FACULTY OF FORENSIC & LEGAL MEDICINE

of the Royal College of Physicians of London

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Registered Charity No 1119599

14 August 2023

IICSA Response
Tackling Child Sexual Abuse Unit,
Home Office, 5th Floor Fry Building,
2 Marsham Street,
London SW1P 4DF.

by email: mr_csa@homeoffice.gov.uk

Dear Sir or Madam,

Re: **Consultation on Mandatory Reporting of Child Sexual Abuse**

I write on behalf of the Faculty of Forensic & Legal Medicine, (FFLM) of the Royal College of Physicians.

The FFLM is a charity set up to develop and maintain the highest possible standards of competence and professional integrity in forensic and legal medicine. The specialty covers professionals working in the following disciplines: forensic medical practitioners (forensic physicians, forensic pathologists, forensic psychiatrists, forensic odontologists); medico-legal and dento-legal advisers; clinicians working in secure and detained settings and medically and legally qualified coroners. Furthermore, our membership includes all healthcare professionals in forensic roles: doctors, nurses, midwives and paramedics.

The FFLM has been recognised by the Home Office as being responsible for the standards to be expected from all healthcare professionals involved in custody healthcare and forensic examination.[1] In addition, in the response to the Violence Against Women and Children Taskforce Report[2] along with the Government's interim response,[3] where it was agreed that the FFLM should set those standards in conjunction with the Forensic Regulator.

Our aims are: *Raising standards in forensic and legal medicine; protecting vulnerable people.*

Children and young people are amongst the most vulnerable people in society, and so we welcome the opportunity to respond to this consultation. Whilst we will try to reply on-line, to ensure we meet the deadline of 23:59 tonight, 14 August 2023, we are replying in this document, by email.

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The attached document covers the questions and our response, representing the views of members of the FFLM.

Many members of the FFLM regularly provide care for children and young people, particularly in the following settings:

- Sexual assault and abuse services, (SAAS),
    - including sexual assault referral centres (SARCs)
- Police custody

Thank you for the opportunity to respond.

Yours faithfully,

Dr Bernadette Butler
PFFLM, FRCOG, MFSRH, PGDip FLM, PGA(MedEd), FFCFM(RCPA)
GMC No: 2441223

President, The Faculty of Forensic & Legal Medicine

References

1. *Hansard*, March 18th 2009, Column 1164W
   Forensic Science - Hansard - UK Parliament

2. The Report of the Taskforce on the Health Aspects of Violence Against Women and Children. March 2010.
   https://www.health.org.uk/sites/default/files/RespondingtoViolenceAgainstWomenAndChildrenTheRoleofTheNHS_guide.pdf

3. Interim Government Response to the Report of the Taskforce on the Health Aspects of Violence Against Women and Children (VAWC). March 2010
   Interim Government Response to the Report of the Taskforce on the Health Aspects of Violence Against Women and Children (VAWC) (fflm.ac.uk)

Consultation on Mandatory Reporting of Child Sexual Abuse
Response of the Faculty of Forensic & Legal Medicine (FFLM)

Q1: To help us analyse our responses, could you please tell us in what capacity you are responding to this consultation. As a…

Select all that apply:

- **Health practitioner**
- **Other**

If you choose 'Other' or wish to clarify your response, please describe the role that best describes you.

On behalf of my organisation, the Faculty of Forensic & Legal Medicine (FFLM) of the Royal College of Physicians

Q2. If you are responding on behalf of an organisation, what is your role within that organisation?

Select one from:

- **Senior leader (Director, Chief Executive) - President**

Q3. We know that we deliver better services when we receive feedback from a full range of backgrounds and experiences in the society we serve. We would be grateful if you could complete the following diversity questions. You can select 'prefer not to disclose' if you would rather not answer any question.

Your sex

Select one from:

- **Female**

Your ethnic origin

Select one from:

- **White - English**

Q4. In sharing findings from this consultation, may we quote from your response?

Select one from:

- **Yes – attribute to my organisation.**

Section 1: Who the duty should apply to

Q5. Is the range of 'mandated reporters' set out by the recommendation (people working in regulated activity with children under the Safeguarding and Vulnerable Groups Act 2006, people in positions of trust as defined by the Sexual Offences Act 2003 and police officers):

- **Appropriate**

Please provide details to explain your response.

- **The difficulty is not just who are designated as 'mandated reporters', but to whom the report is to be made. In children and young people, although there may be a disclosure of abuse, often it may be a set of concerns where child sexual abuse is part of a clinician's differential diagnosis, i.e. a possibility/ a suspicion is present, but notwithstanding a child and a young person has a right to be protected, one has to consider what the consequences of making report might be: and these may sometimes be harmful.**
- **Some of the difficult scenarios are where a child (e.g. a 16 year old, says that the relationship is consensual, but one is concerned that it might not be the case. Ideally the clinician would follow up the child, gain trust and explore what is going on. It may be that it is actually a consensual healthy relationship. If mandatory reporting for such concerns were in place, then this would cause problems.**
- **The clinician could make the report and damage the trust between not just them and the child, but all health providers and the child. The clinician could choose to "not see" any potential red flags so absolving themselves of any responsibility - which will let down children who are actually at risk.**
- **Clinicians' experience is that reports are often made to police when an older adolescent, yet under 18 years, discloses a sexual assault, and the young person clearly stated that was not what they wanted. Clinicians often have challenging conversations and interactions when a safeguarding referral is made, following which - and despite the wishes of the young person being made clear - these are over-ridden and the police are informed. Since sexual abuse is about power, control and the removal of choice by the abuser, consideration must be given to the impact of compounding that loss of control and choice, apparently by not taking into account the wishes of the child or young person.**

Q6: At what level should mandatory reporting apply?

- **Only at an individual level**
- **Only at an organisational level (bodies, institutions or groups)**
- **Both individual and organisational level**
- **Don't know**

We had differing views/ thoughts on this question.

Q7: [If respondent selected 'Only at an organisational level (bodies, institutions or groups)' or 'Both individual and organisational level' in response to the above question] Which organisations or groups should it apply to?

- **Health, Education; which others?**
- **Some thought it would depend on whether it was actual disclosures or suspicions which had arisen. Others said the responsibility falls to the clinician to make the decision, as they are the one who has dealt with the child.**
- **It would be challenging, if for example a clinician's view was there should be a report made by the organisation, e.g. NHS Hospital/clinic vetoed that decision.**

Q8: If there was a mandatory reporting duty at an organisational level, should those impacted be required to report on their activity annually?

- **Yes**
- **Don't know**

- **We had differing views.**
- **Not sure of the use of this activity – what would be the benefits and disadvantages?**

Q9: [If respondent selected 'Yes'] What form should that reporting take?

- **What is the value in a number?**
- **What one would want to know, is:**
    - **Did the children who were at risk get protected?**
    - **Did the children who were not at risk get an unnecessary referral?**
    - **So there needs to be a system that looks at quality issues not quantity.**
- **Also, any review needs to look at the wider picture, what happened?**
- **What was the impact (short medium and long term) to that child an impact on other children - does it stop them coming forwards?**

Section 2: Scope of the duty

Q10: Should a mandatory duty to report go beyond the scope recommended by the Inquiry and cover other/all types of abuse and neglect?

- **Yes**
- **Don't know**

We had differing views, nor were we sure of the use of this? What would be the benefits and disadvantages?

Q11: [If respondent selected 'Yes'] Which types of abuse and/or neglect do you think should be covered?

- **Abuse types often overlap: a child who is sexually abused will experience emotional abuse and probably neglect: their care and needs are neglected.**
- **It also depends on whether this is about responding to a disclosure or suspicion of abuse.**
- **If we accept all types of abuse should be reported, then what might be the response for children living in poverty and the adverse consequences on the child's physical and mental health, affecting their ability to develop to their full potential; see:** [Map of child poverty - The Health Foundation](). **We know more families are having to use food banks and the number of children living in poverty is increasing. Therefore, it could be argued this is a type of local and/or national abuse, depending whether the responsibility is that of the local authority or the Government.**

Q12: What impacts (positive or negative) do you think a mandatory reporting duty would have on:

- Children choosing to make a disclosure, either partially or in full

- **A positive would be that children disclosing abuse and hoping to get referred to authorities, for care support and treatment, would get such a response. This is not the case now: often children may wait weeks or months for support from CAMHS or other services; even worse they may be told, 'they do not meet the threshold'.**
- **See other answers; it may prevent the child from reporting, or compromise the trust, if they had not understood the duty. The child might limit what they disclose.**
- **If mandatory reports were made to police, the child might perceive they are getting into trouble. Also, one needs to consider the impact on other children who witness the consequences, when a peer attends the GP, school nurse, or other setting. Will it inhibit them seeking help?**
- **And this also depends on what is to be reported; clear disclosure vs suspicion. If it were just suspicion, then it would have a big impact on children feeling able to talk; and would have a big impact on clinicians**

feeling able to explore issues with children. They might not want to ask questions for fear of the answers they get.

- **It’s challenging; it’s likely that some teenagers would not be able to work with professionals and build trust, so they are ready to disclose or report abuse. There are concerns about how to respond to possible ‘child on child’ concerns of or actual abuse, when both need safeguarding, yet we have one of the lowest ages of criminal responsibility, in the developed world.**
- **On the other hand, mandatory reporting could allow better information gathering by police (but only if information is shared between forces); or by other agencies. The lack of info sharing between different social care & police areas, e.g. different counties can be problematic.**

- Individuals within scope of the duty reporting known / suspected incidents

- **As well as the education and training there would be the weight of the responsibility of that duty, hence a need for organisational report. They may feel the duty conflicts with the needs of the child and child-centred care.**
- **One colleague who has undertaken a lot of international work shared the following experience: many places have very low reporting rates of sexual abuse and assault. Often, I think it is because of the mandatory reporting and consequences afterwards.**
- **The system needs to ensure a high-quality response all along the line, whether or not mandatory reporting or is in place. Therefore:**
  - **No long waiting lists for counselling.**
  - **No criminal justice system whereby a child reporting in primary school can go through nearly all of secondary school before case comes to trial.**
- **One colleague asked if there should be phased introduction, perhaps with younger children first, e.g. those under 13 years**

- Organisations within scope of the duty reporting known / suspected incidents

- **Organisations are made up of individuals, see last question, Existing safeguarding processes and procedures, properly supervised, audited and reviewed should be sufficient?**
- **Information from clinical colleagues and school-teachers, shared with us, is that when they make a safeguarding referral, they often say that they never get to know the outcome because of "confidentiality" issues. They become frustrated as no feedback at all means they don't learn whether or not their actions / senses were accurate. We and they can't learn.**

- Individuals outside the scope of the duty reporting known / suspected incidents
- **Even if someone does not have a duty, it does not prevent them from making a report – as now.**

- Organisations outside the scope of the duty reporting known / suspected incidents
- **Even if an organisation does not have a duty, it does not prevent it from making a report – as now.**

- Agencies in the wider safeguarding system that are required to respond to reports of abuse.
- **We believe that the public sector services e.g. police, social care and health are already stretched in their abilities to always respond in the most appropriate way.**
- **The concern would be that mandatory reporting would be introduced without properly addressing the resources needed. Furthermore, suspicions may be more common than 'actual' cases and thus potentially make the response to the latter less robust and timely.**

- Members of the public
- **Even if a member of the public does not have a duty, it does not prevent them from making a report – as now. However, a fear of police may prevent them from doing so. Hence there are currently anonymised ways of doing so.**

Q13: At what level of knowledge should a mandatory reporting duty apply?

- Restricted to known incidents of abuse
- Both known and suspected incidents of abuse (based on recognised indicators of abuse)

- **This assumes one can always be sure – it is often not that simple or straightforward.**
- **How is it possible always to be clear/certain: what is a suspicion/concern or on the list of possible explanations, (clinically, the differential diagnosis) and being sure? It is often impossible.**
- **Some colleagues thought it should not be a requirement for a mandatory report for a suspicion.**
  As noted elsewhere, abuse may come into the differential diagnosis of many medical signs and symptoms. We don't want to subconsciously inhibit clinicians from considering abuse if to do so would compel them to go down a path that would damage the relationship with child/family. And of course, could also damage the child and family

Q14: What should be considered a 'disclosure' of abuse?

A clear statement by the child:

- **"This happened to me."**
- **But children may not have the words or understand what has happened to them**
- **Pregnancy in a younger child, e.g. < 13 – but if the boy and girl are both under 13 years…what then?**
- **We know for example a sexually transmitted infection (STI) in a child raises a high index of suspicion of CSA and a safeguarding response, but there are other explanations which are not due to CSA.**
  Other:
- **Sexualised behaviour**
- **Perhaps the child who suddenly starts wetting the bed again?**
- **Behavioural changes?**
- **Clinical findings – hymenal transection in a pre-pubertal girl – but such an examination would arise from a disclosure or a suspicion of CSA.**

Q15. The Inquiry calls for 'recognised indicators of child sexual abuse', which are unspecified, to be set out in guidance and regularly updated – how would you rate your own personal level of confidence in spotting indicators of child sexual abuse?

Option to score 1-10 [1: low confidence, 10: fully confident]

6/7

- **Due to my work, probably higher than it would be if I worked in another area of health so I'd suggest 6/7.**
- **Other colleagues may say higher or lower.**

Q16. How would you rate your sector's current level of confidence in spotting indicators of child sexual abuse?

Option to score 1-10 [1: low confidence, 10: fully confident]

8

It is probably high, but I doubt any individual or service can be 100% confident and to say 10.

Section 3: Sanctions for failure to report

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

- **Neither agree nor disagree**
- **Don't know**

- **We had various views.**
- **This would prevent a tailored response, so assumes 'one size fits all'. The Intercollegiate document, states:** ***The protection of children from abuse and neglect is of paramount importance, with their needs and voice central to considerations.***
- **See** Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff | Royal College of Nursing (rcn.org.uk)

- **Also, it depends on whether based on disclosure or suspicion. It moves into the realm of trying to guess what someone was thinking. And possibly push people not to think about possibility of abuse, then they won't have to disclose.**

- **Mandatory reporting would mean that their needs and voice would not or may not be central to considerations but overridden by a legal duty.**

Q18: Do you believe that any other types of sanction should apply to breaches of the mandatory reporting duty (for example professional disqualification for individuals, or regulatory action in respect of organisations)?

- **Don't know**

- **For regulated professions this clearly already exists and there are various inspectorates for other services, e.g. CQC and HMICFRS. There may be other services where this would be required.**
- **Furthermore, what is the evidence clinicians are not already fulfilling their safeguarding responsibilities and so not adequately protecting children? Clearly clinicians cannot protect children in isolation: other agencies are involved.**

Q19: What is your view on the exception to the duty described in the recommendation (to avoid capturing consensual peer relationships)?

- **Strongly agree**

- **This was a significant issue in the lead up to the Sexual Offences Act, 2003 and the exception which was included in section 74.**
- **Whatever is ultimately decided, it must ensure that young people are not discouraged from seeking sexual health advice to prevent adverse relationship and sexual health outcomes, e.g. sexually transmitted infections, unplanned pregnancy.**

- **Children and young people, like adults, seek health services, expecting to be able to trust those providing the care they need. We must not compromise that trust.**

Q20: Is this exception likely to cause any particular difficulties?

- **No**

- **We are not aware of particular difficulties, as this has been managed for the last 20 years; however, it clearly requires staff to be appropriately trained and be able to seek advice and support in decision-making.**

Q21: Do you think there should be any other exceptions to the duty which mean sanctions should not be applied?

- **No**

- **Except what has already been stated.**
- **Colleagues asked if a clinician with a suspicion would be permitted to adopt a 'watch a see approach', build up trust with a child, try to explore what might be going on?**

Section 4: How to ensure successful implementation

Q22: Can you foresee any overlap or tension with your or others' existing duties or professional requirements which may be introduced by a mandatory reporting duty?

- **Yes**

- **In sexual assault and abuse services, (SAAS), including sexual assault referral centres, (SARCs), advice is often sought by children and young people. Whilst here is a legal requirement to report to the police for those under the age of 13 years, for the older adolescent, children's social care would be the agency usually involved. If mandatory reporting were to be to the police, we would have to amend some of our services with a risk that a young person would not seek advice from us.**

- **As a result, we have concerns about the wellbeing of young people.**

Q23: Do you believe the introduction of a mandatory reporting duty raises any equalities considerations? For example, positive or negative impacts on groups with protected characteristics.

- **Yes**

- **Some groups have greater fear / mistrust of authorities, especially the police. If they felt that a police referral would ensue, it seems likely that they would be more reluctant to seek help and advice.**

Q24. What, if any, kind of protections do you think would need to be in place to ensure individuals making reports in good faith do not suffer personal detriment as a result?

- **It is not just personal detriment to consider, although very important. There may be professional consequences. There must be a clear commitment to address this and would need to involve proactive discussion with the regulatory bodies of those in regulated professions e.g. GMC, NMC, HCPC.**

- **Another scenario, which one might see as a parallel situation, is referrals in relation to possible malignancy, where some clinicians may be very risk-averse (or practice defensive medicine) and refer any presentation, where there is likelihood of a cancer diagnosis is highly unlikely. There are negative consequences for the patient and the service into which they are referred.**

- **As noted in many of the comments already made, this is a significant concern for many clinicians in relation to mandatory reporting.**
    - **If it is introduced then there must be sufficient preparation to ensure that when reports and disclosures are made there will be an appropriate, timely and trauma-informed response**

Q25: Should any additional reforms be implemented to ensure that a mandatory reporting duty successfully safeguards and protects children?

- **Yes**

- **Ensure the procedures and processes are not 'tick box' exercises.**

- **There are clear requirements, included audit and feedback processes embedded into services, processes and procedures.**

- **Children and families can contribute to development of these:**
    - **'no decisions about me/us without me/us'**
- **And also, with the wider public, able to see the outcomes.**

- **However, we are sceptical that this would be a priority in any implementation.**

Q26: Where should reports be made to?

- **Local Authority**

- **To the local authority who can, with the others with whom they work, involve the police: perhaps a multi-agency safeguarding hub (MASH) type of approach.**
- **However, the report must be made to those who are appropriately trained and resourced to respond; i.e. specialists, aware of the positive and potential negative consequences to a child and their family.**
- **As noted elsewhere, this would require massive investment, and for the situation as at present, services are not able to cope/meet the need.**

Q27: The Inquiry recommended that "reports from suspicions or knowledge of abuse should be made as soon as practicable". Should timescales from the point of suspicion/knowledge be defined more specifically?

  - **Maybe**

- **Possibly, but for example, in health, a concern could be resolved by examination and awaiting the result of a clinical test: and it does not follow one can obtain a result within a certain time e.g. 1 working day, 3 working days. This is also about developing a rapport and building trust with the child and their family.**

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

  - **Yes**

- **I assume that whatever was introduced would mean a need to understand the duty/ responsibility and therefore require:**

  - **training/education**
  - **working with others**
  - **introducing new policies and processes as well as systems to ensure they are fit for purpose, e.g. via audit.**

- **Some of our current recommendations might need to be amended or altered.**

Q29: Would you as an individual need to make any changes in order to ensure the successful implementation of a mandatory reporting duty?

  - **Yes**

- **Whatever was introduced would mean a need to understand my own responsibility and that of my employer; so, training/education, working with others, introducing new policies and processes as well as systems to ensure they are fit for purpose, e.g. via audit.**

Q30: Are there any concerns, including the need for additional support, that you would like to flag for your sector?

- **Yes**

- **The concerns exist already: resources, staffing and training.**
- **At present we may find responses are slow, not explained and outcomes not shared; we believe this reflects under-resourcing. Clearly resources would need to improved in order to be able to take on the further work and responsibility arising from mandatory reporting.**

Q31: Are there any additional considerations to ensuring that your sector's workforce or volunteers can meet any new mandatory reporting responsibilities?

- **Yes**

- **We believe this applies to any and all organisations: adequate staffing, education/training and support; in particular recognising the risk of vicarious trauma and proactively addressing it.**

Q32: Besides introducing mandatory reporting, are there any changes that could improve disclosures / reporting / investigations and prosecution of child sexual abuse?

- **If mandatory reporting is introduced, it is self-evident there must be adequate resources to respond appropriately: this includes, but is not limited to recruiting sufficient staff, with appropriate training and support for them to undertake the work. At present, any public services are very 'stretched' and are frequently asked to do more, either with the same - or sometimes fewer – resources. There must be a real commitment to ensure adequate resources, as without careful planning and preparation this would compound the situation. Clearly the staff would be from a number of disciplines and professional groups and the infrastructure must be such to facilitate joint working. Other considerations include ensuring a trauma-informed approach** within the service/services, which applies to those making reports and those responding **to them.**
- **As noted in other answers, what happens for children who disclose, now? They often experience**
    - **Limited services, some not commissioned in line with quality standards, e.g. clinical, psychological.**
    - **Delays in Court processes**

If this is to be introduced, it must be done properly; if we are really committed to protecting and safeguarding children from abuse then we have a duty to ensure that it is. Children have a right to safety and deserve services to be adequately resourced and thus capable to deliver what is required.

Full name:

Dr Bernadette Butler

Job title or capacity in which you are responding to this exercise (for example, member of the public):

President of the Faculty of Forensic & Legal Medicine

Date:

14/08/2023

Company name/organisation (if applicable):

The Faculty of Forensic & Legal Medicine of the Royal College of Physicians

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