



SAFEGUARDING BOARD
ISLE OF MAN

Consent Practice Guidance

A multi-agency guide on information sharing and decision making about parents' or carers' consent.



Isle of Man Safeguarding Board

Approved: August 2025

Review Date: August 2028

Contents

| | Page |
|---|-------------|
| What is consent? | 2 |
| Guidance for multi-agency professionals working with children: Sharing information and making referrals | 3 |
| Dispensing with consent | 4 |
| Working in Partnership: Gaining consent from a young person, parent or carer | 5 |
| Having difficult conversations | 6 |
| Withdrawal of consent: managing emerging concerns | 8 |
| Guidance for Children's Service Practitioners: Decision making following withdrawal of consent | 9 |
| Who to contact if you are unsure of next steps | 10 |
| Flow chart – Decision making on sharing information/making a referral to Children's Services | 11 |

Consent Practice Guidance

The importance of understanding when consent is required and when consent should be dispensed with, is a crucial part of both social work and multi-agency safeguarding practice, which is critical to the identification and response to risk for children and young people. This guidance has been co-developed with Safeguarding Board agencies, leads and practitioners, to strengthen practice and support necessary improvements in understanding when consent can be dispensed with in safeguarding situations. Serious Case Management Reviews, audits, inspections and scrutiny have evidenced that multi-agency practitioners and managers require guidance and support to significantly improve their understanding and practice in relation to consent.

The Safeguarding Board members have fully endorsed this guidance and are keen to ensure it is used to improve practice and prevent abuse and harm to local citizens.

What is consent?

Consent is defined as:

“any freely given, specific, informed and unambiguous indication of his or her wishes by which the data subject, either by a statement or by a clear affirmative action, signifies agreement to personal data relating to them being processed”.

In most cases, where there are no child safeguarding concerns, you must seek consent. Where a child does not have the competence and they do not appear to be Gillick competent¹ to understand and make their own decisions, then consent must be sought from a safe person with parental responsibility for that child.

In most cases, you are required to obtain *explicit consent*. This means there is no doubt as to the wishes and agreement of the person.

Implicit versus explicit consent:

A GP refers a patient to a specialist with their agreement. The GP will assume that the patient has given **implicit consent** to share information with the specialist by agreeing to the referral.

A family support worker starts working with a family. At the start of their work, they go through a form with the family to get written agreement as to which other professionals they can speak with (e.g. school, health visitor). This is **explicit consent** to share information with these professionals.

Consent may be given verbally or in writing, but where possible, it is always better to get that consent in writing. If consent is given verbally, you must make a record that clearly evidences how that consent was given. This is to avoid any future dispute.

¹ Gillick competence is the legal standard in UK (and Isle of Man) medical law used to assess whether a child under 16 can consent to their own medical treatment *without* requiring parental consent or notification. It originates from the 1985 House of Lords case Gillick v West Norfolk & Wisbech AHA .

Consent must be freely given and must be specific and informed. You must be open and honest and cannot mislead or deceive.

A person may wish to limit the consent they are prepared to provide. For example, a person may consent to the disclosure of the information to one party but not to others.



| Good practice | Not good practice |
|---|--|
| Leave the child or adult in no doubt about what you are asking them to consent to. | Avoid the issue of consent altogether because you don't want to ruin your relationship with the parent or carer. |
| Record what you have gained consent for: e.g. to share information or to start an assessment. | Gain consent for one thing and assume that this covers 'all'. |
| Be clear about how the individual has the right to withdraw consent at any time. | Give the impression that verbal consent is a constant that cannot be changed or revisited. |

Guidance for multi-agency professionals working with children: Sharing information and making referrals.

Guidance specifically for social workers and managers can be found on page 9.

Challenges around consent are slightly different for professionals working with families in schools, health settings, police, nurseries, CAMHS and other settings across the third and voluntary sectors.

There are some 'given's in sharing information about families that make decision making easier. These include situations where clear practice standards exist regarding when information will be shared, with or without consent. Some scenarios include:

In an emergency department:

When a child or young person has tried to take their own life. A referral will be made to Children's Services and Psychiatric Services, whether or not the child or parent/carer consents.

When police attend a call out to an incident of domestic abuse and a child or children are present (including unborn children):

When the police go to the home of a child and there has been a call out in response to an incident of domestic abuse, the police will automatically share this information with Children's Services, with or without consent.

Another scenario where it is relatively easy to decide if consent to share information should be dispensed with is where it is very clear that a child has suffered harm.

For example:

- Where a child tells you they have been sexually harmed
- Where a child has an injury that they could not have received by accident
- Where a parent or carer tells you that they have hurt a child
- Where you believe a child or young person is being harmed due to Fabricated or Induced Illness².

In these scenarios, it is clear that consent should be dispensed with to share information with Children's Services and or the Police because not to do so would place the child at direct risk of harm.



Parent's or carer's consent can and should be dispensed with in any instance where it is believed that not sharing information with Children's Services or the Police would place a child at risk.

Dispensing with consent

In other scenarios decision making about dispensing with a parent's or carer's consent to share information can be more complex. For example, where a child is presenting as experiencing neglect.

Neglect is a very harmful type of abuse that can cause lifelong harm to children emotionally, intellectually and physically – but it is best understood as a form of abuse which is cumulative i.e. the effects and presence of the abuse build up over time. This makes decision making about dispensing with a parent's or carer's consent very complex in these instances.

In the following case scenario, Orla is at risk, but the evidence of immediate harm is less clear:

Orla is 2 years old. She has 5 older siblings. Children's Services have been involved with the family on and off for over 7 years due to concerns about neglect.

Orla's oldest siblings are 16 and 17. They were made the subjects of child protection plans when they were young. The mother has entrenched alcohol misuse issues and also has poor mental health. She has periods when she can cope very well with the needs of the children, but over the years, these good periods have been outnumbered by times when she has really struggled. During these periods, the older children have been expected to care for the younger children and at very difficult times, the children have been sent to live with members of the wider family.

² For further reading on this please go to Fabricated or induced Illness/Perplexing Presentations at https://www.proceduresonline.com/iom/sb/files/perplex_present.pdf

The older children do not attend school as often as they should.

Orla is often not brought to her health appointments. She has not had all her immunisations. When she has been seen by the health visitor, she is usually in full nappies and has had severe nappy rash. Her weight is much higher than you would expect given her birth centile weight. She had been seen to be 'prop fed' despite the advice of the health visitor that this is potentially dangerous.

In this scenario, Orla is not at risk of immediate danger, but if her needs continue to be unmet, she will suffer harm. If you are Orla's health visitor or Orla goes to your nursery, you have a duty to refer her to Children's Services.

To safeguard Orla, you will need to have a potentially difficult conversation with Orla's mother, setting out your concerns.

If Orla's mother does not give you permission to make a referral to Children's Services, this would place Orla in immediate increased risk and therefore advice should be taken from a supervisor or the nominated safeguarding lead in your organisation. The mother's consent should be overridden. The parent or carer still be told you are making a referral and the reasons why, unless there is a belief that doing so will place Orla at increased risk.

Or for instance, Daniel:

Daniel is 9 years old. He goes to a local mainstream school, although his attendance is poor as he often worries about his mother, who struggles to get out of bed in the morning to get him to school.

Daniel can at times smell of urine, and he has been seen picking food out of the school bins. His dirty uniform and hair have meant that other children have started to poke fun at him and he is falling behind with his schoolwork.

Daniel has spoken in school about not being happy at home and that he often feels unsafe.

Again, Daniel is not in immediate danger, but he is likely to experience harm if action is not taken. There are signs of neglect that would necessitate action, for example, poor school attendance, falling behind with his schoolwork, being hungry and poor personal hygiene. Most importantly, Daniel has spoken about feeling unsafe.

In this instance, if you are his teacher or the Designated Safeguarding Lead, you need to speak to his parent or carer about your concerns. If they do not give you permission to share information and make a referral to Children's Services, their consent needs to be overridden to safeguard Daniel. The parent or carer still needs to be told the referral is being made and the reasons why.

Working in Partnership: Gaining consent from a young person, parent or carer.

It is good practice to seek the consent of the young person, parent or carer to share information and make a referral. It is only appropriate to dispense with consent when you believe it will affect the safety of a child or young person. Let's consider Pradeep's circumstance:

Pradeep is 12 and attends a local mainstream school. He lives with autism and a diagnosis of ADHD. He has always had very good attendance and has good support from his mother to achieve his full potential in school. He always attends school in uniform and has a small group of friends.

Pradeep's father lives off Island and does not have any contact with him. No wider family can offer support to Pradeep and his mother.

Lately, it has been noted that Pradeep has started to arrive late in the mornings, he is more distracted than usual and has started to lash out at his peers when frustrated.

Pradeep has spoken about how his mother is struggling emotionally and financially since the loss of her job.

Pradeep's mother is fiercely protective of him and is very private about her family. At times, it has been difficult to have conversations with her about Pradeep, without her getting very upset.

In Pradeep's case, there are signs that could potentially indicate neglect, for example, poor time keeping, changes in his behaviour and his mother's low mood. However, it is important to consider the parenting he has received up until recently, i.e. there have not been any other concerns to date, and there is a history of Pradeep's mother parenting him very well. In this instance, there is no reason why a conversation cannot take place with Pradeep's mother. Although she is very protective of Pradeep and is very private, this does not mean that she shouldn't be asked for consent to be signposted to Early Help or Children's Services for some short-term support.

Even if it is likely that she will become very upset or angry, it is necessary to have a conversation with her to gain her consent to share information before seeking support from Early Help or Children's Services. If the parent or carer declines the referral, this should be respected, given that the concerns don't indicate the child is unsafe or at risk. For further guidance about which service may best meet a family's needs, you should refer to the Threshold and Continuum of Need Guidance on the Safeguarding Board Website³.

Reluctance to have a difficult conversation should not stop action to safeguard a child.

Having difficult conversations:

It is almost always best practice to share your concerns with a parent or carer before you share information with Children's Services via a referral. Parents or carers can often feel under attack, criticised and or undermined.

The following principles should guide effective, difficult conversations with parents or carers:

- Always take time to plan the conversation before you speak to parents or carers.
- Be open and honest.
- Use basic language, avoid jargon.
- Explain your duty to safeguard children's welfare, 'duty of care' to report your concerns.

Before your conversation:

Plan how you are going to broach your concern and how to respond to different responses e.g. anger, denial, emotional breakdown etc.

- Choose a time and place to give full privacy.
- Consider the timing of the meeting (e.g. a tired, crying baby etc.) depending on the urgency of the concern.

³ <https://www.safeguardingboard.im/news/threshold-and-continuum-of-need-guidance/>

- Adapt your style to the parent or carers; consider language barriers or learning difficulties.
- Acknowledge your own anxiety about dealing with a difficult situation as it may affect your communication style.
- If previous experience of the parent or carer suggests they pose a risk, make a full risk assessment and do not meet alone.

The conversation:

- Consider your position in the room so no one feels trapped.
- Ensure children can't overhear you and are occupied (provide toys etc.)
- Be straightforward - tell the parent or carer a referral to Children's Services is going to be or has been made but frame the concern in a model of help and support.
- Give clear explanations.
- Always remain confidential and professional.
- Words are sometimes really hard to find when approaching a parent or carer - use 'active listening'.
- Do not: argue, interrupt, give advice, pass judgement, jump to conclusions or let the parents or carers sentiment affect you.
- Avoid excessive reassurance ...it may not be all right.
- Do encourage the parent or carer to talk.
- Clarify what the parent or carer means.
- Summarise what the parent or carer has said.
- Consider your communication style: tone, pitch, speed of voice, body language (body slightly to the side, with an open stance or sit); be calm and make eye contact and appreciate that they may need to talk.
- Consider the parent or carer's point of view, which may be influenced by: bad experience of services, lack of trust, learning difficulties, cultural and language barriers.
- Explain the nature of your concern using tact and diplomacy but be direct and use factual information "Jodie was not brought for the last two appointments, what is the reason for this?"

Framing your conversation - examples:

This is not an exhaustive list and you may want to use a technique of your own, following the general principle of open and probing questions:

Avoid using "**I think**" which indicates it could be your own opinion.

Avoid using jargon, try: -

- "I need to talk to you about the injury to XY's face, can you tell me what happened?"
- "XY has been very lethargic today and says he has not slept, is there anything going on that might be troubling him?"
- "XY's behaviour has changed dramatically over the last few weeks, (s)he has gone from being a happy, outgoing child to a very quiet, withdrawn child. Have you any idea what could have caused this?"

- “Whenever there is a worry about any child, or they mention something about being hurt and we are worried it was not an accident, we legally have to pass on that information to Children’s Services – you may have read this in the parent’s information/handbook when XY started?”
- “XY told a member of staff he is slapped every night. All settings are expected to talk to Children’s Services when children say things like this, and Children’s Services have asked me to talk to you about this. Can you tell me what happened?”

Questions can start with the following:-

- “is there any reason why.....”
- “we need to have a chat.....”
- “XY has said.....”
- “I have noticed XY has seemed hungry in the mornings, is (s)he managing to have breakfast before he comes to school?”
- XY has a bruise on his face but he can’t remember how it happened, do you know how he did it?”⁴

Withdrawal of consent: managing ongoing concerns

Services provided under a Child with Complex Needs plan can only be provided with parental consent. Most support under a Child with Complex Needs plan ceases when the needs of the child or children have been met. In some cases, parents or carers withdraw their consent for support when concerns about a child may still be present. Decision-making for Children’s Services is complex at this point, especially where children have suffered neglect. Children’s Services must decide if closing the case would increase the risk to the child to the level that they may be likely to suffer significant harm. If the concerns are not at this level, then Children’s Services are compelled to close the case after a discussion with multi-agency partners and a clear recording of how the decision has been made.

These scenarios can leave professionals with ongoing anxiety about the welfare of some children. If professionals have ongoing concerns, the following steps can be taken to effectively analyse the risks and strengths of a family. By taking these steps, the level of risk to a child should be better understood:

- Build a detailed chronology to help understand the family history. If your agency does not have its own template, an example of a template can be found in Appendix 1.
- Consider what difference it would make if a social worker were working with the family.
- Identify the strengths in the family.

⁴ Adapted from Lewisham Safeguarding Children Partnership Guidance – accessed 29.04.2025

- Try to be clear about what harm you think the child will suffer if Children’s Services stop working with the family.
- Consider what else your agency can offer the family to offset any concerns.
- Consult the Isle of Man Safeguarding Board Threshold Guidance on the website⁵

If there continues to be a professional difference of opinion that cannot be resolved, where appropriate you should seek advice via supervision. If the issue remains unresolved, the Safeguarding Board Escalation Policy should be followed, found on the Board website⁶.

Guidance for Children Services Practitioners: Decision making following withdrawal of parents' or carers' consent.

Withdrawal of consent to receive support under a Child with Complex Needs (CWCN) plan:

Any provision of services under a CWCN is done so voluntarily. The young person, parent or carer has the right to withdraw consent to receive services at any time. If they do withdraw consent and there are no safeguarding concerns, the case must be closed.

If there are continuing concerns, a full analysis must take place to support decision-making about escalation into child protection procedures. Again, decision-making for children who have or continue to be exposed to neglect is particularly complex.

For example:

Naveah is 5 years old. She has four older siblings aged 6, 8, 12 and 15. She lives with her mother and older siblings. Naveah’s wider family and father live locally and have intervened in the past when the children have been unsafe.

Naveah is receiving support under a CWCN as over the years she has been neglected, there have been periods where the mother, with the help of the wider family, have been able to meet the children’s needs. Her older siblings have been on child protection plans in the past.

When the mother has struggled to cope, Naveah’s school attendance has dropped, her presentation at school has been poor, the home conditions have been cluttered and dirty and she has spoken about not wanting to live with her mother. The care the older children offer Naveah sometimes masks the concerns.

Naveah’s school attendance, the home conditions and her presentation have improved over the past 3 months. However, this is against a backdrop of 18 months of support under a CWCN plan.

Recently, the wider family and Naveah’s father have said that they can no longer offer the same levels of support as before and that the mother needs to ‘step up’.

Naveah’s mother has withdrawn consent to receive services under the CWCN plan as she is tired of being told what to do and feels that all of the concerns are now resolved.

⁵ <https://www.safeguardingboard.im/media/d3lmigim/threshold-guidance-final-version-27-06-24.pdf>

⁶ <https://safeguardingboard.im/media/jkead2ti/escalation-policy.pdf>

In Naveah's case, there appear to have been some recent improvements. The family history shows periods where her mother copes well, and with the help of the wider family, the children's needs are met. However, the family history indicates that improvements are rarely maintained, and the crucial family support that has helped keep the children safe in the past is no longer available.

This case needs a full analysis where the social worker and manager must:

- Ensure there is a full chronology to identify periods of stability and good parenting, as well as recurring patterns of concerns.
- Ensure the voice of the child is understood (where age appropriate)
- Ensure that the lived experience of the child is as well understood as possible.
- Record the decision to close the plan with a clear contingency e.g. if a further referral is received in the next 6 months, the planning should escalate into child protection planning.
- Record the decision to escalate into child protection procedures and the rationale for doing so.

Cases where young people appear to be beyond the control of their parent/s and experiencing harm can also be a complex context for decision. For example:

Mona is 14 years old. There are concerns about the exploitation of Mona. She is using drugs and alcohol. Risks to Mona have been increasing as she has started to go missing more often and for longer periods. She has attended the hospital on a couple of occasions due to health issues linked to the use of ketamine. Mona has also started to self-harm.

Mona has been suspended from school for using drugs on site.

Mona has support from Motiv8 and CAMHS, which she has engaged with sporadically in the past. Both parents want Mona to be safe, but they had a bad experience with Children's Services a few years ago. As a result, they have said they no longer want the support of Children's Services. Mona is also saying she no longer wants a social worker.

In this case, there are very clear risks to Mona. While willing, her parents have not been able to keep her safe and prevent an escalation in her drug use and self-harm. On balance, Mona would likely suffer serious harm if Children's Services were to withdraw. On that basis, it would be necessary to trigger a child protection investigation and for steps to be taken to safeguard Mona.

In all cases where decision-making is particularly complex, the social worker and manager should:

- Call professionals meeting with those working closely with the child or family.
- Request an independent audit of the case to assist decision-making.
- Seek the support of a senior manager.

Who to contact if you are unsure of the next steps

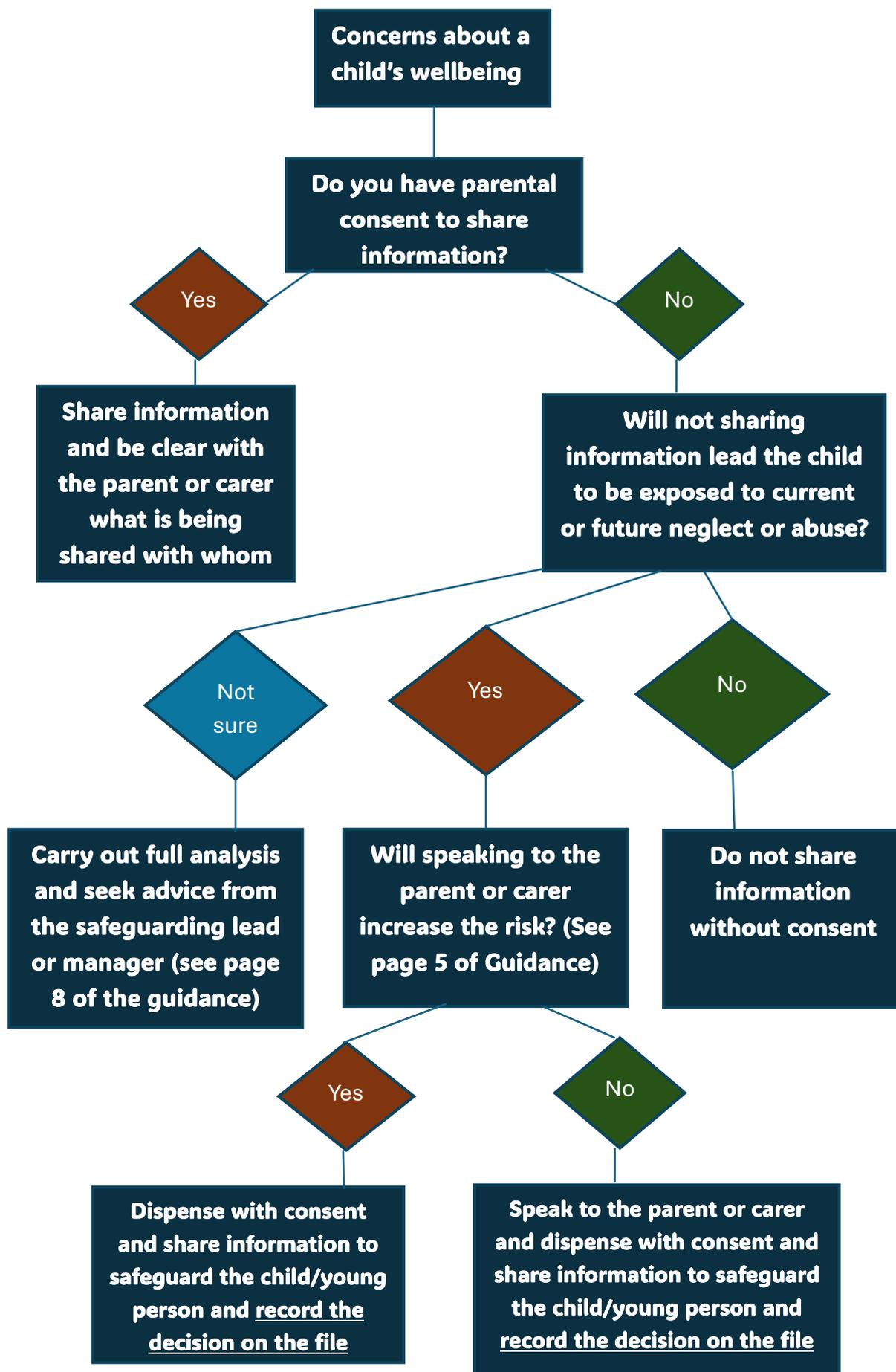
Where a child or young person is not open to Children's Services, the MASH is available to discuss individual cases where professionals are unsure about what to do next. Parental consent is not required for a hypothetical conversation between a concerned professional and a social worker, where the family name is not disclosed.

Who to contact for further advice:

| Role/Organisation | Support |
|-----------------------------|--|
| Teacher | Designated Safeguarding Lead |
| Health visitor/school nurse | Safeguarding Children Team Health |
| Police Officer | The MASH Sergeant |
| Nursery manager or worker | The Early Years Team or Duty Social Worker |
| Midwife | Safeguarding Children Team Health |
| CAMHS | Safeguarding Lead/Manager |
| Social worker or manager | Senior manager or legal advisor |

Remember: whatever your decision about dispensing with consent, always record your decision-making.

Flow chart on decision making and dispensing with parent's or carer's consent



Appendix 1 – Chronology Template

Chronology of significant events

Child Name:

Date of Birth:

Agency/Author:

| Date/Time | Source of Information | Event | Analysis of event to include the impact on the child / the child's voice |
|------------------|------------------------------|--------------|---|
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