



Procedures and Practice Guidance for Working with Young People who are Sexually Active

This document is built on Working Together to Safeguard Children 2006 and based on Guidance developed by Kent Safeguarding Children Board.

Professionals may lawfully provide advice and guidance to young people including those under the age of 13.

- 1.8 When a professional becomes aware of a young person under 16 who is engaging in sexual activity they will make an initial assessment using the risk assessment tool. The risk assessment should also be completed by professionals working with children of 16 or 17 as young people of this age are often engaging in potentially harmful relationships. This is especially relevant for older people with additional needs.
- 1.9 The emphasis is on working with the young person and their partner where appropriate to reduce any harmful aspects of their behaviour by providing advice and services. This is most likely to be achieved by a referral to sexual health specialists or by seeking their advice.
- 1.10 Where the sexual behaviour is assessed as being seriously harmful (significant harm) then the professional should consult with children's social services with a view to making a referral of child protection concern. Urgent cases should be referred immediately.
- 1.11 The role of Kent Police in responding to the Birchard Inquiry includes making checks of young people's partners where known on a gender-neutral basis without recording this as a crime unless agreed with the agency making the request.
- 1.12 Kent Police will keep a record of their check of the relevant indices for intelligence purposes. When a young person reports that sexual activity took place without their consent then this should be reported directly to Kent Police.
- 1.13 The assessment of Fraser competence is extended to all professionals working with sexually active children and young people and they will be required to maintain their duty of confidence unless there are concerns of a child protection nature.
- 1.14 There may be specific circumstances where the decision to inform the parents or carers that their son or daughter is sexually active could lead to further child protection concerns and these factors will be subject of careful consideration in any strategy discussion. On rare occasions it may not be safe for the parents of the young person to be informed.
- 1.15 In order to ensure that young people are not deterred from seeking sexual health services then the rationale for these procedures will be made explicit to young people.
- 1.16 Overcoming the apparent contradictions in the guidance and the law in order to safeguard young people will require complex professional

judgements and these procedures should be used as a framework for making them.

- 1.17 If the professional concerned finds that these procedures conflict with their religious or moral beliefs and this conflict might affect the care or advice of provided, then this should be discussed with their line manager.
- 1.18 This guidance is designed to be applicable to all children and young people who are sexually active including disabled children and young children who also have a right to a private life and protection from harm.
- 1.19 The sexual behaviour of children and young people is an especially complex and emotive area and if in doubt all professionals are advised to seek advice on an anonymous basis from their nominated child protection lead.
- 1.20 Completed risk assessments should be kept on file in order to inform the MSCB audit function in ensuring that sexually active children and young people are properly safeguarded and in respect of monitoring the implementation of these procedures.

2. Introduction

- 2.1 This document is designed to guide the response of all professionals who come into contact with children and young people under the age of 18 who are sexually active. The term 'professional' in this context has been used to cover all persons working in the statutory private or voluntary sector who provide services for children or young people.
- 2.2 The procedures have been formed within the context of government policies that support the principle that young people should be able to access sexual and reproductive health services without fear of their parents or carers being informed without their consent unless they are at risk of significant harm. It is important to note that these procedures are gender neutral and apply to straight, gay, lesbian, bisexual and transgender relationships.
- 2.3 The procedures and guidance provide a framework for assessing the risk of harm to sexually active young people and how referrals of child protection concern, children in need and the common assessment framework will be managed. The role of Kent Police in this process is also described.
- 2.4 The procedures are intended to respond to consensual or ostensibly consensual sexual relations. Where there is evidence to suggest that

sexual activity took place without the consent of one of the parties then this should be reported to Kent Police.

- 2.5 Young people under the age of thirteen cannot lawfully consent to sexual activity and there would always be reasonable cause to suspect that the child, whether girl or boy, is suffering or is likely to suffer significant harm. There is a presumption that such cases should be discussed with a nominated child protection lead and referred to children's social services. All such cases must be fully documented including where a decision is made not to share information.
- 2.6 Sexual activity with a child under 16 is also an offence. Where it is consensual it may be less serious than if the child were under 13, but may nevertheless have serious consequences for the welfare of the young person.
- 2.7 The aim of the guidance is to provide a framework for ensuring that potential crimes against children are investigated without unnecessarily drawing underage parties into the criminal justice system or deterring young people from accessing sexual health services. This is an important distinction, as while sexual activity involving young people might not be lawful, it is not always abusive or seriously harmful.
- 2.8 The recommendations of the Bichard Inquiry underpin the guidance in Working Together 2006¹ for responding to allegations of harm arising from under age sexual activity on which these procedures are based. Consequently it is essential that those working with sexually active young people are aware of the issues raised in respect of deficiencies in police and social services' information systems which allowed a male aged 21 to be in sexual relations with eleven girls and young women aged 11 to 17 without anyone identifying that he might pose a risk and he subsequently obtained a position of trust.
- 2.9 These factors are particularly relevant in respect of adults who have formed what are ostensibly consensual relationships with young people under the age of 16 who may be exploiting them and are of course acting unlawfully. Where there is a duty of trust or the young person is suffering harm the procedures extend to young people aged 16 and 17.

The procedures therefore provide a facility for checking police indices for intelligence purposes only into the circumstances of the other party in an underage sexual relationship where there are concerns the

¹ HM Government (2006) Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (London: TSO, Paragraph 5.23 p105)

relationship is seriously harmful as might occur where the other party is an adult.

- 2.10 Ensuring that children and young people are both safeguarded and have access to sexual health services has also to be considered in the context of the 25 - 40 per cent of sexually active young people who it is thought are abused or exploited by other young people.² In so doing it is helpful to consider the sexual behaviour of children and young people on a continuum from mutually agreed, consensual experimentation to very serious crimes such as rape. Much of this behaviour however is not abusive and will form an important and necessary part of young people's development.
- 2.11 This is arguably the first time that the state has taken such a direct role in assessing the sexual behaviour of children and young people. The statutory outcomes³ of *staying healthy* and *keeping safe* may conflict in this context as the legislation and the associated guidance can appear contradictory. Overcoming these apparent contradictions in order to safeguard young people will require complex professional judgements and these procedures should be used as a framework for making them.
- 2.12 Young people subject of a referral of child protection concern will seek reassurance as to what will happen next as a result of the referral and they will naturally be concerned whether their parents will be informed. This procedure and guidance address their concerns and it is recommended that all professionals who may come into contact with sexually active young people should read this document in order that they can advise young people accordingly.
- 2.13 In order to ensure that young people are not deterred from seeking sexual health services then the rationale for these procedures will need to be made explicit to young people as well as the professionals who will implement them. A message for young people is provided at Annexe I to this guidance.

3. The principles underpinning procedures:

- 3.1. The welfare of the child is paramount and professionals should work together when assessing the risk of harm when underage sexual activity is taking place.

² NCH (1992) The report of the Committee and the Enquiry into Children and Young People who sexually abuse other children (London: NCH)

³ Section 10(2) Children Act 2004

- 3.2. When working with young people it must always be made clear to them that absolute confidentiality cannot be guaranteed and that in some circumstances the sharing of [proportionate] information with other agencies will be required to safeguard them.
- 3.3. Where a professional becomes aware of a young person under 16 who is engaging in underage sexual activity they will make an initial assessment using the risk assessment tool found at Annexe A of these procedures. Should concerns arise that the relationship is potentially harmful then the professional will always discuss the case with a nominated child protection lead.
- 3.4. It is helpful to consider underage sexual activity occurring on a continuum from sexual exploration and penetrative sex to behaviours that may be assessed by a professional as being harmful or seriously harmful (significant harm).
- 3.5. It is envisaged that all cases of 'seriously harmful' behaviour will be referred to children's social services. Where the behaviour is assessed as being 'harmful' then a decision may be made in conjunction with the professional's nominated child protection lead to manage the risk by providing services and working with the young person to reduce the harmful aspects of their or their partner's behaviour.
- 3.6. In those cases where there is a concern that a relationship is 'seriously harmful' the professional should carefully balance the benefits of knowing a sexual partner's identity against the potential loss of trust in asking for or sharing such information.
- 3.7. Each case should be treated on its merits within this procedural framework. Thus, for example, a girl of 15 who is considered to be having a consensual sexual activity with her boyfriend of 18 would not be referred to children's social services providing there are no other significant risk factors. In contrast, if the girl were 13 then this age differential would suggest that the relationship may be seriously harmful.
- 3.8. If requested, Kent police will make checks of young people's partners where known on a gender-neutral basis without recording this as a crime unless the referrer or the members of a subsequent strategy discussion recommend that it should be treated as such. Kent Police will keep a record of their check of the relevant indices for intelligence purposes.
- 3.9. There is also a facility for a consultation with the police child abuse investigation unit or children's social services on an anonymous basis via a nominated child protection lead within the organisation or agency concerned.

- 3.10. Limited information may lawfully be shared to establish whether further information needs to be shared in the context of s47⁴ enquiries.⁵ This facility for an initial sharing of limited information is an important element of these procedures as it is unlikely that information or concerns about a child or young person and their partner will be held by a single agency.
- 3.11. It is recommended that prior to making a referral of 'child protection concern' to children's social services the referrer should obtain a formal consultation with their local duty and initial assessment team.
- 3.12. Professionals are advised that nothing in these procedures will obviate the need for the police and Children's Social Services to commence s47 enquiries and a criminal investigation in respect of non-consensual sexual activity or seriously harmful behaviour.
- 3.13. All professionals are reminded that they must respect the duty of confidentiality to a young person where the young person is assessed as being Fraser⁶ competent unless there are concerns of a child protection nature which require this duty to be breached. Professionals should seek advice from a health professional, on an anonymous basis if they do not feel confident in assessing whether a young person is Fraser competent.
- 3.14. The overarching aim of the procedures is for professionals working with children engaging in under age sexual behaviour to make an initial assessment of their circumstances using this guidance as a framework. In cases where the behaviour is considered to be harmful or seriously harmful then they must consult with a nominated child protection lead.

4. Moral Issues for Professionals

- 4.1. If the professional concerned finds that these procedures conflict with their religious or moral beliefs and this conflict might affect the care or advice provided, then this should be discussed with their line manager.
- 4.2. It is important to note that s28 of the Local Government Act 1986 (also known as Clause 28) was repealed on 18th November 2003 and it is no longer unlawful to discuss issues of homosexuality with young people.

⁴ Section 47 of the Children Act 1989, an enquiry undertaken by the Local Authority to enable them to decide what action they should take to safeguard or promote a child's welfare.

⁵ HM Government (2006) *ibid.* Working Together (para 5.21 p105)

⁶ See Appendix D of these procedures, Fraser Guidelines and the Role of Care Professionals

5. Definition of Sexual Activity

- 5.1 Under the Sexual Offences Act 2003, penetrative sex with a child under 13 is classed as rape. Working Together 2006⁷ states that where the allegation concerns penetrative sex or where other **intimate** sexual activity occurs there would always be reasonable cause to suspect that a child, whether girl or boy, is suffering, or likely to suffer significant harm.
- 5.2 Sexual activity with a child under 16 is also an offence. Where it is consensual it may be less serious than if the child were under 13, but may nevertheless have serious consequences for the welfare of the young person.
- 5.3 For the purposes of these procedures, Section 9 of the Sexual Offences Act 2003⁸ is shown in detail below in order to provide a definition of sexual activity. It should be noted that this definition also applies to child sex offences committed by children or young persons [s13 Sexual Offences Act 2003].

(1) A person aged 18 or over (A) commits an offence if-

(a) he intentionally touches another person (B)

(b) the touching is sexual, and

(c) either-

(i) B is under 16 and A does not reasonably believe that B is 16 or over, or

(ii) B is under 13

(2) A person is guilty of an offence under this section, if the touching involved -

(a) penetration of B's anus or vagina with a part of A's body or anything else,

(b) the penetration of B's mouth with A's penis

(c) penetration of A's anus or vagina with a part of B's body, or

(d) penetration of A's mouth with B's penis

- 5.4. The above definition does not provide a definition of non-penetrative intimate sexual touching and the extent to which sexual activity or touching is considered to be intimate will require a judgement by the professionals concerned. For example a girl or boy of 11 masturbating

⁷ HM Government (2006) *ibid.* (Paragraph 5.25 p105)

⁸ The Sexual Offences Act 2003

a boy of 15 would have a different significance to that of consensual mutual masturbation between two 15 year olds.

- 5.5. Professionals are advised that understanding and implementing the Sexual Offences Act 2003 requires expert knowledge and it is the responsibility of the police and the Crown Prosecution Service to make decisions about whether a criminal offence has been committed and whether a criminal prosecution should ensue.
- 5.6. Professionals may however seek a consultation on an anonymous basis. For example, a professional via their nominated child protection lead may seek clarification as to whether a relationship falls within the legal definition of a breach of trust, s27 Sexual Offences Act.
- 5.7. The age of consent for young people who are in a relationship of trust is 18. Broadly speaking the definition of persons who may have a duty of trust includes family members, baby sitters / au pairs, foster carers, teachers, youth workers, foster carers or social workers. If in doubt seek advice.

6. Guidance and legislation

- 6.1. The primary legislation and guidance falls within the Children Act 1989, Working Together 2006, the Sexual Offences Act 2003 with its related guidance, and the Revised Guidance for Health Professionals on the Provision of Contraceptive, Sexual and Reproductive Health Services for Under 16's.⁹
- 6.2. The Home Office guidance entitled "Working with the Sexual Offences Act 2003"¹⁰ states that:

Although the age of consent remains at 16, the law is not intended to prosecute mutually agreed teenage sexual activity between two young people of a similar age, unless it involves abuse or exploitation. Young people, including those under 13, will continue to have the right to confidential advice on contraception, condoms, pregnancy and abortion.
- 6.3. It is important to note that the impact of gender neutrality within the Sexual Offences Act 2003 means that the parties in an under age sexual relationship have the potential to be classified by the police as

⁹ Department of Health (2004) Best Practice Guidance for Doctors and other Health Professionals on the provision of Advice and Treatment for Young People under 16 on Contraception, Sexual and Reproductive Health

¹⁰ Home Office Communications Directorate (May 2004) Working within the Sexual Offences Act 2003

both offender and victim. This could have life long repercussions for the children or young persons concerned.

- 6.4. The Children Act 1989 Guidance and Regulations¹¹ provide a helpful outline of how social care professionals should respond when working with all sexually active young people and especially with regard to young people who have experienced abuse and neglect and are living away from home. A summary of this guidance is shown below and at Annexe E.
- 6.5. The experience of being cared for should include the sexual education of the young person if the young person's school does not provide this. This is considered to be absolutely vital since sexuality will be one of the most potent forces affecting any young person in the transition from childhood to adulthood.
- 6.6. In working with sexually active young people, advice and guidance should extend beyond contraception. It should include the emotional aspects of sexuality, such as the part that sexuality plays in the young person's sense of identity; the emotional implications of entering into a sexual relationship with another person; and the need to treat sexual partners with consideration and not as objects to be used. The needs and concerns of lesbian, gay, bisexual and transgender young people must also be recognised and approached sympathetically.
- 6.7. Those responsible will need to bear in mind the particular needs of different young people including the sexual needs of young people with mental or physical disabilities. Young people who have been abused, or have been in touch with abused young people, may need special counselling if they are not to regard sexual feelings as a matter for shame or to regard sexual relationships as impersonal and exploitative.
- 6.8. The Teenage Pregnancy Strategy¹² provides useful information about young people subject to multiple risk factors as their likelihood of teenage parenthood increases significantly. For example, young women experiencing multiple risk factors have a 31% probability of becoming a mother under 20, compared with a 1 % probability for someone experiencing none of these risk factors. Similarly, young men experiencing the same risk factors had a 23% probability of becoming a young father compared to 2% for those not experiencing any of these risk factors.
- 6.9. Member agencies of the Medway Safeguarding Children Board may also be subject of separate codes of practice such as the GMC

¹¹ DoH (1991) The Children Act Guidance and Regulations Volume 4 Residential Care (London HMSO)

¹² DfES (2006) Teenage Pregnancy, Accelerating the Strategy to 2010 (DfES Publications Nottingham p12)

guidance entitled "Children and Young People: Doctors' Roles and Responsibilities"¹³ and the Relationships and Sex Education Policy and Guidance for Looked after Children.¹⁴ The DfES provides sexual and relationship guidance for head teachers, teachers and governors.

7. Assessment and Referral to Children's Social Services

- 7.1 This will necessarily involve progressing through a number of stages. The first is to establish the age of the child or young person and the implications of this as shown below. It is recognised that some young people will not immediately provide their true age or reveal any identifying features of their partner. This in itself should not rule out the provision of sexual health advice and treatment. However, professionals should be aware that the Bichard Inquiry found that the name of man in question had been known to the agencies for some considerable time.
- 7.2 Making professional judgments involving the age and age differential in young people's sexual relationships is always a complex undertaking and will usually require consultation with a supervisor or nominated child protection lead. The risk assessment tool is designed to assist in making these judgments and should be considered with the factors below.
- 7.3 The Committee of Enquiry into children and young people who sexually abuse other children found that there is cause for concern if there is an age difference of more than two years, or if one of the children is pre-pubertal and the other post-pubertal. (NCH, 1992, p.4)¹⁵ The issue of whether an action is abusive becomes less clear as the age gap narrows and the sexual acts become less physically intrusive. In addition, the Committee of Enquiry (ibid NCH) notes that a young child can abuse an older child if the older one is disempowered because of disability. There are also examples of young people who have sexually abused adults.
- 7.4 Young people, particularly those in later adolescence, may struggle with the transition to adulthood fluctuating between different types of behaviours, sometimes wanting to be the independent adult and at other times presenting as a dependent child. This can be a particularly

¹³ GMC (2007) Children and Young People: Doctors' Roles and Responsibilities (General Medical Council)

¹⁴ KCC (2005) Relationships and Sex Education Policy and Guidance for Looked After Children (Kent County Council Children's Social Services March 2005)

¹⁵ NCH Their report of the Committee and Enquiry into Children and Young People who sexually abuse other children (London: NCH)

concerning time for their family and professionals, especially when the young person rejects advice and support. (Pearce 2006)¹⁶

- 7.5 At the same time this transition can be interrupted by a manipulative adult, intent to create and widen the rift between the child or young person and their supportive networks, and they may become harder to manage as this is the point that they are most rejecting of help.
- 7.6 As a consequence interventions may need to be differentiated with younger adolescents requiring the full measures of the child protection process. In contrast the older adolescent may benefit from an approach that recognises them both as suffering significant harm and as active agents who can be helped to gain constructive control of their circumstances. (ibid Pearce 2006)
- 7.7 It is likely that in all such cases a strategy discussion will be required in order to make decisions about the best way forward, including how to respond to the other party. There may be situations of seriously harmful behaviour where the young person's duty of confidentiality may need to be preserved and their parent/carer is not informed provided that progress is made in reducing the harm.

Stage (i): Establishing the age of the child or young person

- 7.8 Cases of underage sexual activity, which present cause for concern, are likely to raise difficult issues and should be handled particularly sensitively. Children and young people may need time to establish trust before sufficient information is available to make an informed assessment of their needs and any risk of harm.

Children under the age of 13

- 7.9 A child under 13 is not legally capable of consenting to sexual activity. Any offence under the Sexual Offences Act 2003 involving a child under 13 is very serious and should be taken to indicate a risk of significant harm to the child. Cases involving under 13's should **always** be discussed with a professional's nominated child protection lead. Under the Sexual Offences Act 2003, penetrative sex with a child under 13 is classed as rape.
- 7.10 Where the allegation concerns penetrative sex, or other intimate sexual activity, there will always be reasonable cause to suspect that a child, whether girl or boy, is suffering or is likely to suffer significant harm. There is a **presumption** that the case will be reported to children's social services and that a strategy discussion will be held. All cases involving under 13's should be fully documented, including giving

¹⁶ Pearce J (2006) Who Needs to be Involved in Safeguarding of Sexually Exploited Young People? Child Abuse Review Vol 15: 326-340

detailed reasons where a decision is taken not to share information. These records should be made available for subsequent audit by Medway Safeguarding Children's Board

- 7.11 The strategy discussion should include the professional making the referral, and representatives from children's social services, police public protection and other relevant agencies. Particular sensitivity will be required where the other party is also under 13 as both children may be at risk of significant harm.
- 7.12 Although a child under the age of 13 cannot give consent to sexual activity this does not mean that consent to certain activities never occurs, nor should it imply that those over 13 are able to consent freely.

Children and young people aged 13-15

- 7.13 Sexual activity with a child under 16 is also an offence. Where it is consensual it may be less serious than if the child were under 13, but may nevertheless have serious consequences for the welfare of the young person. Practitioners may find the following definition useful since it goes some way to overcoming the limitations of the age differential.

Consent is based on choice. Consent is active not passive. Consent is possible only when there is equal power. Forcing someone to give in is not consent. Going along with something because of wanting to fit in with the group is not consent ... If you can't say 'no' comfortably then 'yes' has no meaning. If you are unwilling to accept 'no' then 'yes' has no meaning.¹⁷
(Adams 1984)

- 7.14 Consideration should be given in every case of sexual activity involving a child aged 13-15 as to whether there should be a discussion with other agencies and whether a referral should be made to children's social services. The professional should make this assessment using the risk assessment tool and the guidance contained within these procedures.
- 7.15 Within this age range, the younger the child, the stronger the presumption must be that sexual activity will be a matter of concern. Cases of concern should be discussed with the nominated child protection lead and subsequently with other agencies if required. Where confidentiality needs to be preserved, a discussion can still take place as long as it does not identify the child (directly or indirectly).

¹⁷ Adams, C, Fay, J and Loreen-Marlin, J (1984) No is not enough: Helping teenagers avoid sexual assault (San Luis Obispo, Calif: Impact)

7.16 Where there is reasonable cause to suspect that significant harm to a child has occurred or might occur, there is a presumption that the case is reported to children's social services and a strategy discussion convened to discuss appropriate next steps. All cases should be carefully documented including where a decision is taken not to share information.

Children aged 16 - 17

7.17 Sexual activity involving a 16 or 17 year old, though unlikely to involve an offence, may still involve harm or the risk of harm. Professionals should still bear in mind the considerations and processes outlined in this guidance in assessing that risk, and should share information as appropriate. It is an offence for a person to have a sexual relationship with a 16 or 17 year old if they hold a position of trust or authority in relation to them.

Stage (ii): Using the Common Assessment Framework (CAF) ¹⁸

7.18 The CAF is intended to provide a simple process for a holistic assessment of a child's needs and strengths, taking account of the role of parents, carers and environmental factors on their development.

7.19 A common assessment can be done at any time where there is concern about how well a child or young person is progressing and can include children engaging in underage sexual activity. The decision about whether to undertake an assessment should normally be made jointly with the child and/or parent. However, if the child is old enough and competent (Fraser competent) to understand they may make their own decision.

7.20 In those cases where there are concerns about the sexual activities of a young person who is Fraser competent the CAF may provide a framework for applying the risk assessment tool and can provide the context for a referral to another agency such as sexual health services. The procedure for dealing with referrals of child protection concern is shown below.

Stage (iii): Using the Risk Assessment Tool

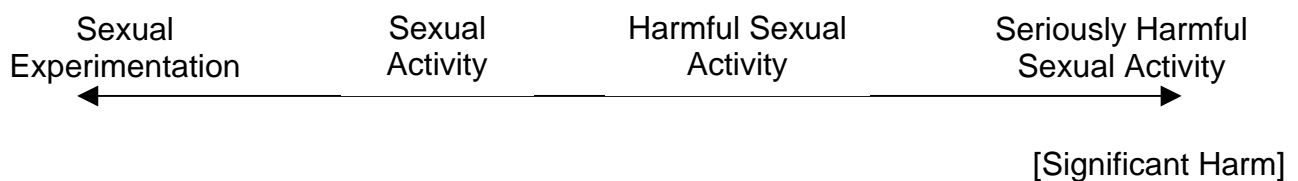
7.21 The risk assessment tool is based on the guidance in Working Together 2006¹⁹ and provides a range of factors that should be taken into account when assessing whether or not the sexual activity is harmful. The assessment tool is not an empirically validated instrument for assessing risk and should be considered as a measure to assist professional judgements.

¹⁸ The Common Assessment Framework has not yet been implemented. Details can be found at http://www.everychildmatters.gov.uk/delivering_services/caf/

¹⁹ Ibid Working Together 2006 (paragraph 5.27)

7.22 The decision making process and the reasons justifying a course of action will need to be recorded and signed by the professional concerned - whether or not a decision is made to discuss with a nominated child protection lead. The assessment tool is located at Annex A of these procedures and the continuum of sexual activity is shown below.

The Sexual Activity Continuum



Applying the Risk Assessment

7.23 The professional concerned should complete the risk assessment tool using the information and knowledge that they have at the time. As more information becomes available then the assessment should be reviewed. The tool is designed to provide a simple yes or no and a brief comment against each dimension based upon the information available.

7.24 The professional should then make a judgement about where the sexual behaviour lays within the continuum based on the totality of the information available. Wherever possible this should be carried out in conjunction with the child or young person. If the behaviour is considered to be harmful or seriously harmful then there should be a consultation with the professional's nominated child protection lead and there should be a careful record kept of the discussion that can be made available for future audit by MSCB. The nominated child protection lead should also be consulted if the professional feels that further information is required before completing the assessment.

7.25 Assessments that indicate the behaviour may be harmful or seriously harmful may be made subject of a consultation with the Police and Children's Social Services on either an anonymous basis or by sharing a limited amount of information including the name of the partner where known. Kent Police will not treat this as a crime without the agreement of the referrer and children's social services will similarly not treat this as a referral.

- 7.26 Cases of harmful behaviour will not normally be referred to children's social services. In these circumstances a professional, in consultation with a nominated child protection lead, would work with the young person in order to reduce the level of perceived harm and avoid the risk of alienating them from accessing sexual health services. Any such arrangements should be subject of regular review with the professional's nominated child protection lead and a careful record kept.
- 7.27 Confidentiality is never absolute and, in most cases, competent professionals will be able to articulate the need for information from the police public protection unit in a manner that does not undermine the integrity of the agency concerned.
- 7.28 Decisions not to refer cases of seriously harmful behaviour (significant harm) to the police child abuse investigation unit and children's social services must be made within the agency's supervision arrangements and at first line manager level or above.
- 7.29 Where there is a disagreement between professionals about the harm relating to the sexual activity or in respect of the circumstances of the parties involved then a meeting of the relevant professionals should be convened. These procedures are reliant on a considerable degree of trust between the professional and the child and within the professional group. Failure to respect the other's position within the context of these procedures could deter young people from accessing sexual health services and leave them at risk of significant harm.

Confidentiality

- 7.30 Decisions to share information with parents require professionals to use their judgement and should be informed by the guidance on Information Sharing and Confidentiality in the Kent and Medway child Protection Procedures. However, the test of competence in respect of underage sexual activity falls within the ambit of the Fraser guidelines which are found at Annexe D.

This guidance along with the associated test of Gillick competence was initially directed at clinicians rather than other professionals involved with sexually active young people but have now been extended as described in the guidance.

- 7.31 The Sexual Offences Act 2003 clarifies the role of teachers, health care professionals, sexual health counsellors and Connexions/youth workers in providing sexual health advice. This states that;

Professionals are not liable to prosecution when they are acting to protect a child or young person, including those with a mental

*disorder from becoming pregnant or promoting their well being by giving advice.*²⁰

- 7.32 Consequently a wider range of professionals will be required to make judgements as to whether a young person is Fraser competent and this test is provided in these procedures for that reason. The role of care professionals in respect of contraceptive advice [etc] to young people is contained in Annexe D of these procedures.
- 7.33 For those children who are referred to children's social services and the police, it will normally be necessary for professionals to inform the parent or carer of the reasons for the enquiries being made. This may be highly sensitive for the child and their partner if also a young person. The strategy discussion will therefore need to address the potential for further child protection concerns arising as a result of the s47 enquiries being made.
- 7.34 In exceptional circumstances a decision may be made not to inform the young person's parent or carer. The circumstances that might lead to such a decision being made to withhold information are:
- There would be a risk of significant harm to the young person, or their partner, if their parents were to become aware that their son or daughter was sexually active. Gay, lesbian, bisexual or transgender relationships may present additional difficulties for the young person. Similar issues may arise in respect of faith or culture.
 - The young person's ability to access confidential sexual advice would be compromised if his or her parent or carer was advised and the strategy discussion had decided on the information available that s.47 enquiries were not required or that the young person was not found to be suffering significant harm.
 - There is a risk of contaminating evidence in a criminal investigation.

Thresholds for Referring to Children's Social Services

- 7.35. The decision whether or not to make a formal referral to children's social services and the police must be made within the supervision arrangements of the organisation concerned in consultation with the professional's nominated child protection lead.

²⁰ Home Office (2004) Working with the Sexual Offences Act (Home Office Communications)

Responding to individual cases of young people engaged in mutual experimentation or sexual activity

- 7.36 Where an agency involved knows that a young person is sexually active and the risk assessment does not raise concerns then the professional should continue to make arrangements for the young person to receive confidential advice and support from appropriate sexual health or other relevant services.

The circumstances of the case should be periodically reviewed with the young person using the risk assessment tool as trust develops and more information becomes available.

Responding to Individual cases of Harmful Behaviour

- 7.37 Where it is assessed that the sexual activity is harmful the professional should continue to make arrangements for the young person to receive confidential advice and support and refer to other agencies as required.

- 7.38 In all such cases there should be an agreement with the young person to establish means by which the harm can be reduced. The circumstances of the case must then be periodically reviewed using the risk assessment tool in conjunction with the young person. In all such cases there should be regular consultations with the professional's nominated child protection lead.

- 7.39 If concerns persist an anonymised consultation with children's social services should be made. Proportional information can also be shared including the young person's name in order to check if they are known to children's social services without this being treated as a referral. If the name and details of the other party in the relationship is known then Kent Police and children's social services will check their indices. In respect of the police child abuse investigation unit this can be carried out on a 'no-crime' basis as described at Annexe B.

- 7.40 It is important to note that only nominated child protection leads²¹ can make a request for intelligence checks from the police public protection unit. Such requests will be made using the designated request form which should be faxed to the local police public protection unit.

Responding to individual Cases of Seriously Harmful Behaviour

- 7.41 In these cases where a practitioner has concerns that a relationship presents a risk of significant harm (seriously harmful behaviour within the risk assessment tool) to a child or young person they should make

²¹ Nominated child protection leads include: named or designated doctors or nurses, children's safeguarding officers, senior staff within teenage pregnancy units and GUM units and GUM clinics and nominated child protection leads within other agencies.

a consultation with children's social services unless there is a risk of immediate harm when a referral of child protection concern will be made. During this consultation the professional can also request a consultation with the local police public protection unit, if details of the other party are known or other concerns such as a breach of trust are thought to have occurred.

- 7.42 Good practice indicates that children or young persons should normally be informed that a referral of child protection concerns is being made unless there is a likelihood that evidence will be contaminated. If there is doubt about how to manage the competing imperatives of keeping the child or young person informed and of preserving evidence then an anonymous consultation should be made before informing the young person.
- 7.43 If a referral of child protection concern is required then this should be made verbally via Customer First (on 01634 334466) followed by a written referral within 48 hours as described in the Kent and Medway Child Protection Procedures. The risk assessment should be faxed at the time of the referral.
- 7.44 Practitioners who may wish to make a referral of Child in Need should complete an Inter-Agency Referral form and seek the consent of the child or young person, as there is a duty of confidentiality in respect of sexual activity unless there are concerns of a child protection nature. Young people who are Fraser competent can also be assisted in completing a CAF for which only their consent is required.

Abuse through Sexual Exploitation

- 7.45 If there are concerns that the child or young person may be at risk of abuse through sexual exploitation (prostitution or pornography, including creating/exchanging images, grooming etc through the internet), a referral to Children's Social Services and to Kent Police **must** be made in accordance with the Kent and Medway child Protection Procedures.

Stage (IV): Referring to Children's Social Services and Police Child Abuse Investigation Unit (CAIU)

Children under the age of 13 years

- 7.46 There is a presumption²² that all cases of children under the age of 13 years believed to be engaged in penetrative sexual relationships or intimate sexual activity should be referred to Children's Social Services and the Police. Children's Social Services will discuss the case with the

²² These procedures also provide for those cases where a referral of child protection concern is not made.

local Police CAIU and convene a strategy discussion. See overleaf for the next steps.

Children aged between 13 and 15 years

- 7.47 In cases where Children's Social Services receive a referral of child protection concern and identify a risk of significant harm or are aware that an offence may have been committed against a child, they will hold a strategy discussion with the police and the referrer.
- 7.48 Kent police will check their indices of the parties involved on a 'no crime' basis unless otherwise agreed with the referrer and share this information with children's social services. Children's social services and the police child abuse investigation unit will, together with other involved agencies determine the need or otherwise for child protection enquiries to be made in line with the Kent and Medway child Protection Procedures.
- 7.49 In those cases where children's social services are made aware of a sexually active young person and decide **not** to initiate child protection procedures then this decision must be made by a first line manager or above; **and only after the Police indices have been checked.** These circumstances may also apply to looked after children for whom children's social services have a duty of care.
- 7.50 A decision to not make a formal referral to the Police will usually only be made by children's social services after an initial assessment, when there is clear evidence that the young person is not being abused or exploited through the sexual relationship. The decision and reasons must be recorded contemporaneously in the children's social services record for the young person. Issues of confidentiality will require careful consideration.
- 7.51 In most cases where a practitioner has concerns that a relationship presents a risk of harm to a young person, there will be a process of interagency information sharing and discussion in order to formulate an appropriate plan. Immediate or ongoing support should be offered to the young person whilst an appropriate single or multi-agency plan is put in place.

Criminal Investigation

- 7.52 It is an offence for any young person to engage in a sexual relationship under the age of 16. Nevertheless, in the majority of cases, it will not be in the best interests of the young person for criminal proceedings to be instigated against them or their partner unless there are specific concerns about the nature of the relationship. Annexe B of these procedures outlines the role of Kent Police and includes guidance about

responding to requests for information about individuals believed to be in an under age sexual relationship.

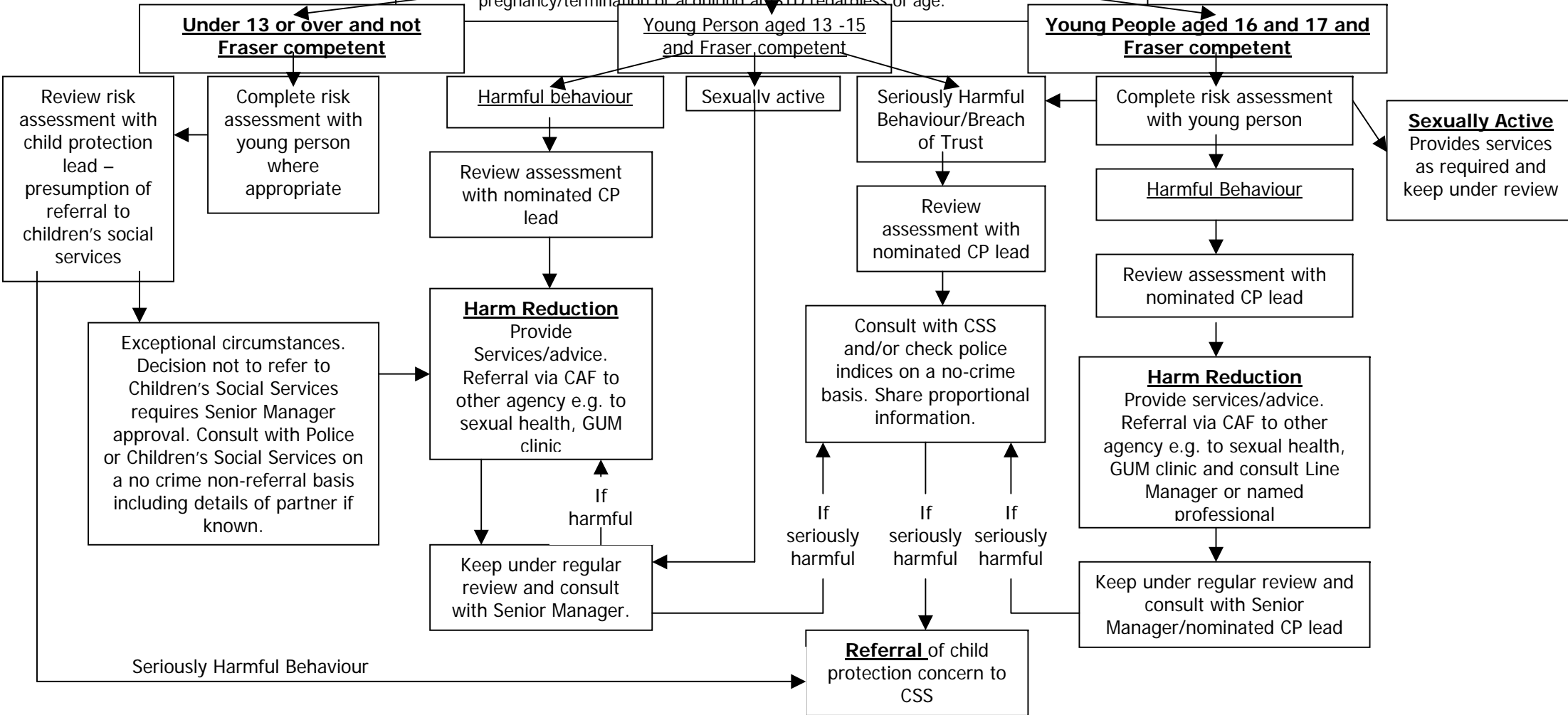
Safeguarding Young People 16 and 17 years

- 7.53 Consensual sexual activity is not an offence with young people who have reached the age of 16. Nevertheless young people aged 16 and 17 are still vulnerable to harm through an abusive sexual relationship. Practitioners providing services for this age group need to assess their safety and well being using the risk assessment tool and should make a referral of child protection concern to children's social services if they are suffering significant harm.
- 7.54 The fact that the young person is older than the age of consent should not exclude them from being safeguarded and professionals are reminded that the KMSP apply to children up until their eighteenth birthday.
- 7.55 Experience obtained by sexual health professionals within Medway has indicated that the sexual behaviour and relationships of this older age group can be particularly problematic and such young people may be vulnerable to predatory behaviour by adults who dis-inhibit them with alcohol or substances and where there can be a significant power differential.
- 7.56 Young people 16 and 17 years old are not deemed able to give consent if the sexual activity is with an adult in a position of trust or a family member as defined by s27 Sexual Offences Act 2003.

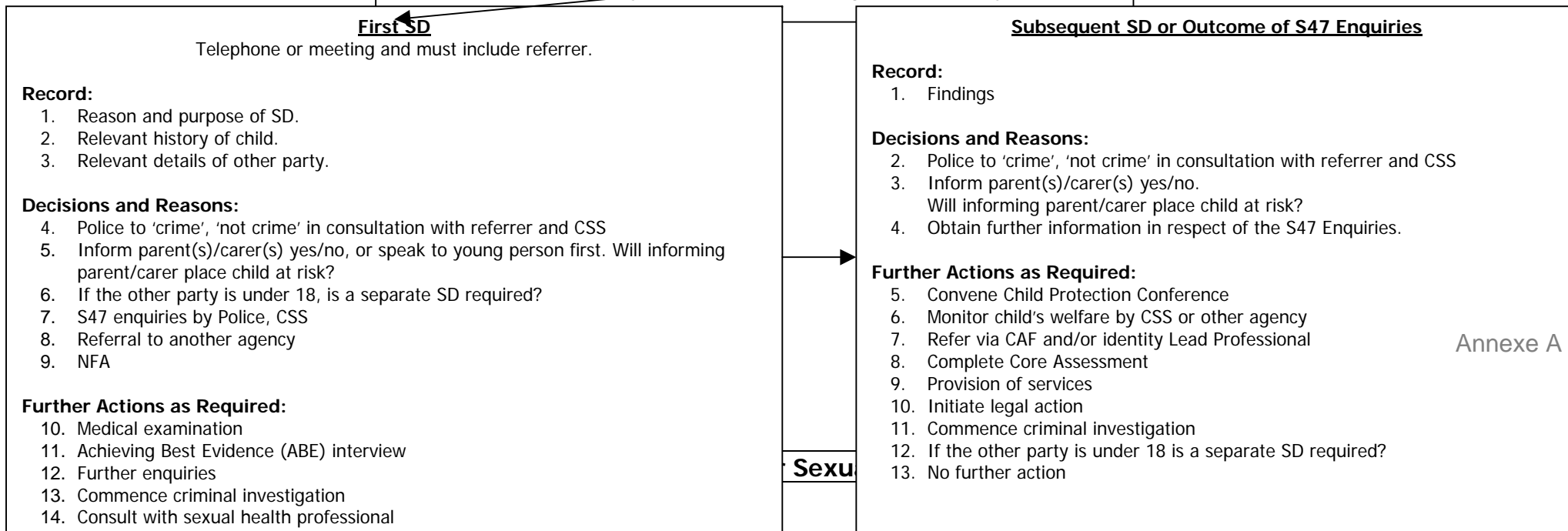
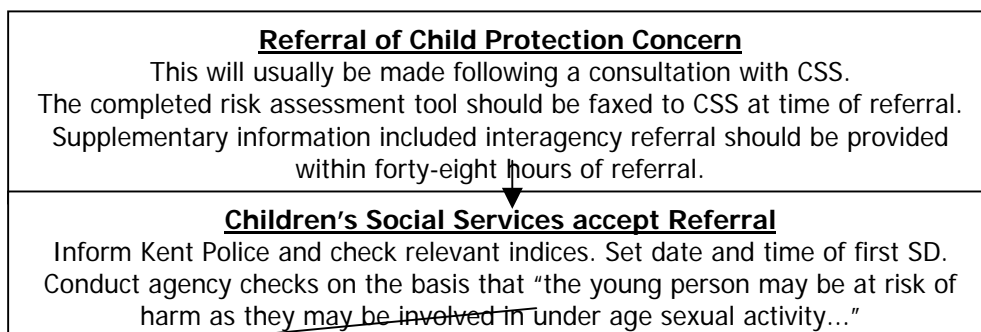
Flowchart: All Professionals working with Children and Young People aged under 18 who are Sexually Active

Professionals should attempt to build rapport and trust with the young people and seek the following information:

- The age of the young people and details of their sexual partner
- Establish whether the young people is Fraser competent
- Advise on limits of confidentiality
- Complete the risk of assessment tool with the young person
- Continue to provide services: "It would be against a young person's human rights to withhold appropriate contraceptive advice and/or treatment to prevent pregnancy/termination or acquiring an STD regardless of age."



Flowchart: Strategy Process for Children and Young People considered potentially at risk of significant harm resulting from their sexual activity



Annexe A

Sexu

Disagreement/Dissent

Where there is a disagreement between the parties about where the parent(s) or carer(s) should be informed or whether the matter should be treated as a crime by Kent Police then the matter should be reviewed by the Local District Manager, the CAIU Detective Inspector and the nominated Child Protection Lead of the referring agency.

1. The age of the child	Sexual activity at a young age is a very strong indicator that there are risks to the welfare of children, whether boy or girl, and possibly others. This is particularly relevant if one of the parties is pre-pubertal. Children under 13 cannot lawfully give consent to sexual activity and there is a presumption that they will be referred to children's social services.		
2. The level of maturity and understanding of the child.	Is the child/young person competent to consent to the sexual activity?		
	Is there a relationship of trust? A legal definition is provided at s27 Sexual Offences Act 2003.		
3. The child's living circumstances or background.	Has a child in need [s17] or referral of child protection concern [s47] ever been made on any party?		
	Do cultural or religious beliefs have an impact on their circumstances and/or sharing information?		
4. Coercion or bribery.	Has the child been encouraged to exchange sex for favours or other inducements such as supply of alcohol or substances?		
	Is there evidence of persuasion, emotional blackmail, threats or use of pornography?		

MSCB Risk Assessment Tool for Sexually Active Young People

Indicator of Risk or Harm	Considerations for Assessment	Concern Yes/No	Comment
5. Familial Child Sex Offences	At this stage of the assessment is any family member considered to be "a risk to children" or have convictions for sexual offences?		
	Does the following sexual partner fall within any of the following categories beyond the normal family relationships? Step-parent, foster parent, step sibling who live in the same household or have been regularly involved in caring for the child; or care workers such as nannies or au pairs if they live with or regularly care for the child.		
6. Behaviour of the child	Is the child withdrawn or anxious?		
	Is there a pattern of 'casual' sexual relationships with different partners?		
	Are there more than two other persons involved in the sexual activity?		
7. The misuse of substances or alcohol as a disinhibitor	The child or young person may be unaware or reluctant to acknowledge that alcohol or substances may be offered to facilitate sexual activity with them.		
	The young person's own behaviour in misusing substances or alcohol may place the young person at increased risk of harm, as they may be unable to give informed consent.		

MSCB Risk Assessment Tool for Sexually Active Young People			
Indicator of Risk or Harm	Considerations for Assessment	Concern Yes/No	Comment
8. Secrecy	Has the sexual partner attempted to secure secrecy beyond what might be considered usual in a normal teenage relationship? Advice may need to be sought from a sexual health expert.		
9. Power imbalance	Is the relationship reasonably equal and consensual? Power imbalances can occur in many different forms including threats and aggression.		
	Is there an age differential greater than 3 years?		
10. Disability impending choice	Disabled children and young people are more likely to be abused than non-disabled children. However, disabled children and young people have a right to a private life, which should be respected. See Home Office MenCap ²³ guidance. The Sexual Offences Act provides an offence of sexual activity against persons with a mental disorder impending choice. ²⁴		

²³ Home Office/Mencap (undated) Protecting You From Sexual Abuse: A booklet about sexual abuse & the law for young people under 16 with a learning disability

²⁴ Section 79(6) SO Act 2003 provides the interpretation of 'mental disorder' as the meaning given by s1 of the Mental Health Act 1983

Assessment Outcomes

Date of Assessment:

Outcome	Decisions (tick as many as required)		
More Information Required	<ul style="list-style-type: none"> • Continue to provide advice and/or services as necessary. • Referral to specialist services such as sexual health or GUM. • Harm reduction and manage the risk without referral to CSS or Police – details specified in notes. • Gain trust and review as more information becomes available. • Obtain more information about sexual partner. • Professional to review with young person in _____ weeks'/months' time. • Discuss with named professional and review risk assessment. • Consult with children's social services. • Check police indices on a 'no crime' basis via a named professional only. • Immediate referral of a potential crime to Kent Police. • Referral of child protection concern to children's social services. 	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Activity (no immediate concerns)		<input type="checkbox"/>	<input type="checkbox"/>
Harmful Sexual Activity		<input type="checkbox"/>	<input type="checkbox"/>
Seriously Harmful Sexual Activity		<input type="checkbox"/>	<input type="checkbox"/>
<u>Additional Information re: action to be taken (use continuation sheet)</u>			
<u>Views of Young Person (use continuation sheet)</u>			

Signatures – Date of Review of Assessment:

Professional		Young Person	Named Professional	
Name	Position	Name	Name	Position

The Role of the Child Abuse Investigation Unit (formerly SIU)

Request for police information and referrals to the police

In cases of concern, where sufficient information is known about the sexual partner the agency concerned should check with other agencies, including the police to establish whether there are any child protection concerns about that individual. The police will normally share this information without beginning a full investigation if the agency making the check requests this.

Automatic formal referral to the police may stop young people confiding in social care and health practitioners, including those young people most at risk of abuse. Nevertheless, the police may hold information about individuals who pose a danger to young people, which is not necessarily known to other agencies.

Kent Police Service have agreed therefore that, for the purposes of these procedures, the police child abuse investigation unit will provide information about children and their sexual partners for the purposes of an agency's risk assessment (to which no decision has been made regarding making a referral or reporting of a crime) without treating the information as a formally referred allegation of crime. The police will record the request for intelligence purposes in order that potential abusers can be identified.

This information may only be obtained from the police child abuse investigation unit via a nominated child protection lead, children's safeguarding officer and managers of teenage pregnancy units and genito urinary clinics using the prescribed form.

Protocol for Professionals who require information from Kent Police under this guidance

1. Nominated child Protection Leads will make the request to the Police.
 - 1.1 Contact will be made with the relevant Detective Sergeant of the Child Abuse Investigation Unit (CAIU) within that area by fax (see details).
 - 1.2 The fax will contain the following details
 - Name of professional and supervisor making request
 - A reference number and return fax number
 - Name and date of birth of client (please see additional information below).
 - Name and date of birth of client's sexual partner(s)
 - A signed declaration stating that ' information required in relation to MSCB risk assessment tool SAYP 3 '
 - Contact details of professionals included.
2. On receipt of the fax the CAIU will make the following Police checks;
 - a) Police National Database (PNC)

- b) All local intelligence data bases (including Genesis, lotus notes, ViSOR)
 - c) The Detective Sergeant will then make a considered decision as to the relevance of the information in the knowledge that this is for a risk assessment, under this guidance.
 - d) The decision and information returned for each name supplied will be either;
 - NO relevant information
 - Or
 - Relevant information held by Police
(No other information will be given at this stage)
 - e) The decision will then be faxed back.
3. The professional on receipt of response stating '**Relevant information held by police**' will either
 - a) Seek further consultation
 - b) Make a referral
 - c) Report a crime
 4. If the D/Sgt of the CAIU feels that the information held by the Police is so current and of such importance there will be an expectation that the Officer would make contact with that 'agency' or the SSD.
 5. Unless urgent the Police will reply within 3 working days.
 6. If the requesting agency believes that the client and / or partner may have or had, residence elsewhere in the country (UK) and this may have an impact on the risk assessment; then direct consultation with the D/Sgt CAIU should be made after receiving the result of the local checks. The consultation will be around further checks being made, by making use of the IMPACT NOMINAL INDEX (INI).
 7. Details of the request will be placed on the (Police) CAIU spreadsheet and the fax filed for auditing and reference purpose.
 8. It should be noted that due to the difficulty of retrieving information with only Name and Date of Birth, consideration should be given by the requesting agency to include Place of Birth and / or an address. The decision to include this will remain with the requesting agency with the knowledge of the limitations. (For example the surname Smith / Jones / Brown will be difficult to process without a place of birth and an address)
 9. If as a result of a decision being made by the requesting agency to make a referral under the Kent and Medway child protection procedures (Children Act 1989 / Children Act 2004) the Police will then reveal the relevant information to the appropriate agencies.
 10. The Police are fully aware of the difficulties confronted by agencies

dealing with young persons requesting advice regarding sexual health. Kent Police will remain open for a consultation especially under certain aspects of the law such as section 27 of the Sexual Offences Act 2003 (re advice on breach of trust).

11. It is emphasised that failure to respect an agency's position, within the context of these procedures, could deter young people from accessing sexual health services and leave them at risk of significant harm.
12. It is understood that building confidence with clients is essential and that consent should be obtained from the relevant client as a matter of good practise. This guidance has been considered in light of the Crime and Disorder Act 1998, Section 115, Data Protection Act 1998, Children Act 1989, Human Rights Act 1998 (article 8) and the Common Law of Confidence.

Referrals of an alleged crime made to Kent Police

13. In cases where an agency or an individual contacts the Police with an allegation of crime or potential crime the Police will receive the information and create an allegation of crime report and pass to the local Child Abuse Investigation Unit and assess the need for emergency action to protect a child or young person.
14. The CAIU will then make a referral of child protection concern to the local Children's Social Services Department according to the Kent and Medway Child Protection Procedures and undertake the following actions:
 - Share relevant information and have initial strategy discussion with children's social services, and the referring professional as a minimum and confirm the need if any for a criminal investigation and s.47 enquiry and agree any fast-track actions.
 - Attend the strategy meeting (or hold a more detailed strategy discussion) and plan the s47 enquires, ensuring that the interests of the child remains paramount.
 - Conduct investigative activities as agreed and, if relevant, ensure the coordination of s.47 enquiries.
 - Conclude the investigation and decide, in consultation with the Crown Prosecution Service, an appropriate criminal justice disposal, taking into account the wishes of the victim, the public interest, and the views of relevant professionals who are working with the child or young person.

The Role of Children's Social Services (CSS)

Children's social services have three main roles in working with sexually active children and young people who may be sexually active:

1. Undertaking enquiries and a core assessment of children who have been made subject of a referral of child protection concern.
2. Within their role as key worker with children in need including those subject of a child protection plan, and;
3. Working with children looked after by the local authority.

Referrals of child protection concern and child in need

If requested the duty and initial assessment team (DIAT) will provide a consultation with professionals concerned about the welfare of a sexually active child or young person who is under the age of 18. Duty and initial assessment teams may benefit from forming strong links with nominated child protection leads in sexual health services.

The consultation will be usually be on an anonymous basis but where the referrer is prepared to share limited information²⁵ with CSS then the DIAT manager or senior can advise whether the young person is known and if there are any concerns about either party's welfare. This limited sharing of information will not constitute a referral. However if this is indicated then a formal referral of child protection concern or an inter agency child in need referral should be made through the County Duty Service. (CDS)

If a referral of child protection concern is accepted the DIAT manager will convene a strategy discussion (SD). The first SD may be a telephone discussion or a meeting and should always include the police and the referrer. The flowchart on page 25 of these procedures sets out the process for strategy discussion. A decision about whether or not the parent or carer should be informed will be made giving full weight to the child or young person's circumstances including whether they are Fraser competent. Members of the SD will take into account the views of the referrer and other members of the SD and refer to the guidance within these procedures before making a decision as to when to inform the parent or carer. This decision will be taken in tandem with the discussion on whether or not the police should deal with the matter at least in the first instant on a 'no-crime' basis. These factors should be kept under review at any subsequent strategy discussions.

Consideration should also be given as to whether the other party if under 18 may be at risk of harm from the sexual activity or as a result of the referral.

²⁵ Ibid Working Together 2006 (paragraph 5.21 page 105)

Where a parent or carer makes a referral to CSS that their son or daughter is sexually active then the matter may be dealt with either by completing the risk assessment tool with the young person and their parent / carer on a child in need basis and in consultation with Kent Police or via a strategy discussion and s47 enquiries.

In all cases of under age sexual activity that come to the attention of CSS and where the other party can be identified then social workers will always obtain a check of the police indices on a 'no crime basis' in the first instance.

This should also apply to children aged 16 or 17 where there are concerns that behaviour may be harmful or involve a breach of trust or where the young person has additional needs.

The role of social workers working with children and young people within the community who are on their caseload and known to be sexually active

These cases can prove very difficult to manage as the social worker may become aware of the child or young person who is sexually active and the parent or carer does not have this information. The social worker should take advice and refer to this guidance in order to inform decision-making.

It is lawful for a social care professional to engage in formal discussions prior to supporting a visit to the local contraception or sexual health service (Annex D). This advice can also be provided to children below the age of 13. The social worker should always advise the agency concerned that they have signposted the young person.

The social worker should complete the risk assessment tool with the young person if necessary without the knowledge of the parent or carer. Where there are concerns that the relationship is harmful then the social worker should discuss the matter with their supervisor and / or nominated child protection lead. A referral of child protection harm to the DIAT will be made if the child or young person's sexual behaviour is seriously harmful.

The role of social workers with looked after children who are sexually active

Looked after children have the same rights to a private life, as do all young people, but their circumstances are naturally more complex. For example they are entitled to seek contraceptive advice from a sexual health professional without their social worker or carer being informed, provided that they are Fraser competent. At the same time the young person may inform their social worker that they are sexually active and do not want their foster carer told or vice versa.

In these circumstances the child or young person should be advised that it is necessary for both foster carer and social worker to both be aware as there is a partnership of care. This is unlikely to come as a surprise to 'looked after' children as they know that their social worker and foster carer are kept informed about all aspects of their care.

Looked after children may not want their parents informed and this should normally be respected unless agreed otherwise by a strategy discussion. This should apply to all looked after children whether or not the local authority shares parental responsibility.

Information about a young person's sexual behaviour should not normally be discussed at a LAC review unless there is a concern that the relationship and behaviour is seriously harmful. If it does need to be discussed as a result of concerns about the young person's welfare or safety then this should only occur with restricted persons present. For example if the young person does not want their parent or teacher to know then this should be respected unless there are compelling reasons for this information to be shared.

Wherever possible the social worker and foster carer should complete the risk assessment tool with the young person and the social worker should consult with their supervisor or nominated child protection lead if there are concerns that the relationship or behaviour is harmful.

The social worker may benefit from seeking advice from a sexual health professional on an anonymous basis. Where there are concerns that the relationship or behaviour is seriously harmful then a referral of child protection concern must be made.

Where sexual activity between children or young people within a foster or children's home takes place then reference should be made to the guidance at Annex E, children living away from home.

Those working with looked after children should be aware of the research cited in the Teenage Pregnancy Strategy (2006).²⁶ This found that by the age of 20 a quarter of children who had been in care were young parents and 40% were mothers. The prevalence of teenage motherhood among looked after girls under 18 is around three times higher than the prevalence among all girls under 18 in England.

²⁶ DfES (2006) Teenage Pregnancy: Accelerating the Strategy to 2010 (DfES Publications Nottingham, p12)

Fraser Guidelines (1985), see also Gillick

It is considered good practice for doctors and other health professionals working with young people to follow the criteria outlined by Lord Fraser in the case of *Victoria Gillick v West Norfolk and Wisbech Health Authority and the Department of Health and Social Security*. These are commonly known as the Fraser Guidelines and apply to the specific dilemma of providing contraceptive advice to girls without the knowledge of their parent(s) or carer(s):

- The young person understands the health professional advice;
- The health professional cannot persuade the young person to inform his or her parents that he or she is seeking 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 without parental consent.
- There are no age constraints ; in assessing Fraser Competence and health professionals may lawfully provide contraception to children under the age of 13. However, the risk assessment tool should always be used to establish whether the child or young person is suffering significant harm and decisions made accordingly.

Gillick Competence

The test of Gillick competence in contrast provides clinicians with an objective test of competence in a wider area than contraception. This identifies children under 16 who have the legal capacity to consent to medical examination and treatment, providing they can demonstrate sufficient maturity and intelligence to understand and appraise the nature and implications of the proposed treatment, including the risks of and alternative causes of actions.²⁷

Limitations of role for social care professionals and foster carers

Social care professionals are not health professionals so they should not give specific advice on forms of contraception but they can engage in formal discussions prior to supporting a visit to the local contraception or sexual health service. This may include talking to young people about contraception and abortion and providing information on contraception and abortion. Workers should also make young people aware of emergency contraception, where it can be accessed and how to make use of such services effectively.

²⁷ Wheele, R (2006) Gillick or Fraser? A plea for consistency over competence in children: Gillick and Fraser are not interchangeable (BMJ Vol 332, 8 April 2006, p851)

Considering whether there are additional indicators of risk

Sexually harmful behaviour by children and young people

In respect of sexual abuse, there are sometimes perceived to be difficulties in distinguishing between normal childhood sexual development and experimentation, and sexually inappropriate or aggressive behaviour. Expert professional judgement may be required, within the context of knowledge about normal child sexuality, the context of the abusive behaviours and the child's development and family and social circumstances. (Working Together 11.36)

It is always difficult to define sexually harmful behaviour by children and young people. There is a dearth of literature on childhood sexuality and little is known about normal sexual development' and there is a lack of large scale research on children and young people who display sexually harmful behaviour.²⁸

Retrospective studies present a broad consensus that between 25-35 per cent of all alleged sexual abuse involves young, mainly adolescent, perpetrators (Cawson et al, 2000²⁹; Horne et al, 1991³⁰; Kelly et al, 1991³¹; Morrison, 1999³²; Royal Belfast Hospital and Queen's University of Belfast, 1991³³). Based on this estimate and child protection register statistics, Morrison calculates that over 10,000 children were sexually abused by another child or young person in 1994 (Morrison, 1999).

The majority of those who display sexually harmful behaviour are adolescent males but young children and females also commit sexually harmful acts. Little is known about the ethnic origin of children with sexually harmful behaviour. However, children with learning disabilities are over-represented within this group but the reason why is not fully understood.³⁴

It is not known how many of the retrospective victimised group attempted to access sexual health services or tries to speak with close adults or professionals or whether they are a separate population from those young

²⁸ Lovell, E (2002) Children and young people who display sexually harmful behaviour (NSPCC Public Policy Group) January 2002

²⁹ Cawson, P, Wattam, C, Brooker, S and Kelly, G (2000) Child maltreatment in the United Kingdom: a study of the prevalence of child abuse and neglect (London: NSPCC)

³⁰ Horne, L, Glasgow, D, Cox, A and Calam, R (1991) Sexual abuse of children by children (Journal of Child Law, 3(4), 147-151)

³¹ Kelly, L, Regan, L and Burton, S (1991) An explanatory study of the prevalence of sexual abuse in a sample of 16-21 year olds (London: Polytechnic of North London, Child Abuse Studies Unit)

³² Morrison, T (1999) Is there a strategy out there? (In Erooga, M and Masson, H (eds) Children and young people who sexually abuse others; challenges and responses (London: Routledge)

³³ Royal Belfast Hospital and Queen's University of Belfast (1990) Child Sexual Abuse in Northern Ireland: a research study of incidence (Antrim: Greystone Books)

³⁴ Ibid Lovell, E (2002)

people accessing sexual health services. It may be the case that as adults, this group of sexually active young people were able to reflect on their circumstances and realise that they were being exploited or abused. They may not have appreciated this at the time or they were not able to speak out about being abused.

Professionals working with sexually active young people should therefore be mindful of what is known about the continuum from consensual exploration to seriously harmful sexual behaviour and of the prevalence of sexually harmful behaviour inflicted by young people on children or other young people.

Children living away from home

Where sexual activity takes place in a children's home or foster placement a very clear distinction will need to be made between seriously harmful behaviour which requires external child protection intervention and normal childhood behaviour and sexual exploration which should be dealt with by care staff.

Abuse will need to be reported and investigated as with any other abuse and these procedures should inform the process of assessment bearing in mind the particular vulnerability of looked after children to non-consensual sexual activity. A child in a children's home or foster home has the same rights to protection by the police and care agencies as any child. It is important that training and written guidance addresses the boundaries between behaviour which can be regarded as "normal" and behaviour which cannot. Bullying or intimidation also needs to be taken into account.

Assessing this distinction is complex and must be done in consultation with a named professional and the child's social worker.

Such behaviour will have implications for other children within the placement who might have been abused by the same child but not told their carers or have known about the abuse but felt too afraid or guilty to tell anybody. It is important that staff in children's homes co-operate fully with external investigators in order that the full extent of abuse is discovered and that the children involved receive proper counselling and the implications of the incident(s) for the future plans of each child are considered methodically. Staff or carers will require managerial support to deal effectively with this process and avoid defensiveness. In this way the precipitate removal of children, which may not be in their long term interests, is most likely to be avoided.

Disabled children

Disabled children have a right to a private life and at the same time they are more vulnerable to abuse. Their circumstances are complex and their emerging sexual identity can be a time of particular difficulty for them and those who care for them. There are a number of reasons for this including:

- Their need for intimate care from others where it may be difficult for them to set and maintain physical boundaries.
- They may have an impaired capacity to resist or avoid abuse or unwanted sexual attention from peers, or other young people or adults.
- Some disabled young people do not have a lawful capacity to consent to sexual activity (s.30 Sexual Offences Act 2003). The Risk Assessment Tool at Annex A takes this factor into account.
- They may have communication difficulties, which may make it difficult to tell others if they feel uncomfortable in a relationship or they may feel inhibited to complain for fear of losing services or being transferred.
- Disabled children are especially vulnerable to bullying, intimidation or abuse by their peers.

Young people with a disability can be labelled in one dimension only and not seen as anything but a disabled child and where their emerging sexuality is seen as a problem or an added vulnerability. Disabled children frequently live their life according to other people's rules and may become internally compliant. Shared-care arrangements might undermine protective attachments. Ethnic minority status and a disability can compound the problems.

Many myths about disabled children exist; for example, that they are not sexually attractive or desirable so will be protected. But their vulnerability may be appealing, as is their lack of assertiveness. Perpetrators may rationalise their actions as "their only chance of a sexual experience" - "it's not harmful, it's educational", and the perceived lower status of disabled children may lower taboo levels. A further hazard for disabled children is if they do disclose and are not believed that they are more vulnerable to psychotic breakdown. (Hobbs et al 1999)³⁵

With long standing abuse the child may have accommodated the abuse, as with other children, and not be able to speak of the abuse even if it has become evident to others. (ibid Hobbs et al 1999).

Children of Black and Ethnic Minority Culture (BEM)

³⁵ Hobbs, Hanks and Wynne (1999) *Child Abuse and Neglect: A Clinician's Handbook* (Churchill Livingstone/Elsevier Science)

Little is known about the sexual exploitation of young people from different ethnic backgrounds and whether different groups are affected in different ways to others.³⁶ Where ethnicity has been considered an issue, those discussions have tended to centre on young people trafficked into the UK for purposes of sexual exploitation. Little focus has been directed towards young people from minority ethnic background who are born and raised in the UK.³⁷

Ward and Patel (2006)³⁸ found that the sexual norms of the Bangladeshi community meant that the relationship in which these young women were involved were forbidden, and for this reason were usually secretive and hidden. At the same time it was found that the many of these young women's reference points for information concerning sexual experience were limited and they were often ill informed. A review of services to BEM young women found that professionals viewed problems as being between the parents' traditional values and the young women's more 'westernised' ways, thus locating the problem within the family or community values. The outcome being that for some young women, child protection procedures were not enacted early enough. This is supported by Lees (2002)³⁹ who has suggested that white social workers were less likely to engage black families in child protection at an early enough stage.

Professionals should be mindful of interpreting young women's (or men's) problems in BEM communities as being one of a cultural clash within the family.

It is precisely the family issues of conflict and discord that underpin the young women's problems in the first place.

Black and minority ethnic children are not a homogenous group and some groups may be more likely to be at risk of sexual exploitation than others.⁴⁰

Working with young People who are Lesbian, Gay, Bisexual or Transgender

Professionals working with sexually active LGTB young persons should maintain an awareness that this group of young people are at increased risk of suicide, alcohol and drug misuse, emotional difficulties, self harm and unwanted pregnancies than their heterosexual peers.

³⁶ Chase, E and Stathan, J (2004) The commercial exploitation of children and young people: An Overview of key literature and data (Thomas Coram Research Unit, University of London)

³⁷ Ward, K and Patel, N (2006) Broadening the Discussion on 'Sexual Exploitation': Ethnicity, Sexual Exploitation and Young People (Child Abuse Review, Vol 15: 341-350)

³⁸ Ibid Ward, K and Patel, N (2006)

³⁹ Lees, S (2002) Gender Ethnicity and Vulnerability in Young Women in Local Authority care (BJSW 32: 907-922)

⁴⁰ Ibid Lees, S (2002)

LGTB young persons are at risk of homophobic bullying within school and may experience hostility, rejection and sometimes violence from within their own families. As the young person concerned contemplates their emerging sexuality within what is a frequently homophobic society then they may try to adopt heterosexual norms and heterosexual relationships or turn to alcohol or substances.

Consequently professionals should be aware that for some young people with whom they are working, the problematic behaviours encountered might conceal an emerging LGBT sexual identity which may reflect the known difficulties for LGBT young people in "coming out". In addition some young people within certain faith groups or minority cultures may experience additional difficulties and their emerging LGBT sexual identity may place them at considerable risk.

Professionals may be uncertain as to how to respond to the specific needs of this diverse group of young people and should seek advice on an anonymous basis from a sexual health professional and/or children's social services.

Useful information can be obtained from:

<http://www.dh.gov.uk/en/Managingyourorganisation/Equalityandhumanrights/sexualorientationandgenderidentity/index.htm>

http://www.teachers.org.uk/resources/pdf/Tackling_Homophobia.pdf

<http://www.kent-gay-police.co.uk>

Role of Schools and Other Professionals visiting Schools

Schools and Education Services have a vital role to play in supporting the health and welfare needs of children and young people in line with the Every Child Matters agenda. It is imperative that all staff involved have a clear understanding about their responsibilities relating to confidentiality and information sharing: *'Schools must be absolutely clear about the boundaries of their legal and professional roles and responsibilities. A clear and explicit confidentiality policy should ensure good practice throughout the school which both pupils and parents understand'* (Para 7.1 DfES Guidance: Sex and Relationship Education 2000).

Section 175 of the Education Act 2002 also places a statutory duty on schools and Education Services to safeguard children and promote their welfare. Any professional within such a setting who becomes aware of sexually active children and young people must consider this procedure when assessing risk and considering whether or not the information needs to be shared with key professionals in other agencies, particularly when the child is insistent that they do not want their parents informed. An initial consultation should be held with the Designated child Protection Co-ordinator within the School/Service who will apply the Risk Assessment Tool as appropriate with the member of staff sharing the concern. It is vital that the completed Risk Assessment Tool is retained on the child's record to provide evidence of the rationale behind the decision making process of whether or not to refer. If at this Stage a School/Service is still unclear about whether or not to refer the matter to the police or social services then a consultation can be sought with a member of the Children's Safeguards Team (01622 696366) who provide immediate support and guidance to children's schools in all matters relating to child welfare. **When in doubt - consult.**

This procedure also applies to visiting professionals who have been commissioned to provide a Service to a school (e.g. School Counsellor, Education Psychologist etc). Any concern regarding underage sex that becomes apparent or a disclosure of significant harm by a child to the visiting professional must be discussed with the school's designated person for child protection. This will ensure that appropriate information is shared and a more informed decision taken on whether or not to refer. If a referral is considered to be appropriate then agreement needs to be established on who takes responsibility for referring the matter to Children's Social Services in line within the Kent and Medway child Protection Procedures or Inter-Agency referral process and how the young person is to be informed.

Specific guidance for school nurses

School nurses employed by NHS Trusts must follow Kent and Medway Child Protection Procedures and adhere to policies and procedures pertinent to their own employer. They must consult with either their own line manager or the

named doctor or nurse for child protection for their Trust. Good communication between the school nurse and the school is paramount to safeguarding children and any procedure for information sharing between the school nurse and the designated child protection lead (DCPC) with the school should also be followed. Fraser competent young people who are not deemed to be at risk of serious or significant harm are entitled to confidential advice and support.

School nurses employed directly by schools should follow the school's agreed child protection procedures, which should include an agreement regarding those young people which the health professional assess to be Fraser competent and not at risk of serious or significant harm.

Role of Health Professionals

Health Professionals play a key role in providing advice on staying healthy and safe, signposting, administering medication and assessing risks to sexually active young people. These professionals may include:

- Professionals working in General Practice (GPs, Practice Nurses and Nurse Practitioners)
- Those employed by other independent contractors (Pharmacists)
- Professionals working in the community (School Nurses, Health Visitors and Midwives)
- Professionals employed by specialist services (Family Planning and Genito Urinary Medicine)
- Professionals working in acute specialties (Accident and Emergency and Minor Injuries)

However, a young person may approach any health professional for advice and support. Health professionals may have the opportunity to work with a young person over a prolonged period of time but may also be required to assess risk based on one single 'cold contact'.

The nature of the role of the health professional often leads to the greatest dilemmas associated with sexually active young people, particularly the balance between safeguarding, legislation and professional codes of conduct relating to confidentiality. These dilemmas must be resolved by consulting with designated or named nurses and doctors, or children and families social services. On occasions, legal advice may be sought within the health economy.

Following the introduction of the Common Assessment Framework, some health professionals may be best placed to act as lead professionals for sexually active young people.

Guidance for good practice

All health professionals (including those employed by independent contractors) must be trained to recognise signs of abuse and how to act on their concerns (NSF, 2004).

Assess risk using this guidance:

The health professional's duty of confidentiality to the young person is not absolute. In rare cases confidentiality may be breached because there is a greater public interest or sufficient information to suggest that the child may be at risk of harm; health professionals have a duty to give information when seeking consent to disclose information in the same way as they do in respect

of seeking consent to treatment, depending on the capacity of the particular child / young person. The advice needs to be careful and full, setting out what the professional sees as the potential consequences, risks / benefits of disclosure versus non disclosure.

Health professionals have a duty to maintain accurate and contemporaneous records which detail how the assessment of risk has been made, whether information has been shared or not and why such a decision has been made, including any further advice sought or signposting to other agencies.

Professionals should consider requesting identification from the young person, but this must be considered alongside an assessment of the risks of not treating or giving advice if such a request is declined.

When administering emergency contraception, the health professional is advised to ensure that where possible they should witness the young person taking the medication.

Role of Connexions Advisors

Connexions Kent and Medway offer a universal service of impartial information advice, guidance and support for young people 13 - 19 years old (up to 25 for those with learning difficulties or disabilities). All staff (personal advisers and support staff) are required to undertake child protection training which is updated every three years or sooner. There is also additional training as part of the continuous professional development programme which covers child protection.

Personal Advisers work in a range of settings including secondary and special schools and have Connexions Access Points, in outreach projects and working on a caseload basis with young people requiring more intensive support.

Connexions Kent and Medway is a member of the Kent and Medway Safeguarding Children Board, and all responses to concerns about young people who are sexually active should conform to the Kent and Medway Child Protection Procedures. Personal advisers working within school settings, who receive disclosures or are made aware of concerns of a child protection nature, are advised to work within the school's child protection policy.

Connexions Kent and Medway currently have two named child protection officers and two members of the senior management team, who will assist personal advisers who have concerns. Connexions Kent and Medway's Child Protection Procedures align with the Kent and Medway Child Protection Procedures.

Messages for Young People:

The message to young people should continue to be one that provides for confidentiality unless there are concerns that the young person is a risk of significant harm. The young person should be advised that there is a risk assessment tool that will be applied to all cases of underage sexual activity and wherever possible, the young person should be invited to contribute to this assessment. Where the assessment indicates that the activity may be harmful or seriously harmful then the young person should normally be advised that this would require further discussion with a named lead professional. At this stage active consideration should be given to making a referral to Children's Social Services.

However, in those cases, where the relationship is assessed as harmful a decision may be made in consultation with the named lead to work with the young person to reduce the harm whilst keeping the circumstances of the case under review. A lead professional may be appointed.

Young people should be advised of the facility for a professional via their nominated child protection lead to obtain a check on their sexual partner from Kent police on a no crime basis should the circumstances of the case suggest that this might be necessary. Children's social services Duty and Initial Assessment Teams will also make a check of their information system in respect of either party in the relations if so requested by a nominated child protection lead of the agency concerned.

Statement for Young People – Sexual Offences Act 2003

"In England and Wales, the law on Sexual Offences has been updated. Under this law, the legal age for young people to consent to have sex is still 16, whether you are straight, gay or bisexual. The aim of the law is to protect the safety and rights of young people and make it easier to prosecute people who pressure or force others into having sex they don't want. Forcing someone to have sex is a crime. Although the age of consent remains at 16, it is not intended that the law should be used to prosecute mutually agreed teenage sexual activity between two young people of a similar age, unless it involves abuse or exploitation. Under the Sexual Offences Act you still have a right to confidential advice on contraception, condoms, pregnancy and abortion, even if you are under 16. But remember, whatever your age, you shouldn't have sex until you feel ready. For more information about sex and relationships visit www.ruthinking.co.uk."

A useful Kent based website for young people and professionals alike, 'for young people' is available from this link: <http://www.foryoungpeople.co.uk>

Example case scenarios encountered by sexual health professionals

Harmful behaviour potentially managed without a referral to children's social services

- A 16 year old female who has had several older partners. Current partner is 27. She is consenting to sex and she believes he is doing her a favour and increasing her confidence by having sexual relations with her.
- A 16 year old not registered with GP and who is 8 weeks pregnant. Mother and father aware but not happy. The young woman has refused termination of pregnancy and says that partner and his parents will support.
- A 15 year old male having consenting sex with other males. Age of partners is not known. He travels to London clubs and has an STI.
- A 15 year old female drinking heavily. Numerous sexual partners which are usually 'one night stands'. Her partners are generally other teenagers.
- A frequent occurrence is where girls aged 14 or 15 are having consenting sex with males aged 18 19, 20. The young people are Fraser competent. Often parents are aware and do not see this as a problem.

Factors to take into account

There is a facility to check the police and social services indices of the other party where there is a relationship of concern and or a significant age disparity. Young people may be prepared to reveal information about themselves or their partner provided this is conducted on a 'no crime', 'non referral' basis.

Provided that a careful assessment has been made and this is kept under review with a nominated child protection lead, 'harmful' relationships can be managed locally by providing services signposting or a referral to another agency.

Young people who are thought to be at risk of prostitution will require particularly sensitive handling in order to avoid them losing contact with vital sexual health services. In these difficult cases professionals should seek advice and consult with children's social services and the police child abuse investigation unit on an anonymous or partial sharing of information basis.

For older young people, the professional, in consultation with a nominated child protection lead, or the strategy discussion if one is convened, may use an approach that recognises the young person both as suffering significant

harm and as active agents who can be helped to gain constructive control of their circumstances.

Seriously harmful behaviour that would lead to a referral to children's social services: A composite case example

A 14 year old boy resents himself at a young person's clinic requesting condoms. Initial assessment identifies he is in a relationship with an 18 year old girl. The relationship appears to be consensual for both parties. Advice regarding the age gap of the girlfriend is given. He assures the nurse that it is a consensual relationship. A few condoms were provided and the nurse requests that he comes back for more next week with his girlfriend for a more in-depth assessment. He agrees to co-operate.

The nurse arranged a consultation with her manager and her nominated child protection lead. The advice given to the nurse was that if they both attended again to try and engage with the girlfriend in order to complete the assessment including her date of birth and address. (NB not all young people will provide this information)

They couple attend a week later and are seen together and an assessment is undertaken. They are holding hands and talking openly. The nurse advises them that their relationship is unlawful and that the girlfriend is committing an offence under the Sexual Offences Act 2003. A conviction could lead to her being assessed as a person who poses a risk to children (formerly a Schedule 1 offender). During the assessment the boy indicates that there is a third party involved - a woman aged 21.

Outcome

This case was referred to Social Services; a joint investigation with both police and social services was conducted. It was found that the older female was known to children's social services, and in the past had been sexually abused. She was engaging in sexual activity with both of the younger parties. The boy's behaviour at school had gone from being one of a model pupil to a very disruptive young person, and he had been excluded from school after threatening a young female teacher.

NB. The presence of the third party elevated the risk. The age differential applies whether the younger party was a boy or a girl.

Pharmacy

A young girl requests emergency contraception. The pharmacist can assess risk by exploring issues using the assessment tool.

- Age: ascertaining the girl's date of birth reveals that she is 14.
- She states that she does not know the boy's name or date of birth.
- Level of understanding - the Pharmacist must establish the girl's level of understanding, or Fraser competence, prior to prescribing the emergency contraception.

General enquiries with the child should be made covering items 3, 4, 5, 6, 7, 8, 9 of the risk assessment wherever possible, in order to assess risk.

If concerns arise, the Pharmacist should consult with a Designated or Named Doctor or Nurse for child protection or contact children's social services.

Pharmacists should ensure that they can supply contact details for sexual health / family planning services where appropriate.

If a disclosure of seriously harmful behaviour is made, then the police should be called.