Health Working Group Report on Child Sexual Exploitation

An independent group chaired by the Department of Health focusing on:

Improving the outcomes for children by promoting effective engagement of health services and staff

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Information Sharing

'There is nothing within the Caldicott Report, the Data Protection Act 1998 or the Human Rights Act
1998, which should prevent the justifiable and lawful exchange of information for the protection of children or prevention of serious crime.' [65]

All health professionals can be confident in carrying out their duty to safeguard sexually exploited children (and vulnerable adults) by knowing when and how to share confidential information, even without consent.

What children say about confidentiality

"It is better for services to be clear and open at the beginning about having to pass information on – so it isn't a shock." [25]

"If confidentiality does get broken and we haven't been properly prepared or informed about this, here's what we'd like to see happen:

Using professional discretion

The sharing of health data is a challenging balancing act for health professionals, who need to maintain confidentiality wherever possible, whilst also complying with section 1 (1) of the Children Act 1989 – that the welfare of the child should be the paramount consideration.

Whether or not information should be shared comes down to the professional discretion of the healthcare team – it should not be an individual decision.

Sharing some health information can help to identify children at risk/victims and help to disrupt sexual exploitation: 'There will be other cases where practitioners will be justified in sharing some confidential information in order to make decisions on sharing further information or taking action – the information shared should be proportionate.' [28]

Multi-agency risk assessment

We have already confirmed the challenge for frontline practitioners that in some cases sharing of information is needed before a judgment can be made about the level of risk a child is facing from sexual exploitation. The initial issue may relate to a single concern, e.g. a change in physical appearance, self-harm or substance misuse, but through this assessment process, what at first may appear to be low risk can become significantly more serious as the wider circumstances of the child's daily life are understood.[28]

Local areas therefore need to have specific procedures in place to enable key professionals to pool information and to undertake an assessment of risk.

Any provider of relevant health services could improve the sharing of information across agencies in order to tackle child sexual exploitation.

Safeguarding and sexual health services

Working Together to Safeguard Children is clear that:[35] *'fears about sharing information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children;'* also that local multi-agency information sharing arrangements should be in place and no professional should assume that someone else will pass on information which they think may be critical to keeping a child safe.

The legislative framework for sharing information includes sections 10 and 11 Children Act 2004 which confer on agencies the duty respectively, to cooperate to improve wellbeing of children and to safeguard and promote the welfare of children.

Whilst sexual activity by children under 16 years is classified as an offence under the Sexual Offences Act 2003, teenagers, including under 13s, are entitled to receive confidential sexual health advice and contraception (in the context of Gillick competence and Fraser Guidelines).[66] Health service legislation prohibits the sharing of information on STIs and terminations except in very specific circumstances.

In practice, *'It is essential that the nurse [or health professional] informs the young person that this information will only remain confidential if she feels that he or she does not require further investigation or safeguarding. The dangers and risks must be explained to the young person and why a certain course of action that may be contrary to their wishes, needs to be taken It is essential that*

the child is helped to understand how and why decisions are being made and that they are supported to cope with the action taken.' [67]

"I would rather that services are straight up at the beginning about confidentiality. Otherwise they tell you it's confidential and then you end up telling them stuff and then they pass it on and say 'oh we're worried about you and we had to tell someone' – and then you get more angry." 25

There is some consensus amongst service providers and health care professionals that sharing information, particularly around STIs and terminations, could deter children from seeking help.68. This needs to be balanced with the fact that these children might be at considerable risk of harm. Research from the US found that girls who have had a termination are six times more likely to commit suicide in the six months after the termination than teenagers who have not had a termination.[69]

Caldicott2 Review[70]

The second review conducted by Dame Caldicott on health and information sharing recognised that more work needs to be done to ensure that information is shared appropriately about children at risk of harm (including through child sexual exploitation). The Caldicott Report and Government response note that there are cultural challenges around information sharing that need to be addressed:

'Indeed, the duty to safeguard children or vulnerable adults may mean that confidential information should be shared, even without consent, because it is in the public interest to do so where there is a risk of significant harm to a child, either directly through abuse or neglect.'

The Caldicott2 Report recommends that:

'The Department of Health should work with the Department for Education to investigate jointly ways to improve the safe sharing of information between health and social care services and schools and other services relevant to children and young people, through the adoption of common standards and procedures for sharing information.' The Government response to this recommendation was that 'there would be clear benefits if a single, common approach to sharing information for children and young people could be adopted.'

References:-

25 Association for Young People's Health, University of Bedfordshire, National Working Group (2013), Be Healthy Project

65 Lord Carlile (2002), Too Serious a Thing – The Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wale

66 NSPCC (2012). Gillick Competency and Fraser Guidelines. NSPCC Factsheet

67 Daniels and McAlinden (2012), The Sexual Offences (NI) Order 2008: implications for nurses, School of Nursing and Midwifery, Queen's University

68 Bastable and Sheather, Mandatory reporting of all sexually active under-13s, BMJ 2005; 331: 918-9 (2005)

69 Garfinkel B et al (1986), Stress, Depression and Suicide: A Study of Adolescents in Minnesota. Responding to High Risk Youth, University of Minnesota Extension Service

70 Department of Health (2013), Information: To share or not to share? Government response to Caldicott Review