PROTOCOL FOR PROFESSIONALS WORKING WITH SEXUALLY ACTIVE YOUNG PEOPLE UNDER THE AGE OF 18 IN SHROPSHIRE AND HEREFORDSHIRE

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Introduction.

This protocol has been devised with the understanding that most young people under the age of 18 will have an interest in sex and sexual relationships.

It is designed to assist those working with children and young people to identify where these relationships may be abusive, and the children and young people may need the provision of protection or additional services.

It is based on the core principle that the welfare of the child or young person is paramount, and 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.

All agencies which have contact with children and young people should use this protocol to develop and implement local protocols for their own staff.

1. Assessment

1.1 In assessing the nature of any particular behaviour, it is essential to look at the facts of the actual relationship between those involved. Power imbalances are very important and can occur through differences in size, age and development and where gender, sexuality, race and levels of sexual knowledge are used to exert such power. (Of these, age may be a key indicator, e.g. a 15 year old girl and a 25 year old man). There may also be an imbalance of power if the young person's sexual partner is in a position of trust in relation to them e.g. teacher, youth worker, carer etc. In the assessment, workers need to include the use of sex for favours e.g. exchanging sex for clothes, cds, trainers, alcohol, drugs, cigarettes etc. Young people could also have large amounts of money or other valuables which cannot be accounted for.

1.2 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. Staff need to be aware that the Sexual Offences Act 2003 recognises the rights of people with a mental disorder to a full life, including a sexual life. However, there is a duty to protect them from

abuse and exploitation. The Act includes 3 new categories of offences to provide additional protection (Appendix 1)

1.3 In order to determine whether the relationship presents a risk to the young person, the following factors should be considered. This list is not exhaustive and other factors may be needed to be taken into account -

1.3.1 Whether the young person is competent to understand and consent to the sexual activity they are involved in using the test outlined in the Fraser guidelines (Gillick Competent) – see 1.4.

1.3.2 The nature of the relationship between those involved, particularly if there are age or power imbalances as outlined above

1.3.3 Whether overt aggression, coercion or bribery was involved including misuse of substances/alcohol as a disinhibitor

1.3.4 Whether the young person's own behaviour, for example through misuse of substances, including alcohol, places them in a position where they are unable to make an informed choice about the activity

1.3.5 Any issues of culture, gender and ethnicity which may impact on the young person.

1.3.6 Any attempts to secure secrecy by the sexual partner beyond what the professional would recognise as usually occurring in a teenage relationship

1.3.7 Whether the sexual partner is known by the agency as having other concerning relationships with similar young people in which case the police should be notified

1.3.8 If accompanied by an adult, does that relationship give any cause for concern?

1.3.9 Whether the young person denies, minimises or accepts concerns

1.3.10 Whether methods used to secure compliance and/or secrecy by the sexual partner are consistent with behaviours considered to be 'grooming'(Appendix 1)

1.3.11 Whether sex has been used to gain favours (e.g. swap sex for cigarettes, clothes, cds, trainers, alcohol, drugs etc.)

1.3.12 The young person has a lot of money or other valuable things which cannot be accounted for.

1.4 It is considered good practice for workers to follow the Fraser guidelines when discussing personal or sexual matters with a young person under 16. The Fraser guidelines are complimentary to the concept of Gillick competence, but are specific to those providing advice and treatment to young people under 16 years of age. These hold that sexual health services can be offered without parental consent providing that;

1.4.1 The young person understands the advice that is being given

1.4.2 The young person cannot be persuaded to inform or seek support from their parents, and will not allow the worker to inform the parents that contraceptive/protection, e.g. condom advice is being given

1.4.3 The young person is likely to begin or continue to have sexual intercourse without contraception or protection by a barrier method

1.4.4 The young person's physical or mental health is likely to suffer unless they receive contraceptive advice or treatment

1.4.5 It is in the young person's best interest to receive contraceptive/safe sex advice and treatment without parental consent

1.4.6 The young person's wishes and feelings should always be taken into account when professionals are making decisions which affect them.

2. Process

The following assessment process should be undertaken in accordance with the following documents:

2.1.1 The Framework for Assessment, with due regard to the particular factors identified in this protocol at 1.4.

2.1.2 Department of Health Best Practice Protocol for Doctors and other Health Professionals on the provision of Advice and Treatment to Young People Under 16 On Contraception, Sexual, and Reproductive Health. (Appendix 2)

2.1.3 Working Together (2006)

2.1.4 Shropshire and Herefordshire Safeguarding Board's Inter Agency Child Protection Procedures for Safeguarding Children

2.1.5 The Common Assessment Framework [CAF] and, for Shropshire, the ISA Toolkit

2.1 In working with young people, it must also be made clear to them that absolute confidentiality cannot be guaranteed, and that there will be some circumstances where the needs of the young person can only be safeguarded by sharing information with others. Ref: Information sharing; Practitioner's Guide, Working Together 2006, and, in Shropshire, the ISA Toolkit.

See: www.ecm.gov.uk/informationsharing

This discussion with the young person may prove useful as a means of emphasising the gravity of some situations; however the consent of the young person should always be gained wherever possible.

2.2 On each occasion that a young person is seen by an agency, consideration should be given as to whether their circumstances have changed or further information has been given which may lead to the need for referral or re-referral. In Shropshire, the child index will show where other agencies have been involved,

provision of services, and whether there is currently a lead professional.

2.3 In some cases urgent action may need to be taken to safeguard the welfare of a young person. However, in most circumstances there will need to be a process of information sharing and discussion in order to formulate an appropriate plan. There should be time for reasoned consideration to define the best way forward. Anyone concerned about the sexual activity of a young person should initially discuss this with the person in their agency responsible for child protection. There may then be a need for further consultation with the Team Manager of the Initial Assessment Team in your area. All discussions should be recorded, giving reasons for action taken and who was spoken to.

It is important that all decision making is undertaken with full professional consultation, never by one person alone (agency procedures must include Protocol on how this is to be undertaken within their own organisation).

2.4 When a referral is received by an Initial Assessment Team, enquiries will be made, followed by a Strategy Discussion with partner agencies including the Police. 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.

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, Children and Young People's Services and other agencies may hold vital information that will assist in an assessment of risk.

2.5 Following any Strategy Discussion there may be one of these outcomes:

2.5.1 no further action

2.5.2 a common assessment undertaken which may identify the young person as a child in need, requiring additional services provided via a team- around- the -child [TAC] meeting, and plan.

2.5.3 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

2.5.4 the outcome of any referral will be formally reported to the referring agency when all investigations are complete

2.5.5 A police investigation. During this process agencies must continue to offer appropriate support to the young person, particularly in cases where criminal proceedings are planned.

2.6 Any girl, below the age of 18, who is pregnant, must be offered specialist support and Protocol by the relevant services. This may be through a variety of community support agencies, including those that are part of multi agency teams [MAT's], or statutory agencies. [See specific Protocol for under 13's].

3. Young People under the Age of 13

3.1 Under the Sexual Offences Act 2003, children under the age of 13 are considered of insufficient age to give consent in law, to sexual activity.

The Police must be 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. (Recommendation 12 of Sir Michael Bichard's report)

3.2 In **all** cases where the sexually active young person is under the age of 13, there is a presumption they are at risk of Significant Harm until an assessment has been undertaken, *using the Protocol in this protocol*. The assessment findings should inform the decision whether to report on to statutory agencies such as the Police or Children and Young People's Services.

3.3 A decision **not** to refer can only be made following a case discussion with the designated lead for child protection within the professional's employing agency. When the decision is not to refer, the professional and their agency is fully accountable for the decision, so the highest standard of recording should include clear reasons for **not** making the referral.

3.4 When a girl under 13 is found to be pregnant, a referral to the Children and Young People's Services Initial Assessment Team **must** be made, so that the needs of the mother and unborn child can be fully assessed.

4. Young People between 13 and 16

4.1 Sexual activity with a child under 16 is an offence.

The Sexual Offences Act 2003 reinforces that whilst mutually agreed, non-exploitative sexual activity between teenagers does take place, and that often no harm comes from it, the age of consent should still remain at 16. This acknowledges that this group of young people are still vulnerable, even when they do not view themselves as such.

4.2 Where the child is aged 13-15 yrs, the Lead Professional should give consideration as to whether a referral to the Initial Assessment Team is necessary. This should be informed by the CAF and the assessment outlined in this protocol, with the presumption that the younger the child, the more harmful sexual activity is likely to be.

In the first instance the worker should discuss any concerns with the nominated child protection lead in their agency and subsequently with other agencies if needed, keeping the child's name anonymous if confidentiality is absolutely necessary.

Once a referral has been made to the Initial Assessment Team, the process should follow-on as outlined previously.

Again it is important that accurate recording of case discussions and decisions is kept, particularly where there is a decision not to proceed with a formal referral.

See the note on pregnancy at 2.6.

5. Young People between 17 – 18

5.1 Although sexual activity in itself is no longer an offence over the age of 16, young people under the age of 18 are still offered the protection of Child Protection Procedures under the Children Act 1989. Consideration still needs to be given to issues of sexual

exploitation through prostitution and abuse of power in circumstances outlined above. Young people, of course, can still be subject to offences of rape and assault and the circumstances of an incident may need to be explored with a young person. A person who holds a position of trust or authority in relation to a young person aged 16-18 and has a sexual relationship with them is committing an offence, and as such this **must** be reported to the police, [see Shropshire and Herefordshire's child protection procedures, and your own agency procedures for contact numbers].

6. Child Involved in Prostitution

If you have concerns that the young person may be at risk of sexual exploitation through prostitution, a referral to your local Initial Assessment Team **must** be made. However if the risk is believed to be immediate, then the police should be contacted straight away.

7. Sharing Information with Parents and Carers

7.1 Decisions to share information with parents and carers will be taken using the assessment[s] findings, and professional judgement, which will include the child's wishes and feelings. Decisions will be based on the child's age, maturity and ability to appreciate what is involved in terms of the implications and risks to themselves. This should be coupled with the parents' and carers' ability and commitment to protect the young person. Given the responsibility that parents have for the conduct and welfare of their children, professionals should encourage and support the young person, at all points, to share information with their parents and carers wherever safe to do so.

7.2 In deciding whether there is a need to share information, professionals need to consider their legal obligations, including whether they have a duty of confidentiality to the child. Where there is such a duty, the professional may lawfully share information if the child consents or if there is a public interest of sufficient force. This must be judged by the professional on the facts of each case. Where there is a clear risk of significant harm to a child, or serious harm to adults, the public interest test will almost certainly be satisfied. However, there will be other cases where practitioners will be justified in sharing some confidential

information in order to make decisions on sharing further information or taking action – the information shared should be proportionate.

7.3 The child's best interests must be the overriding consideration in making any such decision including in the cases of underage sexual activity. The cross-Government Protocol. Information Sharing: Practitioner's Guide, provides advice on these issues – see www.everychildmatters.gov.uk Any decision whether or not to share information must be properly documented. Decisions in this area need to be made by or with the advice of people with suitable competence in child protection work such as named or designated professionals or senior managers.

APPENDIX 1
Additional Information

DEFINITIONS

Sexual Grooming

Section 15 of the Sexual Offences Act 2003 makes it an offence for a person (A) aged 18 or over to meet intentionally, or to travel with the intention of meeting a child under 16 in any part of the world, if he has met or communicated with that child on at least two earlier occasions, and intends to commit a “relevant offence” against that child either at the time of the meeting or on a subsequent occasion. An offence is not committed if (A) reasonably believes the child to be 16 or over.

The section is intended to cover situations where an adult (A) establishes contact with a child through for example, meetings, conversations or communications on the internet and gains the child’s trust and confidence so that he can arrange to meet the child for the purpose of committing a “relevant offence” against the child.

The course of conduct prior to the meeting that triggers the offence may have an explicitly sexual content, such as (A) entering into conversations with the child about sexual acts he wants to engage him/her in when they meet, or sending images of adult pornography. However, the prior meetings or communication need not have an explicitly sexual content and could for example simply be (A) giving swimming lessons or meeting him/her incidentally through a friend.

The offence will be complete either when, following the earlier communications, (A) meets the child or travels to meet the child with the intent to commit a relevant offence against the child. The intended offence does not have to take place.

The evidence of (A’s) intent to commit an offence may be drawn from the communications between (A) and the child before the meeting or may be drawn from other circumstances, for example if (A) travels to the meeting with ropes, condoms and lubricants.

Subsection (2) (a) provides that (A's) previous meetings or communications with the child can have taken place in or across any part of the world. This would cover for example (A) emailing the child from abroad (A) and the child speaking on the telephone abroad, or (A) meeting the child abroad. The travel to the meeting itself must at least partly take place in England or Wales or Northern Ireland.

THE SEXUAL OFFENCES ACT 2003

The Age of Consent

The legal age for young people to consent to have sex is still 16, whether they are 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 don't want.

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.

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.

Protecting People with a mental disorder

The act has created three new categories of offences to provide additional protection with a mental disorder.

- The Act covers offences committed against those who, because of a profound mental disorder, lack the capacity to consent to sexual activity.
- The Act covers offences where a person with a mental disorder is induced, threatened or deceived into sexual activity.

- The Act makes it an offence for people providing care, assistance or services to someone in connection with a mental disorder to engage in sexual activity with that person.

BICHARD INQUIRY - Recommendation Number 12

“The government should reaffirm the Protocol 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”.

WORKING TOGETHER TO SAFEGUARD CHILDREN (2006)

Paragraph 5.17

“Whenever LA children’s social care have a case referred to them which constitutes, or may constitute, a criminal offence against a child, they should always discuss the case with the police at the earliest opportunity.”

Paragraph 5.18

“Whenever other agencies, or the LA in its other roles, encounter concerns about a child’s welfare which constitute, or may constitute, a criminal offence against a child, they must always consider sharing that information with local authority 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 taken not to share information, the reasons must be recorded.”

Paragraph 5.20

“In dealing with alleged offences involving a child victim, the police should normally work in partnership with children’s social care and/or other agencies. Whilst the responsibility to instigate a criminal investigation rests with the police, they should consider the views expressed by other agencies. There will be less serious cases where, after discussion, it is agreed that the best interests of the child are served by a children’s social care led intervention rather than a full police investigation.”

ADDITIONAL REFERENCES

- **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.**
  (Department for Education and Skills Teenage Pregnancy Unit 2004).

- **Best practice Protocol for doctors and health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health.**
  (Department of Health July 2004)

- **What to do if you are worried a child is being abused Children's Services Protocol.**
  (Joint publication from the Department of Health, Home Office, Office of the Deputy Prime Minister, Lord Chancellor, Department of Education and Skills).

- **Handling Allegations of sexual offences against children.**
  (Local Authority Social Services Letter LASSL (2004) 21 August 2004).

- **Protocol on offences against children**.
  (Home Office Circular 16/2005)

Further Information Available From

Home Office www.homeoffice.gov.uk/sexualoffences/legislation/act.html
Teenage Pregnancy Unit www.teenagepregnancyunit.gov.uk
Brook www.brook.org.uk
Sex Education Unit www.ncb.org.uk/sef
Cabinet Office www.cabinetoffice,gov.uk
Department of Education and Skills www.dfes.gov.uk
Department of Health www.dh.gov.uk
www.everychildmatters.gov.uk
www.ecm.gov.uk/informationsharing

APPENDIX 2
BEST PRACTICE PROTOCOL FOR DOCTORS AND OTHER HEALTH PROFESSIONALS

Summary
This revised Protocol 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 Protocol 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.

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.

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

Action

- **PCT commissioners and clinical governance leads should bring this Protocol 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.**

- **Directors of Social Services should ensure that social care professionals working with young people are aware of this Protocol and the Teenage Pregnancy Unit Protocol – '*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 2.

All services providing advice and treatment on contraception, sexual and reproductive health should produce an explicit confidentiality policy

which reflects this Protocol 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 which will help fulfil information governance requirements

4.2 *Confidentiality: protecting and providing information.* General Medical Council, London. 2004. *Code of professional conduct.* Nursing and Midwifery Council 2002
An example of an effective training resource is '*Confidentiality and young people: improving teenager's uptake of sexual and other health advice'*. This publication is endorsed by the Royal College of General Practitioners, the British Medical Association, the Royal College of Nursing and the Medical Defence Union.

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.

Duty of Care
Doctors and other health professionals also have a duty of care, regardless of patient age.

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.

Copies can be obtained from Department of Health, PO Box 777, London SE1 6XH.

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:

- *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 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.

APPENDIX 3
Flow Chart for Professionals Working with Sexually Active Under 18's

Protocol Note to Accompany the Flow Chart for Professionals Working with Sexually Active Under 18's

This Note, the Flow Chart and Prompts for Workers are one aspect of a wider Protocol for working with Sexually Active Young People.

INTRODUCTION

1. This process applies to any contact in Shropshire and Herefordshire with a health professional, youth worker, Connexions advisor and voluntary agency worker, with someone who is sexually active and under 18, including requests in non-NHS settings for emergency contraception; chlamydia screening or repeat issuing of condoms. 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.

2. This protocol has been agreed by a wide range of statutory agencies and partners in the voluntary and community sectors. It is aimed at providing staff with Protocol on how contact with sexually active under 18s should be managed. Its use MUST be in conjunction with local Child Protection Procedures.

3. In designing the flow chart, the agencies are clear that at the centre of our contact with the young person is their health and well-being. We have a duty to ensure that we work together to minimise risks to potentially vulnerable young people and in so doing, we must respect an individual's legal rights to privacy and confidentiality

THE PROCESS

4. The decision making process must consider the relationship between the professional and the young person, and seek to build trust as far as possible. 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 the Protocol proposes. As a result, the threshold for discussions with a designated

staff, social care, or the police, may be lower than for a GP who is more confident they will see the young person again.

5. 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 judgement as to how much information they can seek each time.

6. Where a professional worker expects to discuss a case with Named/Designated staff, and/or also with the line manager, or to have an informal conversation outside the NHS thus breaching confidentiality, then this should be done in consultation with the young person, except where the professional believes it is not in their best interests to be informed.

7. Where a serious crime is suspected, advice should be sought from the police at the earliest opportunity to safeguard the child and minimise the risk of any evidence, such as e-mails or pictures, being destroyed before they can begin their investigation. All staff must be aware that the police must 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

8. Any referral or potential referral should be discussed in the first instance with the young person. 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.

9. In law, children under 13 are deemed to be unable to give informed consent to sexual activity, so professionals working with such children need to ensure that they have taken all reasonable steps to protect the child's welfare and prevent them from harm, and that they have operated within the Protocol issued by their organisation.

10. The degree of [Fraser] competence of a young person needs to be assessed on an individual basis and documented. This will vary with age, maturity and with the implications of the treatment or advice they are seeking. Young people under sixteen who are Fraser competent can consent to treatment. A child or young person can say they wish to withhold consent to their information being shared with another agency. A professional, however, may override this if they are of the firm view that not to do so may jeopardise the safety and welfare of the child or young person.

11. Where the young person is under 13 years of age, an assessment must be undertaken as to risk, and advice or Protocol obtained from the organisation's Child Protection lead, the Designated/Named clinician, or line manager. The actions taken by the professional **MUST BE RECORDED** and the rationale for these actions clearly given.

12. Throughout the process it will be important to remember the perpetrator of abuse might be: the patient; male or female; of the same sex; in a caring role for the individual. Similarly not all abuse is recognised as such by the victim at the time, and this is notably the case where a young person is being groomed.

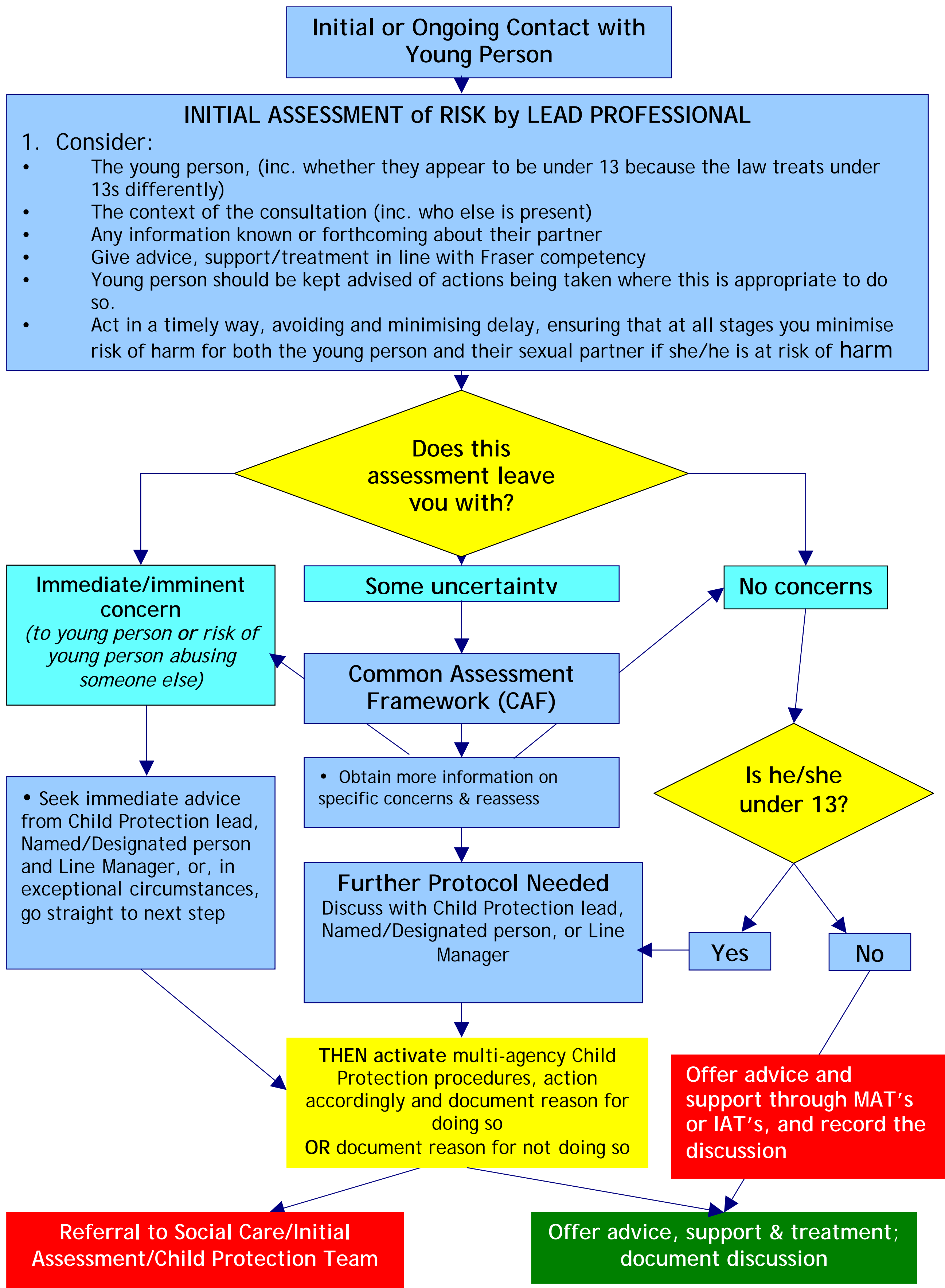
13. In accordance with Protocol from the Department of Health, the health professional is responsible for deciding when a referral is or is not made. Where there is any uncertainty and a referral is not made, the reasons and rationale <u>must</u> be documented in the young person's notes at the time, and for all under 13s this must be recorded because the law treats them as unable to give informed consent to sex.

14. Wherever possible, informal discussions should be carried out in such a way as not to breach confidentiality. In some areas, the police have a Public Protection Unit, through which a Named Doctor or Nurse could routinely check details in person of the individual and their partner on the Sex Offenders Register without breaching confidentiality. Similar checks can be made with the Custodian of the child protection register. In due course community practitioners will be able to consult the Child index, currently being piloted in Shropshire and Herefordshire, which would show indicators of previous activity.

15. Initiating a Child Protection Procedure may involve discussion with a Named/Designated Doctor or Nurse. Where a Youth Worker, Connexions advisor or any other professional is working in a sexual health service for young people, the arrangements for confidentiality, responsibility and reporting arrangements in respect of child protection procedures MUST be clarified in advance. This must be part of Induction and on-going training.

16. 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 the child protection register. However multi-agency intelligence such as the child index currently being piloted in Shropshire and Herefordshire does offer an opportunity to find out what other information is held about a young person, their partner, or their family, by the multi agency teams.

17. It is important to recognise that any information passed to Social Care even in confidence, can be released by a Court Order by a judge in the Family Court. The same does not apply to the Police, who are 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.


Flow Chart for all those Working With Sexually Active Under 18's
Initial or Ongoing Contact with Young Person
INITIAL ASSESSMENT of RISK by LEAD PROFESSIONAL
1. Consider:
• The young person, (inc. whether they appear to be under 13 because the law treats under 13s differently)
• The context of the consultation (inc. who else is present)
• Any information known or forthcoming about their partner
• Give advice, support/treatment in line with Fraser competency
• Young person should be kept advised of actions being taken where this is appropriate to do so.
• Act in a timely way, avoiding and minimising delay, ensuring that at all stages you minimise risk of harm for both the young person and their sexual partner if she/he is at risk of harm
Does this assessment leave you with?
Immediate/imminent concern
(to young person or risk of young person abusing someone else)
Some uncertainty
No concerns
Common Assessment Framework (CAF)
• Seek immediate advice from Child Protection lead, Named/Designated person and Line Manager, or, in exceptional circumstances, go straight to next step
• Obtain more information on specific concerns & reassess
Is he/she under 13?
Further Protocol Needed
Discuss with Child Protection lead, Named/Designated person, or Line Manager
Yes
No
THEN activate multi-agency Child Protection procedures, action accordingly and document reason for doing so
OR document reason for not doing so
Offer advice and support through MAT's or IAT's, and record the discussion
Referral to Social Care/Initial Assessment/Child Protection Team
Offer advice, support & treatment; document discussion

Prompts for workers/professional coming into contact with sexually active under 18s

To only be used in conjunction with Protocol Note and Flow Chart, and relevant child protection Protocol issued by your organisation

Context:	**1.2 General** **(Reasonable level of Trust established with the young person, you have confidence that the young person will be either returning to you for support/treatment, or that you can maintain contact with the young person after the face to face contact has ended)**	
	16/17 year olds	Under 16s
Initial prompts for workers	• Personal Information • Health, social and sexual health history • Do they understand the concept of informed consent? • Is there informed consent between partners? • In seeing the young person, is there anything untoward that gives you cause for concern?	As for 16 and 17 year olds, plus: • Are they Fraser competent?

<table>
<tr><td rowspan="2">Issues to clarify if uncertain or concerned</td><td colspan="2">• Check the child index</td></tr>
<tr><td>• Who does the young person live with, is this a risk?
• Is there any concern about lifestyle issues
• Is there any sign of alcohol or substance misuse relating to the sexual activity?
• Are they still in touch with their peers
• Does the young person or their partner have a Social Worker or a Connexions Personal Advisor?
• Is the other partner present? If so, try to see the young person on their own.
• If not, are they willing to give details of their partner?
• Any age differential
• The relationship (e.g. family, or Position of Trust, such as teacher, youth worker etc.)
• Is there any evidence of coercion? What makes it coercive?
• Any evidence of gifts being used as an incentive to secure consent or secrecy?
• Any evidence of violence, threats, or attempts to gain secrecy?
• Any evidence of self-harm?
• Where did/do they meet? (e.g. internet)</td><td>As for 16/17 year olds, plus:
• Is the other partner present? If so, try to see young person on their own (* note that legal age of consent = 16).
• What is the partner’s occupation? Is this a position of power over the young person?
• Do they go to school?
• If they are under 13, you must ensure that you have sought advice from a Child Protection lead, Named/Designated Person and Line Manager
• If the girl (under 13) is pregnant, referral to the Initial Assessment Team must be made.</td></tr>
</table>

	Opportunistic **(No significant trust established)** **Likely to be a one-off contact with young person, or where you are uncertain if you will see them again**
Initial prompts for workers	• Check the child index (if you have access) • Personal information • Maturity of the young person for their age
Issues to clarify if uncertain or concerned	• Are they Fraser competent? • In seeing the young person, is there anything untoward that gives you cause for concern (including their age)? • Are any peers present? • Are they willing to give personal details? • Do they understand the concept of consent? • Lifestyle issues (e.g. domestic violence, drug or alcohol abuse etc.) • Does the young person or their partner have a Social Worker or a Connexions Personal Advisor? • Is there any sign of alcohol or substance misuse relating to the sexual activity? • Any evidence of violence, threats, or attempts to gain secrecy? • Is there anything else leading to a risk of significant harm? • Any evidence of self-harm?

PROCESS

Consultation	Date	Comments
Practice Group	13th June 2006	Not agreed in principle – see minutes.
Executive Sub-Group	15th June 2006 9th November 2006	Not agreed in principle – see minutes. Changes made to sections 1 and 2.
SSCB	4th July 2006 28th November 2006	More consultation required.
Health Task Group chaired by Frances Phelps	22nd September 2006	Changes made to text, but fundamental basis is accepted. Issue about Gillick v Fraser are resolved.
Participation Team	22nd September 2006	Recommendation for information leaflets made and passed to Media Group for action.
Multi-Agency & Prevention Laura Johnston	17th August 2006 & 23rd October 2006	Changes made to include the ISA process. Document agreed.