Confidentiality and Information Sharing When Dealing with Adult Strangulation Patients

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Institute For Addressing Strangulation

Introduction

Strangulation is common in interpersonal violence such as domestic abuse, rape and sexual assault. There is increasing awareness of the health dangers, such as neck injury, stroke, hypoxic brain injury, associated with strangulation.

There is also evidence that victims of non-fatal strangulation (NFS) in the context of domestic abuse, are at increased risk of becoming a victim of domestic homicide[1, 2].

As awareness of these risks has increased, the Institute for Addressing Strangulation (IFAS) has had numerous enquiries asking for advice around the duties of health professionals to report/share information of cases of non-fatal strangulation, with concerns around where the balance of patient confidentiality, consent and safeguarding lie.

Aims of this document

This document aims to assist clinicians in making decisions about information sharing/safeguarding referrals when dealing with adult patients who either give a history of, or are suspected to have experienced, strangulation. These can be complex and challenging situations where patient confidentiality must be balanced with protecting those at risk of serious harm[3].

The advice given in this document is:

- Aimed primarily at clinicians working in the UK.
- A brief guide for those dealing with patients who have been, or are suspected of having been, strangled in a non-consensual context.
- A complementary resource rather than a substitute for other, more in depth, reading/resources on confidentiality, consent, information sharing and safeguarding (see Reading List, page 7).

As always when considering safeguarding issues, clinicians should:

- Make decisions on a case-by-case basis, considering context, ongoing risk etc.
- Work collaboratively and in partnership with patients as much as possible.
- Consider if, other than the patient, there may be others at risk, such as children or adults at risk.
- Understand that it is wise to seek help and advice from others, e.g. senior colleagues, safeguarding teams, Caldicott Guardians, medical defence organisations, regulatory and professional bodies etc.
- Be familiar with relevant professional standards and regulations, as well as the legislation, guidance and processes that apply in their UK nation (see Reading list, page 7).
- Be aware of local safeguarding procedures and resources including risk assessments (e.g. a DASH risk checklist[4] and multi-agency risk assessment conferences (MARAC)[5] referrals.
- Be mindful of good practice in terms of information sharing as set out by the Eight Caldicott principles[6]. For example:
    - Only the minimum necessary confidential information should be disclosed.
    - Disclosure should be to an appropriate individual or team and to the minimum necessary number of people.
    - Disclosure of information will necessarily be of a confidential nature and a secure method of transmission of the information must be ensured (e.g. encryption, NHS Secure email).

For more information on the clinical management of NFS see Guidelines for clinical management of non-fatal strangulation in acute and emergency care services - Institute for Addressing Strangulation.

Consensual versus non-consensual strangulation

Whilst NFS is frequently used during interpersonal violence, such as domestic abuse, sexual assault and physical violence, it can also occur during consensual activities such as some sports. There appears to be an increasing trend for NFS to occur during consensual sexual activity[7] although this does not necessarily mean that the NFS was consensual. Sensitive, non-judgemental history taking will help elicit if there are safeguarding concerns.

Adults who have been, or are suspected to have been, strangled (non-consensually)

In England, Wales and Northern Ireland, an adult is someone who is 18 years old or over, a child is someone who is under the age of 18 years[8, 9]. In Scotland there are different definitions of a child depending on the legislation. The generally accepted definition of a child in Scotland is anyone who is under the age of 18 years[10, 11].

That said, the various Acts covering mental capacity, across the four nations, apply to those over the age of 16 years.

- England and Wales: Mental Capacity Act, 2005[12]
- Northern Ireland, Mental Capacity Act, 2016[13]
- Scotland, Adults with Incapacity Act, 2000[14]

See BMA toolkits for more information Treating-16-and-17-year-olds-in-scotland-toolkit.pdf[15] and Mental capacity in Northern Ireland[13] which is largely governed by common law.

The General Medical Council (GMC) sets out the principals of adult safeguarding:

GMC's Principles of adult safeguarding

• Adults have the right to live in safety, free from abuse and neglect.
• People are supported to make decisions in their own interests.
• Any intervention should be the least restrictive of the adult's freedom.
• The adult should participate as fully as possible in any decision that is made. Professionals should work collaboratively to provide appropriate protection, help and support[16].

Section 5 of the Nursing and Midwifery Council Code, sets out the professional standards of practice and behaviour for nurses, midwives and nursing associates with respect to patient confidentiality[17].

Does the adult have the capacity to make a decision regarding information sharing/safeguarding referrals?

- Consider the principles of the relevant national mental capacity act (and common law for Northern Ireland) when making this assessment. *See BMA Ethics Toolkits in Reading List and for England Mental capacity - NHS Safeguarding[18].*
- Remember, when making this assessment, that an "unwise" decision does not mean that the person lacks capacity[19].

The adult patient with capacity

Does the adult with capacity give consent to the sharing of information/safeguarding referral?

Yes, consent to share information is given by the patient (who has capacity):

- Follow local safeguarding procedures including making an adult safeguarding referral.
- Consider if there are any children or other adults who are 'adults at risk of harm' and follow relevant safeguarding procedures including referrals as appropriate.

No, consent to share information is not given by the patient (who has capacity):

The GMC's 2017 document Confidentiality: good practice in handling patient information - professional standards - GMC covers this in Sections 57-70[20] and should be read in full. Of note is Section 59:

> ***Section 59 -*** *You should, however, usually abide by the patient's refusal to consent to disclosure, even if their decision leaves them (but no one else) at risk of death or serious harm. (Endnotes 19 and 20), You should do your best to give the patient the information and support they need to make decisions in their own interests – for example, by arranging contact with agencies to support people who experience domestic violence.(Endnote 21), Adults who initially refuse offers of assistance may change their decision over time.*

It is worth highlighting the GMC Endnotes 19 and 20 from the above document:

> ***(19)*** *In very exceptional circumstances, disclosure without consent may be justified in the public interest to prevent a serious crime such as murder, manslaughter or serious assault even where no one other than the patient is at risk. This is only likely to be justifiable where there is clear evidence of an imminent risk of serious harm to the individual, and where there are no alternative (and less intrusive) methods of preventing that harm. This is an uncertain area of law and, if practicable, you should seek independent legal advice before making such a disclosure without consent.*
>
> ***(20)*** *The Department of Health and Social Care in England has published Information sharing and suicide prevention: consensus statement (2021), which is consistent with the principles in this guidance*

Clinicians may be concerned that if the strangulation had occurred, say in a domestic abuse scenario, there may be fear associated with the relationship that is impacting on the person's ability to make a decision around information sharing, medical care etc.

The British Medical Association (BMA) has useful guidance covering these challenges in their document Adults at risk, confidentiality and disclosure of information[21] and in Section 8 of their Ethics Toolkit on Confidentiality[22].

> *"Decisions can be particularly difficult where adults retain capacity under the terms of the Mental Capacity Act (2005) (MCA), but health professionals may believe that they are not making a free and informed choice as a result of pressure from or fear of the abuser, among other possible reasons."*
>
> *"In some circumstances health professionals may seek to disclose information on the basis of the public interest in order to protect competent adults where they have a reasonable belief that the individual will be the victim of serious crime such as violent assault. Here a difficult balance will need to be found between respecting a patient's decision-making rights and an assessment of the likelihood of a serious crime being prevented by disclosure."*

> *"In such circumstances, doctors have no legal authority to make best interest decisions on their behalf, including decisions about the disclosure of confidential health information, and they can be uncertain how to proceed."*
>
> *"Although in the BMA's view disclosure here may be justified, health professionals should keep in mind the difficulty of prosecuting a crime where the victim refuses to participate with the criminal justice system, as well as the impact of disclosure on the patient's trust in the profession."*
>
> *"Given the difficulties associated with preventing crime where the victim refuses to co-operate, disclosure of information without consent in these circumstances is likely to be exceptional. This is likely to be where there is strong evidence of a clear and imminent risk of a serious crime likely to result in serious harm to the individual, and the disclosure of information is likely to prevent it."*
>
> *"Any health professional considering disclosure in these circumstances should take advice from appropriate professional, regulatory or medical defence bodies."*

Bearing all of this in mind, as previously stated on Page 1 of this document, clinicians should understand that it is wise to seek help and advice from others, e.g. senior colleagues, safeguarding teams, Caldicott Guardians, medical defence organisations, regulatory and professional bodies etc.

Whatever the eventual decision, the rationale for either disclosing or deciding not to release information should be carefully recorded contemporaneously.

Remember to consider if there are any children or other adults who are 'adults at risk of harm' and follow relevant safeguarding procedures including referrals as appropriate.

The adult patient who lacks capacity

It is likely, but not a certainty, that, in the scenario where a patient who lacks capacity (but remember capacity is decision and time specific) has been strangled or thought to have been strangled, the sharing of information will be in their best interests (or benefit as per Scotland).

An assessment needs to be made whether the sharing of information is in the best interests/benefit of the patient as per the principles of the relevant national mental capacity act. The BMA has ethics toolkits covering the different nations (see Reading List, page 6):

The GMC document Confidentiality: good practice in handling patient information - professional standards[20]- GMC sets out guidance re disclosure of information, with Sections 55 and 56 covering disclosing information to protect adults who lack capacity.

> ***Section 55*** *- You must disclose personal information about an adult who may be at risk of serious harm if it is required by law (see paragraph 53). Even if there is no legal requirement to do so, you must give information promptly to an appropriate responsible person or authority if you believe a patient who lacks capacity to consent is experiencing, or at risk of, neglect or physical, sexual or emotional abuse, or any other kind of serious harm, unless it is not of overall benefit to the patient to do so.*

Section 56 *- If you believe it is not of overall benefit to the patient to disclose their personal information (and it is not required by law), you should discuss the issues with an experienced colleague. If you decide not to disclose information, you must document in the patient's records your discussions and the reasons for deciding not to disclose. You must be able to justify your decision.*

Remember to also consider if there are any children or other adults who are 'adults at risk of harm' and follow relevant safeguarding procedures including referrals as appropriate.

Frequently asked questions

1. Do I have to report the strangulation to the police?

There is no mandatory requirement to report all strangulation cases to the police.
Information sharing decisions would need to be made on a case-by-case basis and in accordance with the relevant guidance from regulatory and professional bodies as per the advice given above.

There is a case discussion example that includes strangulation on the GMC website: GMP in action: GMC guidance brought to life[23].

2. Must all adult strangulation patients have a safeguarding referral and a referral to a MARAC?

Each case should be assessed on its own merits and will also depend on whether the patient has been assessed as having capacity or lacks capacity and whether there are any children or other adults who are 'adults at risk of harm'.

Where a patient is identified as having been subjected to domestic abuse, a risk assessment such a DASH[4] should be discussed with the patient, including a discussion about whether the patient is willing to consent to the disclosure of confidential information.

In most instances where there is a disclosure of strangulation as part of the DASH, this should prompt a MARAC[5] referral regardless of overall score.

However, any disclosure of confidential health information to the MARAC (or similar agency) must usually be with consent in accordance with the guidance above from the relevant regulatory and professional organisations.

As a MARAC will also involve sharing of information with other agencies, the clinician will need to factor this in and explain the extent of the sharing when seeking consent.

Further Information

GMC confidentiality decision tool interactive flowchart - Confidentiality decision tool - GMC[24]

Social Care Institute for Excellence MCA - Best interests principle - SCIE[25]

Caldicott Guardians
Caldicott Guardians[26] are senior people within organisations that help ensure confidential information about patients is used ethically, legally, and appropriately. Their responsibilities include advising on disclosures of confidential information (particularly in situations of legal and/or ethical ambiguity).

There are 8 Caldicott Principles:

Principle 1: Justify the purpose(s) for using confidential information.
Principle 2: Use confidential information only when it is necessary.
Principle 3: Use the minimum necessary confidential information.
Principle 4: Access to confidential information should be on a strict need-to-know basis.
Principle 5: Everyone with access to confidential information should be aware of their responsibilities.
Principle 6: Comply with the law.
Principle 7: The duty to share information for individual care is as important as the duty to protect patient confidentiality.
Principle 8: Inform patients and service users about how their confidential information is used.

Reading List

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  - Mental-capacity-act-guidance-england-and-wales-updated-feb-2025.pdf
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[3] BMA (2025). BMA Ethics Toolkit Confidentiality.

[4] SafeLives. *Dash risk checklist and FAQs - SafeLives*

[5] SafeLives. Learn more about the Marac - SafeLives

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[9] The Children (Northern Ireland) Order. (1995). https://www.legislation.gov.uk/nisi/1995/755/contents/made

[10] Children (Scotland) Act. (1995). https://www.legislation.gov.uk/ukpga/1995/36/contents

[11] Children and Young People (Scotland) Act. (2014). https://www.legislation.gov.uk/asp/2014/8/contents

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