Dear Sir/Madam

REPORTING AND ACTING ON CHILD ABUSE AND NEGLECT: GOVERNMENT CONSULTATION

The British Medical Association (BMA) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 170,000, which continues to grow each year.

The BMA recognises that doctors have a vital role in identifying and responding to child abuse and neglect. We welcome many recent measures aimed at strengthening and improving the child protection system.

The BMA’s responses to the questions in the Home Office and Department for Education’s consultation document can be found at Annex A, and the BMA’s position paper on mandatory reporting of child abuse at Annex B.

Yours sincerely

Raj Jethwa
Interim Policy Director
Policy Directorate
### Consultation questions

#### The current child protection system

1. To what extent do you agree or disagree with the following statements about the current child protection system?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child protection training for practitioners should be improved so that they are better qualified and able to provide the right help at the right time to keep children safe.</td>
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<td>More needs to be done within the child protection system to encourage new and innovative systems to better protect children.</td>
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<tr>
<td>Organisations with child protection responsibilities need to work better together.</td>
<td>√ Doctors frequently report that they would like feedback on cases they report to children’s services and the police</td>
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<td>Practitioners and organisations with child protection responsibilities sometimes recklessly fail to take proper action (including reporting) to stop or prevent child abuse and neglect.</td>
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<tr>
<td>Child abuse and neglect is generally under-reported by practitioners involved in children’s lives.</td>
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<td></td>
<td>√ There are variations depending on the type of practitioner and the form of abuse</td>
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</table>
**Other measures that could be introduced**

**The introduction of a mandatory reporting duty**

2. To what extent do you agree or disagree with the following statements?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don’t know</th>
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<tbody>
<tr>
<td>Mandatory reporting will generate more reports of suspected and known cases of child abuse and neglect.</td>
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<tr>
<td>Increased reporting may divert attention from the most serious child abuse and neglect cases.</td>
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<td>Increased reporting could mean that abuse and neglect would be captured at an early point in a child’s life.</td>
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<tr>
<td>Mandatory reporting could have an adverse impact on the child protection system (e.g. impacting recruitment and retention of staff, creating a culture of reporting rather than acting, negatively impacting the serious case review process).</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
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<tr>
<td>Mandatory reporting could dissuade victims from disclosing incidents of abuse and reduce ‘safe spaces’ for children.</td>
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<td></td>
<td>✓ this is a significant concern for some doctors but we are not aware of any clear evidence of this.</td>
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<tr>
<td>Mandatory reporting could lead to greater prevention and awareness of abuse and neglect.</td>
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<td>✓</td>
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<td>The introduction of a mandatory reporting duty would not in itself mean that appropriate action would be taken to protect children.</td>
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</table>
A mandatory reporting duty would ensure that those best placed to make judgements about whether abuse or neglect is happening – i.e. social workers – do so.

3. To what extent do you agree that the introduction of a mandatory reporting duty would directly improve outcomes for children?

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don't know</th>
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<tbody>
<tr>
<td></td>
<td>✓</td>
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√ taking into account the vital prerequisites listed below.

4. Please outline any risks or benefits regarding the introduction of a mandatory reporting duty that haven’t been articulated in the consultation.

The BMA has been considering the issue of mandatory reporting for a number of years, continually evaluating the evidence and weighing up the potential risks and benefits. The BMA supports in principle the introduction of mandatory reporting legislation. The BMA believes, on balance, that the benefits of introducing a mandatory reporting duty outweigh the risks; but there are a number of prerequisites critical to the safe introduction of any new legislation, including:

1. A public health focus – shifting professionals and the public’s perception of child safeguarding reporting and intervention.
2. Awareness - raising awareness of child abuse amongst professionals and the public.
3. Training and support – ensuring adequate resourcing of up-to-date accessible training and round the clock support and advice for professionals.
4. Pathways - proper resourcing of appropriate care pathways.
5. Commitment to scientific evaluation - ongoing evaluation of the impact and effectiveness of any new measures.

The BMA’s detailed policy on mandatory reporting of child abuse is set out at Annex B.

In response to the question regarding risks and benefits, one of the challenges in rating whether a risk or benefit could happen is that all are possible. Whether they materialise in practice will depend on how any mandatory reporting duty is implemented, the context within which it is implemented, and the government’s ongoing commitment to ensure it is fit for purpose – for example, by ensuring adequate resourcing of:

- awareness campaigns
- training and support
- care and safeguarding pathways
We hope that lessons can be learnt from the implementation of the female genital mutilation (FGM) mandatory duty to report – see response at page 11.

In addition to the potential risks, benefits and issues listed in the consultation paper, the BMA would add the following:

Possible benefits:

- Ensures people take responsibility for reporting rather than assuming someone else will do so.
- Makes a clear statement that government is taking the problem of child abuse seriously.
- Depending on how a system is developed, there is the potential to develop a standardised and uniform reporting and response mechanism. This in turn could enable an overview of the true nature and extent of child abuse and neglect in England.
- In addition to raising awareness, it should be an opportunity to educate key professionals and the wider population about the importance of tackling child abuse and the appropriate processes for reporting.
- A clear steer that there are no legal obstacles to reporting child abuse and neglect.

Possible risks:

- The child protection system gets overloaded with significant resource implications and potential detrimental impact on severe cases of abuse of which social services are already aware. There is both an explosion in the number of reports and a proportionate decline in the number of reports which are substantiated.
- It inhibits self-referrals by both children and parents as they lose control of what happens to them because the professional they disclose to must then report the incident.
- It may discriminate against vulnerable populations who may be subject to over-reporting.
- It is a reactive rather than a proactive system.
- Doctors will be legally obliged to report in the exceptional cases where it is contrary to the best interests of a child.
- That a system designed to increase public trust may actually increase suspicion and distrust.

Possible issues:

- That the threshold for reporting may be challenging in practice without adequate training – particularly in cases of intermittent and/or low level neglect and emotional abuse.
- How abuse is defined – for example, the BMA’s response to the government’s recent consultation on a statutory definition of child sexual exploitation (CSE) highlighted concerns that the proposed definition might include young people engaged in normal sexual behaviour. This could deter young people from seeking professional advice for fear of initiating child safeguarding procedures.

As noted earlier, these are potential benefits and risks – the BMA believes many risks can be mitigated and benefits promoted if they are given due consideration in the development and implementation of any new duty.
The introduction of a duty to act

The following questions seek your views on the possible introduction of a duty to act.

5. To what extent do you agree or disagree with the following statements?

<table>
<thead>
<tr>
<th>A duty to act could strengthen accountability on individuals and organisations in protecting children from abuse and neglect.</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don’t know</th>
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<tbody>
<tr>
<td>Doctors already have a duty but it may be reinforced with a new duty. Other regulated professionals may not have the same detailed duties.</td>
<td>✓</td>
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<table>
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<tr>
<th>A duty to act could have an adverse impact on the child protection system (e.g. impacting recruitment and retention of staff, and negatively impacting the serious case review process).</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
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<td>✓</td>
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<tr>
<th>A duty to act on child abuse and neglect would be more likely to lead to better outcomes for children than a duty focused solely on the reporting of child abuse and neglect.</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don’t know</th>
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<td>✓ until the necessary prerequisites are in place to introduce mandatory reporting</td>
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<tr>
<th>A duty to act allows professionals discretion to decide what action should be taken to best protect children in each case.</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don’t know</th>
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<tr>
<td>✓</td>
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<tr>
<th>The focus of sanctions for the duty to act on deliberate or reckless failures would ensure that</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don’t know</th>
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<tr>
<td>✓</td>
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</table>
those responsible for the very worst failures in care would be held accountable.

6. To what extent do you agree that the introduction of a duty to act would directly improve outcomes for children?

<table>
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<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
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7. Please outline any risks or benefits regarding the introduction of a duty to act that haven’t been articulated in the consultation.

The BMA has no additional benefits and risks to add to those outlined in the consultation document. Doctors are already subject to professional and legal obligations to act. For example, the General Medical Council’s (GMC) guidance Protecting children and young people: The responsibilities of all doctors,1 The Children Act 19892 and Working Together to Safeguard Children.3

New legislation will re-affirm these obligations and potentially widen their scope to other professional groups. A duty to act in some circumstances is also highlighted in the BMA’s position paper on mandatory reporting – a ‘mandatory duty to discuss’ which could, if appropriate, be without identifying the child. Introducing a ‘duty to act’ could be immediately beneficial in ensuring appropriate action is taken, whilst establishing the necessary prerequisites to introduce a mandatory reporting duty in the long-term.

8. Having considered the issues outlined in the consultation and your answers above, which of the following would be most preferable? Please choose one option only.

<table>
<thead>
<tr>
<th>Please tick</th>
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<tbody>
<tr>
<td>Allowing the package of reform measures focused on improving how the whole system responds to child abuse and neglect to be implemented before considering the introduction of additional statutory measures.</td>
</tr>
<tr>
<td>The introduction of a mandatory reporting duty focused on increasing the reporting of child abuse and neglect.</td>
</tr>
<tr>
<td>The introduction of a duty to act, focused on taking appropriate action in relation to child abuse and neglect, with sanctions for deliberate and reckless failures.</td>
</tr>
</tbody>
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3 www.gov.uk/government/publications/working-together-to-safeguard-children
**Scope, accountability and sanctions**

This section is optional and relates only to the possible introduction of a mandatory reporting duty or a duty to act.

9. If a new statutory measure is introduced, do you agree with the following elements of the proposed scope?

A new statutory measure, should, if introduced:

<table>
<thead>
<tr>
<th>Please tick</th>
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<tbody>
<tr>
<td><strong>Apply to all forms of child abuse and neglect (including online abuse and grooming).</strong></td>
<td>✓</td>
</tr>
<tr>
<td><strong>Apply to both suspected and known child abuse and neglect.</strong></td>
<td>See enclosed BMA position paper at Annex B.</td>
</tr>
<tr>
<td><strong>Apply to abuse or neglect encountered during the course of a practitioner’s day-today role only.</strong></td>
<td>✓</td>
</tr>
<tr>
<td><strong>Apply to abuse or neglect within the home and within organisations or institutions, e.g. boarding schools.</strong></td>
<td>✓</td>
</tr>
<tr>
<td><strong>Apply to present day abuse and neglect only (i.e. it would not apply retrospectively).</strong></td>
<td>If applied retrospectively, there would need to be a clear definition of historic child abuse and an assessment mechanism to identify if others might still be at risk. Previous abuse cannot be ignored as it may be as relevant as current abuse.</td>
</tr>
<tr>
<td><strong>Apply to children under 18 only.</strong></td>
<td>✓</td>
</tr>
<tr>
<td><strong>Be triggered if a practitioner had “reasonable cause to suspect” a child was being abused or neglected, or was likely to be abused or neglected.</strong></td>
<td>See enclosed BMA position paper at Annex B.</td>
</tr>
</tbody>
</table>

10. If there are aspects of the proposed scope that you disagree with, or you would like to provide further information to support your answer to question 9, please do so here:

See BMA’s position paper on mandatory reporting of child abuse at Annex B.

11. If you believe new statutory measures should extend to adults, please provide further information, taking into account the existing wilful neglect offence.

The BMA does not believe that the new statutory measures should extend to adults – see response to question 17.

12. Should the proposed activities outlined in paragraphs 65–68 of the consultation and table 1 be included if a new statutory measure were to be introduced?

Yes
13. Please provide your views, noting if any activities listed should be removed, and if there any other activities that should be included.

The consultation document notes that the list is not exhaustive, however, rather than listing a few medical specialties, it should be made clear that all doctors should fall within the scope of any new duty. Doctors who do not routinely have contact with children are often encouraged to consider the ‘child behind the adult’.

The GMC’s guidance Protecting children and young people: The responsibilities of all doctors makes this clear within its key principles:

‘a All children and young people have a right to be protected from abuse and neglect – all doctors have a duty to act on any concerns they have about the safety or welfare of a child or young person.

b All doctors must consider the needs and well-being of children and young people – this includes doctors who treat adult patients’ (para 1)

14. If a new statutory measure is introduced, where do you think accountability should rest (see paragraphs 69–70 of the consultation)?

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<tr>
<th>Please tick</th>
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<tbody>
<tr>
<td>At an individual level.</td>
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<tr>
<td>At an organisational level.</td>
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<tr>
<td>At both an individual level and an organisational level.</td>
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15. If a new statutory measure is introduced, what do you think the type of sanction should be if it is breached (see paragraphs 71–74 of the consultation)?

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<tbody>
<tr>
<td>Existing practitioner and organisation specific sanctions only.</td>
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<tr>
<td>Existing practitioner and organisation specific sanctions plus additional sanctions involving the Disclosure and Barring Service (available only at an individual level).</td>
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<tr>
<td>Existing practitioner and organisation specific sanctions plus criminal sanctions.</td>
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</tbody>
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The BMA welcomes recognition in the consultation document that failings can sometimes be due to factors outside the control of individual practitioners – workload, culture, organisational management. These factors may be exacerbated in an ever more complex and challenging clinical environment.

The BMA strongly believes that the focus of sanctions should be on learning and development opportunities for individuals, teams and organisations. These are available through existing professional and organisational sanctions – for example, the GMC refers to coaching, mentoring, and training in its sanctions guidance.5

Professional sanctions would not preclude referral to the Disclosure and Barring Service (DBS) in some individual circumstances, but this should not be routine for all breaches of a new duty.

The BMA strongly believes that there should not be criminal sanctions for the duties proposed in the consultation paper.

**Additional information**

17. Please detail any additional information that you feel should be taken into account in this consultation. This could include, but is not limited to:

- the operational impact of introducing a new statutory measure including on small businesses such as nurseries or children’s homes;
- how the new duty should interact with the existing FGM mandatory reporting model; and
- any additional research/evidence not referred to in the consultation document.
- The operational impact of extending either of the statutory measures to vulnerable adults

**Statutory duty - prerequisites**

As outlined in response to question 4, the BMA believes that there are a number of prerequisites critical to the safe introduction of any new statutory measure.

1. A public health focus
2. Raising awareness
3. Training and support
4. Appropriate care pathways
5. Commitment to scientific evaluation

The BMA’s position paper on mandatory reporting at Annex B goes into more detail. Many of the principles will apply equally to a ‘duty to act’.

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5 mpts and GMC. Sanctions guidance for members of medical practitioners tribunals and for the General Medical Council’s decision makers www.gmc.uk.org/DC4198_Sanctions_Guidance_20038260.pdf
Female Genital Mutilation (FGM)

The BMA continues to have serious concerns regarding the new FGM mandatory reporting duty, which we and other key health stakeholders have met with the Home Office and Police leads to discuss. We welcome the government’s commitment in the consultation document to ‘continue to work with the police and relevant professional bodies to review the implementation of the FGM mandatory reporting duty’.

The urgency with which the duty was introduced appeared to be politically driven with an increased emphasis on a criminal justice approach, at any cost. We do not believe that potentially significant risks and unintended consequences were fully explored before taking steps that could, in fact, be harmful to those the government were, and are, rightly seeking to protect. For example:

- **Who the report is made to** – the statutory requirement is to report to the police. It is still not clear a year on from the implementation of the duty why:
  - the legislation could not have been drafted to enable reports to be made to police representatives on established safeguarding groups – for example, Multi-Agency Safeguarding Hubs (MASH).
  - why a dedicated specialist police team and/or reporting line could not be developed to manage these potentially highly sensitive notifications.
  - what training the call handlers at the generic ‘101’ non-emergency police number have had with regard to handling FGM reports. For example, the BMA is aware of cases where the call handler has had to be persuaded by the reporting healthcare professional not to send uniformed police officers around immediately (in cases where there was no risk of immediate serious harm warranting the suggested police response).  

- **An evaluation of the effectiveness of the legislation** – a recent letter in the *Archives of Disease in Childhood* has highlighted that there is no national collation of data on the number of FGM reports under the Serious Crime Act. The letter is the consequence of freedom of information (FOI) requests to the Home Office, Department of Health, NHS England, Office for National Statistics and police forces. Without this data, it is difficult to evaluate the effectiveness of this new statutory duty that has been placed on healthcare professionals.

We hope these concerns can be taken into consideration when developing any new statutory child abuse measures, whether to replace or operate alongside FGM legislation, to ensure lessons are learnt and any new measures are fit for purpose.

**Vulnerable adults**

The BMA does not believe that the same statutory measures should be extended to vulnerable adults. There are similar, but also significantly different legal and ethical challenges relating to

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6 See, for example, Dr Mwenya Chimba (Violence Against Women Director) feedback to the Home Affairs Committee on the 6 July 2016 – www.parliament.uk/documents/commons-committees/home-affairs/160706%20FGM%20Roundtable%20Transcript.pdf

7 The BBC reported in December 2014 (www.bbc.co.uk/news/uk-30294094) that “More than a million callers who tried to get through to the police 101 non-emergency phone service in the past year were cut off or decided to abandon their efforts... The number of dropped calls rose by more than 200,000 in the 12 months to September, despite a fall in the overall number of people dialling 101... Some police forces had examples of callers kept waiting more than an hour”.

vulnerable adults. The BMA’s guidance *Vulnerable adults and confidentiality* goes into more detail – available at [www.bma.org.uk/advice/employment/ethics/mental-capacity/vulnerable-adults-and-confidentiality](http://www.bma.org.uk/advice/employment/ethics/mental-capacity/vulnerable-adults-and-confidentiality). For example, the term ‘vulnerable adults’ can encompass both adults with and without capacity. How a doctor may respond to a vulnerable adult with capacity and a competent child will differ. In the BMA’s view, doctors should encourage vulnerable adults with capacity to access and receive appropriate support, but adults with capacity have the right to make decisions about how they manage the risks to which they are exposed and such decisions should ordinarily be respected.
Annex B

BMA position paper – mandatory reporting of child abuse

The BMA supports, in principle, the introduction of ‘mandatory reporting’ child abuse legislation and insists that any introduction is scientifically evaluated.

Mandatory reporting legislation should:

1. contain tiered thresholds for reporting obligations based on the level of harm to a child and whether abuse is known, suspected or abuse is considered a risk
2. apply to all regulated professionals
3. allow reports to be made either to:
   a. the designated officer of a single ‘relevant authority’ or
   b. the designated officer in a limited range of appropriate ‘relevant authorities’ based on the welfare of the child
4. allow reports to be made within a set time period, with some scope within this set period for the timing of the report to be dictated by the individual needs of a child
5. initially address any failures to report by identifying and addressing any training needs for the professional. Ultimately, any sanction for failing to report should be a professional, regulatory sanction; not a criminal sanction
6. only be introduced after a number of prerequisites have been met

What does the BMA mean by ‘mandatory reporting’?

One of the challenges when discussing statutory mandatory reporting is that different people can mean different things by the term. There is also a challenge in designing a system that is simple and straightforward for all professions to understand, whilst allowing some scope to respond most effectively to the individual needs of a child. The BMA’s vision for how mandatory reporting legislation should work, and the prerequisites that need to be in place before such legislation should be introduced, are outlined below.

1. Threshold for mandatory reporting

There should be nationally agreed tiered thresholds for reporting obligations – a possible approach is outlined on page 15. Some tiers should be captured on the face of statute, others in professional standards and guidance. In some cases it should be mandatory to report, in others mandatory to discuss. It is crucial that any legislation does not create barriers to professionals seeking advice at an early stage and/or where there are intermittent low level concerns. Legislation should also allow either a single point of contact or a limited range of appropriate reporting options, for example to organisational safeguarding leads, designated officers in safeguarding authorities or, in cases where a child is at immediate risk of serious harm, additionally to the police. This would enable regulated professionals to exercise their professional judgment, within set statutory limits, as to the best way to promote the welfare of an individual child.

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9 For the purpose of this paper, a regulated professional is a person who is registered and works as — a healthcare professional, a teacher, police officer or a social care worker.
10 For the purpose of this paper, a child is defined as a child or young person from birth until their 18th birthday.
For the purpose of this position paper, the *Working Together to Safeguard Children* definitions of ‘abuse’ are being used (see page 18-19). Within these definitions are a range of physical and sexual acts, and *persistent* emotionally abusive and neglectful treatment *that may result in the serious impairment of a child’s development*.

2. The reporters

The statutory duty to report should apply to all regulated professionals who identify abuse in the context of their professional work. For example, a person who is registered and works as a healthcare professional, a teacher, police officer or a social care worker. The formal part of any statutory reporting process should be user-friendly, quick and straightforward. The duty should fall on the individual. This does not stop the individual seeking advice and support from a more senior and experienced colleague on how best to manage making the report, if time allows.

3. Recipients of the report

Under the legislation, there should be scope for the reporter to report either to:

- a designated officer within a single authority with the necessary specialist skills, experience and resourcing. This person should be a member of a new style multi-agency child protection team and should be able to respond appropriately to the information. A single authority would help ensure clarity for reporters, a clear line of responsibility and accountability, and a coordinated standardised response.

- a designated officer at the most appropriate ‘relevant authority’ based on which professional is best placed to promote the welfare of the child. In many cases this will be a designated person in the local authority with safeguarding responsibilities, not the police. The BMA propose that a ‘relevant authority’ could include:
  - local authority designated officer with safeguarding responsibilities and
  - in addition, in some circumstances, the police.

Whichever approach is adopted, it needs to be clear who has the lead role once a report is made and, where possible, a commitment to keep a reporter updated on any significant developments as a consequence of the report.

4. Timeline

Legislation should be drafted broadly to allow sufficient time for a wide range of circumstances. Reporting should be timely and within a set time period, but there should be some scope within this period for the timing of the report to be guided by the individual circumstances of the case, including ongoing levels of risk. For example, if immediate action is needed to safeguard a child, there should be immediate reporting. If, however, a competent child needs more time to accept and feel in control of his/her situation before any formal reporting, and there are no immediate safeguarding concerns, this should also be accommodated to create a safe and empowering environment. An example is the female genital mutilation (FGM) reporting duty under the Serious Crime Act. Statutory guidance states that it is best practice for reports to be made by close of the next working day, but in exceptional cases the legislation allows reports up to one month after identification.¹¹ The reasons why a decision has been made to not report immediately (but still within the set time period) should be documented.

A possible tiered threshold approach for reporting obligations:

<table>
<thead>
<tr>
<th>Definition</th>
<th>Duty</th>
<th>Duty captured</th>
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</table>
| **‘Known’/ ‘Probable’ abuse** | Where, in the opinion of the regulated professional, abuse is ‘known’ as a consequence of:  
- an under eighteen year old reporting that abuse has been carried out on him/her;  
and/or  
- a healthcare professional observes physical and/or psychological signs of child abuse.  
(Based on female genital mutilation (FGM) Serious Crime Act definition) | Report to a designated officer in a relevant authority.  
A ‘relevant authority’ could include:  
- local authority with safeguarding responsibilities and/or  
- the police | Statute |
| **Suspected abuse** | Where, in the opinion of the regulated professional, there is a serious level of concern about the possibility of child abuse due to certain features and/or indicators.  
(Based on NICE guidelines) | Report to:  
- local safeguarding lead and/or  
- designated officer in ‘relevant authority’. | There are differences of opinion whether this should be captured in statute and/or professional standards |
| **A child is thought to be at risk of abuse (harm may not yet have occurred)** | Where, in the opinion of the regulated professional, a child is considered to be at risk of significant harm. | Report to a designated officer in a ‘relevant authority’. In some circumstances, this may require immediate reporting to the police. | Professional standards |
| **Risk of harm** | Seek advice and report to local safeguarding lead.  
This may lead to a report to a designated officer in a ‘relevant authority’. | Professional standards |
5. Sanctions
The focus of sanctions should be on learning and development opportunities for individuals, teams and organisations. The sanction for failing to report should, if and when appropriate be professional sanctions, and not criminal sanctions.

6. Prerequisites
The BMA’s support ‘in principle’ for mandatory reporting legislation acknowledges that a number of conditions need to be met before legislation can safely be introduced, specifically:

**A public health focus**

a. changing the perception and culture of child safeguarding reporting and intervention, both for professionals and the public (including parents), so intervention is viewed more positively and as a normal part of supporting the welfare of children

**Awareness and perceptions**

b. raising awareness of child abuse amongst professionals
c. raising awareness of child abuse, including any duties of regulated professionals to report, amongst communities and the public at large

**Training and support**

d. developing in partnership with key stakeholders, level three national training standards, including agreed materials and practical courses for professionals. To be successful, there needs to be adequate time and resources ring fenced for the training, funded at a national level. Training should be more than one-off events and include modules on:
   - identifying child abuse, based on the latest evidence
   - how to respond to a child’s safeguarding, physical and psychological needs when child abuse is known, suspected or considered a risk
   - identifying and responding to opportunities for early intervention
   - engagement and communication skills.
e. ensuring good mechanisms are in place for professionals to:
   - have the time to consider and respond to child abuse, and
   - seek timely support and advice 24/7, 365 days a year.

**Pathways**

f. proper resourcing of appropriate care pathways:
   - to support survivors and potential victims of abuse
   - for early intervention supportive measures for families
g. standardising MASHs (multi-agency safeguarding hubs).

These measures would need to be regularly reviewed to ensure that they are, and remain, effective. Any legislation and supporting measures should be designed and developed in conjunction with children, both those that have been abused and those that have not, to ensure they are fit for purpose.
Commitment to scientific evaluation

h. the introduction of mandatory reporting child abuse legislation must be scientifically evaluated. For example, evaluating:
- the impact on the outcomes for children
- the impact on the relationship between healthcare professionals and communities
- any impact on health inequalities
- any unintended consequences

Context

Current obligations

It should be noted that although there is currently no explicit statutory obligation to report child abuse in the UK, there are already legal and professional obligations placed on doctors to respond to child abuse and promote the welfare of children. For example:

- If followed collectively, the GMC guidance,\(^ {14}\) The Children Act 1989\(^ {15}\) and statutory guidance\(^ {16}\) effectively makes reporting of child abuse mandatory, unless it is contrary to the best interests of a child.
- In Northern Ireland there is a statutory duty to disclose any ‘arrestable offence’ under section 5 of the Criminal Law Act 1967, which includes most offences against children (with a few exceptions – for example, consensual underage sexual activity where both partners are under 18).\(^ {17}\)
- In England and Wales, from October 2015 there is a mandatory duty to report ‘known’ female genital mutilation (FGM) in under 18s, to the police, within one month of it becoming known.\(^ {18}\)

Definition of abuse

The definition of abuse currently cited in the statutory guidance *Working Together to Safeguard Children*\(^ {19}\) (England) is:

‘Abuse: A form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others (e.g. via the internet). They may be abused by an adult or adults, or another child or children.’

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\(^ {17}\) The legislation can be found at [www.legislation.gov.uk/ukpga/1967/58/section/5](http://www.legislation.gov.uk/ukpga/1967/58/section/5).

\(^ {18}\) The legislation can be found at [www.legislation.gov.uk/asp/2015/9/section/74/enacted](http://www.legislation.gov.uk/asp/2015/9/section/74/enacted).

Abuse includes neglect and physical, emotional, and sexual abuse, defined in *Working Together* as follows:

<table>
<thead>
<tr>
<th>Physical abuse</th>
<th>A form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.</th>
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<tbody>
<tr>
<td>Emotional abuse</td>
<td>The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or ‘making fun’ of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child’s developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.</td>
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<tr>
<td>Sexual abuse</td>
<td>Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.</td>
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<tr>
<td>Neglect</td>
<td>The persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:</td>
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<td></td>
<td>• provide adequate food, clothing and shelter (including exclusion from home or abandonment);</td>
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<td></td>
<td>• protect a child from physical and emotional harm or danger;</td>
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<td></td>
<td>• ensure adequate supervision (including the use of inadequate caregivers); or</td>
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</tbody>
</table>
• ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs.

Similar definitions are used by the Scottish, Welsh and Northern Irish governments. The Working Together definitions are also used in the NICE clinical guideline *When to suspect child maltreatment*. A statutory definition of child sexual exploitation (CSE) is expected to be added to Working Together in the near future.

October 2016

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