

## COMMENTARY

## Navigating the conundrum of mandatory reporting under the POCSO Act: Implications for medical professionals

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**Abstract**

To address the under reporting of sexual offences against children, the Protection of Children from Sexual Offences (POCSO) Act, 2012, makes reporting of such offences mandatory. The duty to report such offences has been extended to healthcare professionals. The inclusion of healthcare professionals within mandatory reporting, however, strikes at the very foundation of the doctor-patient relationship based on trust and confidentiality and conflicts with the patient confidentiality safeguards of the Mental Healthcare Act, 2017. It also has unintended public health consequences, such as denial of medical termination of pregnancy due to fear of prosecution under POCSO. An urgent reassessment of these mandatory reporting norms for healthcare professionals, and a solution-based approach that harmonises societal interest in the reporting of sexual crimes with the child's right to health is essential.

**Keywords:** Mandatory reporting, consensual sex, adolescents, liability of doctors, healthcare professionals

**Introduction**

The Indian Parliament enacted The Protection of Children from Sexual Offences (POCSO) Act [1] in 2012, to deal exclusively with the issues of sexual exploitation and sexual abuse of children. The need for a special legislation to protect children from sexual offences had long been felt by the Supreme Court of India [2] and by the Law Commission of India [3]. The Act is in furtherance of India's obligations under the Convention on the Rights of Children (CRC), requiring legislative and other measures to protect children from sexual exploitation [4]. It also furthers the constitutional vision of protecting children and preventing their exploitation [5].

POCSO defines a range of penetrative [1:S.3-6] and non-penetrative [1:S.7-10] sexual offences, in gender-neutral terms. It also criminalises sexual harassment [1: S.11-12] and the use of children for pornographic purposes [1: S.13]. The scope of offences, covered by the Act, is much wider than the archaic concepts of "outraging the modesty of woman," "rape" and "unnatural offence" under the Indian Penal Code 1860, (IPC) [6]. To give teeth to the legislation, POCSO adopts a four-pronged approach of mandatory reporting of sexual offences [7], presumption of a culpable intention [1: S.30], placing the onus of proof on the defence [1: S.29] and harsher punishments.

While all these strategies need to be critically analysed for their socio-legal impact, this paper attempts to critique the mandatory reporting norms under Section 19 of POCSO. Mandatory reporting is a legislative tool to tackle the non-reporting of child sexual abuse which imposes a legal obligation on designated individuals and institutions, other than the victim, to report offences. The non-reporting of sexual offences against children often occurs due to the tender age of the victim, societal [8], institutional, psychosocial [9] and other pressures leading to the concealment of such crimes. India, however, is not the first to adopt the mandate to report child sexual offences. It has a chequered history as explained in the next section of the paper.

**Brief history of mandatory reporting practice and norms**

The momentum for mandatory reporting norms was first generated in the US in the 1960's by C Henry Kempe's concept of the "The Battered Child Syndrome" [10], a frequent cause of injury or death of young children at the hands of caregivers or parents. They conducted a nationwide, year-long survey of battered child syndrome across hospitals and found that legal action had been taken against the perpetrators in only one-third of these incidents, allowing the abuse to continue. Very few doctors reported suspicious incidents to the police after medical evaluation. Kempe et al successfully advocated for mandatory reporting by healthcare professionals to public authorities to curb such abuse [11]. Thus, mandatory reporting laws soon became a part of policy across different US States and were, in fact, incentivised through federal funding under "The Federal Child Abuse Prevention and Treatment Act" [12]. Soon, Canada [13], Australia [14], and members of the European

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Union [15] also adopted mandatory reporting laws. Mandatory reporting was endorsed by the Committee on the Elimination of Discrimination against Women (CEDAW) and the Committee on the Rights of the Child in their joint general recommendation in 2019 [16], which proposed mandatory reporting obligations for medical personnel and teachers, who are uniquely placed to identify actual or potential victims of abuse [17]. England remains a notable exception to this, as it does not legally mandate reporting of child sexual abuse [18], despite various consultations on the issue [18].

While mandatory reporting norms have been a favoured policy choice to combat child abuse since the late 1960's, the POCSO version is atypical as shown below and deserves a careful analysis.

### **Application of mandatory reporting to healthcare professionals in India: Interpreting Section 19 of the POCSO Act**

Mandatory reporting is central to the working of the POCSO Act. The Supreme Court in *State of Maharashtra and Anr v Dr. Maroti* [19], observed that "non reporting of the cases will defeat the purpose of POCSO". Section 19 of POCSO requires that "any person, who "has apprehension that an offence under this Act is likely to be committed or has knowledge that such an offence has been committed...shall provide such information" to the police. A report made in good faith confers immunity on the reporter from any civil or criminal liability [1: S.19(7)]; but the failure to report an offence is punishable [1:S. 21]. This gives rise to the questions: Does the provision extend to professionals whose very mandate is based on confidentiality of the interaction? Does it apply to doctors and healthcare professionals alike? If yes, isn't the reporting mandate in conflict with the medical ethics that ordain patient confidentiality? Further, does the law unambiguously define the parameters for prosecuting healthcare professionals?

The Act does not specifically mention doctors and healthcare professionals under S.19; while hospital personnel are expressly mentioned in S.20, relating to duty to report 'material or object which is sexually exploitative of the child [1:S.20]. How then have the provisions of S.19 been extrapolated to include doctors and healthcare professionals? The answer is in the 2013 Model Guidelines under Section 39 of POCSO [20] and the directions of the Supreme Court in *Shankar Kisanrao Khade v State of Maharashtra* [21].

The 2013 Model Guidelines under Section 39 of POCSO categorically state that "When a doctor has reason to suspect that a child has been or is being sexually abused, he/she is required to report this to the appropriate authorities (ie, the police or the relevant person within his/her organization who will then have to report it to the police). Failure to do this would result in imprisonment of up to six months, with or without fine" [20:S.4]. However, it is a well-settled position of law that "guidelines cannot supersede or alter the provisions of the Act or the rules made thereunder" [22]. Further, in

*Shankar Kisanrao Khade*, the Supreme Court while hearing an appeal against the imposition of the death penalty for the repeated rape and murder of a minor girl, was shocked that a witness, despite personally seeing the incident of rape, failed to report it to the police. It issued a slew of directions, including the mandatory reporting of child sexual abuse by medical institutions as follows:

*77.5. If hospitals, whether government or privately-owned or medical institutions where children are being treated come to know that children admitted are subjected to sexual abuse, the same will immediately be reported to the nearest Juvenile Justice Board/SJPU and the Juvenile Justice Board, in consultation with SJPU, should take appropriate steps in accordance with the law safeguarding the interest of the child. [21]*

However, neither the POCSO model guidelines nor the court have considered clarifying the irreconcilable tension between the doctor's duty to report offences and the confidentiality mandate under the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 (IMC Regulations) [23]. Mandatory reporting of sexual offences by healthcare professionals may conflict with medical ethics as it entails a breach of the principles of confidentiality and informed consent [24]. Under the IMC Regulations, 2002, it is the duty of the physician to protect the confidentiality of a patient's information [23: Para 2.2]. S. 23 of the Mental Healthcare Act, 2017 [25] also protects a patient's privacy and confidentiality, not only in respect of "mental health or mental healthcare, but also other treatment and physical healthcare". Patient privacy is also a fundamental right under Art 21 of the Indian Constitution [5]. While the right to privacy is not absolute, and exceptions can be carved out by a law in the public interest, POCSO does not do that clearly. Neither the Mental Healthcare Act, 2017, nor the Code of Medical Ethics Regulations, 2002 [23] empower the doctor or healthcare professional to override confidentiality requirements for the purpose of reporting sexual offences. This is in sharp contrast to the categorically worded child protection laws in some European countries [15] and states in Australia[14] and Canada[13] wherein the laws expressly dispense with professional confidentiality requirements in situations where duty to report offences against children is triggered. Similarly, POCSO should have contained specific guidance on the application of mandatory reporting norms to doctors and healthcare professionals vis-à-vis the principles of privacy and confidentiality, because of their unique position.

Further, mandatory reporting of offences can have an adverse impact on therapeutic outcomes [26]. Administratively also, reporting can be a laborious and time-consuming task for doctors and healthcare professionals as there is no prescribed format for a report under S.19, nor does POCSO specify the circumstances in which healthcare professionals are required to report sexual offences.

## 'Knowledge' of sexual offence: Passive or active duty of healthcare professionals

Under S.19 of POCSO, any person who has "knowledge" of the commission or likely commission of a sexual offence against a child must report that offence to the police. The term knowledge has been explained by the Supreme Court of India in *Jai Prakash v State (Delhi Administration)* [27], as "... a state of mental realisation with the bare state of conscious awareness of certain facts in which human mind remains supine or inactive...."

Whenever knowledge constitutes criminal intent, it is either obvious knowledge of a thing or a fact [28] or passively acquired knowledge on the basis of disclosures made by someone [29]. The law does not require the person to actively obtain knowledge [29]. A healthcare professional is not required to make a roving enquiry to obtain knowledge about the commission of an offence. This has been clarified by the Supreme Court in 2018 in the matter of *Dr. Sr. Tessa Jose v State of Kerala* [29]. The appellants included medical staff charged under S.19(1) of POCSO. They had attended a pregnant girl aged 18, who went into labour in their hospital. It was alleged that the pregnancy of the victim was an outcome of rape committed when she was a minor, and that they could have gathered that she was a minor at the time of conception, and should have taken due care in finding out how the survivor became pregnant. However, the Supreme Court held that fastening criminal liability in the circumstances of the case was too far-fetched. It clarified:

"... The expression used is "knowledge" which means that some information received by such a person gives him/her knowledge about the commission of the crime. *There is no obligation on this person to investigate and gather knowledge.* If at all, the appellants were not careful enough to find the cause of pregnancy as the victim was only 18 years of age at the time of delivery. But that would not be translated into criminality... *Further, a person can be supposed to know only where there is a direct appeal to his senses....*" (Emphasis added) [29]

However, where doctors failed to report sexual offences against children despite being told personally by the child victims of their sexual abuse, they have been prosecuted for violating the mandate to report offences under the POCSO. For instance, in *State of Maharashtra v Dr. Maroti* [19], 17 minor tribal girls had been sexually abused in a school hostel. They were taken for treatment to the respondent-doctor, to whom they divulged the sexual assaults on them, but he did not report this either to the Special Juvenile Police Unit or to the local police. The charges against him under S.21 of the POCSO Act for remaining silent with a view to helping the perpetrators of sexual offences were quashed by the Bombay High Court on the ground of lack of evidence. On appeal, the Supreme Court reversed the High Court's decision, emphasising the "prompt and proper reporting of offences" as pivotal to the working of POCSO. The doctor in this case had

"direct knowledge" of the commission of the offence and therefore was *prima facie* culpable for non-reporting of offences under S.21 of the POCSO Act. What if the victims had not divulged their trauma to the doctor? Was the doctor obliged by law to make an enquiry and actively seek information from the victims? Is he supposed to take on the role of an investigating officer? The answer is a categorical "No".

Despite this, the courts refuse to quash criminal complaints against doctors under S.21 of POCSO even in cases where there is no direct knowledge of a sexual offence [30]. This is in sharp contrast to the cautious approach adopted when dealing with allegations of criminal medical negligence where no investigation is initiated against doctors until the complainant brings *prima facie* evidence against them [31]; or a preliminary enquiry suggests culpability [32:para 111]. In fact, the looming threat of criminal prosecution has a chilling effect on the practice of doctors and has translated into a full-blown public health issue, as explained in the next section.

## Effect of mandatory reporting on public health

The POCSO mandatory reporting norm is omnibus in the sense that it applies to reporting of any sexual offences where the child is below the age of 18 years.

This is unlike the position in many countries, where the mandate to report can be absolute or relative depending upon the age of the child in question [13,14]. They categorise children into various age groups so as to differentiate very young children from teenagers and adolescents for the purpose of reporting. While the mandate to report sexual abuse is absolute in the case of very young children, say when the child is under the age of 13, but not in other cases. In cases of teenaged children say between 13 and under 16 years old, the reporter can make a subjective assessment of the abuse by taking into account the relative position of the victim vis-à-vis the alleged perpetrator, the nature of the act, relationship between the child victim and the perpetrator — whether it is consensual or intimidatory, or exploitative, and their age gap [33].

However, no such latitude is available to the reporters in India and they are required to report in all circumstances, without taking any subjective elements into consideration. Furthermore, POCSO does not recognise consent as a defence; the law deems any sexual activity with a child, i.e. person below the age of 18, as an offence and furthermore any sexual offence against any child must be reported. This complicates the situation for pregnant adolescents wanting to get their pregnancy medically terminated even if such a pregnancy is a result of consensual sexual activity. Reporting of such sexual offences results in a Catch-22 situation, especially when it appears that the pregnancy was not a result of abuse or sexual assault but of a consensual relationship. Medical professionals face an ethical dilemma in

reporting such sexual offences to the police, as reporting may not be in the best interest of the child or desired by the child or guardian of the child. While a minor is permitted to abort the pregnancy with the consent of her guardian [34], the POCSO reporting mandate acts as a hurdle in availing of safe abortion services, [35] and has a chilling effect on a minor's reproductive choices. The rigour of the law forces people to resort to risky, unsafe and at times, unscientific abortion practices including resorting to quacks for termination of pregnancy.

Conscious of the unintended outcome of the mandatory reporting norms under POCSO and championing woman's right to bodily integrity and reproductive choices, a three-judge bench of the Supreme Court speaking through Chief Justice (Dr) DY Chandrachud in *X v Health & Family Welfare Department* [36] has sought to dilute, if not erase, mandatory reporting norms for consensual relationships by adolescents. It held:

*"... If there is an insistence on the disclosure of the name of the minor in the report under Section 19(1) of POCSO, minors may be less likely to seek out RMPs for safe termination of their pregnancies under the MTP Act... **For the limited purposes of providing medical termination of pregnancy in terms of the MTP Act, we clarify that the RMP, only on request of the minor and the guardian of the minor, need not disclose the identity and other personal details of the minor in the information provided under Section 19(1) of the POCSO Act.**" (emphasis added)" [36].*

It must be noted that the decision of the Supreme Court in this case only created a modified pathway for due diligence for reporting sexual offences against children. It diluted the requirement to disclose the personal information and identity of the minor in the report made to the police. But, as a matter of fact, the report still needs to be made.

The question may then be asked: what is the utility of making such a report bereft of the survivor's personal details? If the intention is to shield cases of consensual relations between adolescents from criminal proceedings, why burden the doctor with mandatory reporting to the police? If an anonymous report is made by the doctor to the police, aren't the police still bound to register an FIR under S.166 A of the Indian Penal Code, 1860? In fact, the judgment in *X v Health & Family Welfare Department* raises more questions than it answers. The court dilutes reporting in cases of 'adolescents' but fails to define that term. Does it include children between 14 to 18 or 15 to 18 or 16 to 18? POCSO has also not defined the term "adolescent" therefore opening a Pandora's box for litigation on interpretation of the term. Furthermore, anonymous reporting is to be done even in cases of consensual sexual relationship. How will the doctor find out whether the pregnancy was a result of consensual or non-consensual sexual relationship? Assuming that the doctor is bound by the version of the child on the nature of sexual activity, should the benefit of the case be restricted to those

where the consensual sexual activity was "amongst adolescents"? Generally, age difference is used as one of the metrics to sift romantic liaisons from sexual abuse. Popularly called "Romeo-Juliet laws" in the west, the statutes provide exemption from statutory rape charges only if consensual sexual activity was amongst adolescents, ie both the persons were above a particular age but below the age of 18, or one of them was an adolescent and the partner was not more than 3 to 5 years older than the adolescent. However, no indication is given by the court as to when a doctor is supposed to presume that the relationship was consensual. Lastly, reporting is to be done without naming the adolescent on the request of the minor and their guardian. Should the request come on doctor's enquiry, or voluntarily from the minor/guardian? Is the request to be recorded? Will a mere verbal request suffice or should it be in writing signed by the guardian? Does it require to be video-graphed? No clarity has been provided in the judgment on these important aspects.

Despite this judgment recognising a women's reproductive choices, doctors continue to make abortion services conditional upon the mandate to report. For instance, in *K v The Principal Secretary, Health and Family Welfare Department, Govt of NCT, Delhi* [37], the petitioner's minor daughter, aged 16 years, was pregnant due to a consensual sexual relationship. No doctor, government or private, was ready to terminate the pregnancy of the petitioner's daughter without reporting the offence to the police. Admittedly, neither the girl nor her mother wanted a criminal case. It was only after the High Court of Delhi's direction that the medical termination of pregnancy of the petitioner's daughter was performed.

## Conclusion and recommendations

No doubt mandatory reporting norms are useful tools in combating child sexual abuse, but the problem lies in their overbreadth. The overbreadth results from two axes: first, the failure to clearly list the professionals who have a duty to report; and second, the failure to distinguish between children of various age groups thereby bringing into its fold consensual sex between adolescents. Scholars have long felt the need to decriminalise consensual sexual activity of persons in the age group of 16-18 years. Recent studies have also pointed out that conflation of sexual abuse with consensual sexual activity is injustice of the gravest nature [38, 39]. The general comment No. 20 (2016) on the implementation of the rights of the child during adolescence by the CRC has also suggested the decriminalisation of consensual and non-exploitative sexual activity of adolescents [40]. The law should be refined to respect the choices of an adolescent in a meaningful manner. We need to lower the age of consent to 16 and ensure that mandatory reporting norms are not inflexible with respect to 16-18-year-olds. These changes must be brought in urgently, unless the State wants doctors to be

informants of not only child sexual abuse but also teenage sexual relationships.

We also need to seriously reconsider the criminalisation of non-reporting of sexual offences by doctors and imprisoning them for it. As with medical negligence, FIRs should not be filed automatically against doctors for non-reporting, but only after a preliminary enquiry suggests that there was knowledge of a sexual offence. Further, if action has to be taken against doctors for non-reporting, it may be done by their professional regulatory bodies, not by courts.

Clarity in the language of S.19 of POCSO is the need of the hour. It should be amended to ensure that there is no conflict between the duty to report and medical ethics. Further, we need to balance the public interest in reporting sexual offences with public health. One way to do that is to create internal mechanisms to ensure that doctors are not unnecessarily burdened with duty to report directly to the police. A nodal officer can be appointed for each hospital or group of hospitals in a given local area, who collates the information from doctors and liaises with the police to make the reports. The nodal officer can ensure that frivolous reports are not made to the police.

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## COMMENTARY

### Right to abortion of survivors of rape in India

MANIKA KAMTHAN, RUKSANA AKHTAR

#### Abstract

*The Medical Termination of Pregnancy (MTP) Amendment Act, 2021, contains some progressive changes. However, survivors of rape will continue to go through mental as well as physical trauma to secure an abortion. We argue that the MTP Amendment Act, 2021, fails to address the rights of rape survivors adequately.*

**Keywords:** *right to abortion, rape, MTP Act, right to life, autonomy.*

The Medical Termination of Pregnancy (MTP) Amendment Act, 2021 [1] is viewed as reformative, which attempts to address the limitations of the MTP Act, 1971 [2] which governs abortions in India.

One of the key changes is Section 3, which extends the time limit for termination of pregnancy *in certain circumstances*, from the earlier 20 weeks to 24 weeks. Abortions between 20 and 24 weeks require the recommendations of two medical practitioners. These medical practitioners should “in good faith” believe that the continuation of the pregnancy involves a risk to the pregnant woman’s life or a risk of grave injury to her physical or mental health, or that there is a substantial risk that if the child were born, it would suffer from a serious physical or mental abnormality [1].

Rule 3B of the MTP Act 2021 recognises seven categories of women whose pregnancies between 20 and 24 weeks can be terminated under Section 3(2) (b) of the MTP Act 2021 [2]. These are: (i) survivors of sexual assault, rape, or incest; (ii) minors; (iii) women whose marital status changes during the ongoing pregnancy through widowhood or divorce; (iv) women with physical disabilities; (v) mentally ill women including women with mental retardation; (vi) women whose foetus has a malformation that has a substantial risk of being incompatible with life; or, if the child is born, it may suffer from physical or mental abnormalities and will be seriously handicapped; and (vii) women who are pregnant in humanitarian settings, or disaster or emergency situations.

A major gap in the amended Act is its treatment of abortion in cases of pregnancy caused by rape. Under the Act, a pregnancy beyond 24 weeks may be terminated only where such termination is necessitated by “the diagnosis of any of the substantial fetal abnormalities” by a Medical Board. In

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