

# Guidance for Joint Working between Oxford Health NHS FT and Other Agencies with regard to Disclosure of Non-recent Child Sexual Abuse.

Updated: March 2019

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“The support and protection of children cannot be achieved by a single agency... Every service has to play its part. All staff must have placed upon them the clear expectation that their primary responsibility is to the child and his or her family.”

*Lord Laming in the Victoria Climbié Inquiry Report,  
paragraphs 17.92 and 17.93*

## **General Note for all Users of this Guidance**

*This guidance, like all advice for practitioners in complex situations, cannot hope to cover every eventuality which may arise in day-to-day clinical work. However, it does aim to provide a set of basic principles which should guide practice. At this juncture, it is important to underline a single fundamental principle which underlies this guidance, namely, if a practitioner within Oxford health NHS FT encounters a situation where a patient/client discloses non-recent child sexual abuse<sup>1</sup> and is uncertain about how they should respond, they should seek advice from senior colleagues, managers or the trust safeguarding service. Whatever course of action is decided upon in such situations should be clearly recorded so that subsequent accountability can be assured within the spirit of transparency and defensible (rather than defensive) practice.*

*This guidance focuses particularly on the issue of non-recent child sexual abuse. However, the principles outlined should serve to help practitioners when considering all forms of sexual or other maltreatment whether perpetrated against adults, children or young people.*

## **1. INTRODUCTION**

All practitioners working within Oxford Health NHS FT particularly those in adult mental health services may find themselves in a position where disclosures of non-recent child sexual abuse are made to them. It can at times be difficult for practitioners to make decisions about such matters particularly when it may involve making a decision between their professional duty to their

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<sup>1</sup> For the purposes of this guidance the term non-recent sexual abuse refers to alleged sexual abuse which is reported to have occurred after that time when direct forensic evidence of such abuse is likely to be available. This means that reporting may occur at any time from a period of several days to many years after the alleged events. In practice this guidance is intended to help all practitioners working with patients/clients of any age; it may also be useful in the management of disclosure of current sexual abuse.

patient/client and the prevention of potential harm to a child. This guidance is designed to help practitioners and others in such situations and has been developed by the safeguarding children team in collaboration with colleagues in all directorates of the trust, service user groups and senior colleagues in the police and children's social care.

In order that the current risks to children can be assessed, it is often necessary to share non-recent information about alleged perpetrators. Police and trust practitioners need to have an understanding of each other's roles and responsibilities to enable effective joint working whilst safeguarding children and minimising any detrimental effect to the individual disclosing the abuse.

Individuals who make disclosures of their experience of childhood sexual abuse should be listened to and supported. Practitioners to whom disclosures are made should evaluate whether, in the light of the disclosure, there are ongoing concerns that an alleged perpetrator may still be in a position to perpetrate further abuse against a child which might be prevented by considered information-sharing. The information shared with others should be handled sensitively. If the information is to be shared with other agencies, a clear explanation of this process and what it entails should be shared with the individual making the disclosure (unless there are issues of risk which may mean that it is not advisable or possible to disclose actions around professional information-sharing at that time). In particular, it should be clear that there can be no absolute guarantee as to how a case may progress once information has been shared. It should also be understood that there is a significant chance that children who may be currently at risk of sexual abuse can be protected if information about a perpetrator involved in alleged non-recent abuse is shared.

All staff making use of this guidance must remember that the welfare of the child is the paramount concern (Children Act 1989 c.41 part 1 section1).

Decisions in this area should be embedded within an anti-discriminatory framework. In reality, this means that practitioners should be aware of their own responses to cases, and base practice on clear and ethical principles rather than attitudes. For instance, inquiries have revealed that how practitioners view victims can influence whether information is acted upon. Assumptions about class, gender, ethnicity, disability or age that affect decision-making adversely may be unwittingly harbored. Given the universality of such thinking biases, it is imperative that advice and clinical supervision is made use of when practitioners are involved in complex decisions that unfold over time.

## 2. BACKGROUND

Practitioners are often unclear about whether, when and with whom they should share information in relation to disclosure of alleged previous childhood sexual abuse. Equally, colleagues from other agencies including the police and social care have felt uncertain about whether to act on shared information. This is particularly the case where it is unclear whether information has been shared with or without that individual's consent.

This guidance has been developed to address such issues and is intended to support decision making and joint working. In particular, it is intended to support practitioners from the trust and other agencies so that the needs of young people at risk of abuse and of adults making disclosures of previous abuse can be appropriately addressed.

## 3. POLICY

The duty to share information between agencies to protect individuals from harm is enshrined within the NHS Code of Confidentiality which states:

- “Under common law, staff are permitted to disclose personal information in order to prevent and support detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to others where they judge, on a case by case basis, that the public good that would be achieved by the disclosure outweighs both the obligation of confidentiality to the individual patient concerned and the broader public interest in the provision of a confidential service.”
- “Wherever possible the issue of disclosure should be discussed with the individual concerned and consent sought to share information. Where this is not forthcoming, the individual should be told of any decision to disclose against his/her wishes. This will not be possible in certain circumstances, e.g. where the likelihood of a violent response is significant or where informing a potential suspect in a criminal investigation might allow them to evade custody, destroy evidence or disrupt an investigation”.

*(Confidentiality: NHS Code of Practice, Department of Health 2003, page 34 paragraph 30 & 32)*

Various professional organisations/regulatory bodies support such practice in their own guidance to practitioners (examples of such guidance can be found in Appendix 1 of this document).

#### **4. PROCESS: ADVICE FOR CLINICAL STAFF AND PRACTITIONERS TO WHOM A DISCLOSURE OF NON-RECENT CHILD SEXUAL ABUSE IS MADE**

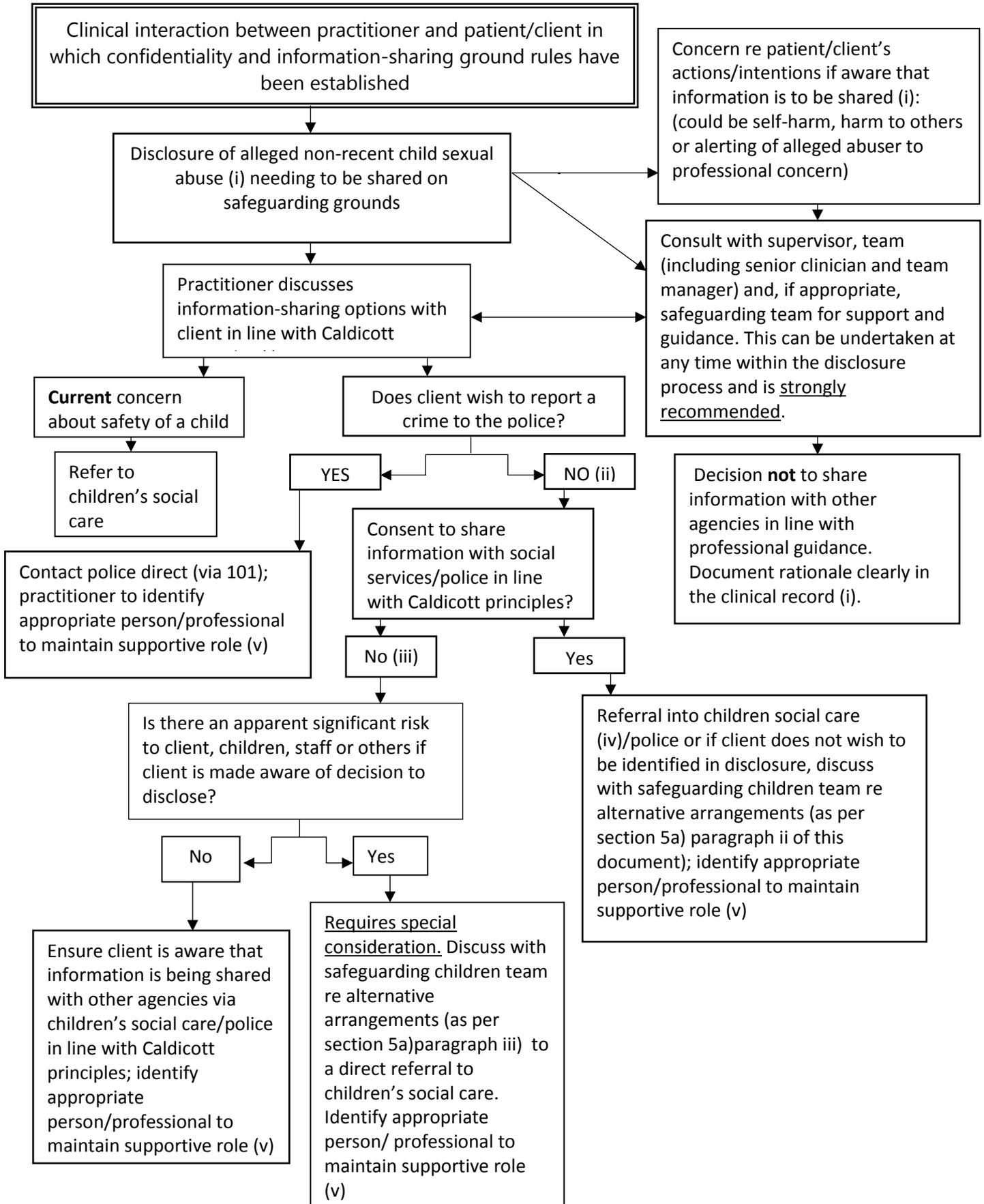
At the beginning of any professional relationship between a practitioner and patient/client it is important that the ground rules governing that relationship are set out. It is now accepted practice that such a process should include an explanation by the practitioner outlining the limits of confidentiality and that information may need to be shared with others if serious concerns in relation to harm for the patient/client or others subsequently arise.

The flow chart (below, page 7) shows the various steps which may occur once a disclosure of non-recent child sexual abuse has been made. The flow chart is supplemented by a number of specific guidance notes which provide greater detail and clarification. This information is further illustrated by an outline of clinical scenarios and vignettes in appendix 3 (p 17).

It should be emphasized that this is a complex issue and that practitioners are **strongly advised to consult with senior colleagues and managers and the Oxford Health NHS FT safeguarding team if doubts arise regarding the appropriate course of action.** This will allow a consensus view about the need for further action and development of a clear plan in this eventuality. This also ensures that decisions are not taken in isolation.

## Flow Chart for Management of Disclosures of Non-recent Child Sexual Abuse

(Roman numerals in text refer to specific paragraphs in guidance)



## Guidance Notes to Supplement Flow Chart

i) Does the information that has been disclosed to you indicate that the patient/client was sexually abused as a child or young person?

Does the information disclosed identify that a child or children may be at current risk of harm?

In particular, consider

- children within the alleged abuser's family or social network
- whether the alleged abuser holds or held a position of trust in relation to children (paid/voluntary)
- whether the nature of the alleged abuse indicates that the alleged abuser may actively seek further contact with children

Are you concerned that if you discuss the sharing of relevant information with the patient/client that they may then seek to inform an alleged perpetrator or undermine any further investigation? If so do not discuss sharing of information and liaise further with senior manager or safeguarding team.

Have information sharing options been discussed with the patient/client? Client and practitioner leaflets have been developed by the safeguarding team to support practitioners and patient/clients with the options available to take forward disclosures of non-recent child sexual abuse. These are available on the safeguarding children intranet page (link below) or copies can be requested from the OHFT communications team; Tel: 01865 902225 Email: [communications.team@oxfordhealth.nhs.uk](mailto:communications.team@oxfordhealth.nhs.uk)

### *Documentation*

Practitioners should ensure that the rationale for any decisions is documented including the reason for sharing/not sharing information and if/where advice was sought. Where appropriate, the third party-sensitive area within Carenotes should be used; for example to document details of an alleged perpetrator.

In circumstances where information is shared by practitioners with the police on behalf of the patient/client for intelligence only, and this is carried out without revealing the source of information, the safeguarding children team will keep a record of the police unique reference number (URN) and Carenotes record number of the patient/client. This is to ensure that details will be kept in case of future requests by the police to help identify or confirm others who may be at risk; in this way, details of the disclosure will not be lost if the practitioner involved in the case leaves the trust.

ii) The alleged abuser may be unknown to the adult patient/client or the patient/client may have made a decision not to disclose the details of the alleged abuser. In making the decision, the patient/client may need help to consider the possibility that the alleged abuser may have harmed others or could do so in future. The right of the patient/client not to give the name of their alleged abuser should be respected. Other relevant information which may clearly lead to identification of the alleged perpetrator, however, should be considered for possible disclosure; if a practitioner is uncertain about such a situation they should discuss this further with a senior manager or the safeguarding team.

iii) Where identifiable information about the alleged abuser is disclosed but consent is not given to share relevant information, it must be explained to the patient/client that the practitioner will need to seek further supervision and guidance. This may include advice from the trust Caldicott guardian. Regardless of whether consent is given to share information, patient/clients should be informed about how information will be shared. They should also be kept up-to-date with progress. Following supervision and guidance for the practitioner, it may be thought that information must be shared even though consent has not been given; at this juncture, consideration should also be given as to whether the patient/client's own identity forms a necessary part of such information (if this is not the case, the information may be shared without reference to its source). At this juncture a decision will also need to be made as to the advisability of informing the patient/client that information will be shared. In some circumstances where such knowledge is perceived to result in an increase in risk to a child, the patient/client, practitioner or others, a decision will be made to share information without the patient/client's knowledge.

If checks on police systems have taken place without the client's knowledge, ensure that this is clearly recorded in the client's clinical record, handed over in transition to other services and included in discharge summaries to partner agencies e.g. GPs.

An alert can be added to the client's clinical record under the safeguarding option. Document in the text box, "information shared without knowledge and consent of client. See 3rd party sensitive tab for details". This is to avoid the client being informed that this has taken place. A clear rationale for the decision not to inform the client should be included.

iv) Ensure that an enquiry to children's social care is made as per the Oxford Health NHS FT Safeguarding Children Policy if there are current concerns about the safety of a child. This will ensure that agencies check their records on relevant adults and children, share information and make a decision as to whether to progress an investigation.

Alternatively, if there are no identified current concerns about the safety of a child the police should be contacted via the 101 service.

v) Ensure within the whole process that the patient/client making the disclosure

continues to be supported and is kept abreast of any developments after information has been shared. The supportive role need not necessarily be undertaken by the involved clinician and may be more appropriately provided by other practitioners or services. 'Support' may range from telephone updates, to supportive therapy, face to face reviews, linking the client up with other help like Victim Support or Oxford Sexual Abuse and Rape Crisis Centre (OSARC) or supporting the client through the court process. Referral to psychological services may need to be considered in discussion with a local psychologist or psychotherapist.

## **5. OTHER CONSIDERATIONS**

### **a) Roles of Agencies and Individual Practitioners**

#### **i) Individual Practitioner**

Depending on circumstances or whether support is being provided to the patient/client from another source, individual practitioners may need to participate in the post-disclosure process by:

- supporting their patient/client and keeping them informed
- seeking appropriate support for themselves (via their manager or the safeguarding team)
- providing a statement to the police
- supporting their patient/client in the course of a police interview

#### **ii) Oxford Health NHS FT Safeguarding Team**

The team will be available for advice and support to trust practitioners in relation to appropriate action following disclosure of non-recent child sexual abuse.

In some circumstances where the disclosure issue is complex and not straightforward, it may be desirable for the safeguarding children team to liaise with children's social care /police once a decision to share information has been agreed with the relevant practitioner and team. This may allow the practitioner to maintain their relationship with the patient/client. In addition, in such situations, the safeguarding team should establish a direct link with a senior police officer (detective chief inspector or the detective inspector for the child abuse investigation team) to allow, on an exceptional basis, preliminary discussion of the case (in line with Caldicott principles). Such discussion will necessarily involve:

- Specific circumstances of the disclosure
- Whether there is consent to share information or whether the patient/client consents to information-sharing but wishes to remain anonymous
- Who the matter has been discussed with in terms of sharing information

- What support is available to the person who has made the disclosure

In such circumstances, the safeguarding team will liaise further with the person who is supporting the patient/client regarding the outcome of the discussion.

iii) Children's Social Care

Children's social care will investigate where a specific child is identified and that child is in need or in need of protection. Where children are not known the police investigation may identify children and as a result children's social care will be informed.

iv) Police

- Police officers receiving information once a children's social care/101 referral has been completed should carefully consider the information that has been shared and inform the relevant practitioner what the likely response will be.
- Where there is immediate risk usual police procedures will be followed.
- Police will seek to identify whether alleged offenders are already known and if so whether they have multiagency public protection arrangements (MAPPA) status. New information may change the risk level and alter an existing management plan.
- Police and other agencies will need to enable an effective response that incorporates the need to protect children and investigate a crime balanced against the need to protect the well-being of the person who is a survivor of child sex abuse. Where there are current child safeguarding concerns, a minuted strategy meeting involving a police supervisor, social care colleagues and any other relevant professional should take place before any further action takes place and the agreed outcomes recorded. The practitioner involved or a member of Oxford Health NHS FT safeguarding children team is likely to be part of such a meeting; the outcome will be fed back to the practitioner and, where appropriate, the patient/client. Police are likely to wish to speak to the patient/client generally within days. Consideration should be given as to how this might be facilitated. If there is a desire for such contact to be delayed, the practitioner will need to make this clear when they make the referral and the reasons why. Contact from the police in the first instance would be by telephone. This would be to arrange an appointment. If this would be better organised through the practitioner, this needs to be documented at the reporting stage.
- Police are also likely to require a statement of first complaint from the health practitioner to whom the patient/client made their initial disclosure. Copies of notes made may also be required but these should be requested by the police in accordance with normal trust process via the health records department.

## **b) Special Circumstances**

### **i) Allegations against those in Positions of Responsibility with Children**

Where it is established or suspected that the alleged abuser continues to work in a position of trust with children, or did so in the past, the professional should follow the local area 'Allegations Against Staff, Carers and Volunteers Procedure'. This will necessitate a referral to the 'Local Authority Designated Officer' (known as a 'LADO'). The trust safeguarding children team will be able to support such a referral.

### **ii) Allegations relating to a Different Local Authority Area**

Where an adult alleges abuse in childhood in a different local authority area, a referral to the adult's local social services should still be undertaken. The children's social care service will make a referral to agencies in the area where children are currently believed to be at risk of harm. The practitioner who is involved with the patient/client should ensure they are clear who is the lead authority investigating, if the case involves more than one authority. Children's social care will provide this information.

### **iii) Allegations regarding former Children's Homes or Residential Schools**

Where the abuse is alleged to have occurred in a former children's home or residential school a referral in to the local children's social care should still be undertaken. The children's social care service will then determine which other local authorities and/employing organisations will need to be involved and which local authority will lead the investigation of children/adults. It is important that there is effective communication about roles and responsibilities between agencies in such circumstances. The trust safeguarding team will again be able to provide support to individual practitioners in such circumstances.

## **c) The Initial Multiagency Response<sup>2</sup>**

In cases where there is considered to be sufficient ongoing concern in relation to the substance of a disclosure of non-recent child sexual abuse, a strategy meeting will be organised as soon as the risk of significant harm is suspected to ensure an effective response.

### **i) Purpose of a strategy discussion**

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<sup>2</sup> For further information about multiagency responses and strategy discussions please refer to local children's safeguarding board procedures which are published for all local authority areas.

- To establish whether a child protection enquiry should be initiated (or continued if it has already started) - and if so, which children should be included.
- To ensure that all agencies that have a responsibility to safeguard can share information safely and securely.
- To ensure that all agencies understand what actions will be taken and by whom a strategy will be formulated.
- To ensure that, where there has been no consent to share the information, all participants understand the issues of whether further action can be taken without the evidence of the patient/client.
- To ensure that the practitioner is able to support and give feedback to the patient (where agreed) as to what will happen next (If appropriate).
- To ensure that the practitioner understands that they are a witness of first complaint and their role in the police investigation.
- To ensure that the police response is coordinated to minimise the risk to the mental well-being of the patient who is a victim of alleged child sexual abuse.
- To agree what action is required immediately and in the short term to safeguard the child. This may include
  - the provision of interim services and support,
  - care arrangements for the child/children
  - urgent actions to remove the child from the risk of harm
  - urgent actions to remove the alleged perpetrator from the child's home
  - where a child is in hospital, consideration of managing contact with the alleged perpetrator and how to secure the safe discharge of the child;
- To determine if legal action is required.

In some situations more than one strategy discussion may be necessary in order to review progress and plan further actions.

If a child protection enquiry (also known as a section 47 enquiry) is initiated, at the end of the enquiry when the child is assessed as either having suffered 'significant harm'<sup>3</sup> or to be at risk of suffering ongoing 'significant harm', an initial

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<sup>3</sup> The Children Act 1989 introduced the concept of 'significant harm' as the threshold that justifies compulsory intervention in family life in the best interests of children, and gives Local Authorities a duty (under Section 47) to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer, significant harm. There are no absolute criteria upon which to rely when judging what constitutes significant harm. Consideration of this should include the degree and the extent of physical or psychological harm together with its

child protection conference is normally convened. This would only take place if a child was identified as being at current risk.

*The conference must take place within 15 working days of the Strategy Discussion or, where more than one Strategy Discussion took place, of the Strategy Discussion at which the child protection enquiry was initiated. It will be decided by the social worker carrying out the child protection enquiry whether attendance at the initial child protection conference by the practitioner involved or a member of the Oxford Health NHS FT safeguarding children team is required. (Procedure for such meetings can be discussed in advance with the safeguarding children team).*

## **6. FURTHER DISCLOSURES AND NEW INFORMATION ARISING**

If at any point in the investigation and multiagency process, specific children are identified this should immediately lead to a referral to children's social care.

## **7. ESCALATION OF CONCERNS**

Where practitioners within Oxford Health NHS FT encounter difficulties with other agencies in relation to the content of this guidance they should seek to escalate such concerns to a senior manager or member of the safeguarding team.

Where practitioners from agencies outside Oxford Health NHS FT encounter difficulties in relation to the practical application of this guidance by trust practitioners, they should seek to escalate such concerns to a senior manager or member of the safeguarding team.

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duration and frequency.

## **APPENDIX 1: Professional Guidance on Information Sharing**

- General Medical Council

“In exceptional circumstances, there may be an overriding public interest in disclosing personal information without consent for important health and social care purposes if there is no reasonably practicable alternative to using personal information and it is not practicable to seek consent. The benefits to society arising from the disclosure must outweigh the patient’s and public interest in keeping the information confidential”

*(GMC Confidentiality: good practice in handling patient information 2017 p. 47, paragraph 106)*

- Nursing and Midwifery Council: Code of Conduct

- “Make sure people are informed about how and why information is used and shared by those who will be providing their care” (5.2)
- ‘Share necessary information with other health and care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality’ (5.4)
- ‘Act without delay if you believe that there is a risk to patient safety or public protection’ (16)
- ‘Raise and if necessary, escalate any concerns you may have about patient or public safety... and use the channels available to you in line with our guidance and your local working practices’ (16.1)
- ‘Raise concerns immediately if you believe a person is vulnerable or at risk from harm, neglect or abuse’ (17.1)
- ‘Share information if you believe someone may be at risk of harm in line with the laws relating to disclosure of information’ (17.2)

*(NMC: The Code. Professional standards of practice and behaviour for nurses and midwives 2018)*

- British Psychological Society: Practice Guidelines Third edition

In exceptional circumstances it may be necessary to breach the client’s confidentiality with or without their immediate knowledge or consent. This would be the case where there are significant risks to the client’s psychological wellbeing; where the alleged perpetrator may be a current risk to others or where there is risk of jeopardizing a potential investigation. Any decision to breach confidentiality cannot be taken lightly but can be justified and accounted for if made in good faith because of safeguarding concerns. This is supported by professional guidance. (7.3)

*(The British Psychological Society: Practice Guidelines Third edition, August 2017)*

The British Psychological Society have produced guidance specifically for disclosures of non-recent (historic) child sexual abuse, see link below:

<https://www.bps.org.uk/news-and-policy/guidance-management-disclosures-non-recent-historic-child-sexual-abuse-2016>

It is impossible to include all professional bodies' guidance for information-sharing however see links below to pharmacy, dentists and health, care professions council and HM Government advice for practitioners providing safeguarding services.

<http://www.pharmacyregulation.org/>

<http://www.cpd.org.uk/index.aspx>

<https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/>

<https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice>

## **APPENDIX 2: Caldicott Principles for Information Sharing**

### **1. Justify the purpose(s)**

Every single proposed use or transfer of patient identifiable information within or from an organisation should be clearly defined and scrutinised, with continuing uses regularly reviewed, by an appropriate guardian.

### **2. Don't use patient identifiable information unless it is necessary**

Patient identifiable information items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

### **3. Use the minimum necessary patient-identifiable information**

Where use of patient identifiable information is considered to be essential, the inclusion of each individual item of information should be considered and justified so that the minimum amount of identifiable information is transferred or accessible as is necessary for a given function to be carried out.

### **4. Access to patient identifiable information should be on a strict need-to-know basis**

Only those individuals who need access to patient identifiable information should have access to it, and they should only have access to the information items that they need to see. This may mean introducing access controls or splitting information flows where one information flow is used for several purposes.

### **5. Everyone with access to patient identifiable information should be aware of their responsibilities**

Action should be taken to ensure that those handling patient identifiable information - both clinical and non-clinical staff - are made fully aware of their responsibilities and obligations to respect patient confidentiality.

### **6. Understand and comply with the law**

Every use of patient identifiable information must be lawful. Someone in each organisation handling patient information should be responsible for ensuring that the organisation complies with legal requirements.

### **7. The duty to share information can be as important as the duty to protect patient confidentiality**

Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and

professional bodies as outlined in: 'Information: To share or not to share? The Information Governance Review.' Department of Health April 2013 page18). Professional guidance in support of this is referenced in Appendix 1 (above).

## **APPENDIX 3: Scenarios and Clinical Vignettes Illustrating the Guidance**

This guidance cannot cover every clinical nuance or situation, but when an adult client discloses, the likely scenarios are:

- the client discloses abuse but does not wish it to be reported to other agencies (police and/or social services)
- the client discloses abuse and is not well enough to make their own report to other agencies but the clinician has sufficient information and believes the risk is substantial enough to require reporting
- the client discloses abuse and gives consent to the clinician to make an informal/ anonymous report to the police or social services on their behalf
- the client discloses abuse and is prepared to make a formal statement to the police (i.e. to report a crime)

This can be captured more simply in the diagram below:

1

**disclosure but client does not want to report**

(clinician may need to pass information on without knowledge and / or consent)

If information is to be shared without knowledge, safeguarding children team to discuss with senior police officer within TVP.

2

**disclosure and client wants to report formally to police and social services**

information can be passed on with knowledge and consent but client may need briefing about not inadvertently alerting the alleged abuser

3

**disclosure but the client is unfit or unable to report**

(clinician passes on information with or without knowledge and/ or consent)

If information is to be shared without client's knowledge, safeguarding children team to discuss with senior police officer within TVP.

4

**disclosure and client wants to report informally/ anonymously to the police or social services**

information can be passed on with knowledge and consent but client may need briefing about not inadvertently alerting the alleged abuser

Safeguarding children team to share information with senior police officer within TVP/social care manager, if client does not want to report disclosure through "101" or Crime stoppers.

## **Clinical Vignettes Illustrating Scenarios Outlined Above**

### **1. Disclosure but client does not want to report**

'Susie' is in her 30s, and has been referred for treatment of her depression. She makes a disclosure of CSA when the clinician is drawing out a family tree and asks about childhood experiences. The assessment reveals that the alleged abuser is a family member who has access to your client's children. She has given you the name of the alleged abuser. Susie becomes very anxious and does not want to disclose any further information to you when she realises you are concerned about what you have heard.

### **2. Disclosure and client wants to report formally to police and social services**

'Jonathan' is in his thirties, and suffers with low self-esteem, occasionally uses cannabis and has severe OCD. He has fears about dirt and germs. He is working with your team to help improve his symptoms. He discloses that he was sexually abused by a friend of the family when he was 11 years old, and that he thinks that this man also abused other children. He has heard about other cases in the media and feels that he wants to do something to protect other children, and feels he would be prepared to speak to the police and social services.

### **3. Disclosure but the client is unfit or unable to report**

'Naima' is from a Muslim background, and has been referred to you for help with depression. She is in her mid-twenties and has a history of contact with mental health services. She has been sectioned on two occasions, and is currently depressed and at risk of suicide. You've been working with her for two months when she discloses that she was sexually abused by her uncle. She says that she has not disclosed this within the family, as she is worried about rejection from her community and potential 'honour'/ shame based violence. Her uncle has adult children of his own and is well respected within the community.

### **4. Disclosure and client wants to report informally to the police or social services**

'Mia' has chronic and disabling symptoms and has been in contact with mental health services many times. Her disclosure of abuse has been previously logged by other workers. She has a very fragile mental state, a history of serious and repeated self-harm, and has previous admissions to psychiatric hospital. She says she wants to do something to protect other children but is terrified by the idea of having contact with the police.

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Dr Arabella Norman-Nott, Consultant Psychiatrist, Oxford Health NHS FT

Dr Sally Cosgrove, Clinical Psychologist, Oxford Health NHS FT

Dr Khadj Rouf, Clinical Psychologist, Oxford Health NHS FT

Dr Steve Pearce and the Oxford Health Clinical Ethics Committee

## **QUESTIONS OR ENQUIRIES**

Specific clinical questions relating to the issues raised in this guidance should be addressed to the Safeguarding Children's Team consultation line:  
07770648673

Specific questions about this guidance can be addressed to:

Dr Nick Hindley, Lead Named Dr for Children's Safeguarding, Oxford Health NHS FT (nick.hindley@oxfordhealth.nhs.uk)

Lisa Lord, Senior Named Nurse, Oxford Health Safeguarding Children's team (lisa.lord@oxfordhealth.nhs.uk)

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