

# Turning a blind eye to crime:

## health professionals and the Sexual Offences Act 2003

The Sexual Offences Act 2003 defines over 50 crimes. Doctors will become aware of crimes committed by, or on, their patients under the Act, particularly with regard to teenage patients and those with mental disorders. We argue that the exercise of professional judgment is crucial in deciding whether to report such crimes and that the key question is whether there has been abuse.

### THREE HYPOTHETICAL CASES

1. Two 15 year olds sit in the back row at their local cinema holding hands. One offers popcorn to the other. They sneak a kiss.
2. A 79-year-old woman, X, who was widowed aged 30 years, developed Alzheimer's disease 3 years ago. Twenty years ago she developed a sexual relationship with a near neighbour, Y. They live in their separate houses, have never married, but mutually enjoy their sexual relationship. A year ago X was referred to social services for more home support. The carer, who now has a key, walked in to find X and Y in bed together. The carer reported the incident to her line manager, who contacted social services. Social services assessed X as lacking capacity to consent to sex. The next day the police arrive on Y's doorstep.
3. A 14-year-old girl visits her GP and is found to be pregnant. She lets slip the name of her boyfriend. The doctor, fresh from a lunchtime lecture on the Sexual Offences Act, informs both police and social services of the crime that his patient and the youth have committed.

In all three cases a crime under the Sexual Offences Act may have been committed. Should health professionals report these crimes to the police?

### THE SEXUAL OFFENCES ACT 2003

This Act identifies about 55 separate sexual offences. Sections 9 to 15 are relevant to the first and third of the cases above. Box 1 gives some of the key wording from the Act.

As to the second case, sections 30–33 create offences involving sexual activity with people suffering from a mental disorder (Box 2). The touchstone is 'sufficient understanding of the nature or reasonably foreseeable consequences of what is being done ...'. This begs three crucial questions: what is sufficient?; sufficient for what? and; what if one can understand the 'nature' of the act, but not the 'reasonably foreseeable consequences'? What 'for any other reason' might encompass is anyone's guess. Note that marital status is irrelevant. If the social worker's assessment of capacity is correct, Y would have committed a crime even if he and X had been happily married for 50 years.

### A MAGNUM OF CHAMPAGNE

It is reported<sup>1</sup> that when the Sexual Offences Bill was being drafted the Home Secretary offered a magnum of champagne to anyone who could find a way of criminalising behaviour that should be criminalised, but leave outside the criminal law behaviour that should not attract criminal punishment (such as that in the first case on the left). Nobody won the champagne.

The resulting Act creates a very broad range of criminal offences. When someone needs protection from any form of sexual abuse the Act allows criminal proceedings to

### Box 2. The Sexual Offences Act 2003 and people with mental disorder

A person (A) commits an offence if:

- (a) he intentionally touches another person (B);
- (b) the touching is sexual;
- (c) B is unable to refuse because of or for a reason related to a mental disorder; and
- (d) A knows or could reasonably be expected to know that B has a mental disorder and that because of it or for a reason related to it B is likely to be unable to refuse.

B is unable to refuse if:

- (a) he lacks the capacity to choose whether to agree to the touching (whether because he lacks sufficient understanding of the nature or reasonably foreseeable consequences of what is being done, or for any other reason); or
- (b) he is unable to communicate such a choice to A. [Section 30]

be taken in order to provide such protection. But there is a problem: in many situations a crime has been committed, but it would be unhelpful, and indeed often wrong, for proceedings to be taken, or even for the police to be informed. The solution to the problem lies in the proper exercise of professional discretion.

### PROFESSIONAL DISCRETION

There is no guidance for health professionals about the use of discretion, but there is for police officers.<sup>2</sup> With regard to those under 16 years old the guidance states:

*'In deciding whether it is in the public interest to prosecute this offence ... prosecutors may take into consideration factors which include the age and emotional maturity of the parties, whether they entered into the sexual relationship willingly ... The discretion of the CPS not to charge where it is not in the public interest would be particularly relevant where the two parties were close in age, for instance an 18 year old and a 15 year old, and had engaged in mutually agreed sexual activity.'* (Paragraph 50)

### Box 1. The Sexual Offences Act 2003 and children <16 years old.

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. [Section 9]

A person under 18 commits an offence if he does anything which would be an offence under any of sections 9 to 12 if he were aged 18. [Section 13]

The difference between being over or under 18 years is the maximum punishment, not whether or not a crime has been committed.

It goes on to state:

*'It is not intended that young people should be prosecuted or issued with a reprimand or final warning where the sexual activity was entirely mutually agreed and non-exploitative. The way in which the law will be interpreted applies equally to males and females, whatever their sexual orientation. (Paragraph 72)*

This guidance is intended for senior police and the Crown Prosecution Service. We believe it is also relevant to health professionals.

There is no general obligation on either the public or health professionals to report a crime. The importance, for example, of maintaining confidentiality within the doctor–patient relationship is emphasised both by the General Medical Council (GMC)<sup>3</sup> and by the courts.<sup>4</sup> The GMC guidance states that doctors should breach confidentiality when 'there is risk of death or serious harm' and suggests that doctors should not normally breach confidentiality where, in the context of their doctor–patient relationship, they learn that a patient has committed, or will commit, a crime against property. The law recognises that it is in the interests of patients, doctors, and society for patients to trust health professionals to maintain high standards of confidentiality.

There are legal obligations on all citizens to report suspicion about some crimes. Local authorities have a duty under section 47 of the Children Act 1989 to investigate suspected child abuse in their area (Box 3). Health professionals are particularly likely to come across evidence that suggests

such abuse. The fact that a crime has been committed under the Sexual Offences Act, even if this involves children or people with mental disorder, does not necessarily mean that the crime involves abuse, as illustrated by the cases previously mentioned.

We conclude that there is no legal obligation on health professionals to report sexual behaviour involving a patient or client simply because that behaviour might be a crime under the Sexual Offences Act 2003.

### HAS THERE BEEN ABUSE?

When should health professionals inform police about the behaviour of a patient or client that could be construed as criminal under the Sexual Offences Act? The social worker in the second case and the GP in the third case acted, it appears, in the belief that if a crime has been committed the police need to know. But in our view things are not that simple. Suspicion that a crime might have been committed does not preclude the exercise of professional judgement. This is particularly so in the case of behaviour that comes within the broad ambit of the Sexual Offences Act because that Act has been drafted deliberately widely and assumes that sensible discretion will be exercised. The relevant discretion is not just that of the police and the prosecuting authorities: it is that of health and social care professionals too.

The purpose of the Act is to protect people from abuse. Therefore the first questions for a health professional are (a) whether the relevant person has been abused and (b) whether they need the sort of protection that the criminal law can give. If the answer to both questions is no, then there is normally no requirement to take things further, and indeed it may be wrong to do so. If the answer to (a) is yes, the answer to (b) will usually be yes too. But not necessarily. Where the answers to (a) is yes, but that to (b) is no, the safer course is to delegate the exercise of discretion to the police or prosecuting authority. The social worker in the second case should perhaps have made enquiries — perhaps from the woman's GP — about the history of the relationship. The question is whether the woman needs protection and is being abused, and not primarily whether she has

capacity to consent to the sexual act, *whatever that might mean*. In the third case the crucial initial assessment is to find out, initially from the girl herself, about her relationship with the father of her fetus, about whether she felt coerced in any way, and the father's age. The Sexual Offences Act provides some useful guidance to health professionals about what factors might affect the assessment of abuse. For example, were the girl under 13 years old, there would have to be unusual circumstances for health professionals not to take steps to protect her; and if the male were 18 years or over, there should be a (rebuttable) presumption that the relationship is abusive.

### CONCLUSION

The Sexual Offences Act 2003 is relevant for health professionals particularly with regard to patients or clients who have had sexual experience and who are under 16 years old or who have a mental disorder that might affect their capacity to consent. The Act has been worded widely to ensure that those who should be prosecuted for an offence can be prosecuted. The result is that behaviour may fall foul of the wording of the Act when it would be quite inappropriate to consider criminal proceedings. Health professionals should first assess whether anyone has been abused or needs protection before considering informing police about sexual behaviour that according to the letter of the law is illegal. The Home Office guidance for police officers is pertinent to the exercise by healthcare professionals of their discretion to notify the police.

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### REFERENCES

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3. General Medical Council. Confidentiality. [http://www.gmcuk.org/guidance/ethical\\_guidance/confidentiality.asp](http://www.gmcuk.org/guidance/ethical_guidance/confidentiality.asp) (accessed 2 Dec 2009).
4. Wv Egdel [1990] 1 Ch 359.

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#### Box 3. Children Act 1989, section 47.

Where a local authority:

- (a) are informed that a child who lives, or is found, in their area:
  - (i) is the subject of an emergency protection order; or
  - (ii) is in police protection; or
- (b) have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm.

The authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.