
STATES OF JERSEY



STATES OF JERSEY COMPLAINTS BOARD: FINDINGS – COMPLAINT BY X AGAINST THE HEALTH AND COMMUNITY SERVICES DEPARTMENT IN RESPECT OF A DIVISION OF THAT DEPARTMENT (R.62/2019) – RESPONSE OF THE MINISTER FOR HEALTH AND SOCIAL SERVICES

**Presented to the States on 17th September 2019
by the Minister for Health and Social Services**

STATES GREFFE

RESPONSE OF THE MINISTER FOR HEALTH AND SOCIAL SERVICES

States of Jersey Complaints Board

On 19th October 2018 and 7th December 2018, a Complaints Board Hearing constituted under Article 9(9) of the [Administrative Decisions \(Review\) \(Jersey\) Law 1982](#) was held to review complaints by X against the Health and Community Services Department (“HCS D”) in respect of a division of that Department.

On 24th May 2019, the Privileges and Procedures Committee presented to the States the findings of the Complaints Board Hearing (*see* [R.62/2019](#)).

The Minister for Health and Social Services welcomes the opportunity to respond to the Board’s Report dated 24th May 2019 and responds as follows.

Executive Summary of Response

The Minister appreciates the acknowledgement and understanding of the Board, of the complexities of this case, and the competing views and wishes of the adolescent and parents in this matter. The Minister accepts the positive comments in the Board’s report in relation to –

- the adolescent was rightly the priority of HCS D
- respecting the work which HCS D provides to the Island, and to children and families
- HCS D adhered to its policies and procedures when the adolescent withdrew consent.

The Minister acknowledges that the adolescent’s withdrawal of consent and HCS D’s inability to share information regarding care and treatment was difficult, frustrating and distressing to the parents. It was not the intention to exclude the parents. The Minister would like to point out that a number of family sessions had been offered to aim to maintain channels of communication with the parents.

It is acknowledged how difficult that it must be for families of adolescents when consent is declined. This case was exceptional in relation to the steadfast refusal to allow any information to be shared with the parents.

The only exceptions to such refusal are when issues of child protection override maintaining confidentiality. The law permits the disclosure of confidential information necessary to safeguard a child or children. HCS D advise young people that risks of possible significant harm and safeguarding issues will always be shared, but that otherwise conversations can be kept private, as long as the young person, as in this case, was competent to consent to treatment. (Health and Social Services Department Confidentiality Policy 2013.)

As a result of this case, the Department has developed and will issue a practice note to staff, to ensure that communication channels remain open with the parents, while maintaining the confidentiality of the adolescent. The purpose of the protocol would be to maintain the one-way communication with the family and to keep in touch with them. The Department is not able to share care plans or information and would only be able

to receive information, not share it. The Department strives to always work with families as a unit where appropriate, and in cases such as this, will seek to ensure that the voice of the parents remains heard, even if the parents cannot be provided with the information that they request in response.

The Minister can confirm that the Government is currently in the process of reorganising and reviewing the services provided by HCSD as part of the establishment of its OneGov approach to service delivery.

Further, as part of the work programme following the Report of the Independent Jersey Care Inquiry, there is policy work taking place alongside the Children's Legislation Transformation Programme led by the Minister for Children and Housing. The Panel of the Independent Jersey Care Inquiry has recently carried out a review visit to the jurisdiction, and intends to publish a progress report later this year. The policy and legislation programme will be reviewed in light of that report.

Minister's response to findings

It is accepted that the transcript of the Complaints Board Hearing accurately reflects proceedings on 7th December 2018.

The Minister clarifies that X raised a complaint about the care and treatment of their child. The child had reached the age of majority and was an adult at the time of the Complaints Board hearing, and was neither informed of, nor participated in, the complaints process.

The adolescent at all times was considered competent, and had capacity to give and withdraw consent.

The Board set out its findings in Section 5 of its Report. The Minister wishes to respond by addressing the themes and issues outlined in paragraphs 5.1 to 5.12. The **Appendix** to this Response sets out the themes / issues identified in the Report's findings, with the Minister's specific responses alongside them, followed by relevant supplementary information.

APPENDIX

Themes / Issues	Findings	Minister's response
Matters of accuracy in the report	5.1 5.7 5.10	<p>There were no external experts involved in the case. The adolescent was assessed by a consultant employed as a locum, reporting to the appropriate HCSD line manager.</p> <p>The case records, which have been carefully and rigorously reviewed in this process by a senior manager and clinician, are not considered to be inaccurate, nor is it considered that record-keeping was poor. Given that neither the complainant nor the Board has had access to review records, it is unclear how the Board can comment on their quality.</p>
Individual's right to withdraw consent to share information	5.4 5.8 5.9(a) 5.9(c) 5.9(d) 5.9(e)	<p>The Minister is grateful to the Board for its acknowledgment that policies and procedures were followed when the adolescent withdrew consent.</p> <p>The Minister wishes to clarify that once consent by an adolescent with capacity had been withdrawn, it was not possible to involve the parents in an explanation of treatment goals and projected outcomes. This includes sharing information about whether an individual is even involved with HCSD.</p> <p>It is acknowledged that the withdrawal of consent resulting in information not being shared with parents must be very difficult for parents to accept. The General Medical Council ("GMC") 2018¹ states that teenagers may be particularly concerned about keeping confidential information from their parents, but confidentiality is central to the trust between doctors and patients, and an essential part of good care. Without assurances of confidentiality, young people may be reluctant about the care, about seeking medical attention, or giving doctors the information they need in order to provide care.</p> <p>In accordance with the Royal College of Nursing guidance 2019², young people under the age of 16 have the same right to confidentiality as any other patient, which is in keeping with the Nursing and Midwifery Council's ("NMC") 2018³ code of professional standards of practice. Breaking a young person's confidence can damage the relationship with them irrevocably.</p> <p>The Minister does not share the findings of the Board that the adolescent withdrew consent for HCSD to share information with the parents as a result of witnessing the impact that direct interactions with HCSD had on the family. The reasons consent was withdrawn are known only to the individual. Attempts were made by HCSD to put different points of view to the adolescent to encourage information-sharing with the parents; however, the adolescent remained steadfast in their decision. As this was their right and they had capacity to make this decision, there was no choice but to adhere to this direction.</p>

¹ GMC Protecting children and young people: <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/0-18-years/principles-of-confidentiality>

² Royal College of Nursing <https://www.rcn.org.uk/clinical-topics/children-and-young-people>

³ Nursing & Midwifery Council: the code of professional standards of practice and behaviour for nurses, midwives and nursing associates: <https://www.nmc.org.uk/standards/code/>

Themes / Issues	Findings	Minister's response
Involving and communicating with the family	5.2 5.3 5.4 5.5 5.6 5.8 5.9(a) 5.9(b) 5.9(c) 5.9(d) 5.9(e) 5.10	<p>The Minister would like to apologise to the complainant if they consider that there was a lack of communication and continuity of care, and if they feel that they experienced years of uncertainty and frustration with HCSD as a result of the adolescent withdrawing consent to share information with them. This was not the intention of HCSD.</p> <p>The Minister welcomes the Board's recognition of the exceptionally difficult situation HCSD was in when the adolescent withdrew consent for information to be shared.</p> <p>It is agreed that parental involvement is important and to be encouraged. HCSD works with families to facilitate this relationship. However, there can be exceptional circumstances where parental involvement and/or engagement is not in the best interests of the child or young person.</p> <p>The relationship with the family was not completely terminated; opportunities for the family to meet with HCSD were offered; however, these were declined or not attended. It is unfortunate if the parents were left with the impression that nothing was being done as a result of information unable to be shared by HCSD. However, information could only have been shared if it related to significant risk or a safeguarding concern.</p> <p>The consultant who reviewed the adolescent made a number of recommendations which were carried out by the relevant HCSD areas. Clinicians need to have a flexible approach to working with families; this is assessed on an individual basis, depending on the need of the adolescent. This means that sometimes adolescents will be assessed on their own, whereas at other times they will be assessed with their family; therefore it is not unusual for an adolescent to be seen and assessed alone in line with best practice guidelines.</p> <p>The Minister has statutory duties and responsibilities to the child that do not exist to the wider family. Under Jersey law, a child remains a child until the age of 18. While we acknowledge (as in section 5.2) that we aim to work with the wider family unit as much as possible, there is not a statutory responsibility to do this, and we would do this as best practice, in the best interests of the adolescent, and in line with the guidance previously outlined in this response.</p>
Diagnosis of condition	5.3 5.9(d)	<p>The Minister recognises that while parents and carers often pursue a diagnosis or label for their child and their circumstances, having a diagnosis is not always helpful or essential. Research indicates⁴ that adolescents can feel labelled, or that having a diagnosis can have a negative meaning, and adolescents can feel stigmatised or categorised by that.</p> <p>In this case, following initial diagnostic screening, the consultant clinician (a senior experienced professional) considered that no further</p>

⁴ The Anna Freud National Centre for Children and Families: <https://www.annafreud.org/on-my-mind/receiving-support/>

Themes / Issues	Findings	Minister's response
		<p>diagnostic assessments were required. Furthermore, the adolescent made it clear that no further diagnostic screening should be carried out, and withdrew consent for further assessments.</p> <p>The lack of a diagnosis is not a barrier to offer support to families to help deal with behaviours and emotions during adolescent years. In this instance, support and advice had been offered and provided, and strategies suggested on how to deal with the presenting behaviours.</p> <p>The investigation of safeguarding concerns is a matter separate to the care and treatment of a child, with agencies following agreed multi-agency protocols. The parents' frustration was not misconstrued as neglect. It is recognised, by the nature of the subject, that the investigation of safeguarding matters can be a challenging, difficult, and upsetting experience for both child and parents.</p>
Working with the individual	5.3 5.7	<p>Clinicians and professionals have a flexible approach to working with children and families, assessed on an individual basis, depending on need. Sometimes, children and adolescents will be seen on their own for the purposes of assessment and / or treatment / support, whereas at other times they will be seen with their family. It is not unusual for an adolescent to be seen and assessed alone.</p> <p>The GMC states that in some cases, having a parent in the room during a consultation may discourage a child or young person from being open about what has happened to them, or about any concerns or fears they have. In these circumstances, doctors should consider speaking to the child or young person without the parent present, in a suitable environment, and with appropriate support available to them (GMC 2018)⁵.</p> <p>The Minister welcomes the Board's acknowledgment of the hard work that HCSD provides within significant constraints; however, he does not accept that staff movements over the period of this case resulted in a lack of comprehensive notes. Case records were reviewed, and considered by a senior clinician to be of an appropriate standard.</p> <p>It was not appropriate for the adolescent to have only one member of staff throughout their contact with HCSD. Professionals are allocated depending on the best match to meet the clinical needs of the adolescent. Throughout contact with HCSD, it was necessary for different members of the multi-disciplinary team to be involved in assessments and treatments, in order to ensure that the needs of the adolescent were met.</p> <p>The Minister welcomes the Board's acknowledgment that HCSD focused on the rights of the child, in line with the Minister's statutory responsibility.</p>

⁵ GMC Protecting children and young people: <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/protecting-children-and-young-people/communication-and-support>

Supplementary

Applicable policy and legislation

Consent

The adolescent had some time previously withdrawn consent for HCSD to provide any information to parents, or to have access to records or assessments. In cases such as these, practitioners are required to follow the States of Jersey Health and Social Services Consent Policy, which states:

For under-16s

“Following the legal decision in the House of Lords case of “Gillick” in 1985, it is clear that a child under 16 years may consent to medical treatment if he (or she) is judged to be competent to give that consent. This may be helpful in cases where a child who is under 16 years does not want his (or her) parents to be consulted about his (or her) care. The healthcare professional should “seek to persuade” such a child to tell his (or her) parents or allow the healthcare professional to do so. The healthcare professional can only be justified in proceeding without parental consent if the child gives valid consent and the best interests of the child are being served. The healthcare professional must, however, be certain in such cases that the child has sufficient maturity to understand the nature, purpose and hazards of treatment and what it means to give a valid consent. When such situations arise, it may be helpful to obtain assistance from colleagues.”

For children aged 16–18

“The effect of the [Consent to Medical Treatment \(Jersey\) Law 1973](#) is that the consent of a young person who has attained the age of 16 years to any surgical, medical or dental treatment is sufficient in itself and it is not necessary to obtain a separate consent from the parent or guardian. Likewise if a competent child refuses consent to treatment then that decision cannot be overridden by their parent.”

The States of Jersey Health and Social Services Consent Policy has now been updated, and in April 2019 the Department’s ‘Consent to Care and Treatment’⁶ policy was launched. Aspects related to this complaint have not changed, and the actions taken would remain the same. Parental responsibility gradually diminishes as a child grows older, even when they remain legally a minor. If a child is deemed to be competent, the older the child, the more their wishes and feelings should be respected.

Capacity

A person is always assumed to have capacity, unless it is shown that the person lacks capacity in relation to the decision. The assumption of capacity is one of the 5 core principles outlined in the [Capacity and Self-Determination \(Jersey\) Law 2016](#) (see Article 7). While we acknowledge that this Law has been written for people aged 16 and over, the same principles would apply in line with Gillick Competency. It was never deemed that the adolescent in this complaint was considered to lack capacity. The

⁶ Health and Social Services Consent to Care and Treatment Policy (April 2019)
<https://soj/depts/HSS/Registered%20Documents/P%20HCS%20Consent%20to%20Care%20and%20Treatment.pdf#search=consent%20to%20care%20and%20treatment>

adolescent was supported by a number of professionals who assess capacity as part of their everyday working practice.

Safeguarding

Article 42 of the [Children \(Jersey\) Law 2002](#) sets out the Minister's duty to investigate a child's circumstances. Paragraph (1) states –

- “(1) Where the Minister –
- (a) is informed that a child is the subject of an emergency protection order or is in police protection; or
 - (b) has reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm,

the Minister shall make, or cause to be made, such enquiries as the Minister considers necessary to enable the Minister to decide whether he or she should take any action to safeguard or promote the child's welfare.”.