Questions 1 – 4: About you

Question 5: If you are a representative of a group or organisation, please tell us its name and give a summary of the people or organisations that you represent.

We are the UK's independent, statutory regulator of around 788,000 nursing and midwifery professionals. Our vision is safe, effective and kind nursing and midwifery practice that improves everyone's health and wellbeing.

Our core role is to regulate. First, we promote high education and professional standards for nurses and midwives across the UK, and nursing associates in England. Second, we maintain the register of professionals eligible to practise. Third, we investigate concerns about nurses, midwives and nursing associates – something that affects less than one percent of professionals each year. We believe in giving professionals the chance to address concerns, but we'll always take action when needed.

To regulate well, we support our professions and the public. We create resources and guidance that are useful throughout people's careers, helping them to deliver our standards in practice and address new challenges. We also support people involved in our investigations, and we're increasing our visibility so people feel engaged and empowered to shape our work.

Regulating and supporting our professions allows us to influence health and social care. We share intelligence from our regulatory activities and work with our partners to support workforce planning and sector-wide decision making. We use our voice to speak up for a healthy and inclusive working environment for our professions.

Questions 6-7: diversity (Not applicable)

Question 8: In sharing findings from this consultation, may we quote from your response?

- Yes - anonymously
- Yes - attribute to me
- Yes - attribute to my organisation
- No

(9) In addition to the definition of 'regulated activity in relation to children' provided by the Independent Inquiry, the government is proposing to set out a list of specific roles which should be subject to the mandatory reporting duty.

Which roles do you consider to be essential to this list? Please provide details to explain your response.

Firstly, we would like to confirm our shared commitment and support for tackling child sexual abuse in all its forms. In August 2023, we responded to government's initial call for evidence on mandatory reporting of child sexual abuse which this consultation expands upon. We value the opportunity to provide further comment on the revised proposals and outstanding policy questions.

Our initial response already covers some of the questions raised as part of this consultation. We will therefore only be responding to the questions where we believe additional clarification or input from us is required. We kindly ask that both this response and our submission to the initial call for evidence be considered together in unison for an accurate representation of our position on this important initiative.

In response to question 9, it's essential that those considered 'mandatory reporters' are carefully and clearly defined so that individuals are aware of and understand the additional expectations placed on them. While we do not have a view on which specific roles should be subject to the duty, we would like to reiterate the importance that mandated reporters have the relevant skills, knowledge and training to identify and respond to incidents of child sexual abuse.

Our previous response called for the introduction of the mandatory reporting duty at both an individual and organisational level. From the proposals set out in this consultation document, we note the revised suggestion that *"organisations which engage with children through the above categories should notify relevant individuals of their responsibilities under the duty."* We believe that this requires further clarity and explanation.

We agree that organisations will have an important part to play in communicating the duty to mandated reporters. However, as currently drafted, we are concerned that the extent of the obligation for organisations to notify individuals is not sufficiently clear. 'Should' implies that notifications will be considered best practice as opposed to them being a formal requirement, which may increase the likelihood of notifications not being made at all. Further clarity is necessary to understand exactly what is expected of employers, including what constitutes an effective notification, and to understand how this responsibility will be enforced. We would also welcome further clarity about the expectations of education institutions under the reporting duty. In particular, their role in supporting students that may become aware of potential incidents of child sexual abuse over the course of their education and during their practice placements. Education institutions will need clear information and guidelines in order to suitably train and prepare students for their responsibilities within professional practice so that they understand their role and the processes for speaking up.

We are also concerned that the direction for organisations to simply 'notify' individuals of their responsibilities under the duty does not go far enough. Organisations will play an important role in enabling professionals to meet their reporting duties, by providing appropriate safeguarding training and by ensuring policies and processes are in place for individuals to effectively discharge their duty. We believe that the expectation of organisations to notify individuals should be expanded to reflect this.

As identified by the Inquiry, poor leadership behaviours and organisational cultures can seriously undermine an individual's ability to speak out and report concerns. Placing a reporting duty on individuals alone will not address this issue, and there is a risk that this could frustrate or undermine the intended impact of the duty. For these reasons, and those set out in our initial call for evidence, we would like to reiterate our position that any reporting duty should be implemented at both an individual and organisational level. We would welcome further discussion with government on this.

(10) What would be the most appropriate way to ensure reporters are protected from personal detriment when making a report under the duty in good faith; or raising that a report as required under the duty has not been made?

Please provide details to explain your response.

As per our response to the initial call for evidence, we agree with the Inquiry's recommendation that specific whistleblowing protections should be in place for individuals who make reports in good faith, and that this should include a removal of liability for civil proceedings and / or sanctions. However, we do not believe that protections should remove liability from professional regulatory proceedings as this could impede our ability to consider public protection risks.

(11) In addition to the exception for consensual peer relationships, are there any other circumstances in which you believe individuals should be exempt from reporting an incident under the duty?

Please provide details to explain your response.

Under current proposals, a report will not need to be made under the duty if those involved are between 13 and 16 years old, the relationship between them is consensual and there is no risk of harm present. As set out in our response to the initial call for evidence, we agree that an exception should exist to avoid capturing consensual peer relationships. However, we are concerned that the exception, as currently drafted, does not go far enough and could result in reports being made about otherwise consensual relationships not intended to be captured by the duty.

We understand that, for the purposes of the duty, 'child sexual abuse' will be interpreted as any act that would be an offence under the Sexual Offences Act 2003 where the alleged victim was under the age of 18 at the time the abuse occurred. While we understand the need to base the definition of sexual abuse on existing legislation, we are concerned that this could have unintended consequences where mandated reporters are obliged to report consensual sexual relationships between a person that is 15 (and therefore under the legal age of consent) and an 18-year-old despite them being close in age.

As per current Crown Prosecution Service guidance, where sexual activity is genuinely consensual and those involved are fairly close in age and development, a prosecution is unlikely to be appropriate. We believe this is a fair and proportionate response and that this demonstrates the importance of allowing a degree of professional judgement to be exercised in such cases. It also allows for decisions that more accurately reflect the intent behind the Sexual Offences Act, which is to protect and prevent children from harm from non-consensual and abusive sexual acts.

We believe that this scenario needs further consideration. We would welcome similar procedural guidance from government about how mandated reporters should approach similar cases, making clear that professionals can and should exercise their professional judgement and take individual circumstances into account when considering making a report.

(12) We are proposing that there would be criminal sanctions where deliberate actions have been taken to obstruct a report being made under the duty. What form of criminal sanction would you consider most appropriate?

- Fines
- Custodial sentences
- Other

We welcome the decision not to apply criminal sanctions to individuals for failing to make a report. Unfortunately, mistakes can happen. If sanctions are applied, focusing on deliberate acts will help prevent individuals from being unfairly (and disproportionately) penalised for failing to make a report either by mistake or through no fault of their own.

In our initial response we suggested that if sanctions are imposed, they should only apply in the most serious of cases such as where there is a deliberate or conscious decision not to report known instances of child sexual abuse. Based on this principle, we agree with the revised proposals that criminal sanctions should also be applied in instances where another person has deliberately obstructed or delayed a mandated reporter from fulfilling their duty.

While we welcome this revised approach, we do not have a view on the appropriate criminal sanctions as this falls outside of our remit and expertise as a professional regulator. We would however welcome further clarity about the interaction of criminal proceedings with our fitness to practise process, including when and how best to effectively share information respectively.

(13) Should situations where a reporter has been obstructed due to active indifference or negligence also be subject to these sanctions? Please provide details to explain your response, including practical examples where possible.

As above, if sanctions are imposed, we firmly believe that criminal sanctions should only apply in the most serious of cases where there is intent to prevent or obstruct a report. Based on this principle, we have reservations about applying criminal sanctions where a report has been obstructed through 'active indifference' or 'negligence' and we would encourage further consideration and definition of these.

As a starting point, we believe these two situations are not synonymous and should carry different sanctions. Negligence implies a situation whereby a professional overlooked obvious warning signs but was otherwise unaware of the situation at hand. Whereas active indifference implies a situation whereby professionals were fully aware of the situation but decided not to act. For example, in the sphere of clinical negligence there is a separation between the idea of negligent treatment and neglect / unlawful killings which carry different penalties and consequences, which we believe should apply in this case. There will also be a spectrum of activities that might fall under both of these situations, which again may warrant different responses. If criminal sanctions are applied, what constitutes 'active indifference' and/or 'negligence' will therefore need to be clearly and carefully defined to help determine culpability and ensure a proportionate response.

(14). We would like to test the view that professional and barring measures apply to those who fail to make an appropriate report under the duty. Do you agree with this approach? Would different situations merit different levels or types of penalty?

Please provide details to explain your response, including practical examples where possible.

The revised proposals in the consultation document suggest that:

'Breaches of the duty to report will be subject to referral to the Disclosure and Barring Service for barring consideration using existing arrangements under the Safeguarding Vulnerable Groups Act 2006. Barring decisions will take account of representations made by the individual.

All regulated professionals and teachers who are subject to the duty, including those working in private education and healthcare settings, will also be at a minimum subject to professional sanctions to be determined by the appropriate regulating body.'

We believe there are issues with both approaches that need addressing.

DBS barring

Applying barring measures to those who fail to make a report would help ensure greater consistency in outcomes across professional groups subject to the duty – especially between individuals that are not subject to a form of professional regulation and oversight.

However, we are concerned that placing a person on a barring list for failing to report could be disproportionate. The nature of other barring offences involve serious sexual offences or causing deliberate harm, which clearly indicate a person's unsuitability to work with vulnerable groups. While we understand the severity of failing to report child sexual abuse, we would argue that this is not comparable to other barring offences and that treating it as such could be overly punitive and unfair. If DBS measures are considered, they must only be applied where it is identified that the professional presents a clear risk to vulnerable people and should be prevented from working with them in the future.

As covered in our response to the initial call for evidence, we already have existing information sharing arrangements for referring concerns to DBS. This stipulates that concerns should be shared at the conclusion of a fitness to practise case, where an individual's practise has been found impaired, and that they have either caused harm or pose a future risk of harm to children and / or vulnerable adults. To carry out or role effectively, we would need greater clarity about the process for sharing information with DBS under the proposed duty and whether our existing arrangements are compliant.

We would also be interested in understanding the process for sharing information with professional regulators to allow any related regulatory activity to be taken. In certain circumstances, we may be required to impose interim restrictions so that the public is protected while any investigation is carried out by the DBS is progressing.

Action by professional regulators

As set out in our governing legislation – the Nursing and Midwifery Order 2001 - we operate a fitness to practise process which allows us to investigate and take action where a concern has been raised that a registrant has not met our standards for safe and effective practice. There are various stages to our fitness to practise process, and we apply different thresholds and evidential tests throughout to help ensure that we only take forward cases where there is sufficient evidence to warrant a regulatory response, either because the individual presents a risk to the public or where action is necessary to maintain public confidence in our professions and professional standards.

As demonstrated in our initial response to your call for evidence, nurses, midwives and nursing associates already have a professional responsibility to report safeguarding concerns and to comply with national standards and guidelines. This means that, if introduced, a breach of the mandatory reporting duty would likely raise professional regulation concerns and prompt us to investigate.

As a professional regulator, we have a range of sanctions available to us which enable us to respond proportionately to any potential risk presented. For example, where a referral has been made and an investigation has been completed, our case examiners decide whether there is a case to answer or not which can involve a range of outcomes. For example, case examiners can decide that:

- there is no case to answer and close the case with no further action.
- there is no case to answer and close the case with advice given to remind the professional of their responsibilities.
- there is no case to answer and issue a warning, which will be published for a period of 12 months.
- there is a case to answer and recommend undertakings, which will comprise of restrictive and rehabilitative measures to support the professional back to safe and effective practice. These undertakings will be published for as long as they are in place.
- there is a case to answer and refer the matter to our Fitness to Practice Committee.

If a panel of our Fitness to Practise Committee decides that a nurse, midwife or nursing associate’s fitness to practise is impaired, they can consider issuing any of the following. Panels will always consider the sanctions in the order from a caution order to a striking off order to enable a more fair and appropriate response.

- A caution order, which is where the nurse, midwife or nursing associate is cautioned for their behaviour but is allowed to continue to practise without any restrictions. Caution orders can last from one to five years, which will be decided on a case-by-case basis.

- A conditions of practice order, which restricts a professionals practice for up to three years and must be reviewed by a fitness to practise panel before it expires. These orders are typically issued when the concern identified is considered capable of being addressed either through re-training or assessment.

- A suspension order, which prevents the registrant from practising for a specified length of time.

- A striking off order, which is where an individual is removed from our register and prevented from working as a nurse or midwife in the UK or as a nursing associate in England.

Considering the above, we contend that a key benefit to applying professional regulatory measures is that this would enable a fair and proportionate response towards those that have failed to make a report. A full list of the sanctions available to us can be found on our website. We would welcome a more detailed discussion with government about our fitness to practise process and how it operates if helpful.

The range of regulatory sanctions are broadly comparable across the other nine regulators of health and care professionals. However, we are concerned that given the proposed duty will apply to other professional disciplines, there may be an issue around variation in the range of sanctions available which will need to be addressed. One possible way to achieve consistency would be through providing guidance to our fitness to practise panels on child sexual abuse, to ensure they take proper account of whether professionals have failed to report such cases appropriately. We would welcome further conversations with government on how best to approach this.

We also have concerns about how the proposal is currently worded and the potential for this to fetter our discretion when considering a person's fitness to practise. At present, the proposal sets out that regulated professionals who are subject to the duty "*will be at a minimum subject to professional sanctions to be determined by the appropriate regulating body".* This implies that a professional will always be subject to a regulatory sanction for failing to make a report, which would not be the case – nor should it be.

If a professional breached the duty and failed to make a report, this would likely raise professional regulation concerns and prompt us to investigate. However, the purpose of our fitness to practise process is about managing the risk that a nurse, midwife or nursing associate might pose to members of the public in the future. It is not about punishing people for past events. Our processes are focused on assessing whether an individual's fitness to practise is impaired, which means that even where someone has failed to make a report, we may not need to take regulatory action if we are confident that there is no risk to patient safety.

If professional regulation is to be relied on, it is essential that any legislation or guidance is carefully drafted so that we maintain our complete discretion to assess each case on its facts, and for our decisions to reflect the nuances of different circumstances that led to the failure to report. Considering the existing procedural information for mandatory reporting of female genital mutilation, rather than 'will' this guidance specifies that failure to comply with the duty 'may' be considered through fitness proceedings and that this in turn *"may result in a wide variety of recommendations as to suitable action".* We believe that the wording of this guidance is appropriate and should be considered, as it more accurately reflects how our fitness to practise process operates.

(15) Are there any costs or benefits which you think will be generated by the introduction of the proposed duty which have not been set out in the attached impact assessment?

Please provide details to explain your response

We have no further comments to add. Please refer to our initial response to the call for evidence which provides a more detailed assessment of the costs and benefits associated with the duty related to nursing and midwifery professions.

(16) In light of the proposals outlined in this paper, what are the key implementation challenges and solutions reporters and organisations will face?

Please provide details to explain your response, including practical examples wherever possible.

We have no further comments to add. Please refer to our initial response to the call for evidence which provides a summary of key implementation challenges.