

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



# **Bedford Borough Safeguarding Children Board & Central Bedfordshire Safeguarding Children Board.**

## **Protocol & Guidance; Working with Sexually Active Young People**

Version 1 BBSCB & CBSCB Sexually active guidance/protocol	Adapted from Cumbria's protocol/guidance – Sally Stocker July 2010
Version 2 - BBSCB & CBSCB Sexually active guidance/protocol	Amended following the PPG and individual comments
Version 3 – January 2011- BBSCB & CBSCB Sexually active guidance/protocol	Rewritten by Dave Crawford as previous versions not compatible with other agencies professional guidance/ethics and not fully compliant with Working Together

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# **Working with Sexually Active Children and Young People**

## **1. Background and Rationale for this Protocol & Guidance**

1. This is a policy area that has in the past resulted in some LSCB's producing protocols and guidance that were not in accordance with 'Working Together to Safeguard Children' and with which many of the most influential agencies and organisations sought to distance themselves from.
2. In order not to replicate this situation any review of this Protocol and Guidance should take note of the detailed 'Background and Rationale for this Protocol & Guidance' at Appendix 1 of this document.

## **2. Who this is for**

3. All agencies, which have contact with children and young people, should use this protocol to develop and implement local guidance for their own staff.
4. This process applies to contact in the Bedford Borough Council and Central Bedfordshire Council areas by any practitioner including health professional, youth worker, social worker, personal advisor or voluntary agency worker with someone who is sexually active and under 18. This includes those in non-NHS settings for emergency contraception; Chlamydia screening, repeat issuing of condoms and the undercover condom distribution scheme. It does not apply to condom distribution campaigns where there is no one-to-one consultation, nor does it apply to the sale of condoms.
5. Residential workers and Foster Carers already have specific guidance in this policy area which they should follow.

## **3. Guidance for practitioners and their managers in working with sexually active children and young people**

6. There is a wealth of very helpful guidance for practitioners and their managers which cover a range of agencies and organisations including the statutory and public sector as well as voluntary and third sector organisations. Some of these documents have extensive FAQ's which will be of value to anyone working with children and young people.
7. The list below identifies a number of the most common guidance documents (all of which can be found on the Bedfordshire LSCB website for easy reference):
  - Department of Health, Best practice guidance for doctors and other health professionals on providing advice and treatment to young people under 16 on contraceptive, sexual and reproductive health (London: DH, 2004) Copy at Appendix 11 of this document.
  - Enabling young people to access contraceptive and sexual health information and advice: Legal and Policy Framework for Social Workers, Residential Social Workers, Foster Carers and other Social Care Practitioners (DfES, TPU 2004)
  - Enabling young people to access contraceptive and sexual health advice: Guidance for Youth Support Workers (DfES, TPU 2005)

- Extended Schools: Improving Access to Sexual Health Advice Services (DCSF 2007)
  - Signpost Guide for Nurses working with Young People: Sex and Relationships Education, October 2005 (RCN)
  - The role of school nurses in providing emergency contraception services in educational settings, March 2006 (RCN)
8. Practitioners will need to be conversant with and follow the guidance related to their body. Organisations that do not have specific guidance may choose simply to adopt the guidance provided in one of the following documents which most reflects their organisations position.

#### **4. Engaging with children and young people about the issue of sexual health advice, information or provision of sexual health services**

*Working Together' makes clear that cases involving under 13 year olds who are having penetrative sex or are engaged in other intimate sexual activity are likely to involve significant harm to the child or children. Each case should be discussed with the child protection lead in the organisation, with the presumption that the case is then reported to children's social care and that a strategy discussion is held. All cases involving under 13s should be fully documented including detailed reasons where a decision is taken not to share information."*

9. This presumption means that where practitioners choose not to refer cases involving under 13s this follows a discussion with their line manager or child protection lead within the practitioner's organisation and that the decision not to refer is recorded with the reasons why.
10. There are two questions that practitioners will need to address which will require practitioners to follow the procedure in addressing each question when working with children and young people in the area of sexual health and sexual health services. The questions are as follows and each of the procedures for addressing the questions is then addressed as a separate section of this document (the following 2 sections of this documents)
- Is the child or young person of sufficient understanding and intelligence to enable him or her to understand fully what is being proposed i.e. access to sexual health services/treatment (The application of the Fraser guidelines or 'Fraser Competence') (See paragraphs 17 - 22)
  - Is there any reason to believe, or evidence of, sexual exploitation, sexual abuse or coercion (Child Protection) (See paragraphs 23-48)
11. The application of the Fraser guidelines in issuing sexual health and advice or treatment is quite separate from identifying cases of sexual exploitation, sexual abuse or coercion. The two should not be confused.
12. There is no legal obligation to report underage sex except in cases of sexual exploitation, sexual abuse or coercion. Organisations must consider sharing this information with children's social care or the police in order to protect the child or other children from the risk of significant harm. If a decision is made not to share the information, the decision must be recorded<sup>1</sup>
13. Any child or young person, who is pregnant, must be offered specialist support and guidance by the relevant services.

14. That young people continue to receive and access the support and services they need to support continuation of pregnancy or termination. This will necessarily require addressing any school support required for the continuation of education.
15. All staff who work with children and young people in relation to sexual health advice, information or treatment need to be able to weigh up all of the factors and consider the facts of each case in dealing with the conflicting priorities of the need for confidentiality with the possibility of sexual exploitation, sexual abuse or coercion.
16. All practitioners involved in the provision of contraceptive advice, sexual health treatment, provision of emergency contraception; Chlamydia screening, repeat issuing of condoms and the undercover condom distribution scheme will have received and be able to evidence the particular training they have undertaken to support them to deliver the services they deliver.

## **5. Is the child of sufficient understanding – Fraser Competent (Consent to Treatment)**

17. All practitioners must follow the Fraser guidelines (See Appendix 2) in all dealings with children and young people offering contraceptive advice, sexual health treatment, provision of emergency contraception; Chlamydia screening, repeat issuing of condoms and the undercover condom distribution scheme.
18. Lord Fraser ruled in the High Court that a doctor could give contraceptive treatment or advice provided the following criteria (Fraser Guidelines) were met.

That the child or young person(s)

- are mature enough to understand the advice and the implications of treatment
  - cannot be persuaded to inform his/her parents, or to allow the practitioner to inform them
  - is likely to begin or continue to have sex with or without treatment
  - health (physical and/or mental) is likely to suffer without treatment or advice
  - best interests required the practitioner to give treatment or advice<sup>2</sup>.
19. Fraser competence can now be assessed by professionals other than a doctor. The same criteria still apply. If a young person meets them they are termed 'Fraser ruling competent'. The principles of this judgement are now central to consenting minors for all health treatments.
  20. The Sexual Offences Act 2003 (See Appendix 6) further reinforces the ability of practitioners to provide confidential sexual health advice, information or treatment if it is in order to;
    - Protect the young person from a sexually transmitted infection, or
    - Protect the physical safety of the young person, or
    - Prevent the young person from becoming pregnant, or
    - Promote the young person's emotional well being by giving the advice (as long as they do not act for the purposes of encouraging under age sexual activity)

21. This applies to anyone acting in the best interests of the young person such as health professionals, teachers, youth workers, personal advisors, social care professionals and parents.
22. Consultations should be kept confidential even when a decision is made not to provide advice or treatment (for example, if the young person does not understand your advice or the implications of the treatment), other than in exceptional circumstances e.g. Child Protection.

## **6. Is there any reason to believe, or evidence of, sexual exploitation, sexual abuse or coercion (Child Protection)**

23. Cases of sexual activity which present cause for concern are likely to raise difficult issues and should be handled particularly sensitively<sup>3</sup>. Practitioners will want to ensure that children and young people are protected from sexual exploitation, sexual abuse or coercion.
24. If the young person has a learning disability, mental disorder or other communication difficulty, they may not be able to communicate easily to someone that they are, or have been abused, or subjected to abusive behaviour. There is the same duty to protect them from abuse and exploitation. Practitioners need also to recognise the rights of people with a mental disorder to a full life, including a sexual life, which is recognised in law<sup>4</sup>
25. Where the practitioner decides there is sufficient concern that a child or young person is suffering or is likely to suffer significant harm then he/she will always refer his or her concerns to children's social care. That referral should be made using the established procedures. For further information colleagues may wish to read the LSCB Bedfordshire 'Safeguarding Children. A guide for professionals working with children and young people' March 2008.
26. In accordance with best practice in seeking to share information or make a child protection referral practitioners will want to go to considerable lengths to gain the agreement of the young person to the sharing of information or child protection referral except where this may prejudice the case<sup>5</sup>.
27. Where practitioners choose not to refer cases involving under 13s that decision should be recorded following discussion and with the knowledge of their line manager and or child protection lead within the practitioners organisation<sup>6</sup>.
28. There is specific guidance for cases where the child or young person is believed to be victim of sexual exploitation. LSCB Bedfordshire 'Working with children and young people at risk of sexual exploitation'.
29. Working Together 2010 identifies a checklist to help practitioners identify the extent to which a child (or other children) may be suffering, or is likely to suffer, significant harm. Practitioners will want to give consideration to the checklist in weighing up the factors and assessing the facts of each case to help identify whether to make a child protection referral to children's social care
  - the age of the child. Sexual activity at a young age is a very strong indicator that there are risks to the welfare of the child (whether boy or girl) and, possibly, others;
  - the level of maturity and understanding of the child;
  - what is known about the child's living circumstances;
  - age imbalance, in particular where there is a significant age difference;

- overt aggression or power imbalance;
  - coercion or bribery;
  - familial child sex offences;
  - behaviour of the child i.e. withdrawn, anxious;
  - the misuse of substances as a disinhibitor;
  - whether the child's own behaviour because of the misuse of substances places him/her at risk of suffering harm so that he/she is unable to make an informed choice about any activity;
  - whether any attempts to secure secrecy have been made by the sexual partner beyond what would be considered usual in a teenage relationship;
  - whether the child denies, minimises or accepts concerns;
  - whether the methods used are consistent with grooming; and
  - whether the sexual partner/s is known by one of the agencies.
30. An audit of under-14s who attend sexual health clinics has found that an age difference of more than four years between partners is unusual<sup>7</sup>. It is important for practitioners to judge young people's practices by current day standards, rather than their own of years earlier<sup>8</sup>. Practitioners working with young people can be frustrated by how common excess alcohol use is in this age group, who regard getting drunk as normal.
31. In assessing the nature of any particular behaviour, it is essential to look at the facts of the actual relationship between those involved. This may require a level of assessment that may not be possible thorough a single contact with one practitioner.
32. Where there is a relationship of trust with the practitioner, those who are at risk or who are being exploited can start to disclose these issues to a trusted practitioner, who with time can help them to deal with the situation. The decision making process must consider the relationship between the practitioner and the young person, and seek to build trust as far as possible.
33. The amount of information that will be forthcoming will vary from one setting to another, and will be affected by whether the professional has any prior knowledge of the young person. Therefore a pharmacist issuing emergency contraception as a one-off will probably only gain some of the answers to the questions or prompts that the guidance proposes, whereas a GP for example may be more confident that they will see the young person again.
34. Having identified whether their (practitioners) contact with the young person is regular or can be maintained or is likely to be a one off, will affect as a result, the threshold for discussions with designated staff. The discussions with designated staff may include; their manager or the Child Protection Lead within the practitioners organisation. It may also include a hypothetical scenario or hypothetical child protection referral threshold discussion with children's social care or the police. The trigger for discussions is likely to be lower when the opportunity for further discussions between practitioner and young person is less likely. Discussions of hypothetical a scenario/situation must not disclose personal information that could identify the young person as this would be a breach of confidentiality.

35. Practitioners will already be aware that the duty of confidentiality is to the agency or organisation not the individual practitioner. However personal information should only be shared by the practitioner within the organisation on a 'need to know', basis.
36. Some of the answers to these questions may be gained over the course of several consultations. It is up to the professional to use their judgment as to how much information they can seek each time but full account must be taken of the potential or any serious risk to the child in the interim of delaying intervention.
37. Grilling teenagers rarely makes them open up and failing to establish rapport scares them away, which benefits no-one. Practitioners may feel uneasy about a young person's social circumstances without being worried enough to make a direct referral to children's social care. Again, in such circumstances it may be helpful to talk to someone else who knows more about the young person. This should be done with the consent of the young person in order to avoid a breach of confidentiality.
38. A young person may well give permission to talk to a school nurse or youth worker about their concerns. This may allay fears but if the practitioner remains concerned, a referral to social services should be made and the child or young person advised that this is happening before referring unless it is not in their best interests to be informed i.e. it would compromise evidence or investigation.
39. Whilst age should not be an arbitrary factor which determines reporting to children's social care, the younger the child the stronger the presumption must be that sexual activity will be a matter of concern. Where practitioners continue to be unsure and concerns remain these should be discussed with the practitioners line manager and/or practitioners child protection lead.
40. Following discussion with the child protection lead it may be agreed to hold further discussions with other agencies if required. Where confidentiality needs to be preserved (where consent has not been given) a discussion can still take place as long as it does not identify the child (directly or indirectly).
41. It is expected that these discussions will take place as a matter of course for any cases involving children under 13 years with the increased likelihood that this will become a referral to children's social care.
42. Where following these enquiries there is reasonable cause to suspect that significant harm to a child has occurred, or is likely to occur, there should be a presumption that the case is reported to children's social care and a strategy discussion held to discuss appropriate next steps. Practitioners will want to record any cases of concern and where practitioners choose not to refer cases involving under 13s that decision should be recorded following discussion and with the knowledge of their line manager or child protection lead within the practitioner's organisation.
43. Whilst there is no legal obligation to report underage sex unless abuse is suspected, where a serious crime is suspected, practitioners should seek advice from the police at the earliest opportunity to protect the child and minimise the risk of any evidence, such as emails or pictures, being destroyed before they can begin their investigation. All staff must be aware that the police will formally record contact made by an agency. An incident will be recorded as a crime where on the balance of probability an offence defined by law has been committed and there is no evidence to the contrary. If a decision is made not to share the information, the decisions must be recorded<sup>9</sup>.

44. Any referral or potential referral should be discussed in the first instance with the young person. It is best practice that referrals are made having gained the consent of the young person to share information or make a child protection referral. The organisation making the referral then has a duty of care to the individual to secure their physical and mental well-being and offer support during that time.
45. In some cases urgent action may need to be taken to safeguard the welfare of a young person. There may then be a need for further consultation with the Intake & Assessment Team for Children's Social Care in accordance with the BBSCB & CBSCB Interagency Safeguarding Procedures.
46. If you have concerns that the young person may be at risk of sexual exploitation through prostitution, please refer to Children's Social Care Intake & Assessment Team by completion of a referral. If the situation is an emergency, the local police should be contacted immediately. Further advice and guidance is available in the Bedford Borough, Central Bedfordshire & Luton Safeguarding Children Boards – Safeguarding Children & Young People from Sexual Exploitation – <http://www.bedfordshirelscb.org.uk/publications.php>
47. All referrals to children's social care should be made following LSCB Bedfordshire child protection procedures.
48. The flow chart at Appendix 13 provides a useful checklist prompt for practitioners related to this section.

## **7. Other considerations**

49. Each agency must recognise that they only hold some pieces of the "jigsaw". For example, health professionals would not routinely have access to the Sex Offenders register, or to wider multi-agency intelligence about a young person, their partner, or their family, without making a referral.
50. It is important to recognise that any information passed to Children's Social Care, even in confidence, can be released with a Court Order by a judge in the Family Court. The same does not apply to the Police, who may be entitled to withhold information under Public Interest Immunity. This should be considered when disclosing any information that could later put a patient or informant at risk.

## **8. When a referral has been made to children's social care**

51. For further information colleagues will want to be familiar with the LSCB Bedfordshire 'Safeguarding Children. A guide for professionals working with children and young people' March 2008.
52. Working Together places an obligation on children's social care:
 

*"Whenever local authority Children's Social Care has a case referred to it which constitutes, or may constitute, a criminal offence against a child, it should always discuss the case with the police at the earliest possible opportunity"<sup>10</sup>.*
53. When a referral is received by Children's Social Care, an enquiry to the Child Protection Register will be made, followed by a strategy discussion with the Police, the profession making the referral and other partner agencies. This discussion should be informed by the assessment undertaken using this protocol and, in the majority of cases, may be largely for the purposes of consultation and information sharing.

54. In many cases, it will not be in the best interests of the young person for criminal or civil proceedings to be instigated. However, Police and Children Social Care and other agencies may hold vital information that will assist in assessment of risk.
55. Following any referral to Children's Social Care and after a strategy discussion with the Police and/or any other agencies there may be one of these responses:
  - no further action deemed necessary
  - an initial assessment undertaken which may identify the young person as a child in need and additional services provided
  - an initial assessment undertaken which may identify the young person as a child at risk of significant harm and in need of child protection intervention
56. The outcome of the referral will be formally fed back to the referring agency.
57. During this process agencies must continue to offer the service and support to the young person. Young people continue to receive and access the support and services they need to support continuation of pregnancy or termination. This will necessarily require addressing any school support required for the continuation of education. These services will also be a part of the assessment of the girl's circumstances, and must be included within local guidance. Brook, THT (Terence Higgins Trust) and bpas (British Pregnancy Advisory Service) can all provide non biased and non judgmental support to the young person in the decision making process in regards to continuing or not continuing with the pregnancy. Details of Brook, THT and bpas can be found in most directories.

## **9. Information Sharing Guidance for practitioners**

58. The main legal framework (see Appendix 4) relating to the protection of personal information is set out in:
  - The Human Rights Act 1998, which incorporates Article 8 of the European Convention on Human Rights (ECHR), including the right to a private and family life
  - The common law duty of confidentiality
  - The Data Protection Act 1998: covering protection of personal information
59. Further detail regarding each of the above can be found in Information Sharing: Further guidance on legal issues which is a summary of the laws affecting information sharing (2009).
60. Information sharing is key to the Government's goal of delivering better, more efficient public services that are coordinated around the needs of the individual. It is essential to enable early intervention and preventative work, for safeguarding and promoting welfare and for wider public protection. Information sharing is a vital element in improving outcomes for all.
61. The Government understands that it is important that people remain confident that their personal information is kept safe and secure and that practitioners maintain the privacy rights of the individual, whilst sharing information to deliver better services. It is therefore important that practitioners can share information appropriately as part of their day-to-day practice and do so confidently.
62. It is important to remember there can be significant consequences to not sharing information as there can be to sharing information. You must use your

professional judgement to decide whether to share or not, and what information is appropriate to share on a strictly need to know basis.

63. There are also two case studies at Appendix 7 which provide examples of when to share information.
64. There are some key documents that will support individuals and organisations in ensuring that they make decisions about information sharing on a case by case basis.
  - Information Sharing: Guidance for practitioners and managers (published 22<sup>nd</sup> October 2008)
  - Information Sharing: Pocket guide containing a summary of the key decision making considerations from this document (published 22<sup>nd</sup> October 2008);
  - Information Sharing: Case examples which illustrate best practice in information sharing situations (made available online December 2008);
  - Information Sharing: Training materials available for local agency and multi-agency training, and for use by training providers (*made available online December 2008*). Information Sharing: Pocket Guide
  - Information Sharing: Further guidance on legal issues which is a summary of the laws affecting information sharing (2009)
65. Decisions to share information will be taken using professional judgement having followed the Fraser Guidelines and in accordance with the Child Protection Procedures.
66. It will often be in the best interests of children and young people that they are able to gain additional support from an adult they trust even when there is no case for a child protection referral. Practitioners will wish to ensure that they have secured the young persons agreement to share information in these circumstances. In some circumstances the best support may be from a parent or a carer. However, for a range of reasons parents and carers may not be the first point of call and for some young people information sharing with parents or carers could be damaging.
67. Parents have no more rights to information relating to the young person than any other person. Some young people will be vehemently opposed to information being shared with their parents or carers and practitioners will need to respect these wishes.

## **Relevant Legislation & Bibliography**

The Children Act 1989

The Children Act 2004 Education Act 2002

Crime and Disorder Act 1998

Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children. (DCSF 2010)

Safeguarding Children and Young People from Sexual Exploitation. (DCSF 2009)

LSCB Protocols on sharing information about underage sexual activity. Letter to All Chairs of Local Safeguarding Children Boards in England, 28<sup>th</sup> August 2007.

Sexual Offences Act 2003 (HMSO 2003)

Working within the Sexual Offences Act 2003 (Home Office leaflet 2004)

Children and Families: Safer from Sexual Crime. The Sexual Offences Act. (Home Office leaflet 2004)

Sexual Offences Act Briefing. (Sex Education Forum 2004)

Young People and the Fraser guidelines: confidentiality and consent. Fleming CF, The Obstetrician & Gynaecologist 2006;8:235-239

Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health. (DH 2004)

Working with Sexually Active Young People under the age of 18. Pan-London and Sheffield Protocols. Compatibility with the European convention on Human Rights. ADVICE. (Bindmans. Stephen Grosz, Bindman & Partners, 275 Gray's Inn Road, London, WC1X 8QB 46489.2 SEG

UN Convention on the Rights of the Child. (UN 1989)

The Human Rights Act 1998 and the European Convention of Human Rights

Data Protection Act 1998

Information Sharing: Pocket guide. (HM Government 2008)

Information Sharing: Guidance for practitioners and managers. (HM Government 2008)

Information Sharing: Further guidance on legal issues

Information Sharing: Guidance for Practitioners and Managers. Endorsing and supportive statements. (HM Government 2009)

Information Sharing: Case examples. (HM Government 2009)

0-18 years: guidance for all doctors. (General Medical Council 2007)

Confidentiality: guidance for doctors. (General Medical Council 2009)

The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives (NMC 2008)

Contraception and Sexual Health Services for Young People. (Teenage Pregnancy Independent Advisory Group 2009)

Services for Children and Young people (SCYP). Procedures and Core Standards. (NSPCC 2009)

Reporting of Sexual activity in Children Under 13 Years. (Royal Pharmaceutical Society of Great Britain 2005)

The law on sex. Factsheet. (FPA October 2009)

Teenage Pregnancy Strategy: Beyond 2010-12-16

Teenage Pregnancy Independent Advisory Group Annual Report 2008/09. (TPIAG)

Your Welcome. Key messaging for Primary Care Trusts and Children's Trusts. (DH/NHS 2009)

Extended Schools: Improving Access to Sexual Health Advice Services. (DfES 2007)

Under 16s: consent and confidentiality in sexual health services. Factsheet. (FPA March 2009)

Under-16s and confidentiality. Factsheet. (FPA July 2009)

Gillick versus West Norfolk and Wisbech Area Health Authority (1985) 2 All ER 402/Gillick v West Norfolk and Wisbech Area Health Authority (1986) AC 112

LSCB Protocols on sharing information about underage sexual activity. Letter to all Chairs of LSCBs in England. Kevin Brennan MP Parliamentary Under Secretary of State for Children, Young People and Families 28 August 2007

Handling allegations of sexual offences against children. Local Authority Social Services Letter LASSL (2004)21. (DfES August 2004)

Watchdog (GMC) criticises teen sex reporting plans. (Society Guardian Thursday November 3 2005)

Beds & Luton Protocol for Children & Young People at Risk of Sex Exploitation, July 2010 (Bedfordshire LSCB)

Bedfordshire, Cambridgeshire, Luton, Peterborough, Safeguarding Inter-Agency Procedures, June 2008 (Bedfordshire LSCB) and Voluntary & Community Sector (VCS) Safeguarding Children Resource Pack, October 2007 (Bedfordshire LSCB)

Bedfordshire Child in Need Procedures, October 2008 (Bedfordshire LSCB)

Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children (HMSO 1999)

Audit of under-14s who attend sexual health clinics in Gwent: Identifying young people at risk of abuse and exploitation. Cook L, Fleming C, Journal of Family Planning and Reproductive Health Care 2006 in press

Sexual behaviour in Britain: early heterosexual experience. Wellings K, Nanchahal K, Macdowall W, McManus S, Erens R, Mercer CH et al. Lancet 2001; 358:1843-50

Audit of under-14's who attend sexual health clinics in Gwent: identifying young people at risk of abuse and exploitation. (Cook L, Fleming CF. Journal of Family Planning and Reproductive Health Care 2006).

## Background and Rationale to this Protocol & Guidance

1. For some practitioners and organisations the issue of young people's sexual activity and access to confidential sexual health services is the subject of ongoing debate and argument.
2. There also remains confusion amongst some practitioners and their managers about the legal requirements and responsibilities, practitioner and professional guidance and good practice.
3. In the past some LSCB's notably Pan-London and Sheffield had sought to establish policies which required some or all of the following;
  - automatic or mandatory reporting either to the police or social services of underage sexual activity
  - assessment of all young people under 18 who are believed to be engaged in or planning to engage in sexual activity, including police checks on them and their partners
  - all young people, regardless of gender, who are believed to be engaged in, or planning to be engaged in, sexual activity should have their needs for health education, support and/or protection assessed by the agency involved
4. The policies at the time were presumably produced as a response to Sir Michael Bichard Report recommendations 12-13 (See Appendix 3). Bichard was concerned about the interpretation of his report and went on to say for an article in the Guardian on 22<sup>nd</sup> June 2005.

*"Guidance from the London child protection committee (LCPC) requiring teachers, school nurses, doctors and social workers who discover or suspect that a teenager is sexually active to formally assess whether they were at risk of abuse, risked criminalising normal sexual relationships, said Sir Michael Bichard.*

*Sir Michael said his inquiry's call for social workers to share concerns about underage sex with the police was not intended to cover "non-abusive teenage relationships".*

*He told SocietyGuardian.co.uk: "I was quite concerned not to be so heavily handed to bring into criminal jurisdiction non abusive teenage relationships, which is a danger."*

5. It may be unfortunate that the Bichard report was not couched in the more guarded terms in which he expressed himself in this interview as elements of these discredited policies appear to be being recycled even today despite the guidance under the Children Bill 2006, which incorporates the revisions to Working Together to Safeguard Children.
6. LSCB's are expected to develop protocols based on the Working Together guidance. Local protocols which require mandatory reporting arbitrarily on the basis of age are not in accordance with the Working Together guidance or legal precedent as determined by the House of Lords in Gillick.
7. The British Medical Association, the Royal College of General Practitioners, Royal College of Nursing, Royal Institute of Public Health, ARCH (Action on Rights for Children), Association of Teachers and Lecturers, British Association for Sexual Health and HIV, Brook, Children's Rights Alliance for England, Education for Choice, English Secondary Students Association, Faculty of Family Planning and

Reproductive Health Care of the Royal College of Obstetrics and Gynaecology, Faculty of Public Health, FPA (Family Planning Association), Independent Schools Council, Liberty, Medical Foundation for AIDS & Sexual Health (MedFASH), National Youth Agency, Teenage Magazine Arbitration Panel, Terrence Higgins Trust, Youth Access made a joint statement

*“Those working in sexual health settings already have relevant child protection competencies, or ready access to other health professionals who have such competencies. The duty to safeguard children and young people’s health and wellbeing, including being alert to potential abuse, is regarded by all professionals as a matter of the utmost seriousness, and it would be highly regrettable if measures designed to protect children from possible abuse were of themselves damaging to children. **The assessment of a young person’s needs is a skilled process that relies on experienced professional judgment and sensitivity; over-prescriptive guidance fetters the ability of practitioners to respond appropriately to the complexity of each child.**”*

*Although we are wholly sympathetic to the concerns of ACPCs to ensure the adequate protection of young people from abuse, we cannot support protocols that reduce young peoples’ rights to confidentiality and privacy, and expose them to unnecessary police scrutiny. Child protection is multi-faceted and encompasses every aspect of a child and young person’s development, including physical and emotional health. We believe that it is only in an environment where young people have the confidence to talk freely to professionals that the full range of their needs can be properly understood and addressed.”*

8. The House of Lords in Gillick determined that decisions should not be made arbitrarily by reference to age but it was a question of fact to be determined by the doctor or other professional on the facts of each case.
9. The very clear consensus is that a blanket requirement of referral to the police of all under 13 year olds, police checks on partners and assessment (and consequent sharing and recording of information) is an unacceptable interference with confidentiality; that it is not required for the purpose of child protection; that it is more likely to discourage young people from seeking advice and assistance on sexual matters; that properly trained professionals are well able to assess whether in any particular case a child is at risk of significant harm, discuss matters with the child and determine whether information sharing, police checks or referral to the police are necessary; and that the present guidance from the professions and the government strikes the right balance between child protection and the right to respect for private life.
10. Most if not all of the above agencies and organisations have updated their professional guidance to reinforce this position which distances them from practices identified in (Paragraph 3) above. There is little point in promoting an LSCB policy that will not receive support or compliance from the key partners within this area of work.
11. Kevin Brennan MP, Parliamentary Under Secretary of State for Children, Young People and Families on 28th August 2007 wrote to the Chairs of LSCBs about protocols for sharing information about underage activity, in which he said<sup>11</sup>;

*“Local protocols should reflect the requirements in ‘Working Together’, and not depart materially from the guidance. Engaging all key partners is critical to the development and implementation of effective protocols...”*

*I would like to take the opportunity to reiterate some of the key principles set out in 'Working Together' on sharing information on underage sexual activity. Whether or not to breach confidentiality is a judgement for a professional to make based on the facts of each case. The child's best interests must be the overriding consideration in making any such decision.*

*Working Together' makes clear that cases involving under 13 year olds who are having penetrative sex or are engaged in other intimate sexual activity are likely to involve significant harm to the child or children. Each case should be discussed with the child protection lead in the organisation, with the presumption that the case is then reported to children's social care and that a strategy discussion is held. All cases involving under 13s should be fully documented including detailed reasons where a decision is taken not to share information."*

12. This presumption means that where practitioners choose not to refer cases involving under 13s that decision should be recorded following discussion and with the knowledge of their line manager or child protection lead within the practitioner's organisation.
13. The Q&A at Appendix 5 of this document has been found to be particularly helpful to practitioners in getting to grips with their understanding about the interaction of various elements of statutory guidance and legislation as are the FAQs in the documents listed in paragraph 50.

### Existing government guidance

14. Many of the professional organisations above have cited with approval the guidance issued by the Department of Health in July 2004, entitled Best Practice Guidance For Doctors And Other Health Professionals On The Provision Of Advice And Treatment To Young People Under 16 On Contraception, Sexual And Reproductive Health, and in particular the following passage:

*The duty of confidentiality is not, however, absolute. Where a health professional believes that there is a risk to the health, safety or welfare of a young person or others which is so serious as to outweigh the young person's right to privacy, they should follow locally agreed child protection protocols, as outlined in Working Together to Safeguard Children Chapter 5. In these circumstances, the over-riding objective must be to safeguard the young person. **If considering any disclosure of information to other agencies, including the police, staff should weigh up against the young person's right to privacy the degree of current or likely harm, what any such disclosure is intended to achieve and what the potential benefits are to the young person's well-being.***

***Any disclosure should be justifiable according to the particular facts of the case and legal advice should be sought in cases of doubt. Except in the most exceptional of circumstances, disclosure should only take place after consulting the young person and offering to support a voluntary disclosure. (Emphasis added).***

15. NHS Bedfordshire have commissioned Brook to provide young people's contraceptive and confidential sexual health services including increasing and improving young people's access by providing clinics in a number of Upper schools in Bedfordshire. This service is complemented by a condom distribution scheme and Chlamydia testing scheme for young people which is delivered by an ever

increasing number of practitioners from an increasingly wide range of organisations.

16. Reference to the guidance ‘Enabling young people to access contraceptive and sexual health information and advice: Legal and Policy Framework for Social Workers, Residential Social Workers, Foster Carers and other Social Care Practitioners, 2004’ and ‘Enabling young people to access contraceptive and sexual health advice: guidance for Youth Support Workers, 2005’ clearly identifies the expectation that all practitioners will support young people in accessing confidential contraceptive and sexual health services without fear of inappropriate or unnecessary ‘Referral or Information Sharing’.
17. These two guidance documents make clear that confidentiality is to be the norm, in particular since concerns about confidentiality are likely to stop young people from seeking advice; that disclosure without consent will be made only in very exceptional cases; that in particular automatic referral is undesirable; that the balance between confidentiality and child protection involves an exercise of professional judgment and is to be assessed on the facts of the individual case; and that the extent of disclosure – in terms of both content and breadth of dissemination – should be limited to what is strictly required.
18. The legal age of consent remains at 16, whether straight, gay or bisexual. The aim of the law is to protect the rights and interests of young people, and make it easier to prosecute people who pressure or force others into having sex they do not want<sup>12</sup>.
19. Home Office guidance on the Sexual Offences Act 2003 is clear that:
 

*“Although the age of consent remains at 16, the law is not intended to prosecute mutually agreed teenage sexual activity between two young people of a similar age, unless it involves abuse or exploitation. **Young people, including those under 13, will continue to have the right to confidential advice on contraception, condoms, pregnancy and abortion.**” (emphasis added)*

*Working within the Sexual Offences Act 2003 (HMSO 2004)*
20. For the purposes of this policy this means that young people have the right to expect confidential advice, contraception, pregnancy and abortion services, and all other sexual health services and treatment.
21. The Home Office guidance reinforces the legal position that sexual activity between young people is not normally to be the subject of prosecution, that the legislative bias is in favour of the maintenance of confidentiality, and that breach of that confidence will occur only in exceptional cases.
22. The younger the person, the greater the concern about abuse or exploitation. Therefore local policies and protocols reflect the need for social care practitioners to use their discretion in weighing up the circumstances of each individual case to determine whether a formal notification to the police is necessary. Policies which require automatic formal notification to the police may stop young people confiding in social care practitioners, including those most at risk of abuse.
23. It is important to recognise that the police may hold information about individuals who pose a danger to young people, which is not necessarily known to practitioners of other agencies.
24. There is an arrangement where agencies can request information from the police regarding any sexual partners of a young person in undertaking a risk assessment (see Appendix 8). Many organisations consider covertly seeking information in this

way to be contra to their professional guidance codes and ethics in relation to protecting confidentiality. Therefore most organisations will generally leave contact with the police for such information to the discretion of Children's Social Care as part of the section 47 process once a child protection referral has been made.

25. Maintaining the right balance between providing confidentiality and safeguarding young people is a complex and sensitive area of work, requiring clear policies for practitioners. This policy reflects **the need to judge each case individually** and includes procedural commitments to ensure:
  - arrangements for initial discussions about worrying disclosures with a senior colleague or designated Child Protection Officer (within the practitioners service) or member of the or Safeguarding Board without naming the young person concerned;
  - a clear protocol for **sharing information on a strictly need to know basis**, governed by the principle of promoting and safeguarding the young person 's health and welfare;
  - a requirement to inform the young person about what information will be given, to whom, and for what purpose and where and how it will be recorded
  - arrangements for providing the young person with appropriate counselling and support, both during and after any Section 47 enquiry and/or police investigation takes place.
26. As detailed in paragraph 15 Brook have been commissioned to provide young people's contraceptive and confidential sexual health services including increasing and improving young people's access to sexual health services by providing clinics in a number of Upper schools in Bedfordshire.
27. Where the relationship is one of exploitation practitioners will immediately want to refer to the: Children & Young People at Risk of Sex Exploitation protocol.<sup>13</sup>
28. Practitioners must be clear that the main centre of our contact with the young person is their health and well-being and the protocol is based on the core principle that the welfare of the child or young person is paramount. It emphasises the need for professionals to work together in accurately assessing the risk of significant harm when a child or young person is engaged in sexual activity and to minimise risks to them. It recognises the requirement to respect an individual's legal rights to privacy and confidentiality.

### Principles

29. That the policy provides the support and reassurance that practitioners want from their employers in relation to their active engagement of children and young people who are or may become sexually active and the advice, information and access to sexual health services they provide. The policy should also help practitioners in the steps of identifying potential sexual abuse and provide guidance on when to make a referral to children's social care.
30. That the policy provides the support and reassurance that practitioners want from their employers in relation to their active engagement of children and young people in the condom distribution scheme and Chlamydia testing.
31. That the policy has been developed fully in accordance with Working Together to Safeguard Children (2010) and that children's best interests must be the overriding

consideration in making any decisions with regard to child protection, safeguarding and their health and well-being.

32. The policy has also taken into account the range of ethical and professional guidance issued by the national bodies including the British Medical Association and the Royal College of Nursing, The General Pharmaceutical Council as well as the Family Planning Association and Brook. This is fundamental to ensure that the policy can be supported, agreed and complied with by the maximum number of agencies bodies and practitioners.
33. The policy is written on the understanding that those working with children and young people will naturally want to do as much as they can to provide a safe, accessible and confidential service whilst remaining aware of their duty of care to safeguard them and promote their well being. Where referral is necessary practitioners will want wherever possible to ensure that they have gained the support and explicit agreement of the young person to make such a referral
34. The policy is intended to assist practitioners avoid the confusion of genuine child protection concerns with the confidentiality which is owed to young people accessing sexual health services in line with the normal sexual development of young people.
35. It is designed to assist those working with children and young people to identify where these relationships may be abusive or coercive, and the children and young people may need protection (child protection procedures<sup>14</sup>) or the provision of additional services (including for example Child in Need procedures<sup>15</sup>).
36. Evidence shows that young people worry a great deal about the confidentiality of sexual health services, and this is one of the main reasons why they fail to seek advice. If young people are denied access to confidential services, this will close the opportunity to discuss sexual health and gain advice from the trained health professionals, as well as making them more vulnerable to unwanted pregnancies and sexually transmitted infections.
37. Both the law and professional guidance are clear that young people under the age of 16 including those under 13 are entitled to the same level of confidentiality as any adult should expect. This includes confidential advice and treatment when accessing sexual health services. Confidentiality may only be broken when the health, safety or welfare of the young person, or others, would otherwise be at grave risk<sup>16171819</sup>
38. That information relating to children and young people will only be collected and shared in full accordance with the main legal framework relating to the protection of personal information as set out in:
  - The Human Rights Act 1998, which incorporates Article 8 of the European Convention on Human Rights (ECHR), including the right to a private and family life
  - The common law duty of confidentiality
  - The Data Protection Act 1998: covering protection of personal information

An overview of the above legislation can be found at Appendix 4.

39. That all organisations and bodies should encourage and enable children and young people to access sexual health services in the knowledge that they will be treated in confidence except where there are genuine child protection concerns.

This is undertaken as one strand of the governments wider Teenage Pregnancy Strategy: Beyond 2010 (DCSF, DH 2010)

40. In accordance with Working Together to Safeguard Children (2010) and a range of professional bodies including the British Medical Association and the Royal College of Nursing the council will support practitioners in making the best possible judgement in each individual case based on their knowledge, skills and expertise as well as the facts of the case, but recognising that the younger the age of the young person, the greater will be the concerns to ensure that the sexual activity is not abusive or coercive.
41. That all practitioners are sufficiently knowledgeable and expected to engage in basic sexual health work with young people including basic educational activities and provision of information as well as signposting of children and young people to more comprehensive confidential sexual health services.
42. Where practitioners for religious or other reasons do not feel they can offer particular sexual health services to children or young people they must signpost the children or young people to other colleagues or comprehensive confidential sexual health services who can meet their needs.
43. That all practitioners involved in the provision of contraceptive advice, sexual health treatment, emergency contraception; Chlamydia screening, repeat issuing of condoms and, or NHS Bedfordshire's condom distribution scheme will have received and be able to evidence the particular training endorsed by their organisation which they have undertaken to support them to deliver the particular services they offer. The list of approved training providers can be found at Appendix 12.
44. That young people continue to receive and access sexual health services advice, treatment and support alongside any child protection referral that may be made.
45. That young people continue to receive and access the support and services they need to support continuation of pregnancy or termination. This will necessarily require addressing any school support required for the continuation of education. Brook, THT (Terence Higgins Trust) and bpas (British Pregnancy Advisory Service) can all provide non biased and non judgmental support to the young person in the decision making process in regards to continuing or not continuing with the pregnancy. Contact details of Brook, THT and bpas can be found at Appendix 12 of this document and in most directories.
46. That practitioners in accordance with best practice in seeking to share information or make a child protection referral will want to go to considerable lengths to gain the agreement of the young person to the sharing of information or child protection referral except where this may prejudice the case.

## Fraser Guidelines – Consent to Treatment

The *Fraser Guidelines*, also known as the Gillick Competency test. In 1980's the House of Lords ruled that young people under 16, who are fully able to understand what is proposed, and its implications, are competent to consent to medical treatment regardless of age.

In 1985, Wisbech Health Authority was taken to court for providing a minor with contraceptive treatment without parental knowledge<sup>20</sup>. The legality of someone under 16 years of age consenting to medical treatment had not been established at that time. Lord Fraser ruled in the High Court that a doctor could give contraceptive treatment or advice provided the following criteria were met.

That the child or young person(s)

- are mature enough to understand the advice and the implications of treatment
- cannot be persuaded to inform his/her parents, or to allow the practitioner to inform them
- is likely to begin or continue to have sex with or without treatment
- health (physical and/or mental) is likely suffer without treatment or advice
- best interests required the practitioner to give treatment or advice<sup>21</sup>.

Fraser competence can now be assessed by professionals other than a doctor. These criteria still apply. If a young person meets them they are termed 'Fraser ruling competent'. The principles of this judgement are now central to consenting minors for all health treatments.

A survey in Gwent<sup>22</sup> identified that 87% of teenagers under 14 years of age attending contraceptive clinics saw a nurse and clerk only. The Sexual Offences Act 2003 specifically allows a professional to provide sexual health care to minors provided the intention is to protect the minor from sexually transmitted infections, pregnancy, physical harm or to promote the minor's wellbeing. This ruling also applies to teachers, nurses and youth workers. Practitioners providing treatment to minors must continue to assess competence within the Fraser guidelines. Children under 13 years of age have the same rights as older people to seek confidential sexual health advice.

## Richard Report

The Richard report recommendations:

12 The Government should reaffirm the guidance in Working Together to Safeguard Children so that the police are notified as soon as possible when a criminal offence has been committed, or is suspected of having been committed, against a child – unless there are exceptional reasons not to do so.

13 National guidance should be produced to inform the decision as to whether or not to notify the police. This guidance could usefully draw upon the criteria included in a local protocol being developed by Sheffield Social Services and brought to the attention of the Inquiry.

Sir Michael also said in his report

“An alternative way forward would be to require social services, in all circumstances, to refer to the police cases when a criminal offence against a child has been committed, or is suspected of having been committed. I am reluctant, however, to recommend something that takes away all local discretion and that could lead to the referral of cases that were, for example, consensual, involving two young people either side of the age of consent”.

Moreover, an article in the Guardian on 22 June 2005 reports the following:

“Guidance from the London child protection committee (LCPC) requiring teachers, school nurses, doctors and social workers who discover or suspect that a teenager is sexually active to formally assess whether they were at risk of abuse, risked criminalising normal sexual relationships, said Sir Michael Richard.

Sir Michael said his inquiry's call for social workers to share concerns about underage sex with the police was not intended to cover "non-abusive teenage relationships".

He told SocietyGuardian.co.uk: "I was quite concerned not to be so heavy handed to bring into criminal jurisdiction non abusive teenage relationships, which is a danger."

## Information Sharing: further guidance on Legal issues

### The Human Rights Act 1998 and the European Convention of Human Rights

The European Convention on Human Rights has been interpreted to confer positive obligations on public authorities to take reasonable action within their powers (which would include information sharing) to safeguard the Convention rights of individuals. These rights include the right to life (Article 2), the right not to be subjected to torture or inhuman or degrading treatment (Article 3) and the right to liberty and security (Article 5).

Article 8 of the European Convention on Human Rights was incorporated into UK law by the Human Rights Act 1998 and recognises a right to respect private and family life:

- Article 8.1: Everyone has the right to respect for his private and family life, his home and his correspondence.
- Article 8.2: There shall be no interference by a public authority with exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of crime or disorder, protection of health and morals or for the protection of rights and freedoms of others.

Sharing confidential information may be a breach of an individual's Article 8 right: the question is whether sharing information would be justified under Article 8.2 and proportionate.

The right to a private life can be legitimately interfered with where it is in accordance with the law and is necessary, for example, for the prevention of crime or disorder, for public safety, for the protection of health or morals, or for the protection of the rights and freedoms of others. You need to consider the pressing social need and whether sharing the information is a proportionate response to this need and whether these considerations can override the individual's right to privacy. If a child or young person is at risk of significant harm, or an adult is at risk of serious harm, or sharing is necessary to prevent crime or disorder, interference with the individual's right may be justified under Article 8.

### The common law duty of confidentiality

The common law duty of confidentiality is explained in sections 3.12 to 3.16 of the cross-Government guidance *Information Sharing: Guidance for practitioners and managers*. The common law provides that where there is a confidential relationship, the person receiving the confidential information is under a duty not to pass on the information to a third party. However this duty is not absolute and information can be shared without breaching the common law duty if:

- the information is not confidential in nature; or
- the person to whom the duty is owed has given explicit consent; or
- there is an overriding public interest in disclosure; or

- sharing is required by a court order or other legal obligation.

### **The Data Protection Act 1998**

The Data Protection Act 1998 (DPA) deals with the processing of personal (both sensitive and non-sensitive) data. Personal data is data which relates to a living person, including the expression of any opinion or indication about the intentions in respect of the individual. Sensitive personal data is personal data relating to racial or ethnic origin, religious or other similar beliefs, physical or mental health condition, sexual life, political opinions, membership of a trade union, the commission or alleged commission of any offence, any proceedings for an offence committed or alleged to have been committed, the disposal of proceedings or the sentence of any court in proceedings.

Information about an individual will often contain information from several sources, for example from schools, doctors or the police and may contain their names and business addresses. It may also include information about other people, for example the individual's family members. These people are usually referred to in the DPA as 'third parties'. Information about third parties is personal information and should be treated accordingly.

If an individual is no longer alive their personal information is not covered by the DPA although a duty of confidence may require some or all of their personal information to be kept confidential.

## Working Together: Q&A on sexual activity of under 16s and under 13s

Working Together: Q&A on sexual activity of under 16s and under 13s

**Q.** Doesn't Working Together run counter to the Government's Teenage Pregnancy Strategy:

**A.** This guidance does not undermine the importance we place in young people being able to access confidential contraceptive advice. What it does is provide more detailed guidance to help professionals identify and support the minority of young people who are at risk of significant harm. These young people are much more likely to face a range of poor outcomes, including early pregnancy. If we are to really improve the lives of our most disadvantaged young people, agencies must work together to provide supportive early interventions. The effective implementation of this guidance will be through the development of local multi-agency protocols and establishing trust between professionals. The protocol developed by Cumbria and Lancashire is an excellent example of this and has been placed on the Every Child Matters website for others to learn from.

**Q.** Is the Government introducing mandatory reporting of sexual activity involving under 13-year olds?

**A.** No. It is a judgement for a professional to make, in which the child's interests are the overriding consideration. However, the guidance makes clear that it will always be necessary to discuss such a case with a child protection lead in the organisation and sets out a presumption that the case would be reported to children's social care. This is because sex with someone under 13 is a serious offence and indicates a risk of significant harm to the child. Local protocols which require mandatory reporting are not in accordance with Working Together.

**Q.** So you would automatically report without permission?

**A.** Not at all. In some cases of course young people may give permission for information to be shared, so the question of having to decide to breach confidentiality would not apply. It would always be a judgement on professionals though one informed by this guidance and by local protocols.

**Q.** Is the Government trying to criminalise sexual relationships involving under 13-16 year olds?

**A.** No. This guidance sets out a framework for safeguarding sexually active under 13-16 year olds from the harm they may face as a result of or associated with sexual activity – it sets out how professionals should judge when to share information. - and may be at risk from unsuitable partners. The police are among the agencies that are involved when there are concerns about a child's welfare but the key step in the first instance is a discussion between agencies to consider concerns and what if anything should be done in the best interests of the child. The police have confirmed that where an agency asks if they have any information about a person's sexual partner, they will normally share this information without beginning an investigation if an agency requests this.

**Q.** What about doctor/patient confidentiality?

**A.** Guidance on confidentiality has always been clear that confidentiality is not absolute. Professionals need to balance their duty of confidentiality to young people who access sexual services with the need to safeguard sexually active under 13/16 year olds.

**Q.** Surely practitioners should be allowed to use their professional discretion?

**A.** This guidance does not remove that discretion. It does not introduce mandatory reporting, but makes clear that decisions must always be made in the best interests of the child. What it does provide is a framework for looking at these issues.

**Q.** Won't this stop young people seeking contraceptive advice?

**A.** We fully recognise the importance young people place in confidentiality and want to reassure them that this guidance does not change the existing principles of confidentiality. However confidentiality has never been absolute. The Department of Health guidance makes clear that where a health professional believes a young person or others are at significant risk of harm, they should follow locally agreed child protection protocols. Working Together provides more detailed guidance as a framework for those protocols and to help all professionals, including health, to better identify and support young people most at risk.

**Q.** How does Working Together link with the cross-Government information sharing guidance?

**A.** Both sets of guidance make clear that information sharing and joint working are cornerstones of the Government's policy to ensure that children are effectively safeguarded. Both are also clear that where there is evidence or a reasonable cause to believe that children and young people are suffering from or at risk of suffering from significant harm then action must be taken.

**Q.** Surely this information should be passed/shared with to the police automatically?

**A.** Sharing of information must always be justified: for instance, if there is a risk of significant harm to a child or to other children. Conversely, there will be cases which do not justify disclosure, where few or no risk factors are present.

**Q** How can you justify keeping information about children who are having sex confidential from parents but not from services?

**A.** The provision of confidential contraceptive services is an established principle. While practitioners should always encourage young people to tell their parents that they are having sex, they will not themselves pass this information to parents. However, professionals may share information with other agencies if the child consents or if there is a public interest of sufficient force, such as where there is a clear risk of significant harm to a child.

**Q.** Surely parents have the right to know whether their underage children are having sex?

**A.** Children under the age of 16 have the same right to confidentiality as adults. Doctors and other health professionals are able to provide contraception, sexual and reproductive health advice and treatment to children without parental knowledge or consent.

**Q.** Is this guidance consistent with other Government guidance?

**A.** Yes, this is in line with the Department of Health's best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, reproductive and sexual health.

**Q.** How does this link to the Axon judgement?

**A.** The judgement in Mrs Axon's judicial review of the Department of Health's best practice guidance upheld the principle that confidential advice could be provided to young people under the age of 16.

**Q.** Do you need a child's permission to share confidential information about them with other agencies?

**A.** Practitioners will ask the child's permission before sharing information, but if the child refuses, they may still lawfully share information if there is a public interest of sufficient force, such as where there is a clear risk of significant harm to a child.

Teenage Pregnancy Unit/DfES

April 2006

## Sexual Offences Act 2003

1. The aim of the law is to protect the rights and interests of young people and make it easier to prosecute people who pressure or force others into having sex they don't want.
2. The Act **does not limit children's right to sex and relationships education and sexual health support and advice.**
3. The laws on sexual offences do not affect the ability of practitioners to provide confidential sexual health advice, information or treatment if it is in order to protect the young person from sexually transmitted infections or pregnancy, to protect their physical safety or to promote their emotional well-being. Practitioners who follow this guidance are protected and will not be guilty of an offence. This applies to anyone acting in the best interests of the young person such as health professionals, teachers, youth workers, personal advisors, social care professionals and parents.
4. Young people under 16, including those under 13, **can continue to seek sexual health and contraceptive information, advice or treatment in confidence**<sup>1</sup>. All professionals are encouraged to continue providing information and support in line with their organisations' agreed policies.
5. The aim of the Act is to protect young people from abuse or exploitation and the age of consent remains 16 for both boys and girls regardless of sexual orientation. There is **no intention to prosecute mutually agreed sexual activity between young people of a similar age where there is no evidence of exploitation or coercion**<sup>2</sup>. The statement below has been developed to explain the Act to young people and the Home Office has also produced a leaflet explaining the elements of the Act designed to protect children and families, which can be downloaded from.
6. For the purposes of the under 13 offences, whether the child consented to the relevant risk is irrelevant. A child under 13 does not, under any circumstances, have the legal capacity to consent to any form of sexual activity. This means that any penetrative sex will automatically be classified as rape and, except in the cases as in the previous paragraph where a charge is not in the public interest, there is no defence and the defendant could receive a maximum penalty of life in prison.
7. There are 2 briefing leaflets issued by the Home Office which in particular provide most of the guidance and information practitioners working with young people may need. The 2 short leaflets are particularly useful as they contextualise the Sexual Offences Act 2003 with guidance on the application of the act as opposed to some quotes from the act familiar to practitioners which have been used out of context in some other documents, which is particularly unhelpful to practitioners working with young people. The short leaflets are:
  - Working within the Sexual Offences Act 2003, (Home Office 2004).
  - Children and Families: Safer from Sexual Crime. The Sexual Offences Act 2003. (Home Office 2004).

<sup>1</sup> Working within the Sexual Offences Act 2003. (Home Office 2004)

<sup>2</sup> Children and Families: Safer from Sexual Crime. The Sexual Offences Act 2003 (Home Office 2004)

8. Working within the Sexual Offences Act 2003, (Home Office 2004). This leaflet sets out the main laws affecting those who work with children, and those who provide care services to people with mental disorders.
9. Children and Families: Safer from Sexual Crime. The Sexual Offences Act 2003. (Home Office 2004). This leaflet sets out the main laws designed to protect children and families including:
  - Protecting under 13s, under 16s and under 18s
  - Sexual activity with a child
  - Causing or inciting a child to engage in sexual activity
  - Engaging in sexual activity in the presence of a child
  - Causing a child to watch a sexual act
  - Meeting a child following sexual grooming
  - Arranging or facilitating a child sexual offence
  - Indecent photographs
  - Abuse of children through prostitution or pornography
  - Abuse of positions of trust
  - Offences by family members
  - Sexual activity with a child or family member
  - Inciting a child family member to engage in sexual activity
  - Sex between adult relatives
  - Keeping children safe
    - Your relationship
    - In the home
    - In the community
    - Cyber safety
10. The following statement for young people may help young people understand the Sexual Offences Act:

### **Sexual Offences Act (2003): Statement for young people**

In England and Wales, the law on Sexual Offences was updated in 2003. Under this law, the legal age for young people to consent to have sex is still 16, whether you are straight, gay or bisexual.

The aim of the law is to protect the safety and rights of young people and make it easier to prosecute people who pressure or force others into having sex they don't want. Forcing someone to have sex is a crime.

Although the age of consent remains at 16, it is not intended that the law should be used to prosecute mutually agreed teenage sexual activity between two young people of a similar age, unless it involves abuse or exploitation.

Under the Sexual Offences Act you still have the right to confidential advice on contraception, condoms, pregnancy and abortion, even if you are under 16.

But remember, whatever your age, you shouldn't have sex until you feel ready.

For more information about sex and relationships visit [www.ruthinking.co.uk](http://www.ruthinking.co.uk)

## Case Studies

### Case Study 1 - Natasha

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 discusses the situation with the named nurse for safeguarding, but they are unable to persuade Natasha to involve her parents and following the criteria and guidelines outlined by Lord Fraser in 1985 decide on balance that Natasha is capable of giving consent to treatment for her STI. The health practitioner 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 named nurse for safeguarding 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 named 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 named 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.

Information Sharing: Case Examples (HM Government) 2009

### **Case Study 2 - Natalie**

Natalie, a 14-year-old, attends a party, gets drunk and has unprotected sex with John, a 16-year-old from school whom she knows and ‘fancies’. This is her first experience of sex. While she did not enjoy it much she is pleased she is better informed about sex and does not regret it.

Her parents are strict Roman Catholics and she cannot tell them. The next day Natalie attends an Accident and Emergency (A&E) department for emergency hormonal contraception. The staff nurse tells her she cannot be treated without the consent of her mother. Four weeks later a home pregnancy test shows a positive result. Several weeks later Natalie confides in her 18-year-old sister, who instigates a referral for an abortion. The doctor in the clinic wants Natalie to inform her parents, but she feels she cannot. The sister thinks she ought to be able to sign the consent form on Natalie’s behalf.

In the example, Natalie’s sexual intercourse was illegal and John could be charged with rape, even though Natalie agreed to it. It could be argued that, since Natalie was drunk, John was reckless as to whether she consented. In practice, sexual encounters like Natalie’s and John’s are very common and are usually not exploitative. The police and Crown Prosecution Service will only get involved if someone lodges a complaint about the sexual activity and, even then, unless one of the partners alleges assault or there is clear evidence of exploitation, it is unlikely the case would be taken further.

The nurse in the A&E department was wrong to say that Natalie could not be treated without her mother’s consent. Emergency hormonal contraception is safe, simple to take and without significant side effects. Any teenage girl who has found her way to an A&E department for treatment has the capacity to understand that emergency hormonal contraception is likely, but not guaranteed, to prevent pregnancy. In the example, Natalie has already had intercourse and, clearly, her best interests were to receive treatment. The nurse only had to discuss parental involvement and the Fraser guidelines would have been met. Even if Natalie had been 12 years old the same would have been true. The application of the Fraser guidelines in issuing sexual health advice or treatment is quite separate from identifying unlawful sex or abuse.

Assessing capacity to consent to an abortion is more complicated because the risks of an abortion are greater than emergency hormonal contraception and harder to understand. According to the General Medical Council, competence is demonstrated if the young person is able to:

- understand the proposed treatment, its purpose and nature and why it is being proposed
- understand the risks, benefits and alternatives
- understand in broader terms what the consequences of treatment will be
- retain the information long enough to make a decision.

However, it is not unreasonable to expect an intelligent 15-year-old to understand more than a normally developed 16-year-old who, in law, is presumed competent to give consent. Clinicians may want parental involvement so that the young person can have parental support after an abortion. The need for support, however, is a different issue to getting consent. If the girl is Fraser competent and does not want her parents to be involved the clinician must respect her wishes. In the example, if Natalie can understand the implications of the treatment then she should be allowed to sign her own consent form. If she cannot sign, then the only people who can agree to the procedure on her behalf are those with parental responsibility or a court. Her sister cannot do so.

*Risk management Young People and the Fraser guidelines: confidentiality and consent.*

*(The Obstetrician & Gynaecologist) 2006;8:235-239*

## Police Information Request/Referral Process

### Principles

- The need to safeguard and promote the welfare of children and young people is paramount;
- Children and young people have a right to protection, and a right to access the criminal justice system;
- Positive outcomes for children and young people are maximised when agencies work together and co-ordinate their activity.

### Requests for Police Information

In cases where an agency requests information from the police for the purposes of a risk assessment, the police will:

1. Receive the information
2. Search relevant indices and pass the results to legitimate enquirers
3. The fact of the request and details provided will be recorded for intelligence purposes only. Such requests will not be treated as allegations of crime referrals.
4. Depending on the result, the enquirer may then make a subsequent referral.

### Referrals to Police

In cases where an agency contacts the Police with an allegation of crime or potential crime, the Police will:

1. Receive the information and create allegation of crime report
2. Pass to the relevant investigating unit
3. Assess the need for emergency action to protect a child or young person
4. Research information held internally
5. Make a referral to the local Children Social Care according to BBSCB & CBSCB Interagency Procedures (the original referrer should already have contacted Children Social Care).
6. Share relevant information and participate in an initial strategy discussion with Children Social Care, Consultant Paediatrician and the referring professional.
7. Conclude the investigation and decide, in consultation with the Crown prosecution Service, an appropriate criminal justice disposal, taking into account the wishes of the victim, the public interest, and the views of relevant professionals who are working with the child or young person.

## Template Information Request Form

To: Agency

From: Name of Practitioner and Assessing Agency

I am conducting an assessment on a child or young person where there are safeguarding concerns that they are sexually active.

I am contacting you to find out whether you have any information about the following people that may be relevant to my assessment.

I am particularly concerned to know whether you have information that would indicate that any of these people would constitute a significant risk to children or young people in the context of a sexual relationship.

Person A: (some or all of – name, street name, alias, age/DoB, address).

Person B: (some or all of – name, street name, alias, age/DoB, address).

Person C: (some or all of – name, street name, alias, age/DoB, address).

Continue as necessary

Please could you let me know whether you have information in one or more of the following categories:

1. One or more of these people may pose a significant risk to children and Young people in the context of a sexual relationship. A referral should be made to enable the sharing of relevant information. Consent will not be required.
2. One or more of these people may be particularly vulnerable to sexual exploitation. A referral should be made. Consent will be required from subject(s) .... before relevant information can be shared.
3. One or more of these people may have additional needs. Consideration should be given to arranging an assessment using the Common Assessment Framework. Consent will be required from subject(s) .... before relevant information can be shared.
4. No relevant information is held on any of these people on the information provided.

## Code for Crown Prosecutors - Considerations

The public interest requires the prosecution of an offence of unlawful sexual intercourse with a girl/boy under 13 unless exceptional circumstances exist.

You may exercise considerable discretion in relation to offences under Section 6 of the 2003 Sexual Offences Act.

The age of the defendant will be highly relevant. Even if the defendant is over 24, a prosecution may not be in the public interest if he had reasonable cause for believing that the girl/boy was over 16.

The following factors will also be relevant:

- the relevant ages of the parties;
- the emotional maturity of the girl/boy and whether she entered into a sexual relationship willingly;
- the relationship between the parties and whether there was an existence of a duty of care or breach of trust **<refer to Sexual Offences - Abuse of Trust, elsewhere in this guidance>**.

In summary, a man/woman who is considerably older than the girl/boy is likely to be prosecuted, especially if he/she owed her/him a duty of care; whereas it may not be necessary to prosecute a young man/woman with whom the girl/boy has been having a consensual relationship.

The Serious Case Review for Child J had issues in relation to the CPS's decisions making around these issues so please access the Executive Summary at <http://www.bedfordshirelscb.org.uk/publications.php>.

## Best Practice Guidance for Doctors and other Health Professionals

### SUMMARY

This revised guidance replaces HC (86) 1/HC (FP) (86) 1/LAC (86) 3 which is now cancelled.

Doctors and health professionals have a duty of care and a duty of confidentiality to all patients, including under 16s.

This guidance applies to the provision of advice and treatment on contraception, sexual and reproductive health, including abortion. Research has shown that more than a quarter of young people are sexually active before they reach 16<sup>3</sup>.

Young people under 16 are the group least likely to use contraception and concern about confidentiality remains the biggest deterrent to seeking advice. Publicity about the right to confidentiality is an essential element of an effective contraception and sexual health service.

The Government's ten year Teenage Pregnancy Strategy, launched in 1999, set a goal to halve the under 18 conception rate by 2010. This is a Department for Education and Skills Public Service Agreement jointly held with the Department of Health. Progress towards meeting local under-18 conception rate reduction targets is one of the NHS Performance Indicators for Primary Care Trusts (PCT).

The contribution of PCTs to improving young people's access to contraceptive and sexual health advice is a key element of all local Teenage Pregnancy Strategies, linked to implementation of the Sexual Health and HIV Strategy, and is performance managed by Strategic Health Authorities.

The Sexual Offences Act 2003 does not affect the duty of care and confidentiality of health professionals to young people under 16.

### ACTION

PCT commissioners and clinical governance leads should bring this guidance to the attention of all health professionals responsible for the care of young people in any setting.

All services providing contraceptive advice and treatment to young people should:

- Produce an explicit confidentiality policy making clear that under 16s have the same right to confidentiality as adults.
- Prominently advertise services as confidential for young people under-16, within the service and in community settings where young people meet.
- Health professionals who do not offer contraceptive services to under-16s should ensure that arrangements are in place for them to be seen urgently elsewhere.

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<sup>3</sup> Wellings, K., Nanchahal, K., Macdowall, W., McManus, S., Erens, R., et al. (2001) Sexual Behaviour in Britain: early heterosexual experience. *Lancet* 358: 1843-50

- Directors of Social Services should ensure that social care professionals working with young people are aware of this guidance and the Teenage Pregnancy Unit guidance – ‘Enabling young people to access contraception and sexual health information and advice: the legal and policy framework for social workers, foster carers and other social care practitioners’.

### CONFIDENTIALITY

The duty of confidentiality owed to a person under 16, in any setting, is the same as that owed to any other person. This is enshrined in professional codes<sup>4</sup>.

All services providing advice and treatment on contraception, sexual and reproductive health should produce an explicit confidentiality policy that reflects this guidance and makes clear that young people under 16 have the same right to confidentiality as adults.

Confidentiality policies should be prominently advertised, in partnership with health, education, youth and community services. Designated staff should be trained to answer questions. Local arrangements should provide for people whose first language is not English or who have communication difficulties.

Employers have a duty to ensure that all staff maintain confidentiality, including the patient’s registration and attendance at a service. They should also organise effective training<sup>5</sup> which will help fulfil information governance requirements.

Deliberate breaches of confidentiality, other than as described below, should be serious disciplinary matters. Anyone discovering such breaches of confidentiality, however minor, including an inadvertent act, should directly inform a senior member of staff (e.g. the Caldicott Guardian) who should take appropriate action.

The duty of confidentiality is not, however, absolute. Where a health professional believes that there is a risk to the health, safety or welfare of a young person or others which is so serious as to outweigh the young person’s right to privacy, they should follow locally agreed child protection protocols, as outlined in *Working Together to Safeguard Children*. In these circumstances, the over-riding objective must be to safeguard the young person.

If considering any disclosure of information to other agencies, including the police, staff should weigh up against the young person’s right to privacy the degree of current or likely harm, what any such disclosure is intended to achieve and what the potential benefits are to the young person’s well-being.

Any disclosure should be justifiable according to the particular facts of the case and legal advice should be sought in cases of doubt. Except in the most exceptional of circumstances, disclosure should only take place after consulting the young person and offering to support a voluntary disclosure.

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<sup>4</sup> Confidentiality: protecting and providing information. General Medical Council, London. 2004. Code of professional conduct. Nursing and Midwifery Council 2002

<sup>5</sup> An example of an effective training resource is ‘Confidentiality and young people: improving teenager’s uptake of sexual and other health advice’. The Royal College of General Practitioners, the British Medical Association, the Royal College of Nursing and the Medical Defence Union endorse this publication.

## DUTY OF CARE

Doctors and other health professionals also have a duty of care, regardless of the patient age<sup>6</sup>.

A doctor or health professional is able to provide contraception, sexual and reproductive health advice and treatment, without parental knowledge or consent, to a young person aged under 16, provided that:

- She/he understands the advice provided and its implications.
- Her/his physical or mental health would otherwise be likely to suffer and so provision of advice or treatment is in their best interest.

However, even if a decision is taken not to provide treatment, the duty of confidentiality applies, unless there are exceptional circumstances as referred to above.

The personal beliefs of a practitioner should not prejudice the care offered to a young person. Any health professional who is not prepared to offer a confidential contraceptive service to young people must make alternative arrangements for them to be seen, as a matter of urgency, by another professional. These arrangements should be prominently advertised.

### **Good practice in providing contraception and sexual health to young people under 16**

It is considered good practice for doctors and other health professionals to consider the following issues when providing advice or treatment to young people under 16 on contraception, sexual and reproductive health.

If a request for contraception is made, doctors and other health professionals should establish rapport and give a young person support and time to make an informed choice by discussing:

- The emotional and physical implications of sexual activity, including the risks of pregnancy and sexually transmitted infections.
- Whether the relationship is mutually agreed and whether there may be coercion or abuse.
- The benefits of informing their GP and the case for discussion with a parent or carer. Any refusal should be respected. In the case of abortion, where the young woman is competent to consent but cannot be persuaded to involve a parent, every effort should be made to help them find another adult to provide support, for example another family member or specialist youth worker.
- Any additional counselling or support needs.

Additionally, it is considered good practice for doctors and other health professionals to follow the criteria outlined by Lord Fraser in 1985, in the House of Lords' ruling in the case of *Victoria Gillick v West Norfolk and Wisbech Health Authority and Department of Health and Social Security*. These are commonly known as the Fraser Guidelines:

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<sup>6</sup> Confidentiality: protecting and providing information. General Medical Council, London. 2004. Code of professional conduct. Nursing and Midwifery Council 2002

- the young person understands the health professional's advice;
- the health professional cannot persuade the young person to inform his or her parents or allow the doctor to inform the parents that he or she is seeking contraceptive advice;
- the young person is very likely to begin or continue having intercourse with or without contraceptive treatment;
- unless he or she receives contraceptive advice or treatment, the young person's physical or mental health or both are likely to suffer;
- the young person's best interests require the health professional to give contraceptive advice, treatment or both without parental consent.

### **SEXUAL OFFENCES ACT 2003**

The Sexual Offences Act 2003 does not affect the ability of health professionals and others working with young people to provide confidential advice or treatment on contraception, sexual and reproductive health to young people under 16.

The Act states that, a person is not guilty of aiding, abetting or counselling a sexual offence against a child where they are acting for the purpose of:

- protecting a child from pregnancy or sexually transmitted infection
- protecting the physical safety of a child
- promoting a child's emotional well being by the giving of advice.

In all cases, the person must not be causing or encouraging the commission of an offence or a child's participation in it. Nor must the person be acting for the purpose of obtaining sexual gratification.

This exception, in statute, covers not only health professionals, but anyone who acts to protect a child, for example teachers, Connexions Personal Advisers, youth workers, social care practitioners and parents.

Department of Health 2004

## Contact details:

### **Paragraph 43 - Approved Training providers**

All practitioners involved in the provision of contraceptive advice, sexual health treatment, emergency contraception; Chlamydia screening, repeat issuing of condoms and, or NHS Bedfordshire's' condom distribution **scheme** will have received and be able to evidence the particular training endorsed by their organisation which they have undertaken to support them to deliver the particular services they offer.

#### **Approved Training Providers**

- Brook and the Terence Higgins Trust
- Department of Health
- Family Planning Association (FPA)
- NHS (i.e., NHS Bedfordshire provides Sexual Health training that enables professionals and organisations to sign up to deliver the Condom Distribution scheme; Undercover)
- Royal College of Nursing (RCN) and Royal College Of Midwives (RCM)

**If you are unsure as to the validity of the training that you or your staff have attended, please contact the Sexual Health Team at NHS Bedfordshire on 01525 636928 or 01525 636701**

#### **Distributing Condoms via the NHS Bedfordshire Condom Distribution Scheme**

All professionals distributing condoms via the NHS Bedfordshire Condom Distribution Scheme must sign a code of conduct and their organisation sign up to the terms and conditions of distribution. For further information please contact the Sexual Health Team at NHS Bedfordshire on 01525 636928 or 01525 636701

### **Paragraph 45 – Independent services to support continuation of pregnancy or termination**

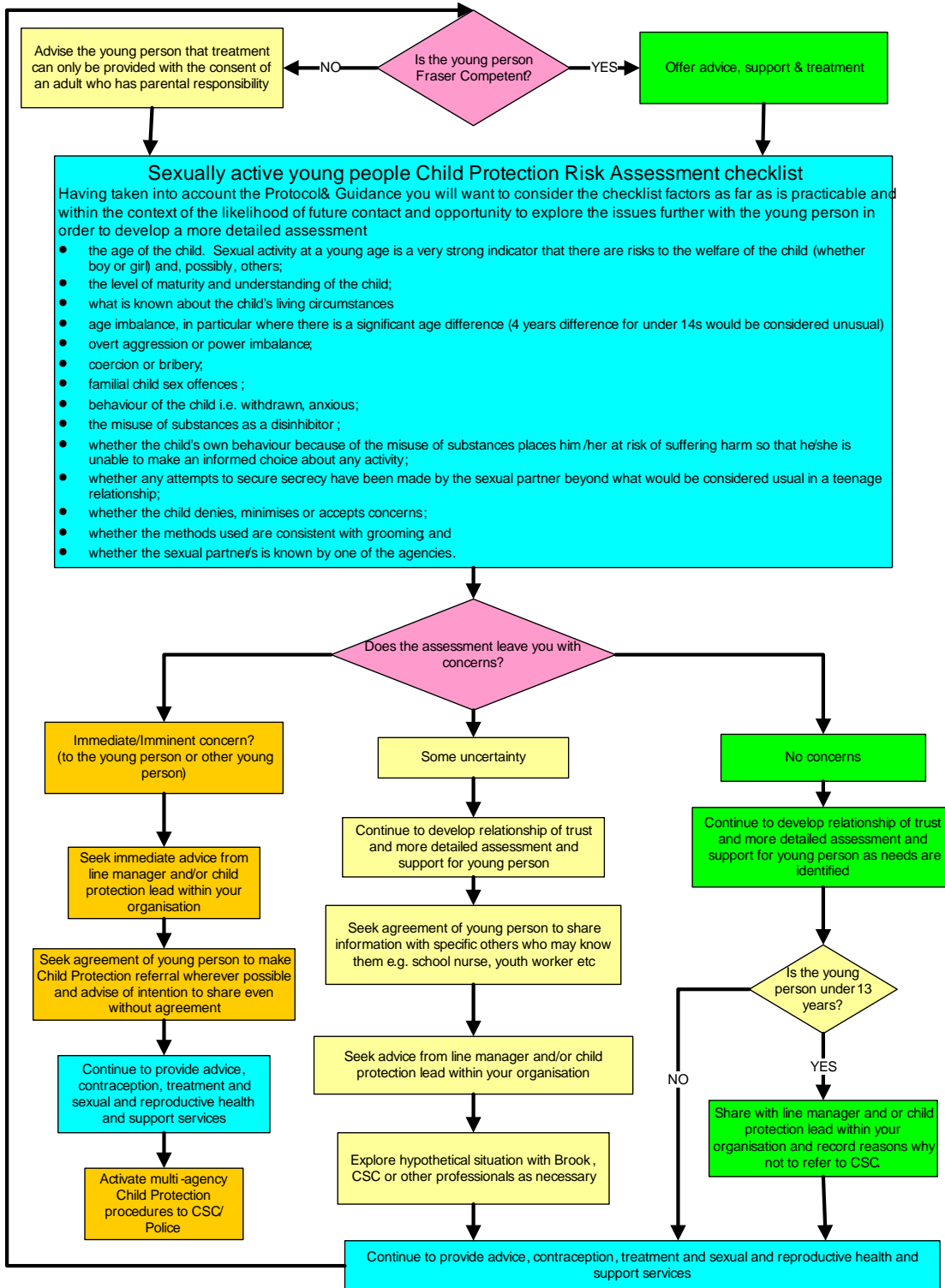
**Brook clinics – Under 25 year olds: Brook Bedfordshire: 01234 761090**

**Terrence Higgins Trust clinics – all ages: Terrence Higgins Trust: 01234 761080**

Patients registered with an NHS Bedfordshire GP can be referred by a health Professional or self refer for NHS funded services via:

**BPAS Action Line - 08457 304030**

Checklist for Practitioners working with sexually active young people (under 18s)



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## **Endnotes**

- <sup>1</sup> Working Together 5.20
- <sup>2</sup> Brahams D. House of Lords rules DHSS guidance on contraception lawful. *Lancet* 1985;2:959–60
- <sup>3</sup> Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health
- <sup>4</sup> Sexual Offences Act 2003 (HMSO 2003)
- <sup>5</sup> Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health
- <sup>6</sup> Working Together 5.27
- <sup>7</sup> Audit of under-14s who attend sexual health clinics in Gwent: Identifying young people at risk of abuse and exploitation. Cook L, Fleming C, *Journal of Family Planning and Reproductive Health Care* 2006 in press
- <sup>8</sup> Wellings K, Nanchahal K, Macdowall W, McManus S, Erens R, Mercer CH et al. Sexual behaviour in Britain: early heterosexual experience. *Lancet* 2001; 358:1843-50
- <sup>9</sup> Working Together 5.20
- <sup>10</sup> Working Together 5.19
- <sup>11</sup> LSCB Protocols on sharing information about underage sexual activity. Letter to All Chairs of Local Safeguarding Children Boards in England, 28<sup>th</sup> August 2007.
- <sup>12</sup> Working within the Sexual Offences Act 2003 (HMSO 2004)
- <sup>13</sup> Beds & Luton Protocol for Children & Young People at Risk of Sex Exploitation, July 2010 (Bedfordshire LSCB)
- <sup>14</sup> Bedfordshire, Cambridgeshire, Luton, Peterborough, Safeguarding Inter-Agency Procedures, June 2008 (Bedfordshire LSCB) and Voluntary & Community Sector (VCS) Safeguarding Children Resource Pack, October 2007 (Bedfordshire LSCB)
- <sup>15</sup> Bedfordshire Child in Need Procedures, October 2008 (Bedfordshire LSCB)
- <sup>16</sup> Confidentiality (GMC 2009)
- <sup>17</sup> 0-18 years: guidance for all doctors (GMC 2007)
- <sup>18</sup> The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives (NMC 2008)
- <sup>19</sup> Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children (HMSO 1999)
- <sup>20</sup> Gillick versus West Norfolk and Wisbech AHA 1986 AC112
- <sup>21</sup> Brahams D. House of Lords rules DHSS guidance on contraception lawful. *Lancet* 1985;2:959–60
- <sup>22</sup> Cook L, Fleming C. Audit of under-14's who attend sexual health clinics in Gwent: identifying young people at risk of abuse and exploitation. *Journal of Family Planning and Reproductive Health Care* 2006 in press.