General Medical Council

GMC response to HM Government's *Reporting and acting* consultation

October 2016

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

We have concerns about introducing a mandatory reporting duty on individual professionals and it is not clear to us that the evidence is sufficient to justify adopting this approach. We agree with the potential risks and benefits of this approach as set out in the consultation document and we feel that overall, the risks outweigh the benefits. In addition, we are concerned about the possible implications of removing professional judgement from disclosure decisions.

All doctors must follow our guidance on child protection, which applies across the UK (http://www.gmc-uk.org/guidance/ethical_guidance/13257.asp). While they do of course have a duty of confidentiality to their patients, they must report child protection concerns to an appropriate organisation (e.g. local authority children's services, NSPCC or the police) unless there are exceptional reasons to believe that doing so would not be in the child or young person's best interests. Such decisions must be taken cautiously, and only in circumstances where the increased risk to the safety or welfare of the child or young person clearly outweighs the benefits of sharing information. We would also expect the doctor to take appropriate advice (for example from a named or designated professional) and to make a record of the reasons for the decision, and any advice taken.

Under a mandatory reporting system, doctors would have no scope to exercise any judgement or discretion about the action they take, however, and may feel driven to act against what they consider to be the child's best interests. When we asked doctors last year about mandatory reporting in a short, self-selecting survey we circulated via our regular newsletter and at a range of different events, 58 percent said that they were unsure about mandatory reporting because each case is different and professional judgement is important (n=664). A further 13 percent were opposed to it, saying it would do more harm than good. 26 percent were in favour of a mandatory reporting scheme and 3 percent did not answer the question.

Child protection is a difficult area of practice that can involve making decisions that are emotionally challenging, complicated by uncertainty and sometimes go against the wishes of parents or other family members. We expect doctors to work with families as far as possible, to discuss any concerns they may have and to seek consent for sharing information unless there are compelling reasons not to do so, but doctors must put the interests of the child or young person first.

We want to see a legislative framework that supports and encourages good practice, and which focuses the minds of professionals on what is the best course of action for a child or young person. As the consultation document acknowledges, a mandatory duty to report focuses professionals' attention on reporting, rather than on the more complex question of what interventions or support are appropriate for the child or young person. There is also a risk that introducing a mandatory duty to act on individual practitioners could undermine the collaborative, multi-agency approach needed to best serve children's needs.

7. Please outline any risks or benefits regarding the introduction of a duty to act that haven't been articulated in the consultation.

We are not in a position to judge whether or not new legislation to introduce a statutory duty to report or act on child abuse or neglect is necessary or desirable at this time. As noted in the consultation document, however, this is not a step that should be taken lightly. If such a duty is introduced it is important to minimise the risks of unintended, adverse consequences that may occur as a result.

In our view, the possible risks of mandatory reporting are more significant than those of a duty to act. As we understand it, a duty to act would allow those who are bound by the duty to exercise discretion about not only what action is appropriate, but what action it is appropriate for them – in their particular role and circumstances – to take. Given the range of different roles that may be covered by any new duty, this seems sensible. For example in some circumstances, perhaps particularly for those in support roles, the appropriate action to take may be raising a concern with a senior or specialist colleague, rather than making a report directly to the local authority.

As it is described in the consultation document, the duty to act would allow doctors to continue to use their judgement to act in the best interests of a child and appears to be more closely in line with the principles in our guidance than a simple duty to make a report. The duty to continue to act after a report has been made (if a report is made) is consistent with our guidance, which expects doctors to escalate their concerns to the next level of authority if they feel that their concerns have not been appropriately acted upon or that a child is still at risk.

Should a duty to act be written into legislation, it will need to be carefully considered and worded to make sure that it is clear what is expected and how individuals will know that they have discharged the duty. Given the importance of getting the detail right, the Government should consider consulting further on any statutory guidance or regulations that would accompany a duty to act, should that be the approach that is chosen.

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

We are not in a position to provide detailed comments on the proposed scope of any new duty, but it is important that the scope is clear and well-understood.

The definition of abuse must be sufficiently articulated for professionals to understand what is expected of them, and to ensure a proportionate response while minimising unintended consequences.

We note that the Government's response to the recent consultation on the definition of child sexual exploitation has not yet been published and in our response to that consultation we made some suggestions about the wording of that definition. In particular, we felt that the proposed definition could capture behaviour occurring in the course of relationships that are not intended to be caught within it.

In the case of a mandatory reporting duty, drawing the scope of the duty too broadly would make more likely an increase in referrals that are inappropriate or that do not meet the threshold for the local authority to take action.

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

We are firmly of the view that a new statutory measure should not extend to adults without a full public consultation on this question. This consultation document provides no information about the existing legislation or current mechanisms for adult safeguarding, or any discussion of the relevant issues risks or benefits for that group of individuals.

We therefore feel strongly that any new duty must not be extended to cover vulnerable adults without a full, separate public consultation that includes a clear analysis of the current legal position, the possible consequences of introducing new legislation in this area, as well as a clear definition of vulnerable adults and discussion of existing mechanisms for protecting those who are at risk.

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

It is outside of our remit to advise on the activities that might fall within the proposed scope, but we note the need to proceed cautiously to avoid unintended consequences. It is vital that those bound by any new duty have sufficient training so that they have the knowledge and understanding to implement it effectively.

16. Please provide further information about the reasons for your answers to the above questions on scope, accountability and sanctions, if you would like to do so.

When considering the possible sanctions available for a failure to follow a new duty, it is important to avoid penalising individuals for organisational failings and to make sure that such a duty does not inadvertently discourage desirable behaviours. For example, as it currently stands, the mandatory reporting proposal would allow for the possibility of applying criminal sanctions to any case in which there was a failure to report, including where this failure was accidental. There is a danger that this could create a culture of fear and could make it more difficult for professionals to admit mistakes or discuss issues openly, meaning that training needs or learning opportunities may not be identified or acted upon.

Doctors are already bound by our guidance and failure to report or otherwise act on child abuse or neglect would already raise questions about a doctor's fitness to practise.

When a serious concern is raised about a doctor, we investigate to see if the doctor is putting the safety of patients, or the public's confidence in doctors, at risk. We collect and review evidence, such as witness statements and reports from experts in clinical matters. We also consider any mitigating or aggravating factors, the current risk that the doctor poses, and whether taking action is in the public interest – for example, to protect patients, maintain public confidence in doctors and to uphold proper standards of conduct and behaviour.

Following the investigation we may issue advice or a warning to the doctor, or we may agree with the doctor that he or she will restrict their practice, retrain or work under supervision.

In some cases, we will refer the case to the Medical Practitioners' Tribunal Service (MPTS) for a hearing. When action is needed to protect the public or to maintain public confidence in doctors, an MPTS panel can suspend a doctor's right to work, or restrict their practice – for example by requiring them to work under supervision, or undergo further training. If necessary, a panel can also suspend or restrict a doctor's right to work while the investigation is conducted. In a few very serious cases, a doctor may be removed from the medical register.

If a failure to meet a new duty to report or act on child abuse or neglect were made a criminal offence, then a conviction for such a failure would increase the likelihood of a finding of impairment and sanction. Convictions are dealt with in a specific way under our fitness to practise procedures and we do not need to re-prove the underlying conduct as a certificate of conviction is conclusive proof that the doctor committed the offence. The likely sanction would depend on the circumstances surrounding the conviction and any aggravating or mitigating circumstances.

DBS sanctions could ensure a consistent approach whether or not the individual is a regulated professional, but it is important that any measures taken are proportionate.

There must be a consistent threshold for barring a doctor for failure to report abuse and this should be based on evidence that the doctor poses a risk of harm to vulnerable groups. Furthermore, if the DBS considered that a doctor presented such a significant risk to vulnerable patients that he or she should be placed on the 'barred list' then questions will also be raised about the doctor's fitness to practise, and the doctor should be referred to us.

17. Please detail any additional information that you feel should be taken into account in this consultation.

Should a new duty be introduced, we recommend the Government considers carefully how the new duty should interact with the existing requirement to report FGM. A new duty to act may sit reasonably straightforwardly alongside the FGM mandatory reporting model, with reporting FGM to the police representing one example of appropriate action in response to a known case of abuse, but it may be more complex if a new mandatory reporting duty is introduced.

While there are some similarities between the two mandatory reporting models, there are also significant differences, as the FGM reporting duty requires professionals to report only known cases of FGM and to report to the police rather than to the local authority. Maintaining two separate systems may increase the risk of confusion and this may affect the success of the duty.

We also recommend that the Government looks closely at how the FGM mandatory reporting duty has been and is being implemented, and considers carefully in advance how any new duty will be implemented, measured and evaluated to make sure that it is achieving its aims.

In particular, we note that the procedural guidance that accompanies the FGM duty was developed very quickly and with limited consultation. Any further detailed guidance that sits alongside either proposed duty should be subject to proper consultation and ongoing evaluation, and the policy should be subject to further development depending on the outcome of that evaluation.