Response from: Royal College of Paediatrics and Child Health

To: The Home Office- Consultation on Mandatory Reporting of Child Sexual Abuse

Due: 30th November 2023

RCPCH Summary Response to the Home Office Consultation on Mandatory Reporting

The RCPCH responded to the Government's call for evidence on mandatory reporting of child sexual abuse in August 2023, providing a synthesis of the available evidence and a clinical consensus and highlighting to the government a number of key issues and considerations in relation to the introduction of mandatory reporting of child sexual abuse. The key points were as follows:

1. **All types of child abuse must fall under any mandatory reporting duty**
2. **A children's rights-based approach must be followed and a children's rights impact assessment must be carried out**
3. **A Government systems impact assessment must be carried out**
4. **Measurable outcomes for children must be built into any plans**
5. **Clearer definitions must be provided before further consultation**

We are disappointed to see an absence of response to most of the above in the Home Office ('the Department')'s newest consultation, which sets out plans for the introduction of mandatory reporting. We attach our response to the initial call for evidence in full, which outlines further the rationale for the above, and would encourage this to be reconsidered in response to this new consultation.

We are additionally extremely concerned by the Government's failure to fulfil its obligations as set out Article 12 of the United Nations Convention on the Rights of the Child to provide children with an opportunity to express their views on all matters concerning them. Given that this proposed policy has direct impact on the children of today and children of the future, it is essential that the government engages directly with them either through the Department for Education or via commissioned engagement with a youth voice organisation. Engagement with adult survivors is extremely important, however cannot replace engagement with children in the current climate.

The RCPCH's position on Mandatory Reporting clearly sets out that there is insufficient evidence that the introduction of a mandatory reporting duty is effective in protecting children and that our social care sector is unlikely to be

able to adapt to this change in legislation without significant investment in training across the public, private and voluntary sectors. Our primary position is, therefore, that it is not appropriate for the RCPCH to respond to the questions outlined by the consultation as these seek to implement a policy which we feel puts children at risk of unintended consequences including the under investigation of reports and a breakdown of trusting relationships with professionals. However, where necessary in the response below, we have incorporated material relevant to the questions that have been posed.

As an alternative, the below sets out our comments and concerns with the impact assessment provided in addition to this consultation, and in particular highlights a number of errors and omissions in the assumptions made. In our view the currently proposed policy must not be implemented. It is apparent from the review of the impact assessment and some of the other information available within the consultation that there are very significant consequences, outlined in our response below, which may arise if this policy is implemented. These are neither, anticipated by the policy impact assessment nor budgeted either adequately or at all.

This policy has tangible impact on the safety of children and their life course into adulthood and so it is essential that any changes made are rooted in evidence. The policy as it stands does not meet this threshold.

We would welcome an opportunity to engage with the Department further on this and can be reached at health.policy@rcpch.ac.uk.

Consultation on Mandatory Reporting Of Child Sexual Abuse- RCPCH Detailed Response

1. **Overarching concerns with the impact assessment: Data, Assumptions and Language**

1.1. It is made clear by the impact assessment that "many aspects of the evidence base underpinning this impact assessment (IA) are still under development" (Page 4, paragraph 5). The impact assessment is therefore not robustly evidence-based. This is likely to result in ineffective policy making for an extremely important policy area. That ineffective policy-making is more likely than not to result in unanticipated costs (both financial and opportunity) within an already over stretched health system; it is more likely than not to result in confusion within the multi-agency safeguarding system; and as a result of both of these it is more likely than not that some children will be placed at increased risk of harm, rather than decreased, as their cases fall into the confusion void caused by the

inadequately described, and inadequately referenced, policy proposals.

1.2. Benchmarking the impact assessment on the policy option of 'do nothing', while standard practice, is not helpful in this context. The IICSA put forward a range of recommendations with an intention for these to be used in tandem. It would have been more helpful to use strengthening of existing mechanisms such as the DBS system or training and education as a comparison for this report.

1.3. We are disappointed to see that a children's rights assessment has not been provided in tandem with this report. Considering a mandatory reporting duty on just one type of child abuse creates a damaging hierarchy of abuse. In the interests of reading-efficiency, rather than replicate all of the evidence base under-pinning this position and therefore refer you to **section 4** in the RCPCH's attached evidence submission for further information on this.

1.4. The assessment suggests that the policy objective of the mandatory reporting duty 'should increase the confidence of victims and survivors feel in knowing that when they make a report to a trusted adult, they will be believed, and that action will be taken. In addition, the introduction of the duty will help increase knowledge and awareness of child sexual abuse across society' (Pg 6, Para 18). The RCPCH would question the evidence basis to this and refer to the Department to our evidence review, which indicates that this has not often been the case when introduced in other jurisdictions.

1.5. It is essential that outcomes for children are the focus of any policy which concerns them. The 'outcomes' proposed in Paragraph 17 (Pg 6) instead refer to processes and indicators. An outcome is that child is protected from abuse, not that reports increase. Please see page 17 of the RCPCH's evidence submission for further information on this.

1.6. Assumptions made on page 9 in relation to the increases in reporting rates are inaccurate, insufficiently specific and cannot be relied upon to make policy decisions. Para. 30 states: 'there is already an existing statutory duty for safeguarding professionals to report child sexual abuse, the new duty turns this into a mandatory duty. The duty also allows for reporting to the police or social services.' This is confusing in terms of sentence structure, but also does not reflect the language used by either the sector or the existing statutory guidance.

1.7. The estimated increase range of 0.1 to 0.5 percent outlined in Para. 31 (page 9) is, by the assessment's own omission, not evidence based. To base the entirety of the impact assessment on this figure with no evidence basis is not only poor policy making but puts children at risk. Underestimating this figure could have significant consequences on the availability of essential children's services, including police and health. It is dangerous to implement a policy with such variable outcomes without a clear, evidence-based understanding of the potential outcomes.

1.8. In relation to the overall increase in reports, the RCPCH would direct the Department to page 14, paragraph 26 of our evidence submission and the subsequent reference list. The impact assessment has used two references to determine that the introduction of Mandatory Reporting 'may' lead to increased referrals. Our comprehensive review of the available evidence suggests that it almost certainly always does and this risks flooding an already over-stretched system. We are concerned that the lack of evidence review undertaken by the department has led to significant underestimation of increased reporting.

1.9. The assessment makes several references to 'abuse and neglect'. We would like to highlight neglect **is** abuse and so this needs to be changed to either just 'abuse' or 'abuse, including neglect'. It is interesting to see the figures for children who are victims of all types of abuse on page 12, and the proposed policy and impact assessment inadequately addresses the impact of a reporting duty for all types of child abuse. Individual categories of abuse cannot be taken in isolation just as children who suffer from one type of abuse often co-suffer from another type of abuse.

1.10. The assumptions made about the resource required to read new guidance must be reviewed. We believe that a more appropriate summary of the reading rate paragraph would be: *"based on the analysis of 190 studies (18,573 participants), it is estimated that the average silent reading rate for adults in English is 238 words per minute (wpm) for non-fiction material. These estimates – from 19 scientific studies – are lower than the commonly cited numbers previously reported. Reading rates are lower for children, old adults, and readers with English as second language and this must be taken into account when considering that a proportion of the workforce who will need to read about the mandatory reporting duty will not speak or read English as their first language. These assumptions do not take into account the flow charts, sector-specific guidance, training materials, teaching programmes, mandatory training, and policy updates that will need to be read by professionals to whom the*

duty will apply".[1]

1.11. The assumption that new guidance accompanying the mandatory reporting legislation will be 10 – 90 words long appears to be an error of gross underestimation. The guidance and Procedural Information for the mandatory reporting of FGM, for example, is 7,550 words long. This assumption, which is the basis of a significant apportionment of the cost of implementation, means that the figures on page 13 cannot be relied upon. Further, it is striking that there are significant categories of health professionals missing from the impact assessment (all of whom will see children in their clinical practice, for example emergency medicine medical practitioners; forensic physicians; sexual health physicians; and those doctors and dentists training in postgraduate speciality training programmes.

1.12. We feel that the sequencing of this policymaking is not conducive to really hearing the sector and creating effective, evidence-based policies for change. The RCPCH awaits the Government response to the first Call for Evidence, which closed in August 2023. Without a summary of the evidence presented to the Government, and their response, it is difficult to consider in full the implications of this policy.

2. The full economic assessment makes no provision for:

2.1. Increased time for public sector colleagues to make the report. Our members working in paediatric health have told us anecdotally that they can be on hold for over 45 minutes and sometimes, on occasions, up to 90 minutes in order to make a report to the police (via the non-emergency 101 number) where they have concerns about, for example, female genital mutilation. This is indicative of a system which is already not coping with reporting levels. The cost to the NHS of this unexpected work must be built into the impact assessment, both in relation to the cost of the practitioner's time but also the opportunity cost of the activity they must deprioritise in order to complete this activity.

2.2. The additional local authority work and multi-agency work as required by s47 Children Act 1989 in relation to an increase in reports. This includes strategy meetings, secretariat support, preparation and data gathering.

[1] See, for example, Brysbaert M. How many words do we read per minute? A review and meta-analysis of reading rate. Journal of memory and language. 2019 Dec 1;109:104047

2.3. The requirement for additional training and confidence building for all professionals who work with children, updates to internal operating procedures, onboarding and governance processes across the public, private and voluntary sector.

2.4. The costs associated with fall in uptake in voluntary roles, on which the children's sector relies, due to fear of criminal repercussions or an increase in DBS referrals as a result of ineffective education on the new reporting duty.

3. Applying the proposal- practical implications for consideration

3.1. The provisions outlined in Para 17b and Para 17c (page 7) are problematic from a health point of view as this suggests that the duty to report would only apply to criminal offences under the sexual offences act. This isn't the same language as statutory guidance uses (for example in Working Together to Safeguard Children) so there will be a significant (uncosted) training need to upskill practitioners to understanding the wording of criminal offences. Working Together to Safeguard Children and other relevant legislation would need reviewing in order to make sure the language is consistent, which will require additional cost.

3.2. Only applying this legislation to child sexual abuse will cause confusion for professionals as to which disclosures fall under this duty. The evidence shows us that most often, sexual abuse is accompanied by other forms of abuse. In reality, children rarely make singular, clear, verbal disclosures of sexual abuse. Significant guidance and training would be required in this area, which has not been adequately costed for.

3.3. The impact assessment refers to "precautionary reporting" without further explanation. Any inclusion criteria would need to be tight and explicit otherwise the system will be flooded with precaution- from the text in the assessment we are not confident that the Government has the relevant expertise in order to do this without unintended, or unanticipated, consequences.

3.4. Table 6 on page 13 is missing several key healthcare practitioners, including emergency medicine physicians, the sexual health physicians, the forensic physicians, the doctors who are training in any specialty which

may deal with a child under the age of 18 years. As a result, both wage and volume of professionals are significantly underestimated.

4. **Further issues identified**

4.1. Scope of the duty: At present it is unclear which of the government's policy proposals will be incorporated into primary legislation and which therefore require a "must" or "shall"; and which will be incorporated into statutory guidance and can therefore remain as "should".

4.2. Misunderstanding of professional regulatory sanctions: At present the policy proposals appear to misunderstand that there are no "mandatory sanctions" for medical professionals failing to, for example, report abuse. Whilst there are professional requirements, regulations, and guidance; this does not equate to a mandatory sanction if a report is not made. The government therefore needs to be explicit about whether it intends to introduce legislation bringing in mandatory professional sanctions, via – in the case of medical practitioners for example – the General Medical Council or Medical Practitioners Tribunal Service.

4.3. What needs to be reported? At present the section on "witnessing child sexual abuse" is inadequately explained and it is difficult to see how this could be incorporated effectively into legislation. For example, the current definition of "witnessing" child sexual abuse includes the viewing of indecent images of children. It is unclear whether the policy intention is that a professional working in regulated activity who, in the course of their duties, witnesses someone else viewing indecent images of children, must make a report [a situation which we would respectfully suggest is relatively (or even very) rare, or if the government propose an alternative policy and whether this will be set out in legislation or guidance.

4.4. Process for reporting: it is not clear what the government's proposed definition of "as soon as reasonably practicable" is and this requires clarification.

4.5. Territorial extent: there is a lack of clarity about the policy intention regarding territorial extent. Is it, for example, that a professional working in regulated activity in England who receives a disclosure of (relevant) abuse having occurred anywhere in the world must make a report; or is it something else?

4.6. What is a disclosure? It is unclear how this policy is protective of children's rights under the Equality Act 2010 to not suffer discrimination

on the grounds of age. How is it proposed that the rights of pre-verbal children, or those with additional and/or complex needs who might be non-verbal or who might communicate in a different way, will be protected by a policy which mandates a report when abuse is disclosed, but not when abuse is identified?

4.7. Recognising disclosures: The evidence basis for the notion that clear disclosures are *not* being reported needs to be explored. It is more likely that professionals are not recognising or understanding the signs that children are showing which indicate sexual abuse, and so are not aware that a disclosure has been made to them. If this is the case, a mandatory reporting duty will not result in more children being protected from abuse, as it does not address the issue of professionals being unaware of the less explicit signs of CSA. Training and support is more likely to imp

4.8. Deterring children from accessing healthcare: We consider that the policy, as worded, is likely to result in fewer children coming forwards to report abuse. For example, it is recognised that some children who self-refer to sexual assault referral centres do so because they prefer to not make a disclosure to the police. It is therefore unclear how these groups of children will be empowered and encouraged to still come forwards to access healthcare knowing that their treating doctor and/or nurse would be required in law to report the allegation "as soon as reasonably practicable". How does this allow for building trust with the young person and allowing for time to give reassurance and assurance (in tandem with the securing of any time-sensitive forensic samples being obtained)?

4.9. Exemptions: if the government does decide to press forward with this policy, despite advice that such a decision is unwise and uncosted, the exemptions to the legal duty to report must be clearly, and unambiguously, set out. In that regard we refer to the NPCC's guidance on "sexting" [2].

4.10. Policy intentions: We note that the government estimates that the policy will result in between two and nine additional custodial sentences. This is a very downstream approach to prevention, recognition, and addressing abuse. Upstream approaches are arguably a better way to act for something that has, at its heart, a public health basis. We can supply

[2] https://news.npcc.police.uk/releases/a-common-sense-police-approach-to-investigating-sexting-among-under-18s

some academic work looking at public health levels of intervention and prevention of child abuse on further request.