

**Bedford Borough Safeguarding Children Board,  
Central Bedfordshire Safeguarding Children Board &  
Working together to safeguard children**



**Joint Bedford Borough, Central Bedfordshire, Luton  
Safeguarding Children Board's, Bedfordshire  
Domestic Abuse Partnership, Bedfordshire Sexual  
Violence Strategy Group & Luton Community Safety  
Partnership Information Sharing Protocol**

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<b>Acronyms</b>	
<b>LSCB</b>	<b>Local Safeguarding Children Board</b>
<b>CAFCASS</b>	<b>Children and Family Court Advisory and Support Service</b>
<b>DA Partnership</b>	<b>Domestic Abuse Partnership</b>
<b>GMC</b>	<b>General Medical Council</b>

**For the purposes of this document children and young people will be referred to as child/ren through out this document.**

**References to ‘vulnerable adult’ should be considered in the context of the definition provided by ‘No Secrets’, namely: “A person over 18 years of age who is or may be in need of community care services by reason of mental health or other disability, age or illness and who is unable to care for himself or herself, or unable to protect himself or herself against significant harm or serious exploitation”**

## **1. Introduction**

- 1.1. It is essential that all agencies work together and share information, using an agreed protocol, to strengthen the processes for safeguarding and promoting the welfare of children and victims of domestic & sexual abuse. It is only when all agencies share the information they hold that a full picture emerges upon which to reach decisions and determine a plan of action to minimise the risk of harm to children and victims of domestic & sexual abuse.
- 1.2. Children and their parents/carers have a right to expect that agencies will overcome barriers to sharing confidential information in a responsible way to ensure that the safety and well-being of children and victims remains paramount.
- 1.3. **Safeguarding and promoting the welfare of children must always be the primary consideration. It should over-ride any perceived risk of damaging the relationship between professional and their client/patient.**
- 1.4. Information sharing is vital to safeguarding and promoting the welfare of children and victims of domestic & sexual abuse. **A key factor in many serious case reviews has been a failure to record information, to share it, to understand the significance of the information shared, and to take appropriate action in relation to known or suspected abuse or neglect.**
- 1.5. We know that practitioners recognise the importance of information sharing and that there is much good practice. Practitioners also tell us that in some situations they feel constrained from sharing information by their uncertainty about when they can do so lawfully. This guidance aims to provide clarity on that issue. It is important that practitioners:
  - are supported by their employers in working through these issues;
  - understand what information is and is not confidential, and the need in some circumstances to make a judgment about whether confidential information can be shared, in the public interest, without consent;
  - understand and apply good practice in sharing information at an early stage as part of preventative work;
  - are clear that information can normally be shared where you judge that a child is at risk of significant harm or that an adult is at risk of serious harm.

**Further guidance Information Sharing: guidance for practitioners and managers (HM Government 2008) can be accessed via**  
<https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00807-2008>

## **2. Purpose and Principles**

- 2.1. The purpose of this protocol is to clarify the principles behind, and the arrangements for, sharing sensitive personal information between all agencies in order to safeguard and promote the welfare of children and victims of domestic & sexual abuse. The protocol refers to a number of legal enactments but is not meant to be a definitive guide to the law in what is a complex and evolving legal framework. In individual cases, professionals

and/or agencies may wish to seek legal advice. Examples given are meant to be illustrative rather than exclusive.

2.2. A basic principle of the Data Protection Act 1998 is that there has to be a 'legitimate basis' for disclosing sensitive personal data. Research and experience have shown repeatedly that keeping children and vulnerable adults safe from harm requires professionals and others to share information:

- About a child's health and development and exposure to possible harm
- About a parent/carer who may not be able to care for a child adequately or safely without help
- About those who may pose a risk of harm to a child.

**In cases of domestic & sexual abuse:**

- Where there are children under the age of 18 years resident in the household.
- Where a victim is pregnant.
- Where a victim is a vulnerable adult.
- Where a vulnerable adult is resident in the household.
- Where there is indication of high risk of death or serious injury
- For the prevention or detection of crime against another person

2.3. In broad terms, therefore, sharing sensitive personal information can be legitimate because often it is only when information from a number of sources has been shared and put together that it becomes clear that a child, vulnerable adult or a victim of domestic or sexual abuse is at risk of or is suffering harm. It is worth bearing in mind those enquiries following child deaths, domestic abuse homicides and other situations where practice has been called into question have repeatedly identified the failure to share information as a contributory factor.

2.4. All LSCB agencies have subscribed to the over-riding principle that the needs and rights of children come first, and that where those needs and rights conflict with those of adults, any conflict must be resolved in the child's favour. At the same time, professionals and agencies will be concerned to balance their duties to protect children from harm with their general duty towards their patient or service user. It is hoped that this protocol will help professionals and agencies in the task of deciding in individual cases where the proper balance lies.

2.5 It is critical that where there is reasonable cause to believe that a child or young person **may be suffering or may be at risk of suffering significant harm, concerns should be referred to Children's Services or the police, in line with Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Board Interagency Child Protection procedures.** In some situations there may be a concern that a child or young person may be suffering, or at risk of suffering significant harm, or of causing significant harm to another child or serious harm to an adult. However, **if there is uncertainty as to whether what has given rise to the concern constitutes 'a reasonable cause to believe', in these situations, the concern must not be ignored.** Practitioners should always talk to someone to help them decide what to do – a lead person on safeguarding, a Caldicott guardian, a manager, an experienced and trusted colleague or another practitioner who knows the person.

2.6 Significant harm to children and young people can arise from a number of circumstances – it is not restricted to cases of deliberate abuse or gross neglect. For example a baby who is severely failing to thrive for no known reason could be suffering significant harm but equally could have an undiagnosed medical condition. If the parents refuse consent for further medical investigation or an assessment, then you may still be justified in sharing information. In this case, the information sharing would be to help ensure that the causes of the failure to thrive are correctly identified.

2.7 Where you have concerns that the actions of some may place children at risk of significant harm or adults at risk of serious harm, it may be possible to justify sharing information with

or without consent for the purposes of identifying people for whom preventative interventions are appropriate. Significant harm to children and serious harm to adults is not restricted to cases of extreme physical violence. For example, the cumulative effect of repeated abuse or threatening behaviour may well constitute a risk of serious harm to an adult.

- 2.8.1 Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Boards & Bedfordshire Domestic Abuse & Sexual Violence Strategy Implementation Groups & Luton Community Safety Partnership strongly supports the principle of working in partnership with children, parents/carers and other family members. This means among other things seeking the consent of the child and family wherever it is possible and consistent with the child's best interests. This should include, wherever possible, seeking clear, explicit and informed consent from the individual(s) concerned for information about them to be shared with **specified** other individuals or agencies. Where such consent can be freely obtained, this is clearly the best way of resolving any potential conflict of interest. Agencies are encouraged to develop procedures for obtaining and recording such consent. However, it is recognised that frequently such consent can not be obtained, either because it is refused, the individual concerned can not be contacted within a reasonable time to give consent or in exceptional cases, even seeking the consent would place a child at greater risk of harm. This protocol relates primarily to the sharing of information where such agreement is not available, although the data protection principles relate to all situations.

## 2.9 Seven golden rules for information sharing

Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Boards and Bedfordshire Domestic Abuse & Sexual Violence Strategy Implementation Group & Luton Community Safety Partnership supports the 7 golden rules for information sharing outlined in the Information sharing: Practitioners' guide Every Child Matters website Practice

**1. Remember that the Data Protection Act is not a barrier to sharing information** but provides a framework to ensure that personal information about living persons is shared appropriately.

**2. Be open and honest** with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

**3. Seek advice** if you are in any doubt, without disclosing the Identity of the person where possible.

**4. Share with consent where appropriate** and, where possible, Respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgment, that lack of consent can be overridden in the public interest. You will need to base your judgment on the facts of the case.

**5. Consider safety and well-being:** Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.

**6. Necessary, proportionate, relevant, accurate, timely and secure:** Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.

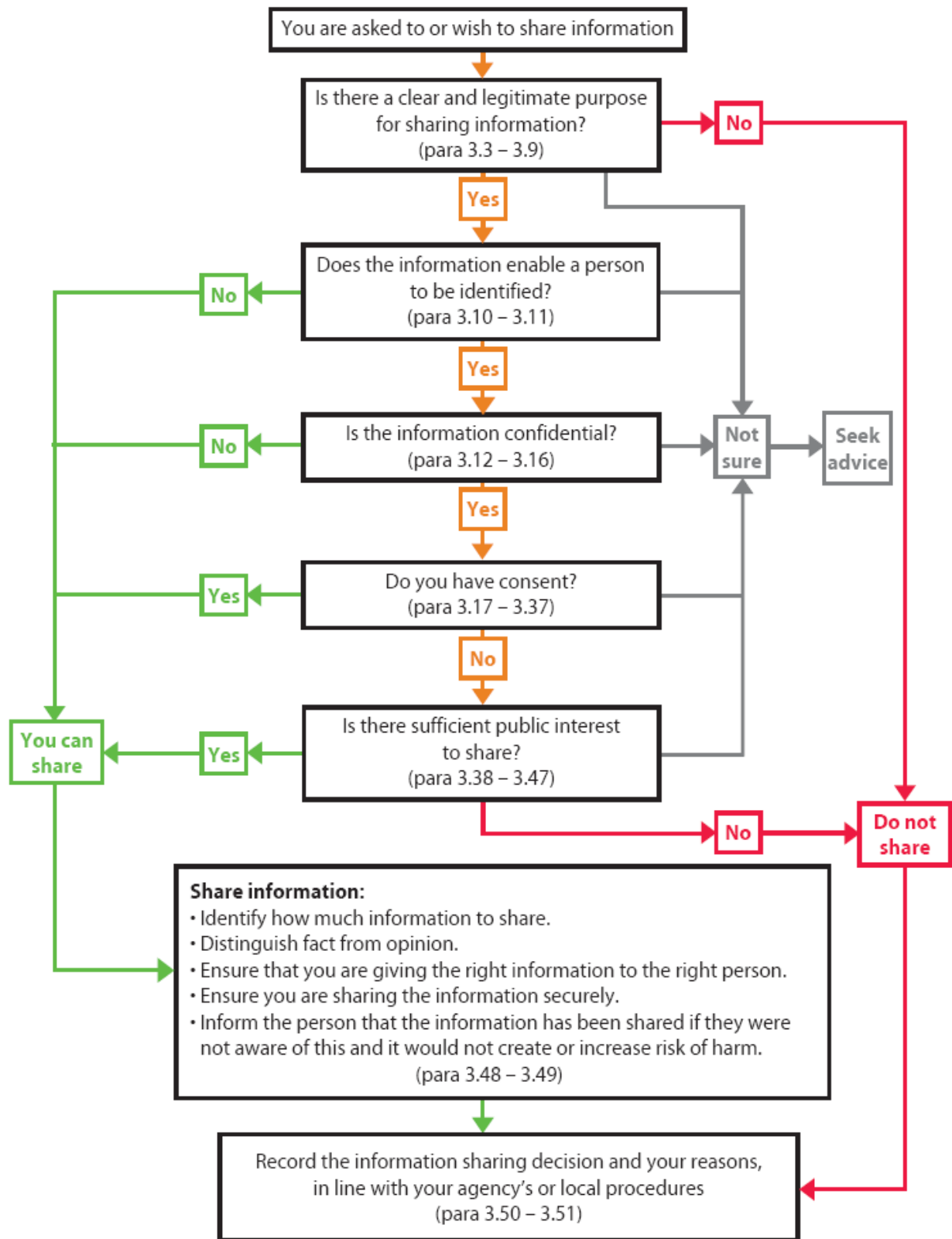
**7. Keep a record** of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

### **3. Practice Guidance**

- 3.1 If you are asked, or wish, to share information, you must use your professional judgment to decide whether to share or not and what information it is appropriate to share, unless there is a statutory duty or a court order to share.
- 3.2 To inform your decision making this section sets out further information in the form of seven key questions about information sharing:
1. Is there a clear and legitimate purpose for you or your agency to share the information?
  2. Does the information enable a living person to be identified?
  3. Is the information confidential?
  4. If the information is confidential, do you have consent to share?
  5. If consent is refused, or there are good reasons not to seek consent to share confidential information, is there a sufficient public interest to share the information?
  6. If the decision is to share, are you sharing information appropriately and securely?
  7. Have you properly recorded your information sharing decision?

These questions are illustrated in the flowchart below. Further information on each of the questions can be found in the remainder of this section.

## Flowchart of key questions for information sharing



If there are concerns that a child may be at risk of significant harm or an adult may be at risk of serious harm, then follow the relevant procedures without delay.

Seek advice if you are not sure what to do at any stage and ensure that the outcome of the discussion is recorded.

## Question 1: Is there a clear and legitimate purpose for sharing information?

3.3 If you are asked, or wish, to share information about a person you need to have a good reason or a clear and legitimate purpose to do so. This will be relevant to whether the sharing is lawful in a number of ways.

3.4 If you work for a statutory service, for example, education, social care, health or justice, the sharing of information must be within the functions or powers of that statutory body. It is likely that this will be the case if you are sharing the information as a normal part of the job you do for that agency. This will also be the case if you work in the private or voluntary sector and are contracted by one of the statutory agencies to provide services on their behalf.

3.5 Whether you work for a statutory or non-statutory service, any sharing of information must comply with the law relating to confidentiality, data protection and human rights. Establishing a legitimate purpose for sharing information is an important part of meeting those requirements. There is more information about the legal framework for sharing information in the document *Information Sharing: Further guidance on legal issues*.

3.6 Individual agencies may have developed specific guidelines and processes for sharing information. You will need to be guided by your agency's policies and procedures and – where applicable – by your professional code.

### Sharing information where you have a statutory duty or a court order

3.7 In some situations you are required by law to share information, for example, in the NHS where a person has a specific disease about which environmental health services must be notified. There will also be times when a court will make an order for certain information or case files to be brought before the court.

3.8 These situations are relatively unusual and where they apply you should know or be told about them. In such situations, you must share the information, even if it is confidential and consent has not been given, unless in the case of a court order, your organisation is prepared to challenge it and is likely to seek legal advice.

3.9 Consent from the individual is not required in these situations and should not be sought because of the potential consequences of refusal. Wherever possible, subject to considerations set out in paragraph 3.11, you should inform the individual concerned that you are sharing the information, why you are doing so, and with whom.

## Question 2: Does the information enable a living person to be identified?

3.10 In most cases the information covered by this guidance will be about an identifiable living individual. It may also identify others, such as a child, partner, parent or carer. If the information is anonymised, it can be shared. However, if the information is about an identifiable individual or could enable a living person to be identified when considered with other information, it is personal information and is subject to data protection and other laws. The remainder of this section provides further information to inform your decision about sharing personal information.

3.11 Wherever possible, you should be open about what personal information you might need to share and why. In some situations, it may not be appropriate to inform a person that information is being shared or seek consent to this sharing, for example, if it is likely to hamper the prevention or investigation of a serious crime or put a child at risk of significant harm or an adult at risk of serious harm.

### Question 3: Is the information confidential?

Confidential information is:

- personal information of a private or sensitive nature; and
- information that is not already lawfully in the public domain or readily available from another public source; and
- information that has been shared in circumstances where the person giving the information could reasonably expect that it would not be shared with others.

**This is a complex area and you should seek advice if you are unsure.**

There are different types of circumstances that are relevant to confidentiality. One is where a formal confidential relationship exists, as between a doctor and patient, or between a social worker, counsellor or lawyer and their client. Here it is generally accepted that

3.13 Sometimes people may not specifically ask you to keep information confidential when they discuss their own issues or pass on information about others, but may assume that personal information will be treated as confidential. In these situations you should check with the individual whether the information is or is not confidential, the limits around confidentiality and under what circumstances information may or may not be shared with others.

3.14 Confidence is only breached where the sharing of confidential information is not authorised by the person who provided it or, if about another person, by the person to whom it relates. If the information was provided on the understanding that it would be

shared with a limited range of people or for limited purposes, then sharing in accordance with that understanding will not be a breach of confidence. Similarly, there will not be a breach of confidence where there is consent to the sharing.

3.15 Information about an individual or family is confidential to the agency as a whole, and not to individual practitioners. However individual practitioners do have a responsibility to maintain the confidentiality of the information. They should only share confidential information with other practitioners in the same agency or team for genuine purposes, for example, to seek advice on a particular case or ensure cover for work while on leave. This should be explained clearly to the individual or family at the start of the involvement.

3.16 Public bodies that hold information of a private or sensitive nature about individuals for the purposes of carrying out their functions (for example children's social care, young people's health services or adult mental health services) may also owe a duty of confidentiality, as people have provided information on the understanding that it will be used for those purposes. In some cases the agency may have a statutory obligation to maintain confidentiality, for example, in relation to the case files of looked after children.

### Question 4: Do you have consent to share?

3.17 Consent issues can be complex and a lack of clarity about them can sometimes lead practitioners to assume incorrectly that no information can be shared. This section gives further information to help you understand and address the issues.

It covers:

- what constitutes consent;
- whose consent should be sought; and
- when consent should not be sought.

**What constitutes consent?**

3.18 Consent must be 'informed'. This means that the person giving consent needs to understand why information needs to be shared, what will be shared, who will see their information, the purpose to which it will be put and the implications of sharing that information.

3.19 Consent can be 'explicit' or 'implicit'. Obtaining explicit consent for information sharing is best practice and ideally should be obtained at the start of the involvement, when working with the individual or family to agree what support is required. It can be expressed either verbally or in writing, although written consent is preferable since that reduces the scope for subsequent dispute. Implicit consent can also be valid in many circumstances. Consent can legitimately be implied if the context is such that information sharing is intrinsic to the activity or service, and especially if that has been explained or agreed at the outset.

An example of **implicit consent** is where a GP refers a patient to a hospital specialist and the patient agrees to the referral. In this situation the GP can assume the patient has given implicit consent to share information with the hospital specialist.

3.20 It is best practice to set out clearly your agency's policy on sharing information when the service is first accessed. The approach to securing consent should be transparent and respect the individual. Consent must not be secured through coercion or inferred from a lack of response to a request for consent.

3.21 If there is a significant change in the use to which the information will be put compared to that which had previously been explained, or a change in the relationship between the agency and the individual, consent should be sought again. Individuals have the right to withdraw consent at any time.

## Whose consent should be sought – children and young people

3.22 You may also need to consider whose consent should be sought. Where there is a duty of confidence, it is owed to the person who has provided the information on the understanding it is to be kept confidential. It is also owed to the person to whom the information relates, if different from the information provider. A child or young person, who has the capacity to understand and make their own decisions, may give (or refuse) consent to sharing.

3.23 Children aged 12 or over may generally be expected to have sufficient understanding. Younger children may also have sufficient understanding. As explained in paragraph 3.30, this is presumed in law for young people aged 16 and older. When assessing a child's understanding you should explain the issues to the child in a way that is suitable for their age, language and likely understanding. Where applicable, you should use their preferred mode of communication.

3.24 The following criteria should be considered in assessing whether a particular child or young person on a particular occasion has sufficient understanding to consent, or to refuse consent, to sharing of information about them:

*Can the child or young person understand the question being asked of them?*

*Do they have a reasonable understanding of:*

- what information might be shared;
- the main reason or reasons for sharing the information; and
- the implications of sharing that information, and of not sharing it?

*Can they:*

- appreciate and consider the alternative courses of action open to them;
- weigh up one aspect of the situation against another;
- express a clear personal view on the matter, as distinct from repeating what someone else thinks they should do; and
- be reasonably consistent in their view on the matter, or are they constantly changing their mind?

3.25 Considerations about whether a child has sufficient understanding are often referred to as Fraser guidelines, although these were formulated with reference to contraception and contain specific considerations not included above. For more details see the Glossary.

3.26 In most cases, where a child cannot consent or where you have judged that they are not competent to consent, a person with parental responsibility should be asked to consent on behalf of the child. If a child or young person is judged not to have the capacity to make decisions, their views should still be sought as far as possible.

3.27 Where parental consent is required, the consent of one such person is sufficient. In situations where family members are in conflict you will need to consider carefully whose consent should be sought. If the parents are separated, the consent would usually be sought from the parent with whom the child resides. If a care order is in force, the local authority will share parental responsibility with parent(s) and practitioners should liaise with them about questions of consent.

3.28 If you judge a child or young person to be competent to give consent, then their consent or refusal to consent is the one to consider, even if a parent or carer disagrees. Where parental consent is not required, you should encourage the young person to discuss the issue with their parents. However, you should not withhold the service on the condition that they do so.

3.29 These issues can raise difficult dilemmas. Wherever appropriate you should try to work with all involved to reach an agreement or understanding of the information to be shared. You must always act in accordance with your professional code of practice where there is one and consider the safety and well-being of the child, even where that means overriding refusal to consent. You should seek advice from your manager or nominated advisor if you are unsure.

### Whose consent should be sought – adults

3.30 It is good practice to seek consent of an adult where possible. All people aged 16 and over are presumed, in law, to have the capacity to give or withhold their consent to sharing of confidential information, unless there is evidence to the contrary.

3.31 The *Mental Capacity Act 2005 Code of Practice* defines the term 'a person who lacks capacity' as a person who lacks capacity to make a particular decision or take a particular action for themselves, at the time the decision or action needs to be taken.

3.32 A person who is suffering from a mental disorder or impairment does not necessarily lack the capacity to give or withhold their consent for information sharing. Equally, a person who would otherwise be competent may be temporarily incapable of giving valid consent due to factors such as extreme fatigue, drunkenness, shock, fear, severe pain or sedation. The fact that an individual has made a decision that appears to others to be irrational or unjustified should not be taken on its own as conclusive evidence that the individual lacks the mental capacity to make that decision. If, however, the decision is clearly contrary to previously expressed wishes, or is based on a misperception of reality, this may be indicative of a lack of capacity and further investigation will be required.

3.33 All decisions taken on behalf of a person who lacks capacity must be taken in their best interests. A judgement about best interests is not an attempt to determine what the person would have wanted. It is as objective a test as possible of what would be in the person's actual best interests, taking into account all relevant factors. Factors to be addressed include:

- the person's own wishes (where these can be ascertained); and
- the views of those close to the person, especially close relatives, partners, carers, welfare attorneys, court-appointed deputies or guardians.

3.34 The *Mental Capacity Act 2005 Code of Practice* provides information on points to consider when assessing a person's capacity to make a specific decision and should be referred to for more detailed guidance (for location see Annex A). These are essentially the same as the criteria set out at paragraph 3.24.

3.35 If you consider that an adult may not have the capacity to give 'informed consent' for information sharing, you must follow the Code of Practice. If you judge that an individual does not have the capacity to make decisions, their views should still be sought as far as possible.

## When consent should not be sought

3.36 There will be some circumstances where you should not seek consent from the individual or their family, or inform them that the information will be shared. For example, if doing so would:

- place a person (the individual, family member, yourself or a third party) at increased risk of significant harm if a child, or serious harm if an adult; or
- prejudice the prevention, detection or prosecution of a serious crime; or
- lead to an unjustified delay in making enquiries about allegations of significant harm to a child, or serious harm to an adult.

3.37 You should not seek consent when you are required by law to share information through a statutory duty or court order. In these situations, subject to considerations set out in paragraph 3.11, you should inform the individual concerned that you are sharing the information, why you are doing so, and with whom.

### Question 5: Is there sufficient public interest to share the information?

3.38 Even where you do not have consent to share confidential information, you may lawfully share it if this can be justified in the public interest. Seeking consent should be the first option. However, where consent cannot be obtained or is refused, or where seeking it is inappropriate or unsafe as explained at 3.36, the question of whether there is a sufficient public interest must be judged by the practitioner on the facts of each case. **Therefore, where you have a concern about a person, you should not regard refusal of consent as necessarily precluding the sharing of confidential information.**

3.39 A public interest can arise in a wide range of circumstances, for example, to protect children from significant harm, protect adults from serious harm, promote the welfare of children or prevent crime and disorder. There are also public interests, which in some circumstances may weigh against sharing, including the public interest in maintaining public confidence in the confidentiality of certain services.

### 3.40 Sharing Information in the Public Interest in a Multi-Agency Forum

(i) If you are asked to share multi-agency documents with other agencies such as initial assessments, core assessments, minutes from multi-agency meetings or any other assessments that pertain to an analysis of risk to the child's welfare, parental consent should be sought as in (3.17- 3.37). This consent can be verbal or written, but written consent is preferable.

(ii) However if consent is refused, a judgment about the impact of not sharing the information needs to be made.

(iii) All agencies have joint responsibility for support and assessment of children when there are concerns about their welfare. It is only when all agencies share the information they hold that a full picture emerges upon which to reach decisions and determine a plan of action to safeguard the welfare of children.

(iv) Some agencies remain involved to support families following brief or lengthy interventions from children's social care. In these instances, it is important that all relevant assessments are provided on request to these agencies, so that they can provide appropriate and informed ongoing support and assessment.

3.41 The key factors in deciding whether or not to share confidential information are necessity and proportionality, i.e. whether the proposed sharing is likely to make an effective contribution to preventing the risk and whether the public interest in sharing information overrides the interest in maintaining confidentiality. In making the decision you must weigh up what might happen if the information is shared against what might happen if it is not and make a decision based on professional judgement. The nature of the information to be shared is a factor in this decision making, particularly if it is sensitive information<sup>6</sup> where the implications of sharing may be

especially significant for the individual or for their relationship with the practitioner and the service. For more on the legal background see *Information Sharing: Further guidance on legal issues*.  
6 As defined in the Data Protection Act. See Glossary for definition.

3.42 It is not possible to give guidance to cover every circumstance in which sharing of confidential information without consent will be justified. You must make a judgement on the facts of the individual case. Where there is a clear risk of significant harm to a child or serious harm to an adult, the public interest test will almost certainly be satisfied (except as described in 3.43). There will be other cases where you will be justified in sharing limited confidential information in order to make decisions on sharing further information or taking action – the information shared should be necessary for the purpose and be proportionate.

3.43 There are some circumstances in which sharing confidential information without consent will normally be justified in the public interest. These are:

- when there is evidence or reasonable cause to believe that a child is suffering, or is at risk of suffering, significant harm; or
- when there is evidence or reasonable cause to believe that an adult is suffering, or is at risk of suffering, serious harm; or
- to prevent significant harm to a child or serious harm to an adult, including through the prevention, detection and prosecution of serious crime.

3.44 An exception to this would be where an adult with capacity to make decisions (see paragraph 3.30) puts them self at risk but presents no risk of significant harm to children or serious harm to other adults. In this case it may not be justifiable to share information without consent. You should seek advice if you are unsure.

3.45 If you are unsure whether the public interest justifies disclosing confidential information without consent, you should be able to seek advice from your manager or a nominated individual in your organisation or local area whose role is to support you in these circumstances. Where possible you should not disclose the identity of the person concerned. Other sources of advice include the Information Commissioner's Office (ICO) and your Local Safeguarding Adults Board or Local Safeguarding Children Board. If you are working in the NHS or a local authority, the Caldicott Guardian may be helpful. Advice can also be sought from representative bodies, for example, the British Medical Association or the Royal College of Nursing.

3.46 All organisations working with children will have a nominated person who undertakes a lead role for safeguarding children. If the concern is about possible abuse or neglect of a child or young person, you should discuss your concerns with your manager or the nominated person within your organisation or area. If you still have concerns, you should refer your concerns to children's social care and/or the police in line with your Local Safeguarding Children Board procedures.

3.48 If you decide to share confidential information without consent, you should explain to the person that you intend to share the information and why, unless it is inappropriate or unsafe to do so (as explained in paragraph 3.36).

### **Question 6: Are you sharing information appropriately and securely?**

3.49 If you decide to share information, you should share it in a proper and timely way, act in accordance with the principles of the Data Protection Act 1998, and follow your organisation's policy and procedures. In relation to sharing information at the front-line, you will need to ensure that you:

- share only the information necessary for the purpose for which it is being shared;
- understand the limits of any consent given, especially if the information has been provided by a third party;
- distinguish clearly between fact and opinion;
- share the information only with the person or people who need to know;
- check that the information is accurate and up-to-date;
- share it in a secure way, for example, confirm the identity of the person you are talking to; ensure that a conversation or phone call cannot be overheard; use secure email; ensure

- that the intended person will be on hand to receive a fax;
- establish with the recipient whether they intend to pass it on to other people, and ensure they understand the limits of any consent that has been given; and
- inform the person to whom the information relates and, if different, any other person who provided the information, if you have not done so already and it is safe to do so.

3.50 In deciding what information to share, you also need to consider the safety of other parties, such as yourself, other practitioners and members of the public. If the information you want to share allows another party to be identified, for example, from details in the information itself or as the only possible source of the information, you need to consider if sharing the information would be reasonable in all circumstances. Could your purpose be met by only sharing information that would not put that person's safety at risk?

### **Question 7: Have you properly recorded your information sharing decision?**

3.51 You should record your decision and the reasons for it, whether or not you decide to share information. If the decision is to share, you should record what information was shared and with whom.

3.52 You should work within your agency's arrangements for recording information and within any local information sharing procedures in place. These arrangements and procedures must be in accordance with the Data Protection Act 1998 – the key provisions of which are summarised in *Information Sharing: Further guidance on legal issues*.

## **4. Medical**

4.1 The General Medical Council (GMC) has produced guidance entitled Confidentiality (2009) and 0-19 years guidance for all doctors (2007). These are available to be downloaded from [www.gmc-uk.org](http://www.gmc-uk.org). It emphasises the importance in most circumstances of obtaining a patient's consent to the disclosure of personal information, but makes clear that information may be released to third parties - if necessary without consent - in certain circumstances. Those circumstances include the following.

### **Disclosures when a patient may be a victim of neglect or abuse**

4.2 If you believe that a patient may be a victim of neglect or physical, sexual or emotional abuse, and that they lack capacity to consent to disclosure, you must give information promptly to an appropriate responsible person or authority, if you believe that the disclosure is in the patient's best interests or necessary to protect others from a risk of serious harm. If, for any reason, you believe that disclosure of information is not in the best interests of a neglected or abused patient, you should discuss the issues with an experienced colleague. If you decide not to disclose information, you should document in the patient's record your discussions and the reasons for deciding not to disclose. You should be prepared to justify your decision. (GMC 2009).

### **Principles of confidentiality**

4.3 Respecting patient confidentiality is an essential part of good care; this applies when the patient is a child or young person as well as when the patient is an adult. Without the trust that confidentiality brings, children and young people might not seek medical care and advice, or they might not tell you all the facts needed to provide good care.

### **Sharing information with the consent of the child or young person**

4.4 Sharing information with the right people can help to protect children and young people from harm and ensure that they get the help they need. It can also reduce the number of times they are asked the same questions by different professionals. By asking for their consent to share relevant information, you are showing them respect and involving them in decisions about their care.

4.5 If children and young people are able to take part in decision-making, you should explain why you need to share information, and ask for their consent. They will usually be happy for you to talk to their parents and others involved in their care or treatment.

## Sharing information without consent

4.6 If a child or young person does not agree to disclosure there are still circumstances in which you should disclose information:

- a) when there is an overriding public interest in the disclosure
- b) when you judge that the disclosure is in the best interests of a child or young person who does not have the maturity or understanding to make a decision about disclosure
- c) when disclosure is required by law

## Public interest

4.7 You can disclose, without consent, information that identifies the child or young person, in the public interest. A disclosure is in the public interest if the benefits which are likely to arise from the release of information outweigh both the child or young person's interest in keeping the information confidential and society's interest in maintaining trust between doctors and patients. You must make this judgement case by case, by weighing up the various interests involved.

4.8 When considering whether disclosure would be justified you should:

- a) tell the child or young person what you propose to disclose and why, unless that would undermine the purpose or place the child or young person at increased risk of harm
- b) ask for consent to the disclosure, if you judge the young person to be competent to make the decision, unless it is not practical to do so.

4.9 If a child or young person refuses consent, or if it is not practical to ask for consent, you should consider the benefits and possible harms that may arise from disclosure. You should consider any views given by the child or young person on why you should not disclose the information. But you should disclose information if this is necessary to protect the child or young person, or someone else, from risk of death or serious harm. Such cases may arise, for example, if:

- a) a child or young person is at risk of neglect or sexual, physical or emotional abuse
- b) the information would help in the prevention, detection or prosecution of serious crime, usually crime against the person
- c) a child or young person is involved in behaviour that might put them or others at risk of serious harm, such as serious addiction, self harm or joy-riding

4.10 If you judge that disclosure is justified, you should disclose the information promptly to an appropriate person or authority and record your discussions and reasons. If you judge that disclosure is not justified, you should record your reasons for not disclosing. (GMC 2007)

## Nursing

4.11 The Nursing and Midwifery Council (NMC)

'The code: Standards of conduct, performance and ethics for nurses and midwives' (2008) states:

- "You must respect people's right to confidentiality."
- "You must ensure people are informed about how and why information is shared by those who will be providing their care."
- "You must disclose information if you believe someone may be at risk of harm, in line with the law of the country in which you are practising."

Alongside this the NMC has produced a Confidentiality guidance sheet available from [www.nmc-uk.org](http://www.nmc-uk.org)

## Appendix 1 – Key Sources of further guidance

### General information sharing guidance

*Information Sharing: Guidance for practitioners and managers* (HMG, 2008) and case examples, training materials and further information about powers/legislation. Available at

<https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00807-2008> .

ICO guidance for organisations on Data Protection Act and other legislation including good practice notes, codes of practice and technical guidance notes

Available at [www.ico.gov.uk/Home/for\\_organisations/data\\_protection\\_guide.aspx](http://www.ico.gov.uk/Home/for_organisations/data_protection_guide.aspx) .

*HM Government Information sharing vision statement* (HMG, 2006)

Available at [www.justice.gov.uk/publications/informationsharingvision.htm](http://www.justice.gov.uk/publications/informationsharingvision.htm)

*NHS Information Governance* (DH, 2007)

Available at

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_079616](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079616)

*Confidentiality: NHS Code of Practice* (DH, 2003)

Available at [www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf](http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf)

*Confidentiality*: (GMC, 2009)

Available at [www.gmc-uk.org/guidance/current/library/confidentiality.asp](http://www.gmc-uk.org/guidance/current/library/confidentiality.asp)

*Confidentiality and Disclosure of Health Information Toolkit* (BMA, 2008)

Available at [www.bma.org.uk/ap.nsf/Content/ConfToolKit08](http://www.bma.org.uk/ap.nsf/Content/ConfToolKit08)

*The NMC Code of Professional Conduct*: (NMC, 2008). Available at [www.nmc-uk.org](http://www.nmc-uk.org)

*Data Protection Act 1998 – Guidance for Social Services*

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH\\_4010391](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_4010391)

*Mental Capacity Act: 2005 Code of Practice* (DCA, 2007)

Available at [www.justice.gov.uk/guidance/mca-code-of-practice.htm](http://www.justice.gov.uk/guidance/mca-code-of-practice.htm)

*MAPPA (Multi Agency Public Protection Arrangements) guidance* (2007)

Available at [http://www.justice.gov.uk/downloads/guidance/prison-probation-and-rehabilitation/public%20protection%20manual/10004894MAPPAGuidance\\_2009\\_Version3.pdf](http://www.justice.gov.uk/downloads/guidance/prison-probation-and-rehabilitation/public%20protection%20manual/10004894MAPPAGuidance_2009_Version3.pdf)

MARAC (Multi-Agency Risk Assessment Conference) toolkits  
Available at [www.caada.org.uk/index.html](http://www.caada.org.uk/index.html)

## Guidance for children's services

### Guidance for working with vulnerable adults

*Working Together to Safeguard Children and What to do if you are worried a child is being abused* (HMG, 2010)

Available at

<https://www.education.gov.uk/publications/standard/publicationdetail/page1/dfes-04320-2006>

*Child Health Promotion Programme* (DH, 2006)

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH\\_083645](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_083645)

*0-18 years: guidance for all doctors* (GMC, 2007)

[www.gmc-uk.org/guidance/ethical\\_guidance/children\\_guidance/index.asp](http://www.gmc-uk.org/guidance/ethical_guidance/children_guidance/index.asp)

*When to share information: Best practice guidance for everyone working in the youth justice system* (2008)

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_084703](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084703)

*Sharing Personal and Sensitive Personal Information on Children and Young People at Risk of Offending: A Practical Guide* (Youth Justice Board, 2005)

[www.yjb.gov.uk/publications](http://www.yjb.gov.uk/publications)

*No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4008486](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008486)

## Links to other information

*Reaching Out: Think Family, analysis and themes from the Families At Risk Review* (Cabinet Office, 2006) and *Think Family: Improving the life chances of families at risk* (Cabinet Office, 2008)

[www.cabinetoffice.gov.uk/social\\_exclusion\\_task\\_force/families\\_at\\_risk.aspx](http://www.cabinetoffice.gov.uk/social_exclusion_task_force/families_at_risk.aspx)

*Every Child Matters* (TSO, 2003)  
Available at <http://www.education.gov.uk/>

Youth Inclusion and Support Panels – information available at  
[www.yjb.gov.uk/en-gb/yjs/Prevention/YISP/](http://www.yjb.gov.uk/en-gb/yjs/Prevention/YISP/)

Single Assessment Process – information available at  
<http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/SocialCare/Chargingandassessment/SingleAssessmentProcess/index.htm>

Common Assessment Framework – information available at  
<http://www.cwdcouncil.org.uk/caf>

*CWDC Share!* (2007-08) – available from the Children’s Workforce Development Council at [www.cwdcouncil.org.uk/cwdc-share](http://www.cwdcouncil.org.uk/cwdc-share)

*Our Health, Our Care, Our Say* (DH, 2006)  
Available at [www.dh.gov.uk/en/Healthcare/Ourhealthourcareoursay/index.htm](http://www.dh.gov.uk/en/Healthcare/Ourhealthourcareoursay/index.htm)

### Links to legislation documents

Information on relevant legislation is given in *Information Sharing: Further guidance on legal issues*. Links to legislation referenced in this document are given below.

The Data Protection Act 1998. Information available at  
[www.ico.gov.uk/what we cover/data protection.aspx](http://www.ico.gov.uk/what_we_cover/data_protection.aspx)

Education and Inspections Act 2005. Information available at  
<https://www.education.gov.uk/publications/standard/publicationDetail/Page1/DCSF-10544006X>

Mental Capacity Act 2005. Information available at  
[www.justice.gov.uk/guidance/mental-capacity.htm](http://www.justice.gov.uk/guidance/mental-capacity.htm)

National Health Service Act 2006. Information available at  
[www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/DH\\_064103](http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/DH_064103)

Safeguarding Vulnerable Groups Act 2006. Information available at  
[www.opsi.gov.uk/ACTS/acts2006/ukpga\\_20060047\\_en\\_1](http://www.opsi.gov.uk/ACTS/acts2006/ukpga_20060047_en_1)

### Links to documents related to bulk or pre-agreed information sharing

*Data Protection and Sharing – Guidance for Emergency Planners and Responders* (HMG, 2007). Available at <http://www.cabinetoffice.gov.uk/ukresilience>

Data handling procedures across government. Information available at  
[www.cabinetoffice.gov.uk/csia](http://www.cabinetoffice.gov.uk/csia)

*Data Sharing Review Report* (Richard Thomas and Mark Walport, 2008)

## Appendix 2 – Glossary

For the purpose of this document, the following definitions have been used. Wherever possible, definitions have been taken from legislation or existing guidance and the source referenced.

**Anonymised information** is information from which a person cannot be identified by the recipient.

**Caldicott Guardian (NHS)** is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information sharing. The Guardian plays a key role in ensuring that the NHS, Councils with Social Services responsibilities and partner organisations satisfy the highest practicable standards for handling patient identifiable information. (DoH website, April 2008).

**Child** means a person under the age of eighteen (Children Act 1989, section 105).

**Confidential information** is information that is not normally in the public domain or readily available from another source, it should have a degree of sensitivity and value and be subject to a duty of confidence. A duty of confidence arises when one person provides information to another in circumstances where it is reasonable to expect that the information will be held in confidence.

**Consent** is agreement freely given to an action based on knowledge and understanding of what is involved and its likely consequences. See also separate entries for explicit consent, implied consent and informed consent.

**Explicit consent** is consent given orally or in writing detailing exactly what the consent is for and in what circumstances it will apply.

**Failing to thrive** denotes poor weight gain and physical growth failure over an extended period of time in infancy.

**Fraser guidelines.** The term arises from the Victoria Gillick case in the early 1980s. Gillick mounted a legal challenge attempting to set a legal precedent which would have meant that medical practitioners could not give young people under the age of 16 treatment or contraceptive services without parental permission. The challenge was successful in the Court of Appeal but then the House of Lords ruled that young people who are under 16 are competent to give valid consent to a particular intervention if they have sufficient understanding and intelligence to enable them to understand fully what is proposed and are capable of expressing their own wishes. Lord Fraser of Tullybelton gave the leading judgement in the House of Lords, hence the reference to the Fraser guidelines. The Fraser guidelines stress that:

- the young person must understand the advice being given and must indicate that they cannot be persuaded to involve their parents;
- the young person would be likely to continue to have sexual intercourse with or without advice or treatment;
- the professional must be satisfied that if the young person does not receive contraceptive advice or treatment their physical or mental health, or both, will suffer; and
- the young person's best interests require the professional to give the contraceptive advice

or treatment, or both, without parental consent.

**Implicit consent** is where the person has been informed about the information to be shared, the purpose for sharing and that they have the right to object, and their agreement to sharing has been signalled by their behaviour rather than orally or in writing. Implicit consent can also be inferred from earlier explicit consent providing there is no change in the relationship with the organisation and the use of the information.

**Informed consent** is where the person giving the consent understands why particular information needs to be shared, what information might be shared, who will use it and how, and what might happen as a result of sharing or not sharing the information.

**Integrated services** are joined up services centred on the needs of service users and are often co-located. This includes consideration of how services are planned, commissioned and delivered. Integrated services move away from the traditional structuring of services around professional disciplines.

**Integrated working** is where services work together effectively to put the person or family at the centre, meet their needs and improve their lives.

**Poor outcomes for children and young people** mean failing to achieve the outcomes that matter most to them, as laid out in Green Paper *Every Child Matters* (TSO, 2003). These outcomes are: being healthy; staying safe; enjoying and achieving; making a positive contribution; and economic well-being.

**Poor outcomes for adult's** means failing to achieve social care outcomes as laid out in the White Paper *Our Health, Our Care, Our Say* (DH, 2006). These outcomes are: improved health and emotional well-being; improved quality of life; making a positive contribution; exercise choice and control; freedom from discrimination or harassment; economic well-being; and personal dignity and respect.

**Personal data (or personal information)** means data which relate to a living individual who can be identified:

(a) from those data; or

(b) from those data and other information which is in the possession of, or is likely to come into the possession of, the data controller (DPA, 1998).

**Practitioner** is the generic term used in this guidance to cover anyone who works with children, young people and/or adults.

**Proportionality** is one of the key factors in deciding whether or not to share confidential information without consent. The principle of proportionality implies that the means should not exceed the ends. In other words, is the information you wish, or have been asked, to share, a balanced response to the need to safeguard a person, or to prevent or detect a serious crime?

**Public bodies** are any public service, for example, a local authority, health services or schools.

**Public interest** is the interests of the community as a whole, or a group within the community or individuals. The "public interest" is an amorphous concept which is typically not defined in legislation. The examples given in the definition of the public interest test below are currently accepted common law categories of the public interest.

**Public interest test** in this context is the process a practitioner uses to decide whether to share confidential information without consent. It requires them to consider the competing public interests – for example, the public interest in protecting individuals, promoting their welfare or preventing crime and disorder, and the public interest in maintaining public confidence in the confidentiality of public services, and to balance the risks of not sharing against the risk of sharing.

**Safeguarding and promoting welfare** is the process of protecting children, young people or vulnerable adults from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care which will enable them to have optimum life chances and enter adulthood successfully.

**Sensitive information** means personal data consisting of information about:

- (a) the racial or ethnic origin of the data subject;
- (b) his political opinions;
- (c) his religious beliefs or other beliefs of a similar nature;
- (d) whether he is a member of a trade union;
- (e) his physical or mental health or condition;
- (f) his sexual life;
- (g) the commission or alleged commission by him of any offence; or
- (h) any proceedings for any offence committed or alleged to have been committed by him, the disposal of such proceedings or the sentence of any court in such proceedings. (DPA, 1998).

**Serious crime** for the purposes of this guidance means any crime which causes or is likely to cause significant harm to a child or serious harm to an adult.

**Serious harm** is defined as death or serious injury to a person's physical or mental health (DH, 2008).

**Significant harm:** The Children Act 1989 states: *"Where the question of whether harm suffered by a child is significant turns on the child's health and development, his health or development shall be compared with that which could reasonably be expected of a similar child"*. There are no absolute criteria on which to rely when judging what constitutes significant harm. Consideration of the severity of ill-treatment may include the degree and the extent of physical harm, the duration and frequency of abuse and neglect, the extent of premeditation, and the presence or degree of threat, coercion, sadism and bizarre or unusual elements. Each of these elements has been associated with more severe effects on the child, and/or relatively greater difficulty in helping the child overcome the adverse impact of the maltreatment.

Sometimes, a single traumatic event may constitute significant harm, for example, a violent assault, suffocation or poisoning. More often, significant harm is a compilation of significant events, both acute and long-standing, which interrupt, change or damage the child's physical and psychological development. Some children live in family and social circumstances where their health and development are neglected. For them, it is the corrosiveness of long-term emotional, physical or sexual abuse that causes impairment to the extent of constituting significant harm. (*Working Together to Safeguard Children*, HMG 2006).

**Vulnerable adult:** The broad definition of a 'vulnerable adult' is a person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation. (*No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*. DoH, 2000).

**Well-being:** For children and young people, well-being is the term used in the Children Act 2004 relating to the five *Every Child Matters* outcomes, i.e. being healthy; staying safe; enjoying and achieving; making a positive contribution; and achieving economic well-being.

## Appendix 3 - Information sharing: Case examples

### *Integrated working to improve outcomes for children and young people*

These eight case examples support the cross-Government guidance document *Information Sharing: Practitioners' Guide* by illustrating for practitioners the practical application of the guidance.

The case examples cover a range of situations of relevance to everyone who works with children and young people, whether they are employed or volunteers, working in the public, private or voluntary sectors. The document is for staff working in health; education; early years and childcare; social care; youth offending; police; advisory and support services, and leisure. It is also for practitioners who work in services provided for adults, for example mental health services and drug and alcohol services, as many of the adults accessing those services may have parenting or caring responsibilities.

The case examples are also suitable for use as discussion materials to support training in information sharing. The eighth example illustrates the potential consequences of information not being shared effectively in a child protection case.

Alongside this guidance, we are publishing:

- the cross-Government guidance *Information Sharing: Practitioners' Guide*;
- a supporting document entitled *Information Sharing: Further Guidance on Legal*

#### *Issues*

a set of training materials available for local agency and multi-agency training, and for use by providers of initial training and continuous professional development for the children's workforce. Go to [www.ecm.gov.uk/informationsharing](http://www.ecm.gov.uk/informationsharing)

### **1. Sharing information with consent to support a parent's parenting capability**

Kate, a single mother with a three year old son and a new baby is visited by a health visitor. Kate appears to be struggling to cope with the children and it becomes clear that since she and her husband separated that she has no family support.

Kate says that she has been feeling really low. She complains that both bedrooms are damp and they are all suffering with chest infections. She says she hasn't reported it to the housing office because she doesn't feel confident enough to go out with the children, particularly to new places. The health visitor suggests that she could arrange an outreach visit for Kate. She explains that the outreach worker can help her make contact with the housing office and arrange for someone to make sure any necessary repair work is carried out to the property. She can also provide her with information about what services are available in the local children's centre and the local area and help Kate identify the ones that would be of benefit to her and the children.

Kate takes up the offer of support and is assigned an outreach worker, Kelly, who calls to arrange an initial visit. On the first visit Kelly takes time to develop a rapport with Kate. She listens as Kate explains how difficult she is finding life as a single mother to a toddler and a new baby, how tired she feels, how she never gets any time for herself and how worried she is about their living conditions. Kelly recognises the importance of making sure that Kate doesn't feel rushed or pressured.

Kate also mentions that she is expecting a visit from the midwife in the next couple of days. Kelly offers to make contact with the midwife supporting Kate to let her know that she has visited the family and also to make contact with the housing office. Kate agrees, saying that it would save her from explaining everything to the midwife and that she appreciates the help getting their home repaired. Kelly explains that she will contact the health visitor to let her know what she and Kate have agreed today.

Kelly contacts the housing office, the midwife and the health visitor to seek any further information about Kate's situation. Each of the agencies must consider whether any of the information they hold should be treated confidentially before sharing any of it with the outreach worker. Some information is shared and it is agreed that they will alert each other if they have any concerns about the welfare of the children. Kelly arranges to visit Kate again a couple of days later. On this visit Kate appears much happier. The housing office has responded to Kelly's call and has arranged to make the necessary repairs to Kate's home.

Kelly takes the opportunity to mention to Kate that the local children's centre has a mother and baby club that has been really successful and suggests that Kate and the children might attend a couple of sessions. She and Kate talk about how it might be good for her to get out of the house and spend time with other new mothers, that it might enable her to make some new friends and possibly develop a local support network. They also talk about how good it would be for her son to mix with other children of the same age. Kelly offers to go to the first few sessions with Kate if it would help her to feel more comfortable.

Kate agrees to give it a go and they make arrangements for Kelly to call for Kate and the children the following week and to go with them to the first session. Kate enjoys the break from her normal routine. Kelly goes with her to another session but then Kate feels able to attend the group without any additional support. Kate continues to meet with Kelly on a regular basis. She appreciates the support, grows in confidence and becomes a regular visitor at the local children's centre, accessing a range of services there and in the local community. In time, Kate returns to work part-time. Kelly helps her to arrange childcare through the centre.

## 2. Sharing information with consent following concerns about a toddler's development

Home-Start is a charity that recruits and trains volunteers to support parents with children under five. Volunteers can have contact with a wide variety of health, social, education and other practitioners while supporting a family.

Cathy is a teenage mother who has no contact with the father of her two young children, Ben (three years) and Jake (six months). She has recently been re-housed in a hostel which is mainly for lone young parents but includes tenants with a wide range of needs.

Cathy was referred to Home-Start by Ben's school nursery because of Ben's erratic attendance at the nursery. Cathy is wary of any agency support due to unhappy experiences as a child but after several visits a trusting relationship was established with the Home-Start organiser and the volunteer assigned to her case.

The main issues that emerged through discussion with Cathy were:

**Ben's attendance at nursery:** Cathy had fled from a violent relationship and was anxious not to let anyone know where they were living. Ben had been allocated a place at a school close to the bed and breakfast accommodation where the family lived at the time he was registered. When the family were moved to the hostel this meant a long walk to and from the nursery for Cathy as there was no cross-town public transport. As soon as she got home from dropping him off, it was time to set off to pick him up again and as a result she often didn't take him. The organiser explained to Cathy that her consent was needed to allow Home-Start to speak to the nursery and share information with them to try and resolve the problem. Cathy was then able to give 'informed consent' to share relevant information. As a result arrangements were made to relocate Ben to a closer school nursery and his attendance improved.

**Ben's health:** The volunteer had concerns about whether Ben had hearing difficulties. Ben had missed many of his developmental checks including the hearing checks as a baby due to the

family changing address frequently, not being sent appointments or not keeping them. Cathy avoided clinics as she felt that staff were critical of her parenting skills. The volunteer raised the concerns with the Home-Start organiser who decided to speak to Cathy about using the Common Assessment Framework for children and young people (CAF) to get a full picture of Ben's needs. The organiser completed the assessment with Cathy and once again consent was sought to share relevant information, this time with the health visitor. The consent to share information Cathy had given previously was for a different purpose and so it was necessary to seek consent again. The volunteer accompanied Cathy and Ben to the clinic. Hearing tests identified that Ben had a problem with adenoids; he was referred on to his GP so treatment could be arranged.

**Cathy's isolation:** The CAF process had also helped to identify that being relocated away from her own family with no easy access to public transport led to Cathy feeling isolated. The volunteer worked hard to get Cathy involved in school events and managed to persuade her to attend the Home-Start group where she met other mothers. Over time Cathy joined in more with group activities and made friends with other young mothers.

### **3. Respecting a parent's refusal of consent to share confidential information following concerns about a child's development**

Jenny and Jack are six and four years old and attend the same school. They have a younger sister aged 12 months.

Jack's teacher is a bit concerned about him because he is quite often late and usually the last to be collected from school, he looks a bit grubby and she thinks he is small and thin for his age. Jack sometimes seems to be very hungry and other children have complained that he is taking food from their lunchboxes. He has sometimes fallen asleep in the classroom.

His teacher decides to speak to her colleague about Jenny and whether there are any concerns about her. Jenny's teacher says that she is also sometimes late and not always very well dressed but is doing well in school and seems happy. The teacher doesn't have particular concerns about her.

Jack's teacher decides to speak to his mother when she collects the children from school about her concerns about Jack's weight and tiredness and says she would like to ask the school nurse to see him and offer some advice.

His mother seems a bit depressed and is rather monosyllabic in her responses - she says she thinks he is fine and she doesn't think it necessary to have him checked. The teacher comments that the mother seems tired and she responds by saying of course she's tired she's got three children under six years old!

Jack's teacher remains uneasy about him and his mother's ability to cope. She decides to seek informal advice from the school nurse about Jack's physical size, hunger and tiredness and the mother's response when concerns were raised with her. The school nurse does not believe the concerns are sufficient to consider a referral to children's social care.

The teacher and the school nurse seek advice from the school's child protection lead and they agree that in the circumstances it would be justified to contact the health visitor who is visiting the youngest child to see if she has any concerns. The health visitor says that the family has been having some difficulties. Working with the family, the health visitor had used the CAF to identify Jack's strengths and needs. The mother trusted the health visitor but had not consented to the information being shared with the school. The health visitor was able to offer additional support to the mother so that the situation should improve. However, she continued to actively monitor the situation.

Some of the information the health visitor has is confidential health information about the mother's mental health. Given the concerns expressed by the school the health visitor says that she will need to seek consent from the mother before sharing any confidential health information about the mother with the school.

When the health visitor raises this with the mother on her next visit, the mother refuses consent to share that information with the school. The health visitor will need to decide whether the public interest in sharing that information with the school outweighs the public interest in maintaining confidentiality. If there is little or no benefit to the children from sharing information with the school then it would be inappropriate to do so without the mother's consent.

The health visitor informs the school that she has decided not to override confidentiality in this case since she believes the benefit to the children would be small, and the mother is accepting services out of school which should help to improve the children's situation. The health visitor and the school staff agree to monitor the situation and confer fortnightly in the first instance, with a view to taking early action, including possible referral to children's social care, if the children's care does not improve. This arrangement is fully documented so that everyone is clear who is responsible for this interim monitoring.

#### **4. Sharing information without consent to enable preventative work with children at risk of involvement in crime and vulnerable to exploitation**

The fire service and police are called to an estate where two cars are on fire. Witnesses say that a group of youngsters who live on the estate are responsible for the fires and maintain that they are also responsible for a lot of vandalism and graffiti and that older people are afraid to go out at night. There are several families that live on the estate that everyone seems to agree are usually responsible for the trouble. In one of the families identified by witnesses:

- Father is suffering from chronic ill health and is unable to work, has been involved in petty crime in the past and did once serve a short prison sentence for handling stolen goods. He says the neighbours and police are 'picking on his kids because he has a bit of a record'.
- Mother is a hard-working woman, a bit depressed and downtrodden, wants what is best for her children but seems defeated in terms of controlling them.
- Jackie, 15 years old, is verbally abusive to her mother and the police when they come to interview them regarding the fires.
- Brett, 14 years old, says he can't see why the police are interviewing them; he denies being involved and says they always get blamed.
- Connor, ten years old, echoes everything Brett says.

Connor and Brett are picked up again one afternoon the following week for stealing sweets and they admit truanting. They are taken home, and their parents claim they last saw them off to school that morning and believed they were in school.

The police decide to issue a Reprimand for the stolen sweets. They are concerned about the risk of poor outcomes for all three children and also the risks to others through their anti-social and offending behaviour. They decide to notify the local preventative partnership, which for the purposes of this case example is the youth offending service (YOS), about these incidents and their concerns. The YOS worker can contact the children's schools without their consent, to obtain further information to help assess the risks to all the children in relation to their potential involvement in criminal behaviour. This would help the YOS worker consider whether they may be children in need, or, at risk of significant harm.

The schools have previously tried to speak to the parents about their concerns for the children without success. The schools have the power to share information with the police and the YOS under the Crime and Disorder Act 1998. However, they will need to decide whether the information they are sharing is confidential and if so, whether or not they need to seek consent to share the information, and if so, from whom.

Connor's school believe he is a bright boy but are concerned that he is aggressive towards other children – his father condones this aggressive behaviour as his way of protecting himself and thinks all kids steal sweets sometime. His mother admits she is concerned about him but wonders what she can do. Connor has told his teacher that he was being bullied into doing 'naughty' things like breaking windows, by some boys who go around with his older brother.

Brett's head of year thinks Brett could do well but he doesn't seem interested, acts the fool in class and enjoys being sent out, then blames everyone for picking on him unfairly. Brett has a learning mentor whom he has told about the situation with his family, where he believed they are always being picked on by their neighbours and he feels he has to take the head of the family role because of his father's illness. This means he has to prove himself as being 'big' and 'hard' so that others show him respect. He says if that means breaking the law then so what; his family comes first.

Jackie's head of year is concerned about her behaviour in the classroom, she can be disruptive, sometimes uses obscene language, and is often trying to test the authority of the teachers. She is openly suggestive towards some of the boys in the class and often walks out of classes if challenged by staff. She smokes a lot and has recently lost a lot of weight. Her parents have not responded to requests from the school to come and discuss their concern. Jackie has told her teacher in confidence that she had got mixed up with an older crowd who had tried to introduce her to drugs and she was worried about how to deal with sexual advances from them.

Some of the information the schools have is confidential. Some of it isn't. The schools judge that in this case all the information they have should be shared without consent if necessary, as they believe that the children may be involved in criminal behaviour and at risk of significant harm. They inform the parents and young people that they intend to share information to enable an informed assessment of the risks to all the children and to determine what action is required to protect them, and others, from harm, promote their welfare and prevent their further involvement in crime. The multi-agency meeting would involve the police, the YOS, the education welfare service, the schools and others that have direct involvement including the school nurse and fire service. The children and parents should, if possible, also be involved in the discussions and the development of the action plan because they are more likely to cooperate if they have had the opportunity to contribute.

A joint plan is developed to establish clear boundaries and monitor the young people's behaviour; enabling them to get access to advice and support about sexual health and drugs, improve their educational achievement and development, and prevent them becoming involved in criminal behaviour.

## **5. Sharing information without consent to enable targeted action to tackle anti-social and criminal behaviour amongst families**

The local authority social inclusion unit, police, probation, youth offending service, housing trust and Connexions services are meeting to develop a planned approach for tackling antisocial and criminal behaviour in their area. This joint action group (JAG), is chaired by the local authority representative with the police representative acting as deputy. The group has established and agreed a standard process for exchanging information with a view to identifying families where additional and targeted support might be appropriate and this is facilitated under section 115 of the Crime and Disorder Act 1998.

The purpose of the monthly meetings is to discuss children, young people and families which are giving one or more of the agencies a cause for concern and to agree what action should be taken, by whom and when. In preparation for the meetings, each agency considers which families it is most concerned about in relation to its functions under the Crime and Disorder Act, and what information it is able to share, taking into account whether any of the information is confidential and, if so, the public interest in relation to sharing such information without consent. The process is documented and an agreed action plan is recorded. Progress is reviewed at each meeting. At this meeting, three families are selected for targeted intervention and support.

**Family 1:** Parents are both drug users on methadone maintenance programmes, the father is on probation following a conviction for drug related offences. Tony, 17, hangs around with a large group, is well known to local police and is often aggressive when approached by them. His sister Louise, aged 14, has also started to hang around in the same group and has told her Connexions personal adviser that she is being pressured by some members of the group to try hard drugs. Children's social care have been in contact with the family and undertaken an initial assessment with respect to both Louise and Tony. This included gaining an understanding of the impact that their parents substance misuse was having on Louise and Tony. The Connexions team manager

explains that the adviser has already spoken to Louise about the dangers of drugs and encouraged her to engage in other activities and to move away from the group. Police suspect that drug and alcohol abuse is rife amongst the group. Members of the general public have reported feeling intimidated or being abused by the group.

**Family 2:** Both parents have been reported to the police by neighbours on several occasions for threatening behaviour. The father has been charged for a public order offence following the threats. Neighbours have also reported concerns about the children, aged 14, 11 and nine. They are often observed on the streets late into the night and appear to be emulating their parents' behaviour – swearing at neighbours, causing damage to property and bullying other children. When the parents are challenged by the neighbours, they refuse to accept that their children are doing anything wrong and become abusive.

**Family 3:** The housing trust has taken a number of anonymous calls reporting suspected domestic violence at the address of this family. Police have also been called to the address following complaints by neighbours. Police report that Charlie, 17, has been convicted of Actual Bodily Harm following a drunken fight in a nightclub – police believes drugs to have been at the centre of the argument. Ben, 14, has been picked up by police on a number of occasions for being drunk and disorderly and returned to the home. The Connexions team manager reports that neither Charlie nor Ben has sought the services of Connexions. The mother insists that there are no problems within the family and that she believes that experimenting with drink is normal teenage behaviour.

The JAG discusses options for offering additional support to the families and where it might be necessary to intervene more directly. They agree what action should be taken, and who will be responsible for ensuring that action is taken and outcomes properly recorded.

As a result of the interventions agreed at the JAG meeting:

**Family 1:** The JAG agrees an assessment of each of the children and the impact of their parents' drug abuse on their welfare is required. Probation are able to confirm that there are no known breaches of parole conditions and that the behaviour of the parents is not currently a cause for concern. Police alert the local community support officers (CSOs) to concerns about the group of youths. Youth workers speak to the group of youths to try to engage them in other activities. Where necessary, CSOs or police will disperse them. A short term, intensive patrol of the area was put in place. Local shopkeepers are reminded about their responsibilities in respect of selling alcohol to those under the age of 18 and that their licence can be revoked if they are found to be deliberately in breach of the law. Support is offered to shopkeepers where intimidation is reported as a reason for selling alcohol to minors. The Connexions adviser works with Louise to identify a youth club that she and her friends can attend. It is reported that she appears to have severed her ties with those who were enticing her into drug use.

**Family 2:** Police ask those neighbours that have reported problems with the family to record details of incidents. They also speak to the family about their anti-social behaviour. The housing trust inform the family that they are at risk of breaching their tenancy agreement and that if necessary, action will be taken. They also make them aware that, depending on the severity of the breach, it could lead to their eviction. Community support officers visit the area at different times during the following month to monitor the situation. Local authority representatives speak to colleagues from the education welfare service who ask for any relevant information from the children's schools to feedback to the next meeting of the JAG. Information collected and shared as part of the JAG process could be used to form the basis of a voluntary Acceptable Behaviour Contract, which in turn would support the evidence required to implement other intervention measures and to issue an Anti-Social Behaviour Order.

**Family 3:** The Connexions service seeks to engage both Ben and Charlie with a view to providing advice and guidance. The adviser discusses options for both education and extracurricular activities with Ben. It becomes clear that Charlie is unemployed and he is invited to attend a meeting with an Adviser about options for employment, education or training. The adviser also discusses opportunities for Charlie to engage in activities such as sport or youth work. As a result of discussions with the young people, they are offered an opportunity to discuss their personal issues with a counsellor. The police family support unit are made aware of the suspected domestic violence and asked to monitor the situation and liaise with other agencies where appropriate.

Parental drug abuse can and does result in children and young people being harmed at every age from conception to adulthood, including physical and emotional abuse and neglect. A thorough assessment is required to determine the needs of each child and the impact of the parent's behaviour on their welfare.

## **6. Sharing information where there is possible abuse of a disabled child**

Helen, aged seven, has cerebral palsy and has very little verbal communication. She is admitted to the children's ward for surgery to her legs. During the admissions process it is noticed that she has some bruising to her legs and thighs. Her mother says that she thinks the bruising may be due to her callipers. The admitting doctor asks Helen how this has happened. The doctor and Helen are not easily able to communicate and the doctor is not able to determine whether the bruises are caused by the callipers or not.

The mother says that Helen has just come back from respite care, that she always comes back in a state and she is considering not sending her any more. The mother has three other children and needs this support to give her a break from her caring responsibilities.

The doctor decides to discuss the bruising with Helen's consultant paediatrician and seek their opinion on how the bruises may have been caused.

The consultant is worried about the cause of the bruising and seeks the mother's consent to share her concerns with children's social care. The mother says that she does not want to involve them because she is worried that Helen would not be able to continue to have the same level of respite care. The consultant decides to override the mother's lack of consent but informs her that she intends to share information with children's social care because she is concerned that Helen may be at risk of harm when she is placed in respite care. Children's social care together with the police and the consultant will need to consider how best to respond to these concerns, keeping an open mind about the possible cause and who, if anyone, might be responsible for the bruising.

## **7. Sharing confidential information without consent in a case of underage sex**

Natasha attends the local genito-urinary clinic with her friend Trina as she has symptoms of a sexually transmitted infection (STI) and she doesn't want to go to her family GP. Natasha says she is 14 years old but the health practitioner thinks that she looks younger. Natasha says she has been having a sexual relationship with her boyfriend for about three months but refuses to give any information about him, she says she is very happy with the relationship and does not feel coerced into doing anything against her will. She says she has not told her boyfriend that she has come to the clinic as she wants to find out if there is a problem first, and she does not want her parents to know anything at all. The health practitioner is unable to persuade Natasha to involve her parents and following the criteria and guidelines outlined by Lord Fraser in 1985 decides on balance that Natasha is capable of giving consent to treatment for her STI and also offers advice about sexual health and contraception. As the tests show Natasha has an STI the health practitioner encourages her to tell her boyfriend as he will need treatment too and Natasha agrees to do so.

Some months later Natasha returns to the clinic with further symptoms, the health practitioner notices that her physical appearance has deteriorated; she appears to have lost weight and she has some faded bruises round the left side of her face. On examination Natasha is found to be pregnant as well as having a different STI than previously. Natasha still refuses to have her parents involved and says she wants a termination of her pregnancy. The health practitioner comments on her bruises and Natasha becomes agitated and says she will come back later for treatment and wants to leave the clinic. The health worker persuades her to stay and discovers that Natasha is upset because she has discovered that her boyfriend has other girlfriends, he has been seen in his car with girls from his workplace, and has tried to persuade her to have group sex with his friends. Natasha says she walked into a door and bruised her face. From this the health worker concludes that Natasha's boyfriend is probably a lot older than her if he is working and driving, that he is also trying to coerce her into sexual activity that she is unhappy about and may have been violent towards her.

The health practitioner arranges to see Natasha for a further appointment in a few days time in order to try and persuade her to involve her parents or another trusted adult in the situation. The health worker also wishes to discuss the situation with the child protection nurse and check with other agencies as she suspects Natasha may have given her false information about her age and address. When Natasha returns to the clinic and cannot be persuaded to involve her parents or another adult, the health worker and the child protection nurse have to make a judgement about reporting their concerns to children's social care and the police and weigh up against Natasha's right to privacy the degree of current or likely harm, what any information shared is intended to achieve and what the potential benefits are to Natasha's welfare.

The health worker and child protection nurse decide that they must make a referral to children's social care and the police as they are concerned that Natasha is at risk of significant harm and that her boyfriend may be violent and could be committing an offence in having a sexual relationship with a young person her age.

In this case, the practitioners involved would need to take account of considerations listed in chapter 5 of *Working Together to Safeguard Children* (in the section 'allegations of harm arising from underage sexual activity') when assessing the extent to which Natasha (or other children who may be being abused by her boyfriend) may be suffering or at risk of suffering significant harm.

## **8. Failure to share information adequately in a child protection case**

Maggie informs her probation officer that she is pregnant. She tells the probation officer the name of the father of her baby. The probation officer recognises the name of the father. She checks the probation records and confirms that he is someone who is known to the probation service. Those records show that the father, Mark, has children with several other women, and that there have been concerns about the safety of all of the children due to his violent and abusive behaviour; that two of the children have been on the child protection register and steps have been taken by their mothers to restrict his access to them.

The probation officer is also aware that Maggie has had a troubled background herself. She was in the care of the local authority as a child, and has a record of a troubled adolescence with offending behaviour. Maggie has had two children previously: one was on the child protection register as a result of neglect and that child now resides permanently with the maternal grandmother; the other child was taken by his father to live with his family. The probation officer is concerned about Maggie's ability to care for and protect her unborn child, particularly with the added concerns of Mark's record of abusive and violent behaviour.

The probation officer telephones children's social care and discusses the case with the team manager and the police and they agree that the case should be referred to them (see the information on section 47 of the Children Act 1989 in section 5 of the document *Information Sharing: Further Guidance on Legal Issues*). Enquiries to the police regarding Mark's previous criminal record reveal that he had convictions but that they are not related to offences against children.

The social worker allocated to the case undertakes an initial assessment with respect to the unborn child. She sees Maggie on several occasions at her mother's house and tries, unsuccessfully, to meet with Mark. Maggie informs the social worker that she and Mark have separated and that she has never had a violent relationship. Once the initial assessment is complete the social worker concludes that no further action is necessary and the case is closed.

The probation officer later discovers that Maggie and Mark have resumed their relationship and reports this to children's social care. The social worker thinks Maggie has a good level of support and stands by her decision following the previous assessment that concluded that no further action was needed.

When the baby is born Maggie moves in with Mark; the community midwife is concerned about the baby's welfare and informs children's social care. The social worker, following consultation with her manager, decides to undertake another initial assessment. She visits Maggie with the baby and reports that Maggie is coping well and the baby appears well cared for, a further visit is agreed for two weeks' time. A letter is sent to Maggie to inform her of the appointment, but there is no reply

when the social worker visits. Two months later, following two further failed attempts to see Maggie and the baby the case is closed by children's social care as there have been no further referrals from the health visitor. The social worker leaves a message for the health visitor to this effect, and requesting that the health visitor monitors the baby and refers again if necessary. The health visitor is unable in the following weeks to get access to Maggie and the child.

The following month the baby is brought by ambulance to the accident and emergency department but is pronounced dead on arrival. Examination of the baby showed numerous bruises to the head and torso and a skeletal survey x-ray showed a fractured skull and left forearm.

The lessons for information sharing identified from a subsequent review of the case are that:

- Practitioners must be curious, open-minded and seek information out, including historical records. In this case a number of agencies had historical records which evidenced Mark's propensity for domestic violence and disregard for the welfare of his children. Similarly records existed which evidenced Maggie's history of being unable to care for her children adequately.
- Information should have been brought together and shared with all the practitioners involved, and used together with current information to assess whether the child was a child in need or whether the child was at risk of significant harm.
- Where there remain concerns about a child's welfare following an initial assessment, rigorous arrangements for follow-up and further communication between practitioners should be clearly agreed and properly recorded.

## Other resources

Information and publications relating to all aspects of the *Every Child Matters: Change for Children* programme - <http://www.education.gov.uk/>

**Information sharing practitioners' guide:** Cross-Government guidance to improve practice by giving practitioners across children's services clearer guidance on when and how they can share information legally and professionally. Available online at <https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00807-2008>

**Common Assessment Framework practitioners' and managers' guides:** Guidance for those implementing and using CAF. Available online at <http://webarchive.nationalarchives.gov.uk/20100113210150/dcsf.gov.uk/everychildmatters/resources-and-practice/ig00063/>

**Lead professional practitioners' and managers' guides:** Guidance for those implementing and carrying out lead professional functions. Available online at <http://webarchive.nationalarchives.gov.uk/20100202100434/dcsf.gov.uk/everychildmatters/resources-and-practice/ig00064/>

**Supporting integrated working training strategy:** Details of the outline training strategy and the range of training modules, including training in information sharing, are available at [https://www.education.gov.uk/publications/standard/\\_arc\\_Performanceachievementandstandards/Page1/HMG-Outline-Training](https://www.education.gov.uk/publications/standard/_arc_Performanceachievementandstandards/Page1/HMG-Outline-Training)

You can download this publication online at <https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00807-2008>