the services are not provided*. A child who is, or is likely to suffer significant harm is clearly a child in need.

**4.15** When deciding upon sharing information, it is important to ask yourself whether such disclosure is a proportionate response to the need to protect the welfare of a child to whom the confidential information relates. Proportionality is a key concept in human rights law. Also, the obligation to co-operate with social services does not imply that you may make an unjustified breach of confidence.

**4.16** We have been informed that a particular area of contention faced by some community paediatricians is when they believe a child is being denied certain educational or therapeutic services because of a parent’s stated belief that they would be harmful, or at least not helpful. When deciding on whether they can justify their proposed course of action, especially if they have felt it necessary to dispense with parental consent to share information, they may be assisted by the terms of Section 17 (or sections 22 and 93 in **Scotland**).

**4.17** One difficult area is that of fabricated and induced illness (FII). The Dept. of Health document, *Safeguarding Children in Whom Illness is Fabricated or Induced* lists symptoms or signs provoking child welfare concerns, including:

*“the child’s normal daily life activities are being curtailed beyond that which might be expected for any medical disorder from which the child is known to suffer.”*

It adds - in bold type:

***“Consultation with peers or colleagues in other agencies may be an important part of the process of making sense of the underlying reason for these signs and symptoms...”***

**4.18** It does not deal with how such consultation might take place within the framework governing confidentiality but doctors might find the document useful if called upon to justify their behaviour.

**4.19** We consider sharing information and skills between the different agencies involved with families is essential if intervention is to be effective. Parliament required social services departments (SSDs) to act as the lead agency but did not expect them to carry out their functions without the information necessary to inform judgements or the expertise, powers and resources necessary to provide appropriate services.

**4.20** Where a SSD is enquiring under section 47, it is the duty of other agencies to

*“assist them with those enquiries (in particular by providing relevant information and advice) if called upon by the authority to do so”*

**4.21** We note that the assistance required may not be limited just to information and advice and subsection (10) provides that persons are not obliged to assist “where doing so would be unreasonable in all the circumstances of the case”.

**4.22** Section 27(1) provides:

*“where it appears to a local authority that any authority or person mentioned in subsection (3) could, by taking any specified action, help in the exercise of any of their functions under this Part, they may request the help from that authority or person, specifying the action in question.”*

**4.23** Section 27 (2) adds:

*“An authority whose help is so requested shall comply with the request if it is compatible with their own statutory or other duties and obligation and does not unduly prejudice the discharge of any of their functions.”*

Section 21 of the Children(**Scotland**) Act makes similar provisions.

- 4.24** The term ‘this Part’ in 27(1) is Part III of the Children Act and includes children in need, duties related to looked after children, secure accommodation, day care and childminding and after-care. Also included is subordinate legislation relating to placing children in families or residential homes and reviewing children’s cases.
- 4.25** The ‘persons and authorities’ are any health authority, any special health authority, any NHS Trust and any Primary Care Trust. In other words, this section imposes a statutory duty on the NHS bodies which employ paediatricians and other doctors. It does not refer to individual professionals, but in practice the duty of the NHS body to respond has to be discharged by the staff it employs for that purpose.
- 4.26** Both the Courts and central government have important roles and Lord Laming’s report may provoke radical changes in this area. The present position is governed by Section 7 of the Local Authority Social Service Act 1970 which states:

*“(1) Local Authorities shall, in the exercise of their social services functions including the exercise of any discretion conferred by any relevant enactment, act under the general guidance of the Secretary of State.”*

**4.27** The Secretary of State’s general guidance currently includes:

- *Working Together to Safeguard Children* 1999
- *Framework for the Assessment of Children in Need and their Families* 2000
- *Children Act Regulations and Guidance* 1991 (10 volumes!)
- *Safeguarding Children Involved in Prostitution* 2000
- *Safeguarding Children in whom Illness is Fabricated or Induced* 2002
- *What To Do If You’re Worried A Child Is Being Abused* 2003
- *Keeping Children Safe. The government’s response to the Victoria Climbié Inquiry Report*
- *IRT: Information Sharing to Improve Services for Children* ([www.cypu.gov.uk](http://www.cypu.gov.uk))

The preface to all but the last of these explains the impact of its being issued under section 7. There may be no immediate penalty for breach but there must be a good reason to justify a significant departure, especially when things go wrong.

**4.28 Scottish** equivalents are:

- Children (Scotland) Act 1995
- Scottish Office - *Protecting Children. A Shared Responsibility: guidance on interagency cooperation 1998*
- Scottish Executive - *Protecting Children. A Shared Responsibility: guidance for health professionals. 2000*

**4.29** Those who elect to read these documents should be aware of a misleading and inaccurate reference in *Working Together*, page 80 - quoting guidance by Butler- Sloss LJ in re G(1996). Dealing with sharing information the Department of Health stated: “The *Working Together* booklet does not have any legal status...” In fact, the ‘booklet’ does have legal status as social services are required to carry out their functions in accordance with the guidance it contains, and failure to do so is likely to give rise to legal liabilities.<sup>3</sup>

**4.30** The remainder of the reference to Butler-Sloss may be helpful to doctors faced with a request for information:

*“...but with the lessons of Cleveland CC v F in mind, the emphasis upon cooperation, joint investigation and full consultation at all stages of any investigation are crucial to the success of the government guidelines...The consequences of interagency cooperation is that there has to be free exchange of information between social workers and police officers together involved in the investigation...The information obtained by social workers is however, confidential and covered by the umbrella of public interest immunity...It can, however be disclosed to fellow members of the child protection team engaged in the investigation of possible abuse to the child concerned.”*

**4.31** The **Scottish Executive** guidance for health professionals (1999) states:

*“...personal information about children and families given to professional agencies is confidential and should be disclosed only for the purposes of protecting children. Nevertheless the need to ensure proper protection for children requires that agencies share information promptly and effectively when necessary.”*

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<sup>3</sup> In *F v Lambeth Borough Council* (2001) the Council was found liable to compensate children in a case involving long term drift and neglect by the authority and, amongst other things, breaching their statutory duties, breaching their duty to act under section 7 guidance and failure to engage other agencies under section 27 of the Children Act.

**4.32** In England & Wales, the role of doctors is defined in two documents:

- *What To Do If You're Worried A Child Is Being Abused* 2003
- *Child Protection: Clarification of Arrangements Between the NHS and Other Agencies* 1995.

They refer to the essential need for all those working in health to participate in interagency support to SSDs. They describe the child's interests being paramount in the context of child protection and to the welfare of children being of the first importance because of their powerlessness to protect their own interests.

**4.33** One requirement seems to have been generally ignored because SSDs have not - as we believe they should - required it to take place under Section 27. It states:

*"Comprehensive service specification for services for children, of which child protection is a key component, should be drawn up by purchasers with providers and other relevant agencies such as social services and education."* (para 2.25 Clarification of Arrangements)

**4.34** We advise that health commissioners should be pressed to enforce this requirement and make their expectations of providers clear so that the latter should then instruct their staff appropriately to ensure the expectations of the guidance are in place. This should include reference to para 3.27 of *Working Together* 1999:

*"Service specifications drawn up by (PCTs) as commissioners should include clear service standards for safeguarding children and promoting their welfare, consistent with local ACPC procedures."*

**4.35** The provisions do not permit blanket exchange of information. A clear framework of professional standards remains. For example, para 2.18 notes that doctors need to feel confident that an approach to statutory agencies will not automatically trigger an inappropriate child protection investigation and that provision exists for necessary professional dialogue to take place with the proper gathering, evaluation and exchange of information, before decisions are made on further action.

**4.36** We believe it would be helpful if doctors could obtain easy, informal access to an experienced social worker, skilled in child protection so that discussion could take place without a formal referral. They should have similar access to the named doctor within their Trust. These channels of communication should be explicit.

**4.37** This would allow doctors greater freedom to share information, albeit with parental consent unless unreasonably withheld, when they are in the early stages of formulating a diagnosis of child abuse including FII.

**4.38** The law is not invariably crystal clear. Paediatricians have told us that mixed messages may be given, even within the same document. For example, para 5.11 and 5.6 of *Working Together* state that parental permission should be sought before discussing the child with another agency, unless doing so may place the child at risk of significant harm. Para 2.27 of the same document, however, reflects the findings of virtually all 36 enquiries into child deaths between Maria Colwell and Victoria Climbié, namely that research and experience dictate that keeping children safe requires professionals and others to share information at an earlier stage. Importantly the paragraph adds:

*“Often it is only when information from a number of sources has been shared and is then put together that it becomes clear that a child is at risk of or is suffering significant harm.” (Para. 3.55)*

**4.39** Doctors should understand that a duty carried out in a manner that ensures it cannot be carried out effectively, is itself a breach of duty. Thus, if seeking permission to disclose information is likely to result in an ineffective enquiry - either because information is not shared or seeking information alerts individuals who might inhibit proper enquiries - this itself may increase the risk of harm, so satisfying paras. 5.6 and 5.11

**4.40** This confusion is more than theoretical. Lord Laming stated:

- *“There was clear evidence that staff...felt inhibited from freely exchanging information relating to children and families due to concerns about alleged legal restrictions on doing so.” (para 17.45 Climbié enquiry)*
- *“...there was confusion among professionals as to when they were allowed to share information with each other without the consent of the child or of his or her carers.” (ibid. para 7.28)*
- *“I was repeatedly told that if a case fell short of a clear section 47 label...no dialogue (Laming’s emphasis) could take place between the protective agencies until the child’s carer had been informed and their permission given.” (ibid. para 17.100)*
- *“This approach to the use of sections 17 and 47 can only be described as dangerous. It is at odds with my understanding of the aspirations of the Children Act 1989.” (ibid. para 17.103)*
- *“The attempt to secure parental permission should not block the initial information gathering and sharing exercise, which must also include talking to the child as appropriate.” (ibid. para 17.105)*

- 4.41** Lord Laming recommended that the Department of Health must make clear, in cases that fall short of an immediately identifiable label, that the seeking or refusal of parental permission must not restrict the initial information gathering and sharing. This should, if necessary, include talking to the child.
- 4.42** The subsequent Government green paper commits it to legislating to remove barriers to sharing information and to give all agencies primary statutory duties to safeguard and promote the welfare of children in carrying out their functions and regulatory agencies. In the meantime, doctors are required to reach their decisions on information sharing properly and be prepared to justify them. Other legal principles must be considered in the context of interagency work, yet we advise that the doctor must not make the mistake of trying to assemble the whole of the jigsaw before seeking help for the child.
- 4.43** Common Law principles also apply. These have been developed by judges through case law and apply until the Courts alter the principles or an Act of Parliament changes or clarifies them. Broadly, common law states that information gathered in respect of a patient will not be disclosed unless there is lawful consent, it is required by statute (for example sections 27 and 47) or the public interest in disclosure outweighs that in non-disclosure.
- 4.44** Generally, at Common Law, consent should be obtained before disclosure of information - from the parents in the case of younger children, from the child where they are of sufficient maturity and from both where practical. Where neither is practical, for the reasons described in paragraph 2.7, the doctor's common law duty to respect the confidence of the parent defers to the need to protect the child.
- 4.45** If a Fraser (Gillick) competent child refuses consent, a person with parental responsibility may consent to treatment or investigations in the child's best interests (except in **Scotland**). We believe this probably applies to disclosure as well.
- 4.46** Where parental responsibility is shared, the consent of one of those is sufficient but human rights principles may require consideration of the interests of others with parental responsibility and even those without - for example an unmarried father.
- 4.47** Public interest disclosure includes that which has the effect of assisting in the prevention or detection of serious crime or necessary for the prevention of harm. Disclosure that ensures proper performance of the framework of statutory provision and guidelines by the agency charged with responsibility to protect children, is in the public interest.
- 4.48** The Crime and Disorder Act 1998 s115 refers to disclosure of information in relation to the

prevention and detection of crime, including issues pertaining to sex offenders, child safety orders and anti-social behaviour orders.

**4.49** We have been told that some paediatricians, particularly those working in community services, are uncertain of their obligations under the Data Protection Act 1998. We agree the legislation and its regulation and guidance are complex. The Data Protection Commissioner's principles quoted in Appendix 4 of *Working Together* 1999 and appendix E of Framework of Assessment 2000, are:

- Personal information should be obtained and processed fairly and lawfully
- It should only be disclosed fairly and lawfully
- It may be disclosed if there is an overriding public interest or justification
- It must be accurate, relevant, held no longer than necessary and kept securely
- Specific exemptions to non-disclosure include the prevention, detection of crime or disorder, apprehension or prosecution of offenders or where these objectives would be prejudiced.

In **Scotland**, children aged 12 and over are presumed to have sufficient maturity to exercise their rights under the Data Protection Act 1998. Children under 12 can do so if they have a general understanding of what those rights are.

**4.50** In the Climbié report, Lord Laming referred to confusion regarding this Act. He found that:

*“Throughout this enquiry it was said repeatedly that when there is professional concern about the welfare of a child, the free exchange of information is inhibited by the Data Protection Act 1998, the Human Rights Act 1998 and common law rules on confidentiality. The evidence put to the enquiry was that unless a child is deemed to be in need of protection, information cannot be shared between agencies without staff running the risk that their actions are unlawful. This either deters information sharing or artificially elevates concern about the need for protection - each of which is not compatible with serving well the needs of children and families.”* (para 17.115)

**4.51** The Commission for Health Improvement (CHI) audit of NHS Trusts, published in October 2003, states:

*‘There is often confusion about what information can be shared between agencies, and about compliance with human rights legislation, data protection regulations and Caldicott guardians on patient confidentiality. Social services mention that some GPs are unwilling to share*

*information about adult family members.'*

**4.52** The Human Rights Act 1998 does not prevent the disclosure of information. Article 8 gives a right to respect for private life, but this is not an absolute right and may be breached if the person:

- acts in accordance with the law
- is pursuing a legitimate aim
- has sufficient and relevant reasons
- acts proportionately

Timely and accurate recording of how decisions were made are crucial.

**4.53** We have considered the implications of clinical negligence litigation. Doctors owe a duty of care to their patients. Those such as paediatricians and child psychiatrists, dealing with families, may be uncertain how far this duty extends. The Court of Appeal clarified the situation in July 2003 (*JD v East Berkshire Community Health NHS Trust and Others* 2003.EWCA Civ 1151). It is now clear that in English law, where the diagnosis of NAI, sexual abuse or FII may be in contemplation, the law accepts that the doctor owes a duty of care to the child. Since the interests of the child and the carer will be "poles apart", it would be unreasonable to impose a duty of care to the parent as well.

**4.54** Failure to act reasonably to protect a child from harm will be a breach of duty which may give rise to liability. As always, the approach of a competent body of professional opinion will be relevant but the approach must also be logical (*Bolitho v City & Hackney HA* 1997). A claimant would have to show that a breach of duty had caused the damage and this may give rise to novel and difficult questions of law. Generally people are not responsible for the consequences of unlawful acts committed by others. Where someone acts in such a fashion the principal defendant will be the parent. However, where the parent is impecunious it may be possible that the paediatrician or their employer will have to compensate the child.

**4.55** Doctors are responsible for their actions in other ways. Failing to intervene when confronted with evidence of abuse may be regarded as serious professional misconduct by the GMC, or as providing grounds for disciplinary action by the doctor's employer. The framework of statutory provisions and guidance, detailed in this chapter, will be relevant in judging the doctor's actions.

**4.56** Of course, an allegation may appear ill-founded only in retrospect, and that provided the suspicions are initially reasonable, the possibility of actionable (retrospectively viewed) ill-founded interventions, should not be a bar to intervention. In practice, this is one of the main obstacles to intervention by doctors – 'what if I got it wrong?'

**4.57** In **Scotland**, the main guidance appears in

- *Protecting Children - A Shared Responsibility-Guidance on Inter-Agency Cooperation (1998)* <http://www.scotland.gov.uk/library/documents-w3/pch-00.htm> and in
- *Protecting Children - A Shared Responsibility - Guidance for Health Professionals in Scotland (1999)* <http://www.scotland.gov.uk/library2/doc11/pcsr-oo.asp>

Both documents place great emphasis on the need to share information in order to protect children.

**4.58** The statutory framework for the provision of childcare in **Northern Ireland** is the Children (Northern Ireland) Order 1995 (HMSO, DHSS).

Article 18 states that it shall be the general duty of every authority to safeguard and promote the welfare of children within its area who are in need.

Article 17 defines “in need”.

Article 66 sets out the duty of Health and Social Service Boards and Trusts to investigate where significant harm is suspected.

The role of area child protection committees is laid down in the guidance document *Cooperating to Safeguard Children* (DHSSPS 2003).

### **KEY MESSAGES**

Familiarise yourself with Sections 17, 27 and 47 of the Children Act (or 93 and 53 of the Children(Scotland) Act

The key test for reporting a case to the social service department (E&W) under S47 is a reasonable belief that there is a real risk of 'significant harm'

The key test for reporting a case to the Reporter to the Children's Panel in Scotland is a perceived need for compulsory measures of supervision.

The requirement to show significant harm only applies in Scotland when considering a Child Protection Order, a Child Assessment Order or an Exclusion Order. It is not a prerequisite for instigating protection procedures.

A child in need who is not receiving services may be at risk of significant harm (E&W) (Section 17)

PCTs, NHSTs and HAs, and therefore their employees, have a statutory duty to assist social services making enquiries under the Children Acts.

You should normally seek permission to disclose information unless you can reasonably conclude this would hinder enquiries or place the child at greater risk.

## 5: The role of psychiatrists

**5.1** Three basic principles are available to guide psychiatrists:

- When children are involved, the need to be aware constantly of the actuality, possibility or risk of abuse or neglect
- Assessing risk and intervening to protect children requires a multidisciplinary and multiagency approach
- The duty to patients, including that of confidentiality, may be overridden by the duty to protect children

**5.2** Child abuse and neglect is relevant to most psychiatric practice. While a parent's mental illness, substance abuse or other incapacity may have a negative impact on their children, this will not necessarily reach a threshold of significant harm. But unless this possibility is borne in mind it may not be recognised. However, it may reach the section 17 threshold for 'a child in need.'

**5.3** Child abuse and neglect often leads to a conflict of interests between children and parents especially when the latter deny the child's allegations or appear unable to care for their children safely or adequately. This conflict may be mirrored in interactions between professionals in different specialties, who see their primary responsibility as promoting the interests and needs of particular family members. Interprofessional cooperation is, therefore, essential.

**5.4** Identifying and assessing children at risk is difficult, particularly if those caring for the *parents* wish to minimise the latter's stressful experiences and increase the self-esteem of individuals concerned. Parents and some professionals may see collaboration with SSDs as a threat to the therapeutic alliance.

**5.5** Psychiatrists primarily responsible for adults have a vital role in considering whether a parent's mental illness significantly adversely affects a child in their care. Some situations are self-evident, for example where the parent or carer expresses ideas of harming the child or is too ill and preoccupied to attend to their child's basic needs. Many situations are less clear, among them the possibility of parental substance misuse. Each situation demands an individualised assessment. It is always necessary to find out who is involved in the child's care and whether such arrangements are satisfactory.

**5.6** Occasionally patients reveal they have perpetrated or are perpetrating abuse. Even where the psychiatrist believes the risk to be in the past or low, it is dangerous not to refer the case to the local SSD under the provisions of the Children Act, paying due attention to consent, confidentiality and the public interest as detailed in the previous chapter.

- 5.7** Elderly patients may present risks to grandchildren - for example risks of sexually inappropriate language or behaviour in dementia or behaviours resulting from delusional ideas about children (or a particular child).
- 5.8** We have been asked how a paediatrician should respond if suspicious of parental mental ill health. We advise that if you are concerned that the mental health of a parent or grandparent (including substance misuse) might affect a child in the family, you can suggest to the adult concerned that they seek referral to psychiatric services through their GP. The paediatrician should inform the GP in writing, with the adult's knowledge, ensuring that their comments are fair, accurate and not speculative. You must make sure to write to the correct GP as adult and child may not be registered with the same individual or practice. It is also open to you to inform social services (with parental knowledge) that you are concerned that a child is 'in need.'
- 5.9** If a paediatrician or other doctor knows that a parent is under psychiatric care and he or she has child protection concerns or concerns about the effect of parental mental ill health on the child, they should seek parental permission to write to the GP or psychiatrist for information and to communicate their concerns. Where a parent refuses permission, the paediatrician is advised to consider carefully whether there are reasonable grounds for suspecting a possibility of significant harm. If so, taking into account, the caveats mentioned in the last chapter, he or she has a duty to inform the local SSD, suggesting they will need to obtain information from the GP or psychiatrist concerned.
- 5.10** Similarly it is open to a paediatrician to communicate with (an adult) psychiatrist whom he or she knows to be treating the family. Again parental and, where appropriate, the child's consent should be obtained. Where it is refused, the arguments debated in the last chapter should determine the doctor's action, remembering that his prime duty is the welfare of the child. Therefore you should request the SSD to take appropriate investigative action.
- 5.11** There may be circumstances where attempting to obtain consent might increase the risk to the child, for example in FII. Where the doctor can reasonably predict the risk to the child of seeking consent is significant and greater than the risk of obtaining it, then he or she may dispense with consent. Full documentation of the evidence on which the judgement is based is essential.
- 5.12** It is always important to inform the treating psychiatrist as to whether or not parent and child have consented to the release of information.

### **KEY MESSAGES**

Psychiatrists primarily responsible for adults should always consider whether a parent's mental illness significantly adversely affects a child's health or development.

All health care professionals have a duty to report to social service departments when they have reasonable grounds for believing a child is at risk of significant harm

Patients should normally be asked for permission to share information about vulnerable children with colleagues.

Where parents refuse permission, doctors must consider whether their responsibilities to the child and their duties with regard to the public interest should supervene.

All decisions, and the reasoning behind them, should be thoroughly documented

## **6: Children/young people presenting to sexual health services**

- 6.1** This section deals with children accessing sexual health services to obtain advice, screening, treatment and interventions to prevent acquisition of sexually transmitted diseases (STIs), and/or contraception. The principles of child protection are as in the rest of this report but there are special considerations for this group which make sharing information more of a problem
- 6.2** Increasing numbers of young people under 18 (children, as defined by the Children Acts ) are sexually active, with the proportion of young people who report heterosexual intercourse before the age of 16 years rising in the 1990s compared with the previous decade.
- 6.3** Sexual intercourse may be voluntary or as a result of sexual abuse or sexual exploitation. These may co-exist. The age of consent for heterosexual and homosexual sex is 16 years in England, and Wales and 17 years in Northern Ireland. However sexual exploitation, such as involvement in prostitution, remains a child protection issue until the young person reaches 18.
- 6.4** **In Scotland**, the age of consent for a heterosexual relationship is 12 for a girl and 14 for a boy. However, girls are protected by Section 5 of the Criminal Law (Consolidation)(Scotland) Act 1995, which makes it a criminal offence for a person to have sexual intercourse with a girl under 16. If the girl is under 13 the maximum penalty is life imprisonment. Between 13 and 16 it is 2 years imprisonment. There is no statutory protection for boys under 16, which means that they may engage in lawful relationships from age 14 if they are consenting. In Scotland the age of consent for a homosexual relationship is 16.
- 6.5** Children involved in sexual activity require input from health services for:
- screening, treatment and prevention advice for sexually transmitted infections
  - emergency and on ongoing contraception and advice
  - access to termination or antenatal services
  - psychosexual/emotional/relationship advice
- 6.6** They usually attend contraception and genitourinary (GUM) services without their parents or carers, who may be unaware that they are utilising services or are sexually active. There are difficulties in providing health services to young people as they are entitled to the same degree of confidentiality as adults and can consent to examination and treatment if Fraser (Gillick) competent. However according to the law sexual activity with a girl or young woman may be defined as unlawful either due to their age, the age of their partner or if they are involved in prostitution. The implications of the Sexual Offences Reform Bill on sexual activity between consenting young people is not clear and will need to be assessed once the bill becomes law.

- 6.7** Sexual activity is particularly an issue for the under 13s in that they can be judged Fraser competent to consent to examination and treatment but are regarded as incapable of consenting to sexual activity (in England & Wales), so careful consideration needs to be given for referral to child protection services or the police.
- 6.8** The care of children and young people is guided by the standards laid down in statute for sexually transmitted disease (STD) services, the Children Acts, the European Convention on Human Rights and the Human Rights Act. This will be further affected by the Sexual Offences Reform Bill (E&W), which defines any penetrative sexual activity under the age of 13 years as rape and any sexual activity between an adult aged 18 or over with a child under 16 as an offence, with a maximum sentence of 14 years imprisonment. The bill, as published, contains the following:
- “ a person acts for the protection of a child if he acts for the purpose of a) protecting the child from sexually transmitted infection, b) protecting the physical safety of a child, or c) preventing a child from becoming pregnant, and not for the purpose of causing or encouraging the activity constituting the offence within subsection (1)(b) or the child’s participation in it.”*
- 6.9** That such young people are sexually active is undesirable from their developmental perspective and presents special problems to sexual health care providers. These vary from case to case and must be dealt with on an individual basis. This can result in conflict between professional codes of confidentiality, the expectations of the client / young person, a young person’s needs for sexual health services and child protection guidance.
- 6.10** National guidelines have been produced on the management of suspected sexually transmitted diseases in children and young people which discuss this in more detail and make recommendations for those working in GUM/Sexual Health services.
- 6.11** Doctors providing these services cannot and should not ignore the child protection issues for these young people. However they must also consider the needs and rights of the young person for confidential and appropriate medical care. If a service is not seen to be confidential then there is a risk that either it will not be accessed or that those attending will not be honest about their age and sexual activity or disclose abuse or exploitation. This can have serious health implications and mean that abuse/exploitation might go unrecognised and the opportunity for supporting the young person and intervening to stop the abuse/exploitation would be lost.
- 6.12** Currently many contraceptive services provide a confidentiality statement that specifies that if

abuse is disclosed it will be reported. The effect of such statements on a young person's willingness to disclose important information about sexual abuse/exploitation and about their partner for contact tracing purposes is unknown. The GUM guidelines recommend the use of risk assessment proforma to ensure addressing risk of abuse and that senior staff are involved, multi disciplinary teamwork in care and decision- making, and close links with paediatricians responsible for child protection as well as the ACPC.

- 6.13** Doctors and nurses working in sexual health services need to be able to discuss clients without initial disclosure of names. The distinction between the need for advice / discussion and referral is an important one. If referral is necessary the child's consent should be obtained, and if refused it may be possible to work with the young person over a period of time in order to obtain consent, unless there is evidence of immediate danger or risk to another child. If disclosure is refused they should be made aware of the referral except in exceptional circumstances. It is essential that every case is dealt with on an individual basis and that close collaboration between services exists.
- 6.14** Although parents/guardians of children being referred to child protection services via paediatricians are usually made aware of the referral, this is not standard practice in sexual health services if the young person has presented without their carer.
- 6.15** Because of the conflict between the medical/confidentiality needs of the young person and child protection issues, doctors are increasingly concerned. The additional clause in the Sexual Offences Bill, if accepted, should help. There is a real danger that unless doctors are allowed to provide a confidential service to young people then sexual health care may be jeopardised for those most in need.
- 6.16** STIs may be diagnosed in young children presenting with symptoms or signs to GUM, paediatric or primary care services. Information about young children diagnosed with genital gonorrhoea or chlamydia must be shared with child protection services, irrespective of parents' wishes. A chain of evidence proforma developed by the Royal College of Pathologists Working Group should be used when samples are taken and processed.
- 6.17** The RCPCH and the Association of Police Surgeons issued guidance, in April 2002, on paediatric forensic examinations in relation to possible child sexual abuse (currently under review). Amongst other issues, it dealt with colposcopy and photodocumentation, stating:

*“Photodocumentation must only be obtained with the specific informed consent of the child and/or person who holds parental responsibility for the child.*

*All still photographs and videos will be coded (identifiable only to the doctors concerned) and retained as part of the doctor's medical records.*

*In obtaining consent the examinee should be advised that the still photographs or videos are diagnostic tools and, consequently, they might be shown to other medical experts instructed by solicitors acting for a defendant.*

*If the child or parent refuses photodocumentation this must be respected and recorded in the notes."*

### **KEY MESSAGES**

Doctors providing sexual health services must balance child protection issues against the young person's right of confidentiality and need for a sexual health service. A service perceived as not confidential may not be used or the young person concerned will not disclose abuse or exploitation.

The GUM guidelines recommend using risk assessment proforma to identify abuse and ensure there is follow-up when immediate disclosure is not made. (ref 21)

Children's need for protection does not diminish the importance of gaining their agreement to sharing information when practicable and time should be allowed to do so where the risk is not immediate.

Abuse should always be considered in those under 16 who are sexually active but anyone under 18 may be subject to protection procedures if they are being exploited. Very careful consideration must be given to those under 13 who are sexually active. Sharing information without parental consent may be necessary - particularly as the young people usually self-refer to sexual health services.

Young persons' refusal for photodocumentation should be respected

## **7: Research issues**

**7.1** Those researching into child protection should be aware of the following publications:

- Royal College of Paediatrics & Child Health: Ethics Advisory Committee. Guidelines for the ethical conduct of medical research involving children. *Arch Dis Child* 2000; 82:177-182
- General Medical Council: Research: The role and responsibilities of doctors. London: GMC 1998
- General Medical Council: Confidentiality: Protecting and providing information. London: GMC 2000
- The Caldicott Committee: Report on the review of patient-identifiable information. Leeds: NHS Executive 1997.
- Health and Social Care Act 2001
- National Health Service, England and Wales, Patient Information Advisory Group (Establishment) Regulations 2001. Made 6th August 2001, laid before Parliament 7th August 2001 came into force 31st August 2001
- Guidance Notes, Section 60 of the Health and Social Care Act 2001. These can be found on the Department of Health Website ([www.doh.gov.uk](http://www.doh.gov.uk)). This Guidance is intended for:
  1. Those wishing to obtain identifiable patient information;
  2. Data controllers who are asked to supply identifiable patient information;
  3. Research Ethics Committees who are asked to advise on the ethical disclosure and use of identifiable patient information.

**7.2** Evidence-based practice is vital for improving clinical care. Recognising this, RCPCH guidelines stress that research involving children is ‘important for the benefit of all children and should be supported, encouraged and conducted in an ethical manner.’ Clearly this includes research into child protection, given the small evidence base and the high risks to children. While they confirm that informed consent is normally regarded as essential, so should always be sought, the difficulties that might arise where a child has been abused and parents decline to cooperate are not addressed.

**7.3** The GMC document, para. 5 notes that participants’ consent must be obtained, save in exceptional circumstances where specific approval not to obtain consent must have been given by a research ethics committee (REC). Para. 6 implies that the same is true of records-based research.

**7.4** Paragraph 30 states:

*“Where data is needed for research, epidemiology or public health surveillance you should:*

*Seek consent to the disclosure of any information wherever that is practicable*

*Anonymise data where unidentifiable data will serve the purpose*

*Keep disclosure to the absolute minimum*

*Keep up to date with, and abide by, the requirements of statute and common law, including the Data Protection Act 1998 and orders made under the Health and Social Care Act 2001 (in England and Wales).”*

**7.5 Section 60 of the Health and Social Care Act 2001 (England and Wales)**

Section 60 of the Health and Social Care Act 2001 enables the Secretary of State to support and regulate the use of confidential patient information in the interest of patients or the wider public good. Parliament agreed to the creation of this power to ensure that patient identifiable information currently needed to support essential NHS activity can be used, without the consent that should normally be obtained, where there is no reasonably practicable alternative.

Regulations made under Section 60 can provide a basis in law for patient identifiable information to be disclosed to specified bodies, (e.g. cancer registries), for specific purposes. This type of ‘specific support’ is required if the intended purposes for obtaining the information are controversial or complex and need detailed description within the regulations. The approval of Parliament, advised by the independent statutory Patient Information Advisory Group (PIAG), is required before such regulations may be brought into force.

Parliament has also agreed to the establishment of ‘class support’ that will provide a lawful basis for using and disclosing patient identifiable information to support relatively uncontroversial processing, for limited and defined purposes, without the need for dedicated Parliamentary consideration. The approval of the Secretary of State, advised where appropriate by PIAG, is required in these circumstances.

The Patient Information Advisory Group therefore forms the basis for performing research in child protection where consent is impractical. These clearly include epidemiological studies.

Secretariat: PIAG Room IN 35G, Quarry House, Quarry Hill, LS2 7UE.

Telephone 0113 254 6019

## **7.6 Guidance On Applications to the Patient Information Advisory Group**

Each application will be subject to the following considerations, which build upon the principles established by the Caldicott Committee.

### **1. Applicant's Details**

In this section you must provide:

- (i) The name of the organisation/individual that is applying for access to patient identifiable information.
- (ii) The name of the NHS organisation which is acting as sponsor for the application. In most circumstances this organisation will have commissioned the work covered by the application. The application must include a separate written recommendation from the Caldicott Guardian of the sponsoring organisation confirming that they have approved the work described in the application.
- (iii) Address for formal correspondence.
- (iv) Name and telephone contact details of the Information Custodian. This person will be responsible for ensuring that data is held securely and processed in accordance with the provisions of the Data Protection Act 1998.

### **2. Basic Purpose**

In this section you must:

- (v) Describe the purpose of the work for which you are seeking access to patient identifiable information. Sufficient detail must be provided to enable the reader to understand the proposal and to ascertain whether or not the purpose(s) can be covered by section 60. The description should also be comprehensive, with all purposes detailed.
- (vi) Describe how this work will benefit patients or the wider public. The

sponsor's letter may support this.

- (vii) List the data items you wish to collect in respect of each patient (eg Name, Postcode, NHS Number, Date of Birth, etc) and briefly explain why each of these items is required. The reasons why anonymised or coded data cannot satisfy the purpose(s) should be explained here.
- (viii) The type of support required should be detailed. If the requirement for patient identifiable information can be covered by class support, the type of class support that is required should be outlined.
- (ix) For research activity, the applicant must provide copies of the research protocol and L/MREC approval letter.

The Data Protection Act contains little applying to child protection research. Section 3.5.2 includes exceptions where confidentiality can be waived, including:

*“Public health and epidemiological investigation, research or survey work which may require linking episodes of care. The ability to establish such links is dependent on the existence in the dataset of some identifying features, usually related to individuals in a population.”*

*“Collection of statistical information where, although the output is aggregated, information is collected and possibly held in patient-identifiable form either to provide the flexibility of analysis or to enable linkage between different events occurring to the same person.”*

**7.8** Many commonly conducted research projects are problematic. For example, small case series, where patients are potentially identifiable but it may be impractical to gain parental consent. Authors may find themselves dependent on whether journal editors are prepared to accept such studies without explicit consent - especially where photographs are used.

**7.9** Consent may also be impractical with population based incidence studies, cohort studies of outcome or diagnostic case-control studies. In general, researchers may have to rely on a 'public interest' argument satisfying their REC, while taking their chance on being able to justify their actions to any complainant.

**7.10** Researchers in the UK must know about the REC review process and should know how to contact COREC and be aware of Governance Arrangements for RECs (GAfREC), available

at [www.corec.org.uk](http://www.corec.org.uk). In such a difficult research area as child abuse and protection these bodies can be important advisers and allies.

**7.11** If you need rapid access to the Court for advice, a useful guide can be found in *Clin Med* 2003;3:587.

**7.12** For those wishing to use photodocumentation, there is an escalator for obtaining consent. It should be obtained from the child if a photograph is to be placed in casenotes. A higher level of specific consent is required if images are to be used for teaching and particular care must be taken to explain the implications if an image is to be submitted for publication. Remember that Powerpoint lectures may be easily transmitted and copied.

### **KEY MESSAGES**

Whenever possible informed consent should be obtained to include patients in a research project

Where this is impracticable, such as with certain epidemiological studies, advice should be sought from the research ethics committee giving due weight to 'public interest grounds' and from the Patient Information Advisory Group.

Courts will take into account the views of a REC but will not necessarily concur

Having data anonymised independently may help but the GMC advise consent is needed to supply notes to the anonymiser

The GMC recognises the dilemmas and is reviewing its guidance

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## Appendix

### RCPCH WORKING PARTY ON THE RESPONSIBILITIES OF PAEDIATRICIANS IN CHILD PROTECTION CASES WITH RESPECT TO CONFIDENTIALITY

#### MEMBERSHIP

Dr Harvey Marcovitch (Chair)	RCPCH
Mr Wes Cuell	ADSS
Dr Mustafa Kapasi	BMA
Dr Vic Larcher	RCPCH (member Ethics/Child Protection Committees)
Professor Margaret Lynch	RCPCH (Chair, Advocacy Committee)
Dr Jean Price	RCPCH (Chair, Child Protection Committee)
Professor Jo Sibert	RCPCH (Wales)
Mr Bertie Leigh	Solicitor
Mr David Spicer	Barrister
Dr Danya Glaser	RCPsych
Mrs Carole Myer	Lay representative
Dr Helen Hammond	RCPCH (Scotland)
Dr Helen King	Faculty of Family Planning & Productive Health Care
Dr Angela Robinson	Medical Society for the Study of Venereal Diseases (MSSVD)
Dr Karen Rogstad	Consultant Physician, GU Medicine

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