

# *Shetland Public Protection Committee*

## Shetland inter-agency Child Protection Procedures



## Safer Shetland – Safeguarding children and young people in Shetland

[www.safersheland.com](http://www.safersheland.com)



May 2019

# SHETLAND INTER-AGENCY CHILD PROTECTION PROCEDURES

## *Safeguarding Children and Young People in Shetland*

To get this information on audio cassette, in large print, or in Braille, or if you require assistance in reading this, please phone **01595 744430/744435**.

Ha meg szeretné kapni ezt az ismertetőt más nyelven vagy más formátumban, hívja a helyi NHS hivatalt a 01595 743060-as számon

Jeśli chcieliby Państwo otrzymać ten materiał informacyjny w innym języku lub formacie prosimy zadzwonić do miejscowego Zarządu NHS pod numer telefonu 01595 743060

ขอรับ ข้อมูลนี้ในภาษาหรือรูปแบบอื่น  
(โทร) คณะกรรมการ NHS ของคุณได้ที่หมายเลข 01595 743060

للحصول على هذه المعلومات بلغة أخرى أو بنسق مختلف، اتصل بالمكتب المحلي لهيئة الرعاية الصحية الوطنية NHS Board على الرقم 01595 743060

এই তথ্যগুলি অন্য ভাষায় কিম্বা আকারে পেতে চাইলে আপনার স্থানীয় এনএইচএস বোর্ড (NHS Board)-কে ফোন করুন। 01595 743060

若要取得另一種語言或形式版本，請致電您當地的 NHS Board : 01595 743060

ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਰੂਪ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਆਪਣੇ ਲੋਕਲ NHS ਬੋਰਡ ਨੂੰ 01595 743060 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ।

یہ معلومات کسی اور زبان یا شکل میں حاصل کرنے کیلئے اپنے این ایچ ایس کے مقامی بورڈ کو پرنٹیفون کریں۔ 01595 743060

<http://www.safershetland.com>

**What to do if you are worried about a child or young person?**

***To make a Child Protection Referral contact the duty social worker. If you are worried or concerned about a child or young person you can contact one of the following agencies:-***

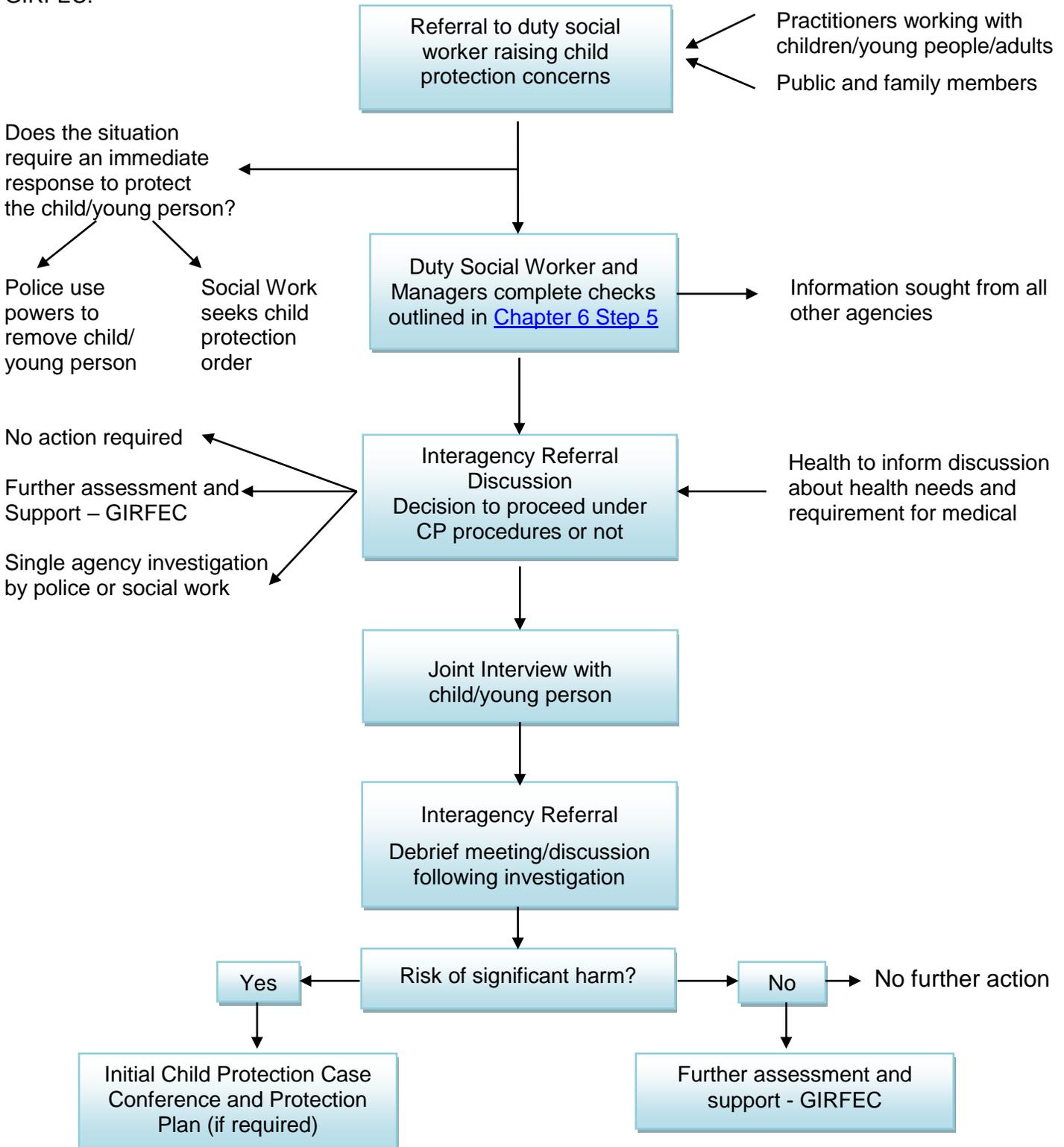
<b>Duty Children's Social Work Service</b>	<b>Telephone</b>
<b>Monday to Friday 9 am – 5 pm</b> <a href="mailto:childrens&amp;families-intake@shetland.gov.uk">childrens&amp;families-intake@shetland.gov.uk</a> (during working hours)	01595 74 4000
Duty Out of Hours Service (outwith above times)	01595 695611

<b>Police</b>	<b>Telephone</b>
<b>24 hour cover</b>  Lerwick Police Station  In an emergency call 999	101

<b>Other numbers</b>	<b>Telephone</b>
<b>Monday to Friday 9 am – 5 pm</b>  SCRA Children's Reporter	0131 244 3780

## FLOWCHART

The process of responding to child protection concerns is represented in diagrammatic form below. At any stage in the process it can be stopped if it is felt that either the child requires immediate emergency measures to protect them or if the information gathered does not require a response under child protection procedures. Some children, young people and families may benefit from further assessments and support through GIRFEC.



## **CONTENTS:**

What to do if you are worried about a child or young person – **[See information with contact phone numbers inside front cover](#)**

	<b><u>Page No</u></b>
<b><u><a href="#">Explanation of Terminology</a></u></b> .....	i
<b>How to Open Hyperlinks</b> .....	i
<b><u><a href="#">Glossary</a></u></b> .....	i

## **SECTION ONE – PROCEDURES:**

### **Chapters**

1. <b><u><a href="#">Introduction</a></u></b> .....	1
1.2 <b><u><a href="#">Getting it Right for Every Child</a></u></b> .....	1
1.3 <b><u><a href="#">Young People Aged 16-18</a></u></b> .....	2
2. <b><u><a href="#">Policy</a></u></b> .....	4
3. <b><u><a href="#">Roles and Responsibilities</a></u></b> .....	6
4. <b><u><a href="#">Definition</a></u></b> .....	8
5. <b><u><a href="#">Recognition</a></u></b> .....	11
6. <b><u><a href="#">Stepwise Guide</a></u></b> – how to make a child protection referral and guidance on responding to child protection referrals (including guidance for police and social workers about investigations) .....	16
7. <b><u><a href="#">Child Protection in Special Circumstances</a></u></b> .....	27
8. <b><u><a href="#">Health Assessment and Medical Examinations</a></u></b> .....	35
9. <b><u><a href="#">Parents and Carers</a></u></b> .....	43
10. <b><u><a href="#">Child Protection Case Conferences</a></u></b> .....	44
11. <b><u><a href="#">Legal Action</a></u></b> .....	60
12. <b><u><a href="#">Child Protection Register Administration</a></u></b> .....	63
13. <b><u><a href="#">Forms and Leaflets</a></u></b> .....	66

## **SECTION TWO – APPENDICIES:**

### **Appendix 1**

- Guidance Notes – Child Protection Orders

### **Appendix 2**

- Appeals process

### **Appendix 3**

- Managing a disclosure of abuse

## **SECTION THREE – PROTOCOLS:**

1. [Guidance for becoming aware of under age sexual activity](#)
2. [Links between Child Protection Case Conferences and the Scottish Children's Reporter Authority](#)
3. [Individual Procedure for the Exchange of Information between Shetland Islands Council and NHS Shetland Accident & Emergency Department](#)
4. [Protecting Children & Young People affected by adults with problem substance use](#)
5. [Managing Significant Case Reviews](#)
6. [Working with Children and Young People who display sexually harmful behaviour](#)
7. [Shetland Multi Agency Procedure for National and Local Missing Children/Family Alerts](#)
8. [Unseen Child and Working with Non-Engaging Families](#)
9. [Safe Use of the Internet](#)
10. [Supporting Children and Young People who self-harm](#)
11. [Vulnerable Young Persons' Protocol \(16-18 years\)](#)
12. [Child Sexual Exploitation](#)

Please note that additional information on a number of topics related to child protection (for e.g. domestic abuse, FGM, parental substance misuse etc) is available from the document library at <https://www.safershetland.com/documents>

## EXPLANATION OF TERMINOLOGY

Throughout this document the terms ‘investigation’ ‘investigate’ and ‘investigative interview’ are used to refer to the activities of the police, the Reporter and the Council’s Children’s Social Work services. Usually these terms imply the gathering of evidence, which is the responsibility of the police and the Reporter. The primary responsibility of social work services in child protection is to gather information and make assessments about the best interests of children and young people. However, for the purposes of this document, the above terms have been used to indicate the activities of all three agencies specifically in respect of child protection.

Throughout these procedures, the terms “child and young person” or “children and young people” are used. These terms refer to all children and young people up to the age of 16 years. In some cases there is reference to “young people aged 16-18”, but this is specified in each section referring to this age group.

## OPENING HYPERLINKS WITHIN THE INTERNET VERSION OF THIS DOCUMENT

To open a hyperlink you should hover over the link and right click when you will be presented with a number of options. Choose “Open Hyperlink” which will take you to the website or document.

## GLOSSARY:

CPC	-	Child Protection Committee
SPPC	-	Shetland Public Protection Committee (from March 2019 the SPPC was created and fullfills all the obligations of a child protection committee)
CPO	-	Child Protection Order
PPU	-	Public Protection Unit Police Scotland
CME	-	Children Missing from Education
CSE	-	Child Sexual Exploitation
DMCP	-	Designated Manager for Child Protection (Social Work)
DMCS	-	Designated Manager for Community Services
FGM	-	Female Genital Mutilation
GIRFEC	-	Getting it Right for Every Child
GP	-	General Practitioner
ICT	-	Information and Communication Technology
LCPO	-	Local Child Protection Officers
LGBT	-	Lesbian, Gay, Bisexual and Transgender
NHS	-	National Health Service
SWIFT	-	Social Work Information System

## **1. Introduction**

- 1.1 Shetland's Public Protection Committee (SPPC), which fulfils all the functions of Shetland Child Protection Committee <http://www.safershetland.com/> – has produced this document as the basis of local practice in relation to child protection. It is consistent with the National Guidance for Child Protection in Scotland 2014 - <http://www.gov.scot/Resource/0045/00450733.pdf> [2014]
- 1.2 SPPC is made up of representatives from a range of organisations including the statutory agencies with responsibility for the welfare of children and young people. SPPC's Constitution is approved by the Chief Officers of Shetland NHS Board and Shetland Islands Council and the Chief Inspector, Shetland Area Command, Police Scotland.
- 1.3 Shetland Islands Council, Shetland NHS Board and Police Scotland have approved this document. The policy, procedures and practice guidance that follow apply to all statutory agencies represented at SPPC, and must be followed irrespective of the source of the referral or its first point of contact.
- 1.4 Third sector organisations providing services to children and young people are represented at SPPC. National Guidance makes it clear that all organisations should adopt local and national child protection procedures. Further guidance for community groups is available at <http://www.safershetland.com/adult-protection-for-community-groups>
- 1.5 Further protocols may be developed to provide additional guidance on specific areas of child protection work. Once approved by SPPC they will be added to these Procedures and shared accordingly.
- 1.6 The Shetland Inter-Agency Guidance is compatible with the equality and diversity principles and duties set out within the Equality Act 2010 -<http://www.legislation.gov.uk/ukpga/2010/15>. The guidance is also compatible with the Human Rights Act 1998. Child protection services in Shetland will ensure that they operate in fair, consistent and reliable ways with an emphasis on participation, respect and inclusion.

## **2 Getting it Right for Every Child (GIRFEC)**

- 2.1 This guidance is rooted in the GIRFEC approach and the provisions of the Children and Young People (Scotland) Act 2014. Every child and young person in Shetland has a Named Person. Where concerns about the wellbeing of the child or young person require co-ordinated intervention from more than one agency, then a Lead Professional will be identified to take on the co-ordinating role. Where evidence suggests that a co-ordinated plan to provide "targeted intervention" involving two or more agencies will be necessary, a Child's Plan will be drawn up. (For further information and to find out who is the Named Person for a specific child or young person please see following web link:  
[http://www.shetland.gov.uk/children\\_and\\_families/GIRFEC.asp](http://www.shetland.gov.uk/children_and_families/GIRFEC.asp)

- 2.2 Where a child or young person is at risk of significant harm – either due to a specific experience of abuse or an accumulation of concerns over a period of time then the primary concern will be for their safety and child protection procedures should be put into place.
- 2.3 For children and young people involved in child protection procedures – either at the referral and investigation stage or if their names are recorded on the child protection register – the Lead Professional will be a social worker from the Children’s Social Work Team. For children and young people whose names are on the child protection register the Child’s Plan will also be the Child Protection Plan.

### **3 16-18 Year Olds**

- 3.1 Young people age 16 – 18 can be at risk of falling between gaps in services. The Children and Young People Act (Scotland) 2014 is clear that all young people up to the age of 18 should have a Named Person in place that can be a first point of contact if the young person requires advice and assistance.
- 3.2 For young people aged 16-18 who are still in Education the Schools Service will provide a Named Person. For young people who have left school and who have not been Looked After, Shetland Islands Council Youth Work Services will provide a Named Person. For any young person who was Looked After on their 16<sup>th</sup> birthday and is entitled to a through care and after care service that service will provide a Named Person.
- 3.3 To ensure that vulnerable young people aged 16 -18 who may be at risk of significant harm have their situation assessed and responded to, please see the Vulnerable Young Person’s guidance [Protocol 11](#) in Section 3 of these procedures.
- 3.4 For young people age 16 to 18 who have been identified as being at risk of significant harm a child protection referral should be made to Children and Families Social work. An initial child protection case conference can be called and a young person over 16 can have their name placed on the child protection register if those attending the conference assess that is the best way to protect them. It would be unusual to register a young person aged over 16, but there is nothing in National Guidance that prohibits this if it is felt to be appropriate. A supportive working relationship with the young person taking account of their views is also important. If a child whose name is already on the child protection register becomes 16 then consideration of continued registration is appropriate as would normally happen at the next Review Child Protection Case Conference - they do not need to be automatically deregistered. What will need to be considered for young people over 16 is whether any of the provisions under the Adult Support and Protection (Scotland) Act 2007 would assist in safeguarding them. The Adult Support and Protection Procedures can

be accessed through the following link –  
<http://www.safershetland.com/adult-protection>

- 3.5 It is possible for a young person to remain on a Compulsory Supervision Order under the Childrens Hearing Act (Scotland) 2011 up to the age of 18, if they are already subject to such an order on their 16<sup>th</sup> birthday. This means that they are “Looked After” and the local authority has a responsibility for their care and welfare up to the age of 26. A young person who is subject to a Compulsory Supervision Order is classed as a child for the purposes of the remedies available under the 2011 Act or the Childrens (Scotland) Act 1995 Act. A Compulsory Supervision Order is part of the Child Protection Framework, and it would unnecessarily complicate matters to deal with a young person who is already being dealt with under this framework under the Adult Support and Protection Procedures. However, it should be noted, that the remedies available under the Adult Support and Protection Framework, such as a Banning Order, would be available to protect such a young person. This is a legally complex area, and staff should seek advice from the Duty Social Worker who can consult with Shetland Islands Council’s legal services, if required.

## **2. Policy**

- 2.1 All children and young people have a right to protection from abuse and exploitation, and to adequate physical, emotional and social care; parents have the responsibility and the right to provide such care.
- 2.2 Children and young people are best cared for in their own families, except where consideration for their safety and welfare dictates otherwise.
- 2.3 The welfare of children and young people must be the paramount consideration in all decisions concerning them; all decisions must be based on children's and young people's best interests.
- 2.4 Each child must be treated as an individual with individual needs, views and beliefs.
- 2.5 Work will be carried out on the basis of partnership with families wherever possible, parents being consulted and involved in all decisions affecting their children, subject to paragraph 2.3 above.
- 2.6 The highest priority will be given to the protection of children and young people from abuse, and all agencies and organisations will ensure that activities carried out in the name of child protection are child-centred, and give paramountcy to the welfare and interests of children and young people.
- 2.7 The views of children and young people should be sought and they have the right to be listened to and to be taken seriously; interview and other procedures will focus on the child or young person, and will reflect his/her views, rights, wishes and needs.
- 2.8 All concerns that children and young people may be at risk of significant harm, have been or are being abused will be investigated in accordance with agreed inter-agency procedures.
- 2.9 All agencies are committed to working in an open and collaborative way, together and with parents, whilst recognising the potential for conflict in child protection situations.
- 2.10 All children and young people will be provided with appropriate support in accordance with their particular needs.
- 2.11 All child protection interventions must be child centred and consistent with the equality and diversity principles and duties set out in the Equality Act 2010 – <http://www.legislation.gov.uk/ukpga/2010/15>.
- 2.12 All Child Protection interventions will be carried out with an understanding of the Human Rights Act and the right to family life, balancing the need to protect children and young people from harm and the rights and responsibilities of parents and carers.

2.13 This policy has been approved by Shetlands Islands Council, Shetland NHS Board, and Police Scotland and adopted by all other organisations represented on Shetland Public Protection Committee.

### **3. Roles and Responsibilities**

3.1 Shetland Public Protection Committee is clear that responding to Child Protection is everyone's responsibility – this includes all professional staff and volunteers working with children, young people and adults. It also includes the general public.

3.2 The statutory responsibility for the investigation of suspected abuse of a child or young person lies with three agencies:

**Police**  
**The Council through its Children's Social Work**  
**Reporter**

3.3 The **Police** - <http://www.scotland.police.uk/your-community/highlands-and-islands/> - have a general duty to protect the public and to investigate matters on behalf of the Procurator Fiscal, where they believe that a criminal offence may have been committed. They will give the Procurator Fiscal any information which will help him or her to decide whether a criminal prosecution should take place. The police will refer a child or young person to the Reporter if they believe that a child or young person may be in need of compulsory measures of supervision. The police will also consult and share information with all other appropriate agencies on matters which relate to the well being of a child or young person.

3.4 The **Children's Social Work Team** located within Shetland Islands Council Children's Services – <http://www.shetland.gov.uk/> – has a duty to make enquiries into allegations of child abuse of every kind; and, where these enquiries suggest that a child or young person may be in need of compulsory measures of supervision, to refer the case to the Reporter.

3.5 The **Reporter** – <http://www.scra.gov.uk/home/> – has a duty to investigate referrals made to the Scottish Children Reporters Administration (SCRA) and to refer a child or young person to a Children's Hearing if the Reporter is satisfied that it is in the child's or young person's interest to provide protection, care, treatment or control on a compulsory basis. The extent and type of investigation is for the Reporter to decide.

3.6 With the responsibility to investigate goes the responsibility for decision-making. All decisions made will be recorded by the relevant organisations in accordance with their own internal practices and procedures.

- 3.7 The **Procurator Fiscal** - <http://www.copfs.gov.uk/> - also has clear statutory responsibilities in relation to the investigation of crime. With regard to child protection matters the Procurator Fiscal has a duty to:
- a) Consider the terms of reports sent in by police or other agencies and to instruct them to make appropriate enquiries;
  - b) Consider bail conditions that may protect a child or young person from an alleged offender;
  - c) Consider whether criminal proceedings are appropriate and if so, to consider how they should be prosecuted taking account of all the circumstances of the offence and the offender;
  - d) Set up contact with the child or young person witness where there is prosecution, in consultation with other agencies;
  - e) Assess with the help of professional colleagues, the most appropriate way for the child or young person to give evidence in any criminal court proceedings and to make appropriate applications to the court;
  - f) Work with the Reporter; and
  - g) Attend Child Protection Case Conferences, if this is appropriate.
- 3.8 **Shetland NHS Board** – <http://www.shb.scot.nhs.uk/> – has a specific role in connection with medical examinations for investigative purposes. Other agencies also have an essential part to play as set out in the following sections of these Procedures.
- 3.9 **Children’s Services (School Staff)** – staff working in a range of school and pre-school settings play a crucial role in the support and protection of children and young people as well as the development of their well being.
- 3.10 For further detailed information about the respective roles of different agencies please see Part 2 of the [National Guidance 2014](#).

## 4. Definition

4.1 **Child abuse and neglect** are forms of maltreatment of a child or young person. Somebody may abuse or neglect a child by inflicting, or by failing to act to prevent, **significant harm** to the child or young person. Children and young people may be abused in a family or in an institutional setting, by those known to them or, more rarely, by a stranger. Assessments will need to consider whether abuse has occurred, or is likely to occur. It is helpful to consider and understand the different ways in which children and young people can be abused.

4.2 The **National Guidance for Child Protection in Scotland 2014** states that the following definitions show some of the ways in which abuse may be experienced by a child or young person but they are not exhaustive, as the individual circumstances of abuse will vary from child to child.

<http://www.gov.scot/Resource/0045/00450733.pdf> [2014]

### ***Physical abuse***

Physical abuse is the causing of physical harm to a child or young person. Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning or suffocating. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes, ill health to a child or young person they are looking after.

### ***Emotional abuse***

Emotional abuse is persistent emotional neglect or ill treatment that has severe and persistent adverse effects on a child's or young person's emotional development. It may involve conveying to a child or young person that they are worthless or unloved, inadequate or valued only insofar as they meet the needs of another person. It may involve the imposition of age or, developmentally-inappropriate expectations on a child or young person. It may involve causing children or young people to feel frightened or in danger, or exploiting or corrupting children and young people. Some level of emotional abuse is present in all types of ill treatment of a child or young person; it can also occur independently of other forms of abuse.

### ***Sexual abuse***

Sexual abuse is any act that involves the child or young person in any activity for the sexual gratification of another person, whether or not it is claimed that the child or young person either consented or assented. Sexual abuse involves forcing or enticing a child/young person to take part in sexual activities, whether or not the child/young person is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. They may include non-contact activities, such as involving children and young people in looking at, or in the production of, pornographic material or in watching sexual activities, using sexual language towards a child/young person or encouraging children and young people to behave in sexually inappropriate ways.

Child Sexual Exploitation is a form of sexual abuse and should always be regarded as a child protection matter. Scottish Government gave the following definition of child sexual exploitation in 2016.

“Child sexual exploitation is a form of child sexual abuse in which a person(s), of any age takes advantage of a power imbalance to force or entice a child into engaging in sexual activity in return for something received by the child and/or those perpetrating or facilitating the abuse. As with other forms of child sexual abuse, the presence of perceived consent does not undermine the abusive nature of the act.”

### ***Neglect***

Neglect is the persistent failure to meet a child’s or young person’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s/young person’s health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, to protect a child/young person from physical harm or danger, or to ensure access to appropriate medical care or treatment. It may also include neglect of, or failure to respond to, a child’s/young person’s basic emotional needs. Neglect may also result in the child/young person being diagnosed as suffering from ‘**non-organic failure to thrive**’, where they have significantly failed to reach normal weight and growth or development milestones and where physical and genetic reasons have been medically eliminated. In its extreme form children and young people can be at serious risk from the effects of malnutrition, lack of nurturing and stimulation. This can lead to serious long-term effects such as greater susceptibility to serious childhood illnesses and reduction in potential stature. With young children in particular, the consequences may be life-threatening within a relatively short period of time.

## **4.3 Significant harm**

Child protection is closely linked to the risk of 'significant harm'. 'Significant harm' is a complex matter and subject to professional judgement based on a multi-agency assessment of the circumstances of the child/young person and their family. Where there are concerns about harm, abuse or neglect, these must be shared with the relevant agencies so that they can decide together whether the harm is, or is likely to be, significant. The [Children and Young People \(Scotland\) Act 2014](#), introduces a legal duty for a wide range of public bodies and those commissioned or contracted to them to share such concerns with a child's/young person's Named Person. Through early and effective intervention and the sharing of wellbeing concerns it is hoped that crisis can be avoided in many cases.

The National Guidance gives the following definitions:

**‘Harm’ means the ill treatment or the impairment of the health or development of the child, including, for example, impairment**

suffered as a result of seeing or hearing the ill treatment of another. In this context, “development” can mean physical, intellectual, emotional, social or behavioural development and “health” can mean physical or mental health.

**Whether the harm suffered, or likely to be suffered, by a child or young person is ‘significant’ is determined by comparing the child’s health and development with what might be reasonably expected of a similar child.**

Establishing whether a child/young person is at risk of significant harm is a complex matter and subject to professional judgement based on a multi-agency assessment of the circumstances of the child/young person and their family. **Where there are concerns about harm, abuse or neglect, these must be shared with the relevant agencies** so that they can decide together whether the harm is, or is likely to be, significant. Significant harm can result from a specific incident, a series of incidents or an accumulation of concerns over a period of time.

There are no absolute criteria for judging what constitutes significant harm. In assessing the severity of ill treatment or future ill treatment, it may be important to take account of: the degree and extent of physical harm; the duration and frequency of abuse and neglect; the extent of premeditation; and the presence or degree of threat, coercion, sadism and bizarre or unusual elements. Sometimes, a single traumatic event may constitute significant harm, for example, a violent assault, suffocation or poisoning. More often, significant harm results from an accumulation of significant events, both acute and long-standing, that interrupt, change or damage the child's/young person's physical and psychological development.

- 4.4 Organisations working with children and young people owe them a duty of care and have specific responsibilities towards them. Everyone has a responsibility to make sure children and young people are safe and well cared for, and should never cause them harm. Therefore, allegations against members of staff (or volunteers) working for any organisation will be investigated under these Procedures. (See further information in [Chapter 7](#).)
- 4.5 More information on significant harm and on specific roles and responsibilities for child protection are to be found in the National Guidance, available on the internet at <http://www.gov.scot/Resource/0045/00450733.pdf>

## 5. Recognition

- 5.1 There are a number of signs which **may** indicate that a child or young person has been abused.

When providing information about possible signs of abuse it is important to remember:

- Any list of signs is not completely definite or exhaustive;
- Child abuse could be one of a number of possible causes, and the existence of one or more symptoms does **not necessarily** indicate abuse;
- The following information should be looked at in the context of the child's or young person's whole situation, and in combination with a range of other information related to the child's or young person's circumstances.

- 5.2 Good practice would always be to seek advice and guidance by contacting the duty social worker if you have any concern about a child's or young person's welfare or safety.

- 5.3 It is reasonable to expect parents and professionals to be seriously concerned by the appearance of these, singly or in combination. **However, assumptions cannot be made on the basis of checklists, and it is essential to make objective assessments at all times.**

The following gives some information about possible indicators of physical, sexual, emotional abuse or neglect and online abuse. There can be an overlap between all the different forms of child abuse and all or some can co-exist. Abuse, including sexual abuse, can be perpetrated by both males and females, including other young people.

### 5.4 General Presentations

Conflicting explanations or inconsistent reports of:-

- Medical treatment;
- Reasons for marks or injuries;
- Reasons for absence from school or missing medical appointments;
- Obvious, non-accidental marks of hand, belt, stick etc;
- Injuries to babies and very young children;
- Delay in parents and/or carers seeking medical attention for their child;
- Children and young people brought for medical attention by parent or carer who was not present when the injury was sustained;
- Features of general neglect of the child's / young person's physical or emotional needs;
- Inappropriate behaviour (including sexualised play or activity) or demeanour of the child/young person or parent;
- Unusual illness suggestive of a fictitious origin; and

- Child's/young person's name already entered on the Child Protection Register.

## 5.5 Physical Abuse

The following indicators may be helpful to practitioners when considering the possibility of physical abuse:-

### Bruises

#### **Bruised eyes are particularly suspicious if:-**

- Both eyes are bruised (most accidents cause only one);
- There is an absence of bruising to the forehead or nose;
- There is a suspicion of skull fracture (bruised eyes can be caused by blood seeping down from an injury above).

#### **Other signs:**

- Bruising in or around the mouth (especially in young babies);
- Grasp marks on the arm or on the chest of a small child;
- Finger marks (three or four small bruises on one side of the face and one on the other);
- Symmetrical bruising (particularly on the ears);
- Outline bruising (e.g. belt marks, hand prints);
- Linear bruising (commonly on the buttocks or back);
- Bruising on soft tissue with no satisfactory explanation;
- Petechial bruising (petechia – small spot caused by an effusion of blood under the skin), tiny red marks on the face particularly in or around the eyes and neck, also the ears, indicative of shaking or constriction;

*NB – Most falls or accidents produce one bruise on an area of the body, usually on a bony protuberance. A child or young person who falls downstairs generally has only one or two bruises. Bruising in accidents is usually on the front of the body as children and young people generally fall forwards. Additionally, there may be marks on their hands if they have tried to protect themselves and attempted to break their fall.*

The following are uncommon areas for accidental bruising:-

- Back;
- Back of legs;
- Buttocks (except occasionally along the bony protuberance of the spine);
- Neck;
- Mouth;
- Cheeks
- Behind the ear;
- Stomach;
- Chest;
- Under arm; and

- Genital or rectal areas

In most instances, reporting concerns about injuries that raise questions about a possible non-accidental cause to the Duty Social Worker is an appropriate first step. The DSW can liaise with NHS Shetland colleagues and a medical can be arranged to assess the injuries. However if injuries are serious then seeking immediate medical help would always be the first priority.

### **Bites**

These can leave clear impressions of teeth and the scientific specialism of Odontology can often identify the abuser.

### **Burns and Scalds**

Distinguishing between accidental and non-accidental burns is problematic but as a general rule burns and scalds with clear outlines are suspicious. Similarly burns of uniform depth over a large area should arouse suspicion. Equally splash marks about the main burn area (possibly caused by hot liquid being thrown).

**NB** *Concerns should be raised when the adult responsible for filling a bath has failed to check the temperature of the bath. A child or young person is unlikely to sit down voluntarily in an excessively hot bath and equally cannot physically scald its bottom without also scalding its feet. A child or young person voluntarily stepping into a bath filled with too hot water will naturally struggle to hop back out again causing splash marks.*

### **Scars**

Many children and young people have scars but staff should be vigilant about an exceptionally large number of differing age scars (particularly if combined with fresh bruising), unusually shaped scars (e.g. circular ones resulting from cigarette burns) or of large scars from burns or lacerations that have not received medical attention.

### **Fractures**

These should arouse suspicion if the explanation for the injury changes or is not consistent with the injury or the age and stage of the child. Concerns can also arise if there is swelling or discolouration over a bone or joint. The most common non-accidental fractures are to the long bones, i.e. the arms or legs. Generally, fractures also cause pain and it is difficult for a parent or carer to justify being unaware that a child or young person has been injured in this manner. It would be rare for a child who is not walking or crawling to sustain an accidental limb fracture.

### **Genital/Anal Area**

It would be unusual for a child or young person to have bruising or bleeding in these areas and medical opinion should be sought.

### **Injuries caused by shaking**

Shaking a child of any age risks injury to the brain, eyes and other parts of the body. This can be life threatening and any concerns about a child being shaken should be immediately referred under these procedures and urgent medical attention sought.

## **5.6 Sexual Abuse**

Children and young people can disclose either spontaneously or in a planned way by making a choice to tell a trusted adult or peer. The following indicators may be helpful to practitioners when considering the possibility of sexual abuse.

### **Physical Indicators:-**

- Injuries to the genital area;
- Infections or abnormal discharge from the genital area;
- Complaints of genital itching or pain;
- Depression or withdrawal;
- Wetting and soiling, day and night;
- Sleep disturbance or nightmares;
- Recurrent illnesses, especially venereal disease;
- Anorexia or bulimia;
- Pregnancy; and
- Phobias or panic attacks.

### **General Indicators:-**

- Self harming;
- Exhibiting sexual awareness inappropriate for the age of the child/young person;
- Acting in a sexually explicit manner e.g. very young child inserting objects into their vagina;
- Sudden changes in behaviour or school performance or attendance;
- Displays of affection which are sexually suggestive;
- Tendency to cling or need constant reassurance;
- Tendency to cry easily;
- Regression to earlier behaviour such as thumb sucking, acting as a baby;
- Distrust of a familiar adult or anxiety about being left with a relative, babysitter or lodger;
- Unexplained gifts or amounts of money;
- Secretive behaviour; and
- Fear of undressing for gym classes or swimming lessons.

## 5.7 Emotional Abuse

The following indicators may be helpful to practitioners when considering the possibility of emotional abuse. In some circumstances they will be applicable to an individual child or young person, in others it may reflect upon all siblings.

### Parents' Behaviour

- Rejection;
- Denigration;
- Scapegoating;
- Denial of opportunities for exploration, play and socialisation appropriate to their stage of development;
- Under stimulation;
- Sensory deprivation;
- Unrealistic expectations of the child/ young person;
- Marked contrast in material provision, or affection and attention provided to other siblings;
- Isolation from normal social experiences preventing the child/young person forming friendships;
- Requesting the child/young person be removed from the home or highlighting difficulties in coping with a child/young person about whose care there is existing professional concerns; and
- Domestic abuse between care givers.

The effects on children and young people who witness domestic abuse are serious. The possibility of such children or young people being physically abused can also be a concern.

### Child's/Young Person's Behaviour

- Frozen watchfulness;
- Fear of carers;
- Refusal to speak; and
- Severe hostility or aggression towards other children/young people.

## 5.8 Neglect

There are factors that can impact on a parent or carer's ability to provide safe care for their child, including substance misuse, domestic abuse, severe mental illness and learning disabilities. These are all issues that can affect a child's/young person's situation to the extent that they are being harmed due to neglect.

The following indicators may be helpful to practitioners when considering the possibility of neglect:-

- Lack of appropriate food;
- Inappropriate or erratic feeding;
- Significantly underweight or obese;
- Hair loss;
- Lack of adequate clothing and unclean clothing;
- Circulation disorders; (which can be caused by the child not being kept warm enough)
- Unhygienic home conditions;
- Lack of protection from adults e.g. allowing a sex offender access to the child, allowing other adults with substance misuse problems to come to the family home;
- Lack of supervision appropriate to the child's/young person's age which may arise due to familial abuse of substances;
- General failure to achieve developmental milestones;
- Lack of parental involvement, care and interest;
- Lethargy and tiredness; and
- Persistently late to school, not attending school or conversely the child/young person who arrives early and appears reluctant to go home;
- Failure to keep routine medical, dental and health visiting appointments;
- Poisoning may occur accidentally if children are not being supervised appropriately and have access to hazardous substances or prescribed medication or illegal substances.

### **Non Organic Failure to Thrive**

Signs of possible non-organic failure to thrive:-

- Significant lack of growth;
- Weight loss;
- Hair loss;
- Poor skin or muscle tone; and
- Circulatory disorders.

## 5.9 Bullying

Bullying is not always easy to recognise as it can take a number of forms. A child may encounter bullying attacks that are:

Bullying may not be a child protection issue that necessitates referral to the Duty Social Worker; however it does cause distress to children and young people. Shetland Islands Council have adopted the Anti-bullying Framework <https://www.safershetland.com/assets/files/Anti-Bullying%20Framework%20Final%20Website1.pdf> and the Schools Service has a dedicated policy to address bullying in schools (<http://www.shetland.gov.uk/education/documents/2018Anti-BullyinginShetlandSchoolsSICPolicy.pdf>) and these should be used to minimise the harm caused to children.

### **Bullying behaviours may include:**

- Physical: pushing, kicking, hitting, pinching and other forms of violence or threats;
- Verbal: name-calling, sarcasm, spreading rumours, persistent teasing;
- Emotional: excluding, tormenting, ridiculing, humiliating.

### **Persistent bullying can result in:**

- Depression;
- Low self-esteem;
- Shyness;
- Poor academic achievement;
- Isolation;
- Threatened or attempted suicide.

### **Signs that a child may be being bullied can be:**

- Coming home with cuts and bruises;
- Torn clothes;
- Asking for stolen possessions to be replaced;
- Losing dinner money;
- Falling out with previously good friends;
- Being moody and bad tempered;
- Wanting to avoid leaving their home;
- Aggression with younger brothers and sisters;
- Doing less well at school;
- Sleep problems;
- Anxiety;
- Becoming quiet and withdrawn.

## 6.0 Online Abuse

It does not matter whether abuse happens online or offline; a child can experience harm and long-lasting damage as a result of abuse. Cyberbullying can make children and young people feel more frightened and helpless than bullying because they feel like they cannot escape.

Many of the signs that a child is being abused are the same no matter how the abuse happens.

**A child may be experiencing abuse online if they:**

- Spend much more or much less time online, texting, gaming or using social media;
- Are withdrawn, upset or outraged after using the internet or texting;
- Are secretive about who they are talking to and what they are doing online or on their mobile phone;
- Have lots of new phone numbers, texts or e-mail addresses on their devices.

**Child/Young Person's Behaviour may be:**

- Withdrawn
- Suddenly behaves differently
- Anxious, clingy
- Depressed
- Aggressive
- Problems sleeping
- Eating disorders, changes in eating habits
- Takes risks
- Misses school
- Obsessive behaviour
- Nightmares
- Thoughts about suicide
- Self-harm
- Alcohol

**Grooming**

Grooming is when someone builds an emotional connection with a child to gain their trust for the purposes of sexual abuse, sexual exploitation or trafficking. Children and young people can be groomed online or face to face, by a stranger or by someone they know. Groomers may be male or female. They could be any age. Many children and young people do not understand that they have been groomed or that what has happened is abuse. Groomers may try to gain trust of a whole family to allow them to be left alone with a child and if they work with children they may use similar tactics with their colleagues.

**Groomers do this by:**

- Pretending to be someone they are not, e.g. saying they are the same age online;
- Offering advice or understanding;
- Buying gifts;
- Giving the child attention;
- Using their professional position or reputation;
- Taking them on trips, outings or holidays;
- Secrets and intimidation to control children.

**Signs of Grooming in Children/Young people may make them:**

- be very secretive, including about what they are doing online;
- have older boyfriends or girlfriends;
- go to unusual places to meet friends;
- have new things such as clothes or mobile phones that they cannot or will not explain;
- have access to drugs and alcohol.

**Child Sexual Exploitation**

Groomers can use social media sites, instant messaging apps, or online gaming platforms to connect with a young person or child. They can spend time learning about a young person's interests from their online profiles and then use this knowledge to help them build up a relationship. Groomers no longer need to meet children in real life to abuse them; increasingly groomers are sexually exploiting their victims by persuading them to take part in online sexual activity.

**When sexual exploitation happens online, young people may be persuaded, or forced, to:**

- send or post sexually explicit images of themselves;
- take part in sexual activities via a webcam or smartphone;
- have sexual conversations by text or online.

Sexual exploitation can be very difficult to identify. Warning signs can easily be mistaken for 'normal' teenage behaviour. **Young people who are being sexually exploited may:**

- go missing from home, care or education;
- be involved in abusive relationships, intimidated and fearful of certain people or situations;
- hang out with groups of older people, or antisocial groups, or with other vulnerable peers;
- associate with other young people involved in sexual exploitation;
- get involved in gangs, gang fights, gang membership;
- have older boyfriends or girlfriends;
- spend time at places of concern, such as hotels or known brothels;
- not know where they are, because they have been moved around the country;
- be involved in petty crime such as shoplifting;
- have unexplained physical injuries;
- have a changed physical appearance, e.g. lost weight;

For more information about Child Sexual Exploitation, please see [Protocol 12](#)

## **6. Stepwise Guide for Child Protection**

### **Introduction**

This Chapter gives a step-by-step guide about how to refer and respond to child protection concerns and applies to all agencies, third sector organisations and also the general public.

This Section is based on the principle of supporting everyone in Shetland to be able to:

### **Recognise**

Be aware that a child or young person may be at risk of abuse and may need support and protection

### **Respond**

Take immediate action when necessary to ensure the safety of all children and young people

### **Report/Refer**

Follow child protection procedures

### **Record**

Record all information including actions, discussions and decisions

**Steps 1 to 4** cover the actions to be taken by any staff from any agency or third sector organisation that have concerns that a child or young person is or may be at risk.

**Steps 5 to 6** relate to the specific actions that will be taken by the investigating agencies.

For ease of reference “staff member” is used to mean anyone employed or working as a volunteer. Members of the public and family members also make child protection referrals and this is referred to where appropriate. Where guidance may differ slightly for different staff, this is indicated.

All allegations of child abuse will be treated seriously and investigated in accordance with these interagency procedures.

## **STEP 1**

### **Concern or Initial Referral about a Child at Risk**

#### **1.1 Person Responsible**

The staff member or any other person who witnesses, suspects or receives information, either from the child/young person or from another person about a child/young person who may be at risk, has a duty to report that information immediately.

#### **1.2 Action to Take**

1.2.1 If the child/young person requires urgent medical attention or urgent police protection, go to [Step 3](#).

1.2.2 If the child/young person has an obvious injury, then staff may seek an explanation from the child/young person or from the child's parents. Even if the explanation indicates an accidental cause then it is always good practice to record that. If a child/young person speaks about experiences of physical harm, neglect, sexual abuse or emotional abuse, then listen carefully, seek basic clarification of what the child/young person is saying and record the information carefully as soon as possible. Further information about how to support a child or young person who discloses abuse is contained in [Appendix 3](#).

1.2.3 If the information about the risk to the child/young person comes directly from the child/young person or from someone else, explain that you cannot keep this confidential and will need to speak to your line manager.

1.2.4 In many cases concerns about a child's/young person's safety may come from a number of events or pieces of information that, when added together, indicate that the child/young person may be at risk. For example neglect or emotional abuse are often the result of a series of events that impact on the child's or young person's physical and emotional care. It is always appropriate to seek advice and make a child protection referral if the information indicates the child/young person may be at risk. Acting quickly to seek advice and share information is important and gives the best opportunity to protect the child.

1.2.5 The timing and nature of further contact with parents must be decided by the investigating agencies following the making of a referral.

## **STEP 2**

### **Consultation with a Manager**

**2.1 People Responsible** – the staff member or any other person and a line manager or supervisor or other designated person in their organisation.

#### **2.2 Action to be Taken**

The staff member will discuss the suspected or alleged harm, mistreatment or neglect with the line manager as soon as possible. If the line manager is not available, then the staff member should speak to a suitable alternative manager. NHS staff can seek the advice of the Nurse Advisor Child and Adult Protection. Anyone who is not a staff member or who is not able to speak to a line manager can seek advice from the Duty Social Worker, without the need to make a formal referral at this stage. Action should be taken immediately to protect the child.

2.2.1 A plan of action should be the outcome of this meeting or discussion. The plan should take the following into account:

- The need for immediate action and any consequent risk to the child/young person, for example, if a child/young person has told a teacher that they have been physically abused, then they may be at risk of further harm when school closes and they return home. Delaying making a referral will reduce the time that the investigating agencies (police and social work) have to respond and this potentially increases the risk to the child/young person.
- The need to share full information that the staff member, the line manager and their agency hold about the child/young person, family composition, address, contact numbers.
- The need to consider the risks to other children/young people and possibly adults too. For example, a child/young person may disclose that they have witnessed domestic abuse involving a physical assault to an adult and this poses future risk to the adult as well as the child/young person and any siblings.
- The concern about the child may also indicate that a vulnerable adult may be at risk and this information should be shared with the Duty Social Worker.

#### **2.3 Specific Guidance for NHS Shetland Health Professionals**

NHS Shetland and the Child Protection Guidance for Health Professionals issued by Scottish Government have agreed that some staff are able to make a direct referral to the Duty Social Worker without consulting with a line manager. These staff have completed the Level 3 training.

- GPs
- Consultants

- A & E staff
- Health visitors
- Midwives

All of these staff can seek advice and guidance from line managers, but are not obliged to do so before making a referral-

Good practice would be that a copy of the written referral would follow the telephone referral and would be shared with line managers, the patient's consultant if made during a hospital stay, and with the Nurse Advisor Child and Adult Protection.

#### **2.4 Specific Guidance for Schools Staff**

Schools staff should seek the advice of a designated person in the school (usually a Head Teacher or Deputy) as soon as possible - teachers may need assistance with covering a class in order that they can do this. No situation where a child is potentially at risk should be left until the end of the school day. Given that Shetland Schools may vary in size and management structures, Quality Improvement Officers based in the Schools Service at Hayfield House will always assist any member of staff who has a concern about a child's safety and who is unable to contact a designated person quickly.

A copy of any child protection referral made by schools staff should be retained for school files and a copy sent to the Quality Improvement Team in Hayfield.

### **STEP 3**

#### **When Immediate Medical Assistance or Police Involvement is needed because a Crime may have been committed or there is an immediate risk of harm**

**3.1 The Person Responsible** – the staff member or any other person.

#### **3.2 Action to be Taken**

3.2.1 If urgent medical assistance is required, take the child or young person to Accident and Emergency or phone for an ambulance.

3.2.2 Where there is a report or suspicion of a crime or if immediate assistance is required, a Child Protection referral can be made direct to the police in an emergency by phoning 999. This may also need to be considered if the safety of the child/young person and the staff member is at immediate risk.

3.2.3 All action taken **must** be recorded and discussed with a line manager or an alternative manager as soon as possible – but do not delay summoning emergency help.

## **STEP 4**

### **Referral to the Duty Social Worker**

#### **4.1 The Person Responsible**

Wherever possible it is better for the Duty Social Worker to receive first hand information, so the referral should be made by the staff member or person who received the information or recognised the risk. If that is not possible, then the line manager to whom the staff member has spoken about the concern for the child/young person should make the referral.

#### **4.2 Action to be Taken**

4.2.1 Once a referral is made by telephone it should be followed immediately by a full and detailed account in writing of the information shared verbally. The Referral Form attached at [Chapter 13](#) should be completed. A copy should be retained for the records of the referring agency. NHS Shetland staff should send a copy to the Nurse Advisor Child and Adult Protection.

4.2.2 The staff member or person making the referral to the Duty Social Worker should make the referral by telephone and provide sufficient information to enable Children's social work to make an informed decision about how to proceed. Referrers should clearly state who they are and what their role is in respect of the child and that the referrer has concerns about the safety of a child or young person.

The following information should be shared verbally and confirmed in writing:

- What the concerns are;
- Other relevant information - Name, address, date of birth, family composition, siblings, parents, carers;
- What has been observed, heard and what sense has been made of the information. It is important that referrers are clear about what is fact and what is opinion and what is the source of the information - for example has the child/young person made a direct disclosure or has the referrer observed something that has raised the concern;
- Details of alleged perpetrator, where known;
- Details of any specific incidents – dates, times, witnesses, any visible injuries;
- Where the child/young person is now;
- Any relevant background information about the child/young person or any history of previous concerns;
- Who is the child's/young person's Named Person and is there already a Child's Plan co-ordinated by a Lead Professional in place;
- If the information indicates that an adult may be at risk.

- If the child has any additional support needs that will require specialist assistance in order to communicate with the child.

## **STEP 5**

### **Receiving a Child Protection Referral by Duty Social Worker**

#### **5.1 Out of Hours Duty Response (tel. 01595 695611 for Out of Hours Duty Social Work – [see Contacts Information inside the front cover of these Procedures](#))**

Shetland is too small to have a waking 24 hour social work response team, but help in an emergency situation or where the risk to a child is such that it will not wait until the next morning can always be obtained at any time of the day or night via the Duty Social Work service.

The after-hours number will be answered by an operator who will contact the Duty Social Worker or Duty Children's Social Work Manager, who will call the referrer back. The referrer will need to provide a number for this purpose. However, if the referrer is unable to give a number, it is important that they provide as much information as possible to the operator, who will pass it on. It is more helpful if the Duty Social worker can speak directly to the person making the referral in order to respond in the best way possible to safeguard a child or young person.

The Duty Social Worker receiving the call will check social work records on SWIFT / O drive and the Child Protection Register to identify if the child or young person is known to the department.

After checking to see if the child/young person is known, the duty social worker will contact the out of hour's manager to discuss what actions may be necessary to take to protect the child/young person. There may be difficulties in seeking information out of office hours however, action will always be taken by social work, involving Police Scotland if necessary, to provide immediate protection to a child/young person if that is required.

Police Scotland should be contacted by dialling 999 if an emergency response is required and 101 for more routine matters.

Information passed to Out of Hours Duty Children's Social work and Police Scotland that a child is at risk of significant harm will always be responded to and the child safeguarded overnight until further plans can be made. Joint Interviews will only be carried out in cases of urgent necessity overnight and at weekends due to the availability of trained social work staff.

#### **5.2 Daytime Duty Response**

Child Protection referrals will normally be dealt with by the Duty Social Worker for the Children's Social Work Team. Child Protection referrals

must take priority over all other work and referrals must be the subject of an immediate assessment.

- 5.3 People Responsible** – the Duty Social Worker receiving the Child Protection referral and the Team Leader assisting the Duty Social Worker.

**All child protection referrals must be responded to within 24 hours. At a minimum this means the Duty Social Worker gathering information to inform an initial risk assessment and having an Interagency Referral Discussion (IRD) with the IRD Sergeant Police Scotland. The timing of any subsequent actions will be informed by the initial risk assessment which should address the safety of the child or young person who has been referred and the risk to others. Timescales will be agreed by the DM and IRD Sergeant**

**5.4 Action to be Taken**

- 5.4.1 The Duty Social Worker will consult with the Team Leader Duty and Intake Team. The Team Leader will decide, on the basis of the information received, if there is a need to urgently protect the child/young person by calling on the immediate support of police officers or seeking advice from the Shetland Islands Council's Legal Services about the requirement to apply for a Child Protection Order (please see [Chapter 11](#) about Legal Orders).
- 5.4.2 The Duty Social Worker is responsible for ensuring that all relevant information relating to the child and family referred is gathered. The following checks will be made. Checks must include background information on any parent/carers/adults involved and all children in the family:
- Social Work records – SWIFT
  - Child Protection Register
  - Health records – GP/Health visitor/Midwife/School Nurse/CAMHS/A&E/Dental/Paediatric, etc. The Nurse Advisor Child and Adult Protection will be able to gather relevant information by checking NHS Shetland records and sharing this with the Duty Social Worker
  - School information
  - Criminal Justice Unit
  - The Named Person and if there is a child's plan co-ordinated by a Lead Professional.
- 5.4.3 The Duty Social Worker or Team Leader will make contact with the IRD Sergeant based at Police Scotland Divisional Child Abuse Investigation Unit (DCAIU) in Inverness.
- 5.4.4 The IRD Sergeant has an immediate duty to respond to the child protection referral by gathering information as detailed below and participating in an Interagency Referral Discussion (IRD):

- Check Police Scotland Database for relevant information in respect of the child/young person and family (Scottish Criminal History System, STORM, IMPACT, Police National Computer, Police National Database, Vulnerable Persons Database, Scottish Intelligence Database, Incident text searches and where relevant foreign conviction checks can be made).
  - Share relevant information with the Duty Social Worker or Team Leader.
- 5.4.5 In situations where allegations are made against a member of staff in any agency, the child protection procedures as laid out here should be followed. However, the Team Leader should consult with the Human Resources service for the agency involved, as decisions may need to be made in respect of suspending the staff member in order to protect other children. HR Services must also be informed of the outcome of any child protection investigation, as this information will need to be considered in any possible future disciplinary proceedings. For more information in dealing with allegations against staff and the specific roles of DSW and Team Leader, please see [Chapter 7](#) Allegations against staff.
- 5.4.6 In situations where allegations are made against kinship or foster carers the Team Leader/Senior Social Worker Family Placement Services should be informed. Please see [Chapter 7](#) for additional information.
- 5.4.7 In situations where the child protection referral has been made due to concerns about radicalisation under the Prevent Counter Terrorism Responsibilities the Single Point of Contact for Prevent should be informed, an Interagency Professionals Meeting held and Prevent procedures followed. Please see [Chapter 7](#).
- 5.4.8 The purpose of an IRD is:
- To collate available information and establish the facts about the circumstances giving rise to concern;
  - To consider and decide if any investigation into the circumstances of the child who has been referred should be conducted as single agency investigation (either Police Scotland or Children's Social Work) or a joint police and social work investigation;
  - To consider the requirement for a Joint Investigative Interview with the child
  - To consider the need for a paediatric or forensic medical as part of the formal child protection investigation in consultation with the Nurse Advisor Child and Adult Protection
  - To also consider the need for a medical to ensure the wider holistic health needs of the child/young person are being met and identify any unmet need. This will be important in a number of situations, but particularly when there are concerns about neglect or emotional abuse. investigation in consultation with the Nurse Advisor Child and Adult Protection

- To agree the nature of the child protection enquiries and the criminal investigation; (see [Step 6 below](#) for detailed planning of an investigative interview, and [Chapter 8](#) for detailed consideration of medical examinations);
- To identify sources and levels of risk;
- To consider and plan any necessary protective action in relation to the child/young person and any others. (See [Chapter 11](#) for detailed procedures in respect of applications to remove the child/young person, or to take other legal protective action).

5.4.9 If at this stage the Team Leader or DSW, in consultation with the IRD Sergeant decides the referral does not need a joint response under child protection procedures then one of the following decisions will be made:

- No further action
- Single agency investigation by either Children's Social Work or Police Scotland. Single agency investigations can still fall under child protection procedures - e.g. social work completing a single agency investigation /assessment in respect of allegations of emotional abuse. If this is the case information about the outcome of the investigation should be shared at a Debrief meeting - see Step 6 below
- Further assessment of the child's/young person's wellbeing needs by Children's Social Work or the Named Person
- Review of existing Child's Plan by Lead Professional

5.4.10 Other than in circumstances where this would be detrimental to the child's/young person's best interests the IRD discussion should plan how to consult and involve the child's parent(s).

5.4.11 The Team Leader should ensure that:

- Decisions are recorded on the SWIFT Database
- The Named Person and/or Lead Professional is informed
- Any further work needed to assess the child's/young person's wellbeing needs is put into action.

5.4.12 The staff member or member of the public who has made the Child Protection referral should be informed of the outcome of the referral within 7 working days and the fact that feedback has been given should be recorded.

5.4.13 If following an Interagency Referral Discussion the IRD Sergeant Police Scotland and the Team Leader decide that the referral needs to be progressed by both agencies under Child Protection Procedures, then the following actions are required:

- In those situations where a Joint Investigative Interview is required, the Team leader and IRD Sergeant Police Scotland will identify an investigating social worker and police officer who are JII trained.

The investigating social worker and police officer will be included in the JII briefing meeting or discussion.

- The Team Leader and IRD Sergeant have the discretion to call an Interagency Child Protection Planning meeting in the circumstances outlined below or if they assess it would benefit a particular case.

## **STEP 6**

### **Planning and carrying out Joint Investigative Interviews and Debriefs**

#### **6.1 People Responsible**

The Duty Social Worker, Team Leader and IRD Sergeant having decided that a Joint Investigative Interview with a child is necessary will call a JII briefing meeting to plan this work. Not all child protection investigations will require a JII, but many will.

In all cases, the decision to proceed with a JII will be taken by Police Scotland and Children's Social work taking into account any relevant information from other agencies

There will be situations when an Interagency Child Protection Planning Meeting involving NHS Shetland Nurse Advisor Child and Adult Protection, Schools staff and any other relevant people (e.g. HR staff, CJU, CAMHS, Third Sector organisation etc.) should be called. The Team Leader and IRD Sergeant have the discretion to call an Interagency Professional Meeting when they feel it would assist them and support the better protection of the child. In the following circumstances, an interagency professional meeting should always be called within a timescale that reflects the risk to the child.

- When a forensic medical examination requiring the expertise of off island paediatric services is required. This will tend to be in situations of more serious suspected non-accidental injury or sexual abuse.
- When allegations are made against a foster carer or kinship carer or a member of staff. The Interagency Child Protection Planning meeting should include the Team Leader/Senior Social Worker Family Placement Services or HR for the organisation the member of staff works for as appropriate.
- When there is a possibility that the child protection referral indicates organised or complex historical abuse (for e.g. Child Sexual Exploitation involving a number of children and abusers, significant online abuse or grooming).

## **Investigative Interviews**

### **6.2 Persons Responsible**

The allocated social worker and police officer who have been briefed at the JII briefing meeting have responsibility for the investigative interview. Social workers and police officers should have completed specific joint interview training. The decision about when to hold a joint interview needs to be informed by the risk assessment - in some cases it will need to take place immediately following the IRD.

### **6.3 Action to be taken**

6.3.1 The Joint Investigative Interview is a formal planned interview with a child or young person carried out by staff trained and competent to conduct it for the purposes of eliciting the child's/young person's account of events (if any) which require investigation. It is important to bear in mind that interviewers must always be objective as, at the time of the interview, it will not be known what proceedings, if any, the record of the interview may be used in, whether criminal, civil or both. Before carrying out any interviews there must be discussion and agreement regarding the venue for interview and the structure of the interview, who will take the lead and the purpose of the interview. This should be agreed at the JII briefing meeting.

6.3.2 The main purposes of the investigative interview are to:

- Learn the child's/young person's account of the circumstances that prompted the enquiry
- Gather any information to permit decision making on whether the child/young person in question or any other child, is in need of protection
- Gather sufficient evidence to suggest whether a crime may have been committed against the child/young person or anyone else
- Gather evidence which may lead to grounds of referral to a children's hearing being established.

6.3.3 A specialist interview suite is available and other premises suitable for carrying out investigative interviews have been identified throughout the isles. Venues used for visual recording must comply with national guidance on this matter to ensure the recording can be used in later proceedings. It is important that any venue needs to be suitable for recording equipment and where the child/young person feels comfortable and safe to speak.

6.3.4 All those undertaking investigative interviewing should be familiar with and follow national guidance. The Scottish Government Guidance can be accessed by clicking on the following link <http://www.scotland.gov.uk/Resource/Doc/365398/0124263.pdf>

## **After a Child Protection Investigation**

- 6.3.5 Following every child protection investigation - whether or not it was conducted by a single agency or included a JII - there should be an Interagency Debrief Discussion that records outcomes and considers any further action. It is the responsibility of the Team Leader and IRD Sergeant to hold a debrief discussion which should involve the Social worker and Police Officer who conducted the JII. If a Child Protection Planning meeting was held then a Debrief Child Protection Planning meeting should also be arranged.
- 6.3.6 Debrief meetings need to consider if there should be an Initial Child Protection Case Conference and ensure that Named People are informed of the outcome of the child protection investigation and any further assessment of the child or families' needs is put in place.
- 6.3.7 Further IRDs may be necessary on receipt of additional information from any investigative interview, medical examination or other relevant source, in order to assist the decision-making process or if risks to other children are identified.
- 6.3.8 Police Scotland have a duty to investigate any crimes that may have been committed against a child. The DCIAU have a responsibility to keep the Team Leader informed of the progress of any criminal investigation and if any adult who is a risk to the child has been arrested, detained, charged or bailed so safe plans for the child can be made.
- 6.3.9 The Team Leader and IRD sergeant have the responsibility of ensuring that all the actions and discussion that take place are recorded carefully on the appropriate shared format ([recording document](#)). Defensible decision-making requires careful record keeping.
- 6.2.10 Disagreements about the methods of progressing the investigation, if not resolved at the IRD, will be referred to the Chief Social Work Officer and Detective Chief Inspector, Public Protection Policy Unit, Divisional Headquarters, Inverness.

### **The Child at the Centre**

Children and young people are not just objects of concern and great care must be taken in any child protection investigation whether or not that includes a JII to respect, Inform and support them.

Conducting the investigations in as sensitive and child centred a way as possible is vital. The following gives some guidance on this approach:

- Providing age appropriate explanations to children and young people about what is happening (a leaflet for children and young people is available from <http://www.safershetland.com/for-children-and-young-people> – at the end of webpage).

- Answering questions as honestly as possible.
- Considering the best way to communicate with a child/young person of a given age.
- Considering if the child/young person has any additional support needs that require more specialist help with communication (please see [Chapter 7, paragraph 7.1](#)).
- Considering the support needs of children and young people – especially those who are very young. In some circumstances children and young people may need a parent or trusted adult to be close by while they are being interviewed for reassurance and support and this need should be respected and accommodated.
- Allowing a child or young person to express their views and to participate in the process as fully as possible.
- Explaining what will happen next – especially if the child or young person will be asked to agree to a medical examination.

## **7. Child Protection in Special Circumstances**

### **7.1 Children and Young People with Additional Support Needs**

7.1.1 Research indicates that children and young people with additional support needs may be up to 4 times more likely to experience all types of abuse than their peers.

7.1.2 They may suffer from **all** forms of abuse, and may be targeted for specific forms of abuse, e.g. sexual abuse, because of their vulnerability. They are often cared for by a range of people in addition to their primary carers and may lack the necessary language to communicate that they are being abused.

7.1.3 Abuse can often go unrecognised and unreported due to assumptions made e.g. assuming that a physical injury or 'challenging' behaviour is attributable to the child's/young person's condition rather than a symptom of abuse – this should be rigorously checked out, taking appropriate specialist advice as needed.

7.1.4 Staff from all agencies working with children and young people with complex additional support needs, whether within their employment or not, will be provided with additional training in communication and recognition to assist in the protection and support of disabled children and young people.

7.1.5 Anyone making a child protection referral in respect of a child with additional support needs should share full information about this. The IRD will need to consider if specialist support in order to communicate effectively will need to be sought.

7.1.6 This will include consideration of what specialist staff could assist in the interview of the child/young person and who could provide the most appropriate support to the child/young person, e.g. in assisting in the use of communication aids.

7.1.7 A list of trained and experienced staff from all disciplines will be made available to the investigating agencies to provide specialist support to children and young people with additional support needs. Staff who can assist are as follows:-

Quality Improvement Officer

Additional Support Needs and Education Outreach Service Manager

Teacher - Vision Service

Teacher - Hearing Impairment and Communication Service

Teacher - Social Communication and Autism Spectrum Disorder

Learning Disabilities Nurse

Social Worker for Children with Additional Support Needs

Principal Teacher – Additional Support Needs, Anderson High School

Depute Head Teacher – Additional Support Needs, Bells Brae Primary School

Outreach Teacher – ASN Outreach (Social Communication and Autism Spectrum Disorder)  
CAMHS Team in the case of children whose additional support needs are connected with a diagnosed mental health issue

- 7.1.8 Should the child/young person be being interviewed as a result of suspected abuse by parents, consideration needs to be given to who would be the most appropriate responsible adult to support them during interview.
- 7.1.8 In some situations it may be alleged that children, young people and adults with additional support needs have harmed children, and it will be necessary for them to be interviewed by police as an alleged offender. In these circumstances, use of the Shetland Islands Council's Appropriate Adult Scheme is important to assist in safeguarding the right of an accused person. This would be agreed at the IRD.

## **7.2 Children who cause harm to self or others**

In some circumstances children and young people display behaviour that causes harm to themselves and also to others. Sometimes the main risk is to self and not to others. In either circumstance a risk assessment or risk management approach being mindful of the need to use child protection processes when appropriate is important. In certain high-risk situations where the criteria is met, a Care and Risk Management (CARM) approach is required- please see below for more information. (In situation where children or young people are posing sexual harm to others please also see [Protocol 6](#))

### **7.2.1 Children who pose a risk to themselves**

The National Guidance for Child Protection is clear that child protection process should apply to children and young people who place themselves at risk

- 7.2.2 Children and young people who place themselves at risk often have a history of abuse and trauma. They may be being exploited- sexually or in other ways- by older young people and adults. In cases of child sexual exploitation, young people can be drawn into relationships that they see as loving, but which are in reality controlling and abusive. The use of social media to groom and exploit can contribute to situations where young people are seen to place themselves at risk
- 7.2.3 The Children's Hearing (Scotland) Act 2011 allows anyone to refer a child/young person to the Reporter to the Children's Panel. Please see [Protocol 2](#) in Section 3 of these Procedures for the Grounds of Referral to the Reporter. The Reporter will make the decision about whether the child/young person may be in need of compulsory measures and that a Children's Hearing should be convened.

7.2.4 While not exhaustive the following list gives the different types of concern that may arise:

- Self harm and/or suicide attempts (Please also see [Protocol 10](#))
- Alcohol and drug misuse
- Running away / going missing – especially if this is a frequent occurrence or has a regular pattern
- Child sexual exploitation and problematic or harmful sexual behaviour (see [Protocol 6](#) and 12)
- Indecent or sexually inappropriate behaviour towards others
- Criminal activity
- Unsafe use of the internet – either the child or young person generating pictures or text that is inappropriate or they are being groomed by someone else. (Please see [Protocol 9 re safe use of the internet](#)).

### **7.2.5 Children who harm others**

In situations where allegations of sexual abuse or other forms of harm are made against a child or young person the child protection procedures will be followed and a child protection investigation undertaken in order to interview the alleged victim or victims. Police Scotland will need to interview any child or young person who is an alleged offender whilst ensuring that they are treated as a child or young person and that they have appropriate legal advice and support throughout any police interviews.

7.2.6 Young people under 16 who are charged with an offence will be referred to the Reporter. In exceptional cases involving a very serious offence young people under 16 can be referred to the Procurator Fiscal and prosecuted in Sheriffs court. An appropriate Youth Justice Service for young people who offend will be provided by the Children's Social Work Team and when required the Criminal Justice Team.

7.2.7 Children and young people who harm others are often distressed and traumatised by events in their own lives and a thorough social work led assessment of their needs, any potential risk they are at themselves or they may pose to others should be undertaken. A detailed child's plan to address need and risk with a social worker as Lead Professional and an interagency core group to monitor progress needs to be in place. There may be occasions when the child or young person's behaviour is as a result of being abused and they are at risk of significant harm. An Initial Child Protection Case Conference may need to be arranged.

### **7.2.8 Care and Risk Management (CARM)**

CARM is a process of interagency risk assessment and risk management led by Children's Social Work for the few young people who present a risk of serious harm to others and in some circumstances to themselves.

CARM is for the highest risk situations involving sexual harm and violence. Sexual harm is defined as follows.

“Young people who engage in any form of sexual activity with another individual, that they have power over by virtue of age, emotional maturity, gender, physical strength, intellect and where the victim has suffered a sexual exploitation” (Youth Justice National Guidance 2013 from Calder 1999)

Violence is defined as

“The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation” (Youth Justice National Guidance 2014 following World Health Organisation 1996)

7.2.9 Children’s Social Work will operate CARM processes as laid down in social work policy and procedure.

7.2.10 Agencies who become aware of a young person engaging in activity that presents a risk of serious harm can refer the young person into the CARM process by making a referral to the Duty Social Worker. Most referrals will come through the following routes:

- From the Police on receipt of information about the alleged involvement of a child or young person under the age of 18 in the perpetration of an offence of a serious or sexual nature;
- From the Lead Professional who holds case management responsibilities for a child or young person where there are significant concerns about the escalation in the frequency and/or seriousness of a child or young person’s offending or risk taking behaviour which is likely to include violence and/or sexually harmful behaviour;
- From the Team Leader, Children’s Social Work co-ordinating a child protection investigation into the victimisation of a child or young person where harmful behaviour of a serious nature by another child or young person under the age of 18 is identified;
- From the Senior Social Worker co-ordinating an adult protection investigation into the victimisation of a vulnerable individual over the age of 16 where harmful behaviour of a serious nature by a child or young person under the age of 18 is identified;
- From any Named Person, multi-agency screening groups or equivalent who have significant concerns about the escalation in the frequency and/or seriousness of a child or young person’s offending behaviour which is likely to include violence and/or sexually harmful behaviour.

### **7.3 Organised or Multiple Abuse**

7.3.1 Features of this could include:

- Groups encompassing one or more families, friends, neighbours and wider networks;
- Enticement or intimidation of children and young people for sexual exploitation;

- Variations in the degree and form of sexual exploitation, including child pornography;
- Groups of adults using the internet to create and distribute child abuse images.

7.3.2 If links are established between cases that suggest the possibility of organised abuse, careful planning of each stage of any investigation must include:

- Sharing full information at regular, planned and well-structured briefing meetings;
- Careful recording of all activity between the agencies;
- Periodic joint assessment of progress and future plans.

**7.3.3 Where it appears that organised or multiple abuse may be involved, the Chief Social Work Officer, Chief Inspector, Police Scotland Shetland Area Command, and appropriate NHS Shetland Representative must be informed, and they will take responsibility for a professionals child protection meeting.**

**The interests of the children and young people will always remain paramount, even to the extent that evidence may be lost if obtaining that evidence would cause serious harm and distress to the children and young people involved.**

#### **7.4 Allegations Against Staff**

7.4.1 Any allegations that a child or young person under the age of 18 has been harmed by a member of staff from any organisation (or volunteer working for any organisation) will be dealt with in accordance with these procedures following the stepwise guide as laid out in section 6. In some instances, an individual doing regulated work can become unsuitable to continue to do this work due to their conduct at work or outside of work.

7.4.2 Anyone who receives an allegation against a member of staff must make a child protection referral immediately following normal procedures.

7.2.3 The Team Leader in Children's Social work will coordinate the child protection investigation and will ensure that the staff member's line manager is informed immediately and the appropriate Senior Manager and HR in the employing organisation

7.2.4 The Team Leader Children's Social work needs to inform appropriate managers that an allegation has been made against a member of their staff. Additionally the following should be notified;

- For allegations against Social Workers or Social Care staff the Chief Social Work Officer should be informed
- For allegation against teacher or other staff employed by schools service – Director Children's Services

- For NHS Staff – Head of HR
- For Police Scotland Chief Inspector Shetland Area Command

Third Sector and Private Employers will need to manage such situations through their own managers, management committees and HR resources.

The Shetland Inter-agency Child Protection procedures should be implemented to conduct the child protection investigation. But these processes should work alongside the organisations own HR procedures.

## **7.5 Allegations Against Foster Carers**

- 7.5.1 The welfare of Children looked after away from home is always paramount. Any allegation against the Foster Carer will be investigated in accordance with the Shetland Inter-Agency Child Protection Procedures and will follow the Stepwise guide.
- 7.5.2 The Council recognises the vulnerability of Carers and the Supervising Social Worker will offer support and advice to the Carer in the event that a Child Protection investigation is undertaken in respect of allegations made against that Carer.
- 7.5.3 The Team Leader/Senior Social Worker Family Placement Services must be informed immediately and included in any interagency professional meeting to plan a child protection investigation if an allegation is made against a foster carer.
- 7.5.4 Immediate consideration will be given to whether a change of placement is in the child's or young person's best interests.
- 7.5.5 A Child Protection Planning meeting will be called by the Team Leader and discussion will consider the choice of investigating social worker, including whether there is a need for help to be requested from another area to ensure independence.
- 7.5.6 Shetland Islands Council recognises the vulnerability of carers and the Supervising Fostering Officer will offer support and advice to the carer in the event that child protection investigation is undertaken in respect of allegations made against carers.

The Fostering Network may also be able to support the foster carer through its advice helpline and counselling service.  
*<https://www.thefosteringnetwork.org.uk/about/about-us/our-work-in-scotland>*

- 7.5.7 Allegations which are made against kinship carers would be investigated as outlined above. Not all kinship carers are supported by the Family Placement Team, but some are and in those circumstances the Team Leader/Senior Social Worker Family Placement should be informed.

## **7.6 Disclosure of Historical Child Abuse**

- 7.6.1 An adult or an older young person no longer at risk may disclose abuse that happened to them as a child. The person may do so by making a complaint direct to the police, or the disclosure may emerge in another context, such as therapeutic work. As well as offering support to the person, the police and the Duty Children's Social Work service should be consulted, and provided with the details of all alleged abusers. If initial enquiries indicate that other children and young people may currently be at risk due to contact with the alleged perpetrator, a Child Protection Planning Meeting must be convened to plan an immediate child protection investigation in accordance with these procedures.
- 7.6.2 Further guidance on handling disclosures of historical abuse is to be found in the National Guidance for Child Protection in Scotland 2014 at <http://www.gov.scot/Resource/0045/00450733.pdf> under the heading "Historical allegations of abuse" (p 149).

## **7.7. Children and Young People Living in the Same Household as Abuser(s)**

- 7.7.1 Information that an abuser may be living in the same household as a child or young person should be referred to the Duty Children's Social Work service immediately, who will consult with Police Scotland in order that the risk to the child/young person may be assessed. In the event of any difficulty in contacting the Duty Children's Social Work service, or where there is an allegation of a crime, a child protection referral can be made direct to the police. A Child Protection Case Conference should be convened if initial assessment suggests continued risks to the child/young person. This applies when an adult is known to have been convicted of an offence listed in Schedule 1 of the Criminal Procedure (Scotland) Act 1995 - <http://www.legislation.gov.uk/ukpga/1995/46/contents> and Schedule 1 of the Sex Offences Act 2003 - or when grounds of referral concerning the adult have been established for a Children's Hearing or similar process such as findings of fact made in a court elsewhere in the UK or abroad. Action should also be considered when agencies have information that suggests an adult in a house with children and young people, or who has substantial contact with children and young people, might have been involved in past abusive behaviour.
- 7.7.2 Adults who access child abuse images online may be identified by Police investigations. Concerns for the safety of any child that they live with or have contact with should be undertaken following these procedures.

## **7.8 Anonymous Referrals**

- 7.8.1 Anyone receiving an anonymous telephone call about concern for the safety of a child or young person should try to obtain the caller's

number. If this is impossible, full details of the concerns for the child/young person should be recorded carefully in writing. Callers should be encouraged to be as specific as possible. Efforts should be made to identify the anonymous caller in order that they may be interviewed about the allegation.

7.8.2 However, **anonymous callers should not be discouraged from sharing the information they have about a child or young person, nor should any pressure be applied that could lead to the caller refusing to provide information.** The protection of children and young people is paramount and it is more important to obtain any information than to identify an anonymous caller.

7.8.3 No referrer can ever be given a guarantee that the anonymity of the person making the referral will be protected, and although in conducting investigations agencies should avoid naming the source of the information whenever this can appropriately be done, callers should be told when and to whom their identity may be disclosed. The caller should be made aware that it is possible that their identity may be revealed in the course of any subsequent police investigation or court case. It may also be the case that the family about whom allegations are made will have strong suspicions about the identity of the referrer, and support in dealing with this should be offered where appropriate, particularly to members of small and isolated communities.

7.8.4 As with any child protection referral, anonymous allegations must be treated seriously, with checks being made and decisions regarding further action taken in accordance with these procedures. Anonymous referrers should be given the opportunity of phoning back to know what action has been taken, although the amount of information that can be given may be limited if their identity is not known or where the referral is of a criminal nature.

## **7.9 Children at Risk of Radicalisation – PREVENT Strategy**

The Counter Terrorism and Security Act 2015 places a duty on Local Authorities and partner agencies to prevent people from being drawn into terrorism. The “Prevent Duty Guidance for Scotland” has been prepared to assist agencies to put this into practice. Staff have a duty to be aware of situations where young people may become radicalised and to stop people becoming terrorists or supporting terrorism. There are threats posed to the UK by terrorism based in the Middle East, but also Northern Ireland and other extremist groups (for example far right wing or racist groups). Young people can be groomed and influenced and this process is very similar to the way in which children and young people can be groomed for other purposes. This can take place online or in the real world. Becoming involved in such activity can be a clear risk to the child or young person as well as a potential risk to others.

Workshops to Raise Awareness of Prevent (WRAP training) and e-learning courses on SIC and NHS Shetland systems should be completed by all staff to comply with legal duties under the Act.

There can be a risk of significant harm and so staff who have concerns about a child or young person who may be being drawn into such activity should either:

- Notify the Child's Named Person who can request that the situation is discussed at the Child Concern Collaborative.

Or

- Make a child protection referral to the Duty Social Worker.

Or

- Contact the police.

There is a single point of Contact for Prevent - currently that role is held by the Deputy Executive Manager for Children's Social Work who should be notified if a concern about radicalisation is raised through child protection or any other process.

Following an initial interagency discussion a plan will be formulated to assist the child or young person and their family. In some cases it may be appropriate to hold a Prevent Professional Concern Case Conference which will be chaired by the Improvement Reviewing Officer and follow appropriate Prevent Procedures.

***Web link to PREVENT Guidance for Scotland:***  
<https://www.gov.uk/government/publications/prevent-duty-guidance>

## **8. Health Assessment and Medical Examinations**

### **8.1 The Need for a Health Assessment**

8.1.1 Discussion between medical, nursing, Children's social work services and police should be encouraged at all stages to facilitate good liaison and the sharing of concerns. Understanding the expertise and roles of each agency will ensure that all respect the contribution provided by each service and that the health needs of the child or young person are not overlooked.

8.1.2 A thorough assessment of the child's/young person's health needs is an essential element in joint investigations. Although it may not provide evidence that a child/young person has or has not been abused, a comprehensive assessment of a child's/young person's and family's medical history and the child's/young person's health can assist the planning and management of any investigations and inform risk assessment. This assessment, alongside information from police, Children's social work and other services, can help determine whether further investigation is necessary.

8.1.3 A medical examination following allegations of abuse, particularly sexual abuse, can often reassure that no long-term physical damage or health risk has occurred and when conducted sensitively may be the start of a healing experience for both the child/young person and their family. The health assessment should also aim to identify unmet health and welfare needs in a very vulnerable child or young person and is integral to the child protection process. The decision on whether an actual medical examination is appropriate should be made during the planning stage with social work, police and with the involvement of relevant health staff.

8.1.4 Medical practitioners may observe signs and symptoms of child abuse while conducting examinations for other purposes. If signs and symptoms of abuse are observed:

- The general examination should be completed;
- The examination specifically for abuse should **not** continue;
- Clinical findings up to the end of the general examination should be recorded;
- A referral should be made to the Duty Children's social work service of Shetland Islands Council immediately;
- In the event of any difficulty in contacting the Duty Children's social work service, or where there is an allegation of a crime, a child protection referral can be made direct to the police.

## **8.2 Comprehensive Medical Assessment**

8.2.1 A comprehensive medical assessment should be considered in cases of child abuse and neglect, even when information from other agencies show little or no obvious health needs. Accurate and comprehensive entries made in the health records are essential. In some cases of child abuse and neglect, there will be no obvious signs or symptoms and some children and young people will require diagnostic procedures.

8.2.2 The comprehensive medical assessment has five purposes:

- To establish what immediate treatment the child or young person may need;
- To provide information that may or may not support a diagnosis of child abuse when taken in conjunction with other assessments, so that agencies can initiate further investigations, if appropriate;
- To provide or evidence, if appropriate, to sustain criminal proceedings or care plans;
- To secure any ongoing health care (including mental health), monitoring and treatment that the child or young person may require; and
- To reassure the child/young person and the family as far as possible that no long-term physical damage or health risk has occurred.

8.2.3 In order to make the most effective contribution, the examining doctor must have all the relevant information about the cause for concern, and the known background of the family or other relevant adults, including previous instances of abuse/neglect or suspected abuse/neglect. Wherever possible, information from the joint investigative interview (see [Chapter 6 Step 7](#)) should be made available to the examining doctor(s).

## **8.3 Arranging a Medical Examination**

8.3.1 The number of examinations to which a child or young person is subjected must be kept to a minimum. Careful planning of the medical component of the examination by experienced medical staff will facilitate this. In planning the medical investigation, it is important to remember that it is the duty of the police to provide best evidence, including medical evidence, to the Procurator Fiscal and the Reporter in appropriate cases.

8.3.2 Appropriate advice is available on a 24-hour basis, from NHS Grampian paediatricians (day time Child Protection Paediatrician NHS Grampian, out of hours on-call paediatrician). In Shetland, the child's GP may be asked to perform a medical examination supported by the Advanced Practitioner (Protection). In situations where the child or young person is brought initially to the attention of Health, and where there are concerns regarding the welfare or safety of a child/young person, the paediatrician or GP should contact Children's social work

services or the police before carrying out any medical assessment. Where information is unclear or uncertain, a comprehensive medical assessment may be undertaken to determine the need for a specialist paediatric or joint paediatric/forensic examination. Where it is clear that a forensic opinion will be required – for example, where there is an allegation or observation of serious physical assault or injury or a disclosure of sexual abuse – the forensic examination should also include a comprehensive medical assessment.

#### **8.4 Specialist Paediatric or Joint Paediatric/Forensic Examination**

8.4.1 A specialist paediatric or joint paediatric/forensic examination may need to be carried out under the following circumstances:

- The child/young person urgently requires more specialist assessment or treatment at a paediatric department (for example, if they have a head injury or suspected fractures);
- The account of the injuries provided by the carer does not provide an acceptable explanation of the child's/young person's condition;
- The result of the initial assessment is inconclusive and a specialist's opinion is needed to establish the diagnosis;
- Lack of corroboration of the allegation, such as a clear statement from another child/young person or adult witness, indicates that forensic examination, including the taking of photographs, may be necessary to support criminal proceedings against a perpetrator and legal remedies to protect the child/young person;
- The child's/young person's condition (for example, repeated episodes of unexplained bruising) requires further investigation; and
- In cases of suspected child sexual abuse, as the medical examination has to be carried out by medical practitioners with specialist skills using specialist equipment.

8.4.2 In some cases, the information gathered from an earlier comprehensive medical assessment may be sufficient together with other supportive evidence (for example, corroboration of the incident from an eyewitness) to enable a conclusion to be reached regarding the allegation. In such cases, there will be no need for further examination. Photographic evidence may be obtained by the police or medical photographer as part of their investigative procedures, but the examining doctors should assist by ensuring that all significant injuries are recorded.

8.4.3 The decision whether a joint paediatric/forensic examination or an examination by a single paediatric examiner is appropriate should be made during the strategy discussion with Children's social work services and police. Relevant health staff should also be involved. Where there is a lack of consensus, this should be resolved by the examining doctor referring the child/young person for a second opinion to a senior paediatric colleague with specialist experience in child protection.

- 8.4.4 The **specialist paediatric examination** provides a comprehensive assessment of the child/young person, establishing the need for immediate treatment and ongoing health care as well as providing a high standard of forensic evidence to sustain any criminal or care proceedings and offering reassurance and advice to the child/young person and carers. The examination is intended to encompass both the child's/young person's need for medical care and the legal requirement for evidence in a single examination.
- 8.4.5 **The joint paediatric/forensic examination** combines a comprehensive medical assessment with the need for corroboration of forensic findings and the taking of appropriate specimens for trace evidence including, for example, semen, blood or transferred fibres. While the paediatrician is responsible for assessing the child's/young person's health and development and ensuring that appropriate arrangements are made for further medical investigation, treatment and follow-up, the forensic medical examiner is responsible for the forensic element of the examination and fulfils the legal requirements in terms of, for example, preserving the chain of evidence. The presence of two doctors in the joint paediatric/forensic examination is important for the corroboration of medical evidence in any subsequent criminal proceeding and is also good medical practice.
- 8.4.6 In cases of **child sexual abuse**, the need for a medical examination should be discussed at a strategy discussion involving police, social workers and medical staff. There should be discussion about the kind of medical examination required. In cases of child sexual abuse the Designated Detective Inspector Police Scotland Public Protection will consult with other agencies regarding the type of medical examination required and advice regarding forensic evidence. For example, will it be a general medical examination as carried out by the child's/young person's own practitioner, or will it be the more comprehensive medical examination required for forensic purposes? The decision should be made, bearing in mind the interests of the child/young person, the needs of the criminal and civil investigations, and the likelihood of a forensic medical examination producing useful evidence. All decisions and the reasoning behind them should be recorded in writing.
- 8.4.7 Account will be taken of the child's/young person's gender and race in making arrangements for a medical examination.
- 8.4.8 Where examination is to be carried out by a local GP it will take place in Shetland at a place appropriate to the child's or young person's needs. Where examination in Shetland is not considered appropriate, the medical examination will be arranged out with Shetland via the paediatrician involved in the strategy discussion.

## **8.5 Timing of Medical Examinations**

- 8.5.1 The timing of the medical examination should be agreed jointly by the medical examiners and the other agencies involved. It may not be in

the child's/young person's best interests to rush to an immediate examination. It may be more appropriate to wait until the child/young person has had time to rest and prepare; this may also allow for more information to become available. It is expected that in the great majority of cases arising in working hours, a comprehensive medical assessment will be carried out locally and quickly by a doctor who knows the child/young person and/or the family and is competent to carry out such an assessment. The paediatrician responsible for child protection will advise on assessments off island. The decision on how best to proceed should always be made in discussion with the other agencies involved.

8.5.2 In cases of alleged sexual abuse it is expected that the examination will be undertaken by the specialist paediatrician in Grampian. The examination must be carefully planned to take place during working hours when skilled personnel and specialist staff are available. Where the incident is believed to have taken place more recently, care must be taken to ensure that forensic trace evidence is not lost. Particular care should be taken to retain clothing and bedding, and to avoid bathing.

8.5.3 Arrangements for medical examinations out with Shetland will be made as follows:

- Directly with the paediatrician involved in the strategy discussion;
- NHS Shetland will negotiate medical arrangements with appropriate counterparts in another health board area if necessary, and any necessary special travel arrangements;
- Children's social work services will make all other necessary logistical arrangements in consultation with NHS Shetland.

8.5.4 Children's Social work services or the police should ensure that the child/young person and parent(s) (and/or any other trusted adult accompanying the child/young person) are fully informed of the arrangements and likely timescale of the investigation as soon as possible.

8.5.5 It is expected that lead personnel (usually the investigating team), and a parent or appropriate adult carer will travel with the child/young person. If it is decided that neither parent is to accompany the child/young person, the reasons must be recorded in writing.

## **8.6 Consent to Medical Treatment**

8.6.1 Consent is required for medical treatment and examination. Parental consent should be sought if the parents have parental rights and responsibilities and the child/young person is under 16, unless this is clearly contrary to the safety and best interests of the child/young person (for example, in urgent circumstances). However, the Age of Legal Capacity (Scotland) Act 1991 - <http://www.legislation.gov.uk/ukpga/1991/50> - allows that a child/young person under the age 16 can consent to any medical procedure or practice if in the opinion of the attending qualified

medical practitioner they are capable of understanding the possible consequences of the proposed examination or procedure. Children and young people who are judged of sufficient capacity to consent can withhold their consent to any part of the medical examination (for example, the taking of blood or a video recording). Clear notes should be taken of which parts of the process have been consented to and by whom.

- 8.6.2 In order to ensure that children and young people and their families give properly informed consent to medical examinations, the examining doctor, assisted if necessary by the social worker or police officer, should provide information about any aspect of the procedure and how the results may be used. Where a medical examination is thought necessary for the purposes of obtaining evidence in criminal proceedings but the parents/carers refuse their consent, the Procurator Fiscal may consider obtaining a warrant for this purpose. However, where a child/young person, who has legal capacity to consent declines to do so, the Procurator Fiscal will not seek a warrant. If the local authority believes that a medical examination is required to find out whether concerns about a child's/young person's safety or welfare are justified, and parents refuse consent, the local authority may apply to a Sheriff for a Child Assessment Order or a Child Protection Order with a condition of medical examination. A child/young person subject to a Child Protection or Assessment Order may still withhold their consent to examination or assessment if they are deemed to have legal capacity. For further information on Child Protection and Assessment Orders, see [Chapter 11](#) of these procedures.
- 8.6.3 The Age of Legal Capacity Act - <http://www.legislation.gov.uk/ukpga/1991/50> - does not clarify the position in terms of parents' rights in this situation. Logic and current health service practice suggest that once the child/young person is considered able to consent on his/her own behalf, the parents' rights to override that consent should cease. However, it is considered good practice to obtain the consent of parents wherever possible.
- 8.6.4 If a child or young person is unable to consent to therapeutic medical treatment, and the parents refuse consent, emergency treatment can be authorised by the doctor. **This does not allow for medical examination for any other purpose than emergency treatment.**
- 8.6.5 A Child Assessment Order may allow for a medical examination to be carried out without the consent of a parent; however, the child's or young person's consent would still be required by the examining medical practitioner.
- 8.6.6 To avoid unnecessary re-interviewing at the examination of any child/young person, the investigators should tell the examining medical doctor as much about the circumstances of the case as possible. Whilst the medical examiner is required to discuss certain

elements with the child/young person it may avoid unnecessary additional discomfort.

- 8.6.7 If the child/young person refuses to give permission, the medical examination cannot go ahead. However, the examining doctor may submit notes based upon any observation of obvious injury, behaviour and so on.
- 8.6.8 Physical signs or symptoms may be inconclusive when viewed in isolation, but can provide a clearer picture of abuse or neglect when seen in conjunction with other information. A psychiatric or psychological examination can highlight emotional or behavioural signs of abuse and/or symptoms of mental distress or illness. In all cases during the investigation stage, staff in all agencies working with children and young people and families must be alert to behaviours that indicate possible abuse. There may be a need for close liaison with child and adolescent mental health services during the investigation. Professionals should also give consideration to issues of self-harm and suicide.
- 8.6.9 More detailed information about the roles and responsibilities of medical practitioners and child protection can be found in *Protecting Children – A Shared Responsibility – Guidance for Health Professionals in Scotland* - <http://www.gov.scot/Publications/2012/12/9727/downloads#res-1> .  
Direct link to document:  
<http://www.gov.scot/resource/0041/00411543.pdf>
- 8.6.10 The doctor should routinely record the results of the medical examination in the child's/young person's health records, and should provide a short report of the medical examination for the Child Protection investigation. A standard format is available for recording and reporting the health assessment / examination. Information gathered from the examination will be taken back to a strategy discussion to inform the planning of further action.
- 8.6.11 Any medical examination under these Child Protection Procedures must ensure that the family is treated with dignity at all times. The following points are considered as best practice and will be complied with, unless prevailing circumstances dictate otherwise.
- If the child or young person expresses a preference for a male or female doctor, all organisations must make sure that, whenever possible, the examination is carried out by a doctor of that gender;
  - If the child or young person asks for a particular person to go with them to the examination, this should be considered;
  - The doctor will discuss with the child/young person and parent the medical results of the examination where appropriate.

## **9. Parents and Carers**

- 9.1 Parents will normally be involved at the earliest stage; however, these Procedures acknowledge that there may be circumstances when it is not in the best interests of the child or young person for this to occur. The decision will be made at the Interagency Referral Discussion and the reasons recorded as set out in Step 6 of the Stepwise Guide at [Chapter 6](#).
- 9.2 It is acknowledged that children and young people live in a number of different family settings and it may be appropriate to include carers, guardians, partners of parents and kinship carers as well as those with parental rights and responsibilities in any investigations or subsequent discussions.
- 9.3 Parents will normally be involved immediately prior to any interview with, or medical examination of, the child/young person, and their support and co-operation sought.
- 9.4 Every effort will be made to uphold the rights of parents, irrespective of their co-operation. In some instances it may be helpful for parents to have the support of an advocate.
- 9.5 At the conclusion of a child protection investigation parents and carers should be advised of the outcome and the future actions agreed. The IRD will consider and identify the agency responsible for advising the parents/carers of the outcome. Communications will be appropriate to the parent e.g. consideration of advocacy support where a parent has a learning disability. A leaflet is available and one should be given to parents unless a specific reason for not doing so is stated and recorded (e.g. has difficulty reading and has agreed an alternative e.g. a recording with contact details). Leaflets for parents are available from the following weblink: <http://www.safershetland.com/for-parents-and-carers> (under the heading "What happens if someone has reported a concern about my child?")

## **10 Child Protection Case Conferences**

10.1 Child Protection Case Conferences are a core feature of inter-agency co-operation to protect children and young people. Their primary purpose is to consider if a child/young person – including an unborn child – is at risk of significant harm and if so to review an existing Child's Plan and/or consider a multi-agency protection plan using the format of the Child's Plan with the aim of reducing risk and meeting needs.

10.1.1 Child Protection Case Conferences (CPCCs) are convened by Shetland Islands Council Children's Services – Children's Social Work as a delegated function of the Shetland Public Protection Committee under its child protection functions. The Conference Chair is accountable to the Chief Social Work Officer.

10.1.2 National Guidance recommends there are four distinct types of Case Conference:-

- the initial child protection case conference
- the pre-birth case conference
- the review child protection case conference
- the transfer child protection case conference

10.1.3 The function of all CPCCs is to share information in order to identify risks to the child/young person collectively and the actions by which those risks can be reduced. The participants should maintain an outcome-focused approach:

- ensuring that all relevant information held by the Named Person and each service or agency has been shared and analysed on an inter-agency basis;
- assessing the degree of existing and likely future risk to the child or young person;
- considering the views of the child or young person;
- considering the views of parents or carers;
- identifying the child's/young person's needs and how these can be met by services and agencies;
- developing and reviewing the Child's Plan – which in child protection cases function as a Child Protection Plan;
- identifying a Lead Professional;
- deciding whether to place or retain a child's/young person's name on the Child Protection Register; and

- considering whether there might be a need for Compulsory Measures of Supervision and whether a referral should be made to the Children's Reporter if this has not already been done.

When considering the need for a Child Protection Case Conference the assessment and weighing up of vulnerability factors in all cases is an important process that includes:

- Factors specific to the child;
- Factors specific to the adults;
- Adverse stress and environment factors;
- Strengths, supports and protective factors

## **10.2 Organising and Chairing Case Conferences**

10.2.1 The agency responsible for convening a child protection case conference is Children's Social Work (Shetland Islands Council Children's Services). Any agency can request that a conference be held in respect of a child or young person who they have assessed as being at risk of significant harm.

10.2.2 The decision to hold a case conference is based on an assessment of risk and a judgement that a child or young person is at risk of significant harm. Following a child protection investigation, the decision to go to conference would usually be made on an inter-agency basis, IRD or Child Protection Planning Debrief meeting or discussion. Where there has been an accumulation of concerns leading to an assessment of risk of significant harm, the Team Leader of Children's Social Work can decide to hold a conference. Wherever possible it would be appropriate to discuss this with an Interagency Child Protection Planning meeting to ensure that all relevant information has been shared and can inform the decision.

10.2.3 Case Conferences will be chaired by the Improvement Reviewing Officer (IRO). If the IRO is not available an appropriate Manager with no case management responsibility will chair child protection case conferences. Please see [10.11 below](#) for further information about the role of the Chair.

10.2.4 The Team Leaders in Children's Social Work are responsible for ensuring that the administrative arrangements are made – this includes a suitable venue, minute takers, chair and invitations to relevant participants in consultation with the child's/young person's social worker and the conference chair. The social worker acting as lead professional has the responsibility to arrange an initial or review CP case Conference. A list of invitees should be provided to social work administrative staff. It is important at this stage to identify any barriers to communication and participation and to make suitable arrangements to support parents, carers, children and young people to be able to

participate fully: for example if the families' first language is not English, then a translator needs to be made available.

### **Participation of Children and Parents**

- 10.2.5 Child protection case conferences should be planned to ensure the full participation of children, young people, parents and carers. This will involve planning times that will suit parents and speaking to children and young people and families about what support they may need in order for them to be able to fully participate. Support should include where required, accessible meeting rooms, augmented communication, translators for children and parents whose first language is not English (and the Language Line or other professional translation service rather than a friend or relative should provide this service).

The Chair should encourage the parent or carer to express their views, while bearing in mind that they may have negative feelings regarding practitioners' intervention in their family. The Chair should make certain that parents and carers are informed in advance about how information and discussion will be presented and managed. Parents and carers may need to bring someone to support them when they attend a CPCC. This may be a friend or another family member, at the discretion of the Chair, or an advocacy worker. This person is there solely to support the parent or carer and has no other role within the CPCC. Parents should be afforded every respect by the Chair and other professionals attending the conference.

- 10.2.6 Child Protection Case Conferences can be distressing and difficult for parents and children and they can bring a supporter or advocate with them to help them. Parents should be afforded every respect by the Chair and professionals attending the conference.
- 10.2.7 All children where appropriate will be supported to attend their conference. CPCCs can be uncomfortable for children and young people to attend and the child or young person's age and the emotional impact of attending a meeting must be considered. A decision not to invite the child or young person should be verbally communicated to them, unless there are reasons not to do so. Children and young people attending should be prepared beforehand so that they can participate in a meaningful way, and thought should be given to making the meeting as child - and family - friendly as possible.
- 10.2.8 All children and young people have the right to express their views and these should be included in the multi-agency Child's Plan prepared by the social worker for the case conference. A format for the child views is included in section 13 and its use is encouraged - although other means of sharing a child's views with the conference can also be used. These could be drawings, voice recordings or messages via social media whatever may assist the child to express their views and wishes.

Information about CPCCs are available for children and young people at:

<http://www.safershetland.com/for-children-and-young-people> at the end of this webpage and for parents and carers from: <http://www.safershetland.com/for-parents-and-carers>.

### **Named People**

- 10.2.9 Named People should be notified using the GIRFEC notification form when a Child Protection Case Conference is being held and also notified of the outcome:  
[http://www.shetland.gov.uk/children\\_and\\_families/GIRFEC.asp](http://www.shetland.gov.uk/children_and_families/GIRFEC.asp), direct to form:  
[http://www.shetland.gov.uk/children\\_and\\_families/documents/NotificationFormV11.docx](http://www.shetland.gov.uk/children_and_families/documents/NotificationFormV11.docx)
- 10.2.10 Named People should also receive a copy of the Child Plan for those children whose names are placed on the child protection register.

### **10.3 Timescales**

- 10.3.1 When an initial child protection case conference is considered necessary then it will be convened as soon as possible, but within **14 working days** of taking the decision to hold the conference.
- 10.3.2 For the timing of the pre-birth conference please see [10.5 below](#).
- 10.3.3 Review case conferences should be planned well in advance and invitations issued at least 15 working days before the conference.
- 10.3.4 If a conference decides that a referral to the Reporter to consider the need for compulsory measures is appropriate then Team Leader should ensure the referral is made within 5 working days of the conference.

### **10.4 Initial Child Protection Case Conference**

- 10.4.1 The purpose of an Initial Child Protection Case Conference (ICPCC) is to allow representatives from across services to share information about a child or young person for whom there are child protection concerns, jointly assess that information and the risk to the child/young person and determine whether there is a likelihood of significant harm through abuse or neglect that needs to be addressed through a multi-agency Child Protection Plan. The ICPCC should also consider whether the child/young person is safe to remain at home and if a referral to the Children's Reporter is required.
- 10.4.2 The ICPCC should be held within 14 working days from the decision being taken that a conference is necessary. During school holidays the Quality Improvement Officer (Schools Service) should be

contacted to ensure that initial child protection case conferences have access to information held by schools.

- 10.4.3 Initial Child Protection Case Conference will consider the situation of all the children and young people in the household even if a child protection investigation has been focussed on the risk to one specific child or young person.

## **10.5 Pre-birth Child Protection Case Conference**

- 10.5.1 The purpose of a pre-birth CPCC is to decide whether serious professional concerns exist about the likelihood of harm through abuse or neglect of an unborn child when they are born. The Lead Professional should prepare an inter-agency plan in advance of the child's birth.

- 10.5.2 They will also need to consider actions that may be required at birth, including:

- whether it is safe for the child to go home at birth
- whether there is a need to apply for a Child Protection Order at birth
- whether supervised access is required between the parents and the child and who will provide this if needed
- whether the child's name should be placed on the Child Protection Register. Where an unborn child is felt to require a Child Protection Plan, their name should be placed on the Register
- whether there should be a discharge meeting from the maternity ward and a handover to community based supports.

- 10.5.3 The pre-birth CPCC should take place **no later than at 28 weeks pregnancy**. In the case of late notification of pregnancy and identification of a risk of significant harm to the unborn baby, an initial conference should be held as soon as possible, but in any case **within 14 working days** of the decision to hold a conference being made. Time to complete a full risk assessment needs to be factored into the allocation of pre-birth child protection referrals and so rapid allocation and close working between maternity services and Children's Social Work is essential. The 28 week deadline is the **latest** point a conference should be held - in most cases it will be better practice to hold the pre-birth conference earlier in the pregnancy.

- 10.5.4 Until the baby is born, the Register will record 'Baby' (surname of mother) and the Register will be updated as soon as the given name is known. A review case conference must be held as soon as reasonably practicable once the baby is born and in any event within **14 working days of discharge from hospital**.

- 10.5.5 The need for an initial pre-birth case conference should be considered:

- where previous children or young people have been removed because of significant harm;
- when an adult who poses a risk to children joins the family;
- where there are concerns about parents ability to protect;
- where there are acute professional concerns re parenting capacity, particularly in relation to parental mental health/learning disability or domestic violence;
- where alcohol/substance misuse could affect the health and wellbeing of the baby;
- where the parent is vulnerable, or has been or is known to services, and may need an assessment of their own needs.

## **10.6 Review Child Protection Case Conferences**

10.6.1 The purpose of a review CPCC is to review the decision to place a child's/young person's name on the Child Protection Register or where there are significant changes in the child's/young person's or family's circumstances. The participants will review the progress of the Child Protection Plan, consider all new information available and decide whether the child's or young person's name should remain on the Child Protection Register.

10.6.2 The first review CPCC should be held **within three months** of the initial CPCC. Thereafter, reviews should take place **six-monthly**, or earlier if circumstances change. Where a child/young person is no longer considered to be at risk of significant harm their name should be removed from the Child Protection Register by the review CPCC. The child/young person and their family/carers may still require ongoing support and this should be managed through a Child's Plan.

## **10.7 Transfer Case Conference**

10.7.1 Where a child/young person is on the Child Protection Register of another authority their name may initially be placed on the Register in Shetland on a temporary basis.

10.7.2 If the child/young person is moving to Shetland on a permanent basis, and the originating authority considers the risk ongoing, or even increased by the move, an initial (transfer) Child Protection Case Conference must be convened as soon as possible and in any event **within 14 days of the move being notified**. A representative from the original area will be invited and their attendance encouraged and facilitated in person or by video link.

10.7.3 The child's/young person's name should be temporarily registered pending the "transfer-in" conference. Where a child/young person is on the register of another authority, great caution should be exercised and rarely would it be appropriate to decline to register in Shetland until

all the available information and current circumstances have been carefully assessed.

10.7.4 If the originating authority consider that the move may be linked to a reduction in risk, they are responsible for convening a Review Child Protection Case Conference to consider de registration. Children's Social work in Shetland should be invited to attend.

10.7.5 For any child/young person whose name is on Shetland's Child Protection Register and who moves to another area permanently, the Children's Social Work Team Leader would be responsible for notifying the receiving area.

10.7.6 Where a child/young person, subject to a protection plan, moves from one local authority to another the child's case records and file need to go with the child.

## **10 Child's Plan for Children whose names are on the child protection Register**

10.8.1 When a Child's Plan incorporates a Child Protection Plan this should set out in detail:

- the perceived risks and needs;
- what is required to reduce these risks and meet those needs; and
- who is expected to take any tasks forward including parents/carers and the child or young person themselves.
- plans should be specific, measureable, achievable, realistic and time bound (and transparent).

10.8.2 Working in partnership with parents, carers, children and young people to reduce risk requires the full engagement of the family and they require support to clearly understand what is being offered to assist them and why. Parent should have a full honest understanding of what needs to change. They need clear information about practitioner's concerns if they are to change parenting behaviour which puts the child or young person at risk.

10.8.3 In addition, Child Protection Plans need to clearly identify:

- the agreed outcomes for the child or young person
- key people involved and their responsibilities, including the Lead Professional (who will be a social worker for children whose names are placed on child protection register) and named practitioners
- timescales
- supports and resources required (in particular, access to specialist assistance)

- the longer term needs of the child and young person
- the process of monitoring and review
- any contingency plans.

10.8.4 Responsibility is shared for the Child Protection Plan. Each person involved should be clearly identified, and their role and responsibilities set out. To preserve continuity for the child/young person and their parents and carers, arrangements should be made to cover the absence through sickness or holidays of key people. Plans should also clearly identify whether there might be a need for Compulsory Measures of Supervision. As part of this continuity, children and young people who are on the Child Protection Register should not be excluded from school unless there is a multi-agency discussion to identify risk factors and strategies to address these.

10.8.5 Head Teachers are expected to discuss with the Lead Professional and Quality Improvement Officer Schools Service for their school if they are considering excluding a child whose name is currently placed on Shetland's Child Protection Register.

10.8.6 Participants should receive a copy of the agreed Child Protection Plan along with the minutes of the child protection case conference **within five working days** of the CPCC. It is recognised that a full comprehensive risk assessment may not be achievable within the timescales of the initial CPCC or the first core group. Therefore, it should be recognised that the early Child Protection Plan may need to be provisional until a fuller assessment can be undertaken.

10.8.7 Under the GIRFEC Guidance the Named Person should receive a copy of the Child's Plan once it is finalised. In most cases the Named Person is likely to have attended the child protection case conference, however in those cases where they were not present the Lead Professional for the child/young person has the responsibility to share this with the Named Person.

## **10.9 Core Groups**

10.9.1 A core group is a group of identified individuals which includes the Lead Professional, the child or young person and their parents and carers, who have a crucial role to play in implementing and reviewing the Child Protection Plan. The core group is responsible for ensuring that the plan remains focused on achieving better outcomes for the child/young person by reducing the known risks. The initial core group meeting should be held **within 10 working days** of the initial CPCC and meet monthly thereafter.

10.9.2 The functions of a core group include:

- refining and finalising the draft plan agreed at the ICPC

- ensuring ongoing assessment of the needs of, and risks to, a child or young person who has a Child Protection Plan
- implementing, monitoring and reviewing the Child Protection Plan so that the focus remains on improving outcomes for the child/young person. This will include evaluating the impact of work done and/or changes within the family in order to decide whether risks have increased or decreased
- maintaining effective communication between all services and agencies involved with the child/young person and parents/carers
- activating contingency plans promptly when progress is not made or circumstances deteriorate
- reporting to RCPCCs on progress and recommending earlier reviews if there needs to be any significant changes to the Child Protection plan, which would include any concerns about non-engagement of the family.

10.9.3 Consideration of the involvement of the child/young person in core group meetings should take cognisance of their age and the emotional impact of attending a meeting to discuss the risks they have been placed at. Children and young people attending must be prepared beforehand to allow them to participate in a meaningful way. It is crucial that their views are obtained, presented and considered during the meeting. This group should provide a less formal way for children and young people, parents and carers to interact with agency and service providers.

10.9.4 The first core group following an initial or review case conference will be chaired by a Team Leader/Senior Social Worker from Children's Social Work. Subsequent core groups will be chaired by the allocated social worker acting as Lead Professional. The IRO or Team Leader/Senior Social Worker may identify cases where it is not appropriate for the allocated social worker/Lead Professional to chair core groups and in these situations the Team Leader/Senior Social Worker will continue to chair. If the Core Group identifies that there needs to be an earlier Review Child Protection Case Conference to make significant changes to the protection plan due to changes in the child's circumstances or level of risk, the Team Leader who chaired the first core group, in consultation with the IRO, is responsible for organising a Review Case Conference within **14 working days**.

## **10.10 Decision to either Place a Child's Name on the Register or to Remove a Child's Name from the Register**

10.10.1 Initial and pre-birth case conferences need to consider if a child/young person or any other children/young people in the household are at risk of significant harm and a Child's Plan that specifically addresses risk as well as need is required. Please see [10.15 below re Risk Assessments](#).

- 10.10.2 Review and Transfer Case Conferences need to consider if registration needs to be continued or not. A child's or young person's name should only be removed from the register when risks have reduced to such an extent that the child's/young person's name would not now be placed on the register. Where a child or young person remains at home, care must be taken not to de-register before there is confidence that the reduction of risk is significant enough to protect the child or young person and likely to be permanent.
- 10.10.3 Following the decision to remove a child's or young person's name from the register the child/young person and family may benefit from further support and guidance. A revised Child's Plan co-ordinated by a Lead Professional, who may or may not be a Social Worker, should then be put in place.
- 10.10.4 Child Protection Case Conference are interagency meetings and **ALL** agencies share the responsibility for making decisions about registration and deregistration. Any professional from any agency who attends the conference has to be prepared not only to share information, but to be clear in their recommendations about the decision to register or deregister. The Chair will seek the views of all participating agencies.
- 10.10.5 Where there is no clear consensus about registration or deregistration, the Chair will use his or her professional judgement to make the final decision, based on an analysis of the issues raised. In circumstances where the Chair has had to make a decision, the Chair will refer the decision to the Chief Social Work Officer for independent scrutiny. The Chief Social Work Officer can request support from the Lead Officer for Adult and Child Protection if that is appropriate.

## **10.11 Role of the Chair**

### 10.11.1 The Chair's role is to:

- in consultation with the Team Leader agree who to invite, who cannot be invited and who should be excluded.
- check that any special arrangements to support the attendance and participation of parents, carers, children and young people have been put in place.
- ensure that all persons invited to the CPCC understand its purpose, functions and the relevance of their particular contribution.
- meet with parents/carers immediately prior to the conference and explain the nature of the meeting and possible outcomes.

- facilitate information-sharing and analysis.
- ensure that the parents/carers are included, respected and supported to take part in the conference and share their views.
- that the child or young person is supported appropriately to attend all or part of the meeting as may best meet their needs in consultation with the Lead Professional.
- ensure that even if children and young people are not present their views are detailed in the Multiagency Child's Plan for the conference (or are shared by some other means) and their views are taken into account.
- facilitate decision-making.
- determine the final decision in cases where there is disagreement.
- wherever possible, chair review CPCCs to maintain a level of consistency.
- where a child's or young person's name is placed on the Register, outline decisions that will help shape the initial Child Protection Plan (to be developed at the first core group meeting).
- identify the Lead Professional (if not already appointed).
- facilitate the identification of risks, needs and protective factors and how strengths can be built on to improve the child's/young person's situation.
- facilitate the identification of a core group of staff responsible for implementing and monitoring the Child Protection Plan.
- agree review dates.
- challenge any delays in action being taken by staff or agencies.
- ensure that timescales are adhered to, including review dates, distribution of minutes and copies of the Child Protection Plan and changes to plans.
- Inform parents, carers and young people of their right to appeal the decision of the case conference and how they can do that. See Appendix 2 Appeals Process.
- Where a child has been a victim of an offence consideration should always be given to applying for Criminal Injuries Compensation. The Chair should ensure that this is discussed and agreed at the conference and if appropriate the Lead Professional will take this forward and make application on the child's behalf.

10.11.2 Child Protection Case Conferences are interagency meetings and decisions about registration should not be taken by a sole agency. A conference at a minimum should have three agencies represented in

order to be quorate and to proceed with the meeting. However, if there are fewer than 3 agencies present the Chair has the discretion to proceed if it is in the best interest of the child and will offer a short term plan to reduce risk pending an early review conference which should take place within 14 working days.

### **Restricted Information**

- 10.11.3 Decisions about how to restrict information need to be made by the Chair. Restricted access information is information that, by its nature, cannot be shared freely with the child/young person, parents or carers and anyone supporting them. The information will be shared with the other participants at the CPCC. Such information may **not** be shared with any other person without the explicit permission of the provider.
- 10.11.4 Anyone who has restricted information that they need to share should let the Chair know at least 24 hours before the conference so that a confidential section of the meeting can be arranged.
- 10.11.5 Restricted information includes:
- Sub-judice information that forms part of legal proceedings and which could compromise those proceedings
  - information from a third party that could identify them if shared
  - information about an individual that may not be known to others, even close family members, such as medical history and police intelligence reports
  - information that, if shared, could place any person at risk, such as a home address or school which is unknown to an ex-partner.
- 10.11.6 Restricted information will normally be shared by agreeing a confidential section of at the beginning of the CPCC. People with whom restricted information cannot be shared – and this includes parents, carers and children and young people – will be excluded from the confidential section of the meeting.

### **Exclusions**

- 10.11.7 Exclusion of parents/carers/supporters of those attending should only occur after serious consideration of exceptional circumstances, for example the threat of, or actual, physical violence or serious disruption, or where a parent's attendance is not in the best interests of the child/young person or where bail conditions preclude contact.
- 10.11.8 There may be circumstance where parents are not excluded, but it is not appropriate for them to be together in the meeting for e.g. in situations where there is domestic abuse, the children have different

parents with different legal responsibilities, or an acrimonious relationship between adults that will detract from the purpose of the conference. In these circumstances the Chair can decide to run the meeting in separate sections summarising for each parent the information shared in the section of the meeting they did not attend.

- 10.11.9 One parent can request that personal information about them is not shared with the other parent and this should be respected and the conference arranged in such a way that this can happen.
- 10.11.10 The decision to exclude a parent before, or during, the conference will be made by the Chair of the Conference.
- 10.11.11 Justification for any exclusion should be recorded in the minute, and include supporting evidence.
- 10.11.12 Where a parent does not wish to attend, or is excluded, or where it is thought that the parent(s)' attendance is not in a child's or young person's interests, it is important to encourage and facilitate the expression of the parent(s)' views: recorded within the multi-agency Child's Plan, in writing, by a recording to be played at the conference, or by a representative.

## **10.12 Child Protection Case Conference Complaints/Comment and Appeals**

- 10.12.1 Dispute resolution is a way of managing:
- challenges about the inter-agency process
  - challenges about the decision-making and outcomes
  - challenges by children and young people or their parents and carers about the CPCC decisions
  - complaints about practitioner behaviour.
- 10.12.2 Pending the completion of the dispute resolution process all protective actions should continue, the child's/young person's name should be added to the Child Protection Register and the Child Protection Plan developed as required.
- 10.12.3 All of the agencies and services involved in child protection work have clear complaints procedures, which should be followed where there is a complaint about an individual practitioner from that agency.
- 10.12.4 Children and young people should be supported by the Lead Professional to challenge a decision.
- 10.12.5 Please see [Appendix 2](#) for more details about an appeals process that can be used by parents and carers if they are unhappy either where they feel that the criteria in child protection procedures has not been met or the process was sufficiently unfair as to invalidate the outcome.

### **10.13 Reports to Child Protection Case Conferences**

- 10.13.1 The Lead Professional (Social Worker in Child Protection cases) will record a multi-agency Child's Plan for the conference within the GIRFEC national framework.
- 10.13.2 The report prepared by the social worker is an multi-agency Child's Plan and will contain information about the child and family from all relevant agencies. Professionals working with the child and family will be asked to provide information to the social worker and this will be included in the Child's Plan making it clear where the information has come from and quoting it accurately. Under the National Guidance for Child Protection agencies retain the responsibility of sharing with a parent the information they have shared with the Lead Professional. Request for information will include a timescale to allow the Child's Plan to be prepared in time for the conference.
- 10.13.4 For initial conferences Child's Plans should be shared with the Chair at least 24 hours before the conference. For review conferences Child's Plans should be shared at least 3 working days before the conference.
- 10.13.5 It is very important that parents, children and young people have time to read and understand the Child's Plans. Social Workers should meet with families to share the Child's Plan at least 24 hours before the conference.

### **10.14 Agency Representatives**

- 10.14.1 CPCC participants need to include:
- Social Worker from the Children's Social Work Team;
  - Education staff where any of the children and young people in the family are of school age or attending pre-five establishments;
  - NHS staff, health visitor/school nurse/GP as appropriate, depending on the child's/young person's age, and the children's paediatrician where applicable; and
  - Police Scotland where there has been involvement with the child/young person and/or parents/carers.
- 10.14.2 Other participants might include other health practitioners (including mental health services), foster carers/residential staff, adult services, housing staff, addiction services, educational psychologists, relevant third sector organisations, representatives of the Procurator Fiscal. Following [Protocol 2](#) in Section 3 of these procedures the Children's Reporter can be asked to attend a child protection case conference in certain circumstances.
- 10.14.3 There may be occasions when it is appropriate to invite home carers, childminders, volunteers or others working with the child/young

person or family to the CPCC. The practitioner most closely involved with the person to be invited should brief him or her carefully beforehand. This should include providing information about the purpose of the CPCC and their contribution, the need to keep information shared confidential and advice about the primacy of the child's/young person's interests over that of the parents/carers where these conflict.

- 10.14.4 Participants attending are there to represent their agency/service and share information to ensure that risks can be identified and addressed. They have a responsibility to share information and provide clarity around other information shared as necessary.

## **10.15 Risk Assessment**

Risk is not just about considerations of concern or harm.

- 10.15.1 Children and young people have to be exposed to experiences that may raise their risk potential at different stages of their growth and development to help them develop into rounded, secure, healthy individuals. Risk is also a dynamic concept with many different aspects to be considered.
- 10.15.2 Risk assessments must take account of current circumstances, past history and future potential.
- 10.15.3 The minimum guidance to be followed when undertaking a risk assessment is the National Risk Framework 2012 (<http://www.scotland.gov.uk/Publications/2012/11/7143>).
- 10.15.4 Children and Families Policy and Procedure updated in April 2019 gives a framework for risk assessments to be considered by the Lead Professional Social Worker for Child Protection Case Conferences.

## 11. Legal Action

Guidance on the following legal information can be found at <http://www.gov.scot/Publications/2014/05/3052/11>

### 11.1 General

11.1.1 Legal action is only appropriate when it is not possible to protect a child by working with the family on a voluntary basis. If a family will not work voluntarily with the Children's social work department then a referral will be made to the Reporter for consideration of compulsory measures of care. In those rare cases where children are at immediate risk of significant harm an order to protect them can be sought from Lerwick Sheriff Court. The option of legal measures should only be considered when other ways to protect the child are not available.

11.1.2 There are three forms of emergency court order available for the protection of children under the Children (Scotland) Act 1995 and the Children's Hearings (Scotland) Act 2011.

These orders are:-

1. Child Protection Order
2. Child Assessment Order
3. An Exclusion Order

11.1.3 The Emergency Authorisations under Section 55 of the 2011 Act from a Justice of the Peace are not available in Shetland because of the nature of the appointments locally. However, a police constable has a power to remove a child to a place of safety in certain circumstances.

### 11.2 Child Protection Order (S.37 of the Children's Hearings (Scotland) Act 2011)

11.2.1 A Child Protection Order ("CPO") is an order authorising the removal of a child from the persons with parental rights to a place of safety or to prevent the removal of the child from a place of safety. Such an order can be sought when the child is at **immediate** risk of **significant** harm. Whilst any person can seek a CPO when the circumstances require it, this is a legal process and is a matter of complexity so whenever possible the action should be pursued by the local authority's legal officers on the instructions of the Children's social work department.

11.2.2 In the event that some other person than the local authority requires to seek a CPO the application should be in [Form 48](#) which follows in [Chapter 13 below](#). If you are a local authority employee you need a slightly different form which is available from the Council's Legal Section or from the Scottish Courts website. The applicant should contact the Sheriff Clerk on 01595 693914 to arrange for a Sheriff to

hear the application. When the Sheriff is out with Shetland either a video-conference will be arranged by the Sheriff Clerk or an Honorary Sheriff will be contacted. The applicant will need to persuade the Sheriff that the child is at immediate risk of significant harm and that the order is necessary.

11.2.3 If the Sheriff grants the order then a copy of the application and the order needs to be served on the parents of the child, or any person specified in the order. This can be done by a person authorised by the Sheriff to do so and will be a [Form 51 – see below](#). If the child is old enough to understand the meaning of the court order then the same papers need to be given to the child with a [Form 50 – see below](#).

11.2.4 The Reporter needs to be notified immediately of the granting of a CPO so a Hearing can be organised. The person who obtained the CPO needs to make a note of the information which was given to the Sheriff to persuade him to grant the order.

11.2.5 More detailed instructions are contained in [Appendix 1](#).

### **11.3 Child Assessment Order (S.35 of the Children’s Hearings (Scotland) Act 2011)**

11.3.1 Only a local authority can apply for a Child Assessment Order. A Child Assessment Order can be sought if;

- There is concern about a child’s safety or welfare; and
- Attempt to assess the child on a voluntary basis have failed; and,
- Additional information is necessary in order for a decision about the child’s safety to be made.

11.3.2 It should be noted that the Sheriff can grant a CPO in response to a Child Assessment Order application if the Sheriff considers this would be a more appropriate order than a Child Assessment Order.

11.3.3 Shetland Islands Council has never yet sought a Child Assessment Order, as if there has been sufficient evidence to justify an urgent intervention there has been enough evidence to seek a CPO. This is in line with the practice throughout Scotland.

11.3.4 Any application for a Child Assessment Order would be sought by the Council’s legal officers on instructions from the Children’s social work department.

#### **11.4 Exclusion Order (S.76 of the Children (Scotland) Act 1995)**

11.4.1 Only a local authority can apply for an Exclusion Order. The effect of the Exclusion Order is to remove the person who presents the risk of significant harm to the child from the home. The criteria for an Exclusion Order are;

- The child is at risk of significant harm because of the conduct of a named person;
- An order is necessary to protect the child;
- The order would better safeguard the welfare of the child than removing the child from their home;
- There is someone other than the named person who is living in the family home who will be able to provide the child with appropriate care if the named person is made to leave.

11.4.2 It should be noted that the Sheriff can grant a CPO in response to an Exclusion Order application if the Sheriff considers this would be a more appropriate order than an Exclusion Order.

11.4.3 Shetland Islands Council has never yet sought an Exclusion Order but has considered doing so in particular cases.

11.4.4 Any application for an Exclusion Order would be sought by the Council's legal officers on instructions from the Children's social work department.

#### **11.5 Emergency Protection of Children by a Police Constable (S.56 of the Children's Hearings (Scotland) Act 2011)**

11.5.1 In circumstances when a CPO would be justified, that is where the child is at immediate risk of significant harm, and it is not practicable for an application to be made to a Sheriff then a police constable can remove a child to a place of safety. This authority will expire after a period of 24 hours following implementation.

11.5.2 If the criteria for a CPO persist following implementation an application to the Sheriff can be made during this 24 hour period.

11.5.3 If the child has been removed by the police following authorisation by the Chief Inspector, Shetland Command, but without the involvement of the Children's social work department, the police will notify duty Children's social work as soon as is practicable. If the child is being accommodated in the police station Duty Social work will arrange for an alternative placement as a matter of urgency.

Examples of the [Form 48 Application for a Child Protection Order](#), [Form 50 Arrangements to Keep You Safe](#) and [Form 51 Notice of a Child Protection Order to a named person](#) can be found in [Chapter 13 below](#).

## **12. Child Protection Register – Administration**

### **12.1 General**

12.1.1 The Child Protection Register is kept electronically and accessed via the Children’s Social Work Information System (SWIFT). A hard copy is kept for back up in a locked cabinet in the Children and Families admin office.

12.1.2 The designated Keeper of the Child Protection Register is the Executive Manager – Children’s Social Work (who is also the Chief Social Work Officer) and the Depute Keeper is the Improvement Reviewing Officer. The SPPC’s Lead Officer will ensure that the Scottish Government is notified of any changes to the Keeper or Depute Keeper.

### **12.2 Section 1: Child Details**

12.2.1 When a Child Protection Case Conference decides to place a child's/young person’s name on the Register, the chair is responsible for ensuring that the appropriate form is completed. Forms are held in Children and Families Social Work. (This form should be taken to the case conference as a checklist.) [See 12.2.4 below.](#)

12.2.2 One form for **each** child or young person in a family must be completed.

12.2.3 All sections of the form must be completed wherever possible.

12.2.4 In the case of an Initial Child Protection Case Conference, the minute taker should prepare a registration form for the chair to sign at the end of the conference in the event of registration. If the child or young person is registered, the form must be checked and signed by the chair on the same day as the case conference decision, and placed in the Child Protection Register. If not required, the form is to be shredded and deleted from the system immediately after the conference.

12.2.5 For Review conferences, the minute taker should bring the registration form(s) to the conference for completion by the chair at the end of the conference. If registration continues, the form is endorsed to that effect, checked and signed by the chair. If deregistered, the procedure in [12.3.4 below](#) should be followed.

12.2.6 When a case conference review decides to retain a child's or young person’s name on the Register, the chair must ensure that the last part of the form is updated with the date and decision of the review as above.

12.2.7 The Register is then updated. Immediately on updating the Register, the procedure set out in the Protocol for use of Shetland’s Child Protection Register in the Accident and Emergency Department at the

Gilbert Bain Hospital should be followed ([see Protocol 3 in Section 3 of these Procedures](#)).

- 12.2.8 The case file (one for **each** child or young person whose name is placed on the Register) must be identified with a removable sticker placed on the outside of the file. When a child's/young person's name is placed on the register the 'hazards' tab on the SWIFT system is completed so that a red alert will appear when the file is accessed.
- 12.2.9 In the event of an enquiry being received by the Children's Social Work team regarding a child's or young person's registration status, information should only be shared on a need to know basis. This information would not be available to the public. The registration document **must** be consulted and a record made that the enquiry has taken place.
- 12.2.10 Completed referral forms must include an indication that the Register has been checked.
- 12.2.11 When notification is received that a child or young person whose name is on the Register in another authority is in Shetland, a Section 1 form ([see 12.2.1 above](#)) must be completed by Duty Children's social work on the day of notification, with as many details as can be obtained; the child's/young person's name should be temporarily registered and a case conference convened in accordance with [Chapter 10](#) if the child/young person is moving permanently to Shetland.
- 12.2.12 In some cases, children and young people whose names are on the Child Protection Register of another local authority may be temporarily resident in Shetland. Details of the child or young person should be noted as above and any temporary monitoring arrangements requested by the originating local authority complied with. It would usually not be necessary to hold a transfer in conference in such circumstances, however the Team Leader may decide a conference is necessary if a child/young person is staying in Shetland for some months.

### **12.3 Section 2: Closed Child Details**

- 12.3.1 When a case conference review decides to remove a child's/young person's name from the Register the chair is responsible for ensuring that the appropriate form is completed.
- 12.3.2 One form for **each** child or young person in a family must be completed.
- 12.3.3 All sections of the form must be completed wherever possible.

- 12.3.4 In the case of Review Child Protection Case Conferences, the minute taker should prepare a Section 2 Closed registration form for the chair to sign at the end of the conference in the event of de-registration. If the child/young person is de-registered, the form must be checked and signed by the chair on the same day as the case conference decision, and placed in the Child Protection Register. If the child/young person remains on the register the form is to be shredded and deleted from the system immediately after the conference, and the procedure at [12.2.5 above](#) should be followed.
- 12.3.5 The Register is then updated. Immediately on updating the Register, the procedure set out in the Protocol for use of Shetland's Child Protection Register in the Accident and Emergency Department at the Gilbert Bain Hospital is to be followed ([see Protocol 3 in Section 3 of these Procedures](#)).
- 12.3.6 The identification sticker on the case file must be removed. The status of the 'hazard' on the SWIFT system is changed to indicate that the child/young person has been previously registered.
- 12.3.7 In the event of an enquiry, this section of the Register **must** be consulted. Information should only be shared on a need to know basis. The information would not be available to the public. The registration document must be consulted and a record made that the enquiry has taken place.

#### **12.4 Section 3: Children Reported as Missing**

[Please see Protocol 7 in Section 3 of these Procedures.](#)

## 13. Forms

### INDEX OF FORMS AND LEAFLETS:

#### Referrals:

##### [Referral form – Form 3](#)

<https://www.safershetland.com/assets/files/1.-duty-intake-referral-final.doc>

[Initial Referral Discussion Form](#)

#### Legal Forms:

[Form 48: Application for Child Protection Order non Local Authority](#)

[Form 50: Notice of Child Protection Order to a child](#)

[Form 51: Notice of Child Protection Order to a named person](#)

[Links to leaflets](#)

**Referrals – Form 3**



Date	Agency making Referral:	Name / designation / contact details:	Relationship to Child(ren):

<b>Do you consider this a Child Protection Referral?</b>	Yes / No
<b>Have you verbally shared the concern with the Duty Social Worker</b>	Yes / No

<b>Do you consider this a Child Welfare Concern?</b>	Yes / No
--	----------

<b>Are you making a request for Early Intervention Service?</b> If yes, please attach Child's Plan(s)	Yes / No
--	----------

Name of Child(ren) referred:		DOB:	Gender	Named Person:
First Name	Surname		Male/Female	
			Male/Female	
			Male/Female	
			Male/Female	

**Address:**

**Contact Details:**

Family Composition					
Name	DOB	Relationship to Child	Employment/School/other	Residence if different	PRR
<b>Parent / carer:</b>					Yes / No
<b>Parent / carer:</b>					Yes / No

Name of other Child(ren) in household:		DOB:	Gender	Named Person:
First Name	Surname		Male/Female	
			Male/Female	
			Male/Female	
			Male/Female	

<b>GP / Health Visitor / Midwife details:</b>	
<b>Early Years / School / College:</b>	
<b>Open Childs Plan:</b>	<b>Yes / No</b> <b>Lead Professional:</b>
<b>Additional Support Needs: If known</b>	<b>Yes / No / Not known</b> If yes please specify:
<b>Ethnic Origin</b>	White / Mixed / Asian or British Asian / Black or Black British / Not Known / Other (please specify)
<b>Religion</b>	Church of Scotland / Roman Catholic / Other Christian / Muslim / Buddhist / Sikh / Jewish / Hindu / Pagan / None / Not Known / Other (please specify)
<b>First Language</b>	English / Not Known / Other (please specify)

<b>Details of Referral e.g. details of alleged perpetrator where known / specific incidents – dates, times, witnesses, any visible injuries / history of previous concerns OR Child Welfare Concerns OR Reason for Early Intervention services</b>

<b>Is Child Aware of Referral? Yes / No</b>	<b>Are Parents Aware of Referral? Yes / No</b>
<b>Where is the child now:</b>	<b>Whereabouts (if known) of siblings:</b>

<b>Summary of previous involvement with Family – please attach agency chronology if available</b>

Signed .....

**Please attach a copy of your agency's chronology and Child's Plan if available, along with this referral and email to: [childrens&families-intake@shetland.gov.uk](mailto:childrens&families-intake@shetland.gov.uk)**



**Children & Families**  
**Part 2**  
**Initial Referral Discussion**

<b>Date:</b> / /	<b>Time:</b>	<b>Manager:</b> Select Select
<b>Discussion with:</b>	<b>Agency:</b> Select Select	<b>Role:</b>

<b>DECISIONS FROM IRD:</b>		
<b>Need for immediate action to protect child(ren)?</b>	Select	If yes, summarise action:
<b>Is medical attention required?</b>	Select	If yes, summarise action:
<b>Is a Paediatric/Forensic Medical Required as part of the formal CP Investigation?</b>	Select	If yes, summarise action:
<b>CP Planning meeting required?</b>	Select	If yes, record in Part 2a. If not, why not?
<b>VRI to be arranged?</b>	Select	If yes, complete Part 2b.
<b>Joint or Single Agency?</b>	Select	Complete relevant section below
<b>Parental Consent Required</b>	Select	If not, why not?
<b>Child(ren) Accommodated?</b>	Select	

<b>Allocate to Social Worker</b>	Select	<b>Name:</b> Select <b>Date:</b> / /
<b>Reason for Decision:</b>		
<b>Outcome of single / joint approach and recommendations:</b>		
<b>Manager Decisions:</b>		

<b>OUTCOME:</b>		
<b>Allocation into team?</b>	Select	<b>Name:</b> Select <b>Date:</b> / /
<b>Convene ICPC?</b> ** to be held 10 days from decision	Select	<b>Date:</b> / /
<b>Reason for Decision:</b>		

<b>Family Notified of Outcome</b>	Select	<b>If yes, by whom/date?</b> / /
<b>Has Named Person been informed?</b>	Select	<b>If yes, by whom/date?</b> / /
<b>LAC:</b>	Select Placement:	Education Informed? Select Health Informed? Select Admin Informed? Select
<b>Has referrer been advised of outcome?</b>	Select	<b>If yes, by whom/date?</b> / /

<b>Manager</b>	
<b>Name:</b> Select Select	<b>Signature:</b>
<b>Date:</b> / /	

<b>ADMIN TASKS</b>	<b>Date:</b>
Duty / Social Worker Allocated on Involvements:	/ /
Referral recorded:	/ /
Outcome Letters Sent:	/ /

<b>Quality Assurance Check</b>

Legal Forms

**Form 48 Application for a Child Protection Order by any person (other than a local authority)  
Section 57 of the Children (Scotland) Act 1995**

Rule 3.30

Case No  
Date lodged

**Application to Sheriff at**

for a Child Protection Order under section 57(1) of the Children (Scotland) Act 1995

**Part 1. Details of applicant and other persons who the applicant believes should receive notice of the application**

APPLICANT	<i>[insert name and address, telephone DX and fax numbers and capacity in which application is made]</i>
CHILD	<i>[insert name, address, gender and date of birth] *</i>
RELEVANT PERSON(S)	<i>[insert name, address and the basis for the person being a relevant person within the meaning of section 93(2)(b) of the Act]</i>
SAFEGUARDER	<i>[insert name, address, telephone DX and fax numbers (if known) of any safeguarder appointed by a children's hearing or court in respect of the child]</i>
LOCAL AUTHORITY	<i>[insert name and address, DX and telephone and fax numbers]</i>
PRINCIPAL REPORTER	<i>[insert name, address, telephone DX and fax numbers]</i>
ANY OTHER PERSON WHO SHOULD RECEIVE NOTICE OF THE APPLICATION	<i>[For example, any person who is caring for the child at the time of the application being made: insert name, address of person and provide details of their interest in the application and/or child]</i>

**\* Note: Information to be provided in Part 3 where applicant does not wish to disclose the address or whereabouts of the child or any other person to persons receiving notice of the application.**

**Part 2. Information about the application and orders sought**

**GROUND(S) FOR MAKING APPLICATION**

*[applicant to provide details of grounds for making the application: see section 57(1) of the Act]*

**OTHER APPLICATIONS AND ORDERS WHICH AFFECT THE CHILD**

*[insert details of any other applications or orders made which affect or are*

*relevant to the child who is the subject of this application]*

SUPPORTING EVIDENCE

The following supporting evidence is produced -

*[list reports, statements, affidavits or other evidence produced]*

**Part 3. Details of Order sought and any terms, conditions or directions**

ORDER SOUGHT: The applicant requests the Sheriff to make a Child Protection Order in respect of the child *[insert name]*

**\*TERMS AND CONDITIONS TO BE ATTACHED TO ORDER**

In terms of section 57(4) the applicant seeks an order to

*[insert details of the order sought].*

**\*DIRECTIONS IN RELATION TO THE EXERCISE OR FULFILMENT OF PARENTAL RESPONSIBILITIES OR PARENTAL RIGHTS**

In terms of section 58(4) or (5) the applicant seeks the following direction(s) -

*[insert details of the direction(s) sought].*

*\*delete as appropriate*

**\*ANY OTHER ORDER(S)**

*[Insert here details and grounds for any order sought in relation*

*(a) to non-disclosure of address or whereabouts of child; or*

*(b) service of restricted documents on child.]*

**Part 4. Details of first order sought from the sheriff**

The applicant requests the sheriff to:

a. Make a child protection order in respect of the said child *[insert name of the child]* on the terms and conditions set out in Part 3 of the application, \* and subject to the directions sought in Part 3 of the application.

\*b. Order the applicant to forthwith serve a copy of the Child Protection Order [and a copy of the application] on,

i. the child, together with a notice in form 50\* or orders service of the following documents only *[insert details of documents to be served on child, e.g. notice in form 50 only]*; and

ii. the persons listed in Part 1. of this application, together with a notice in form 51.

*\*delete as appropriate*

\*c. Order that the address of *[insert name]* should not be disclosed in the application.

\*d. Dispense with service on the child or any other person for the following reasons *[insert details]*.

SIGNED ..... DATE.....

[name, designation and address  
telephone, DX and fax numbers]

**Form 50 Notice of Child Protection Order to a child in terms of section 37 of the Children’s Hearings (Scotland) Act 2011**

Rule  
3.32(A)

**ARRANGEMENTS TO KEEP YOU SAFE**

Court ref. no.:

Dear [*insert name by which child is known*]

I am writing to tell you that because there were worries about your safety the court was asked to sort out some practical arrangements to make sure you are kept safe.

After hearing about your situation the court made an order, called a “Child Protection Order”. That means that the court gave permission to [*insert in simple language the order(s) and any directions granted and their effect on the child*]

If you are unhappy with this order or any authorisation, requirement or direction you can ask the court to change it. For example, you might want to ask the court to allow you [*insert an example e.g. to allow more contact with certain members of the family etc.*]

**Any change must be requested without delay**

If you want to do this you can ask the court which made the order to listen to you. You will need a lawyer to help you.

**Remember** that if you do not agree with the order or any authorisation, requirement or direction you must get advice **IMMEDIATELY**.

**In the meantime you must do what the order says.**

**If you are unsure about what to do you can get free legal advice from a Lawyer or Local Advice Agency or Law Centre about the application and about legal aid. The Scottish Child Law Centre can refer you to specially trained lawyers who can help you. They give advice on their free phone no (0800 328 8970) any time between 9.30 am and 4.00 pm Monday to Friday.**

You will see that, along with this letter, there is [a copy of the application which was made to the court (*delete if appropriate*)], and the order the court has made which affects you. If you decide to get advice, or to ask someone to go to court for you, make sure that you give your advisor a copy of the application, and the court’s order.

SIGNED ..... DATE.....

**Form 51 Notice of Child Protection Order to a named person under section 37 of the Children's Hearings (Scotland) Act 2011**

Rule 3.32(b)

Court ref. no.:

**Notice of Child Protection Order made section 37 of the Children's Hearings (Scotland) Act 2011 in the Sheriff Court at**

To *[insert name and address of person to whom notice is given]*.

You are given notice of the making of a Child Protection Order in respect of the child *[insert name, address, gender and date of birth of child]* by the sheriff at *[name of sheriff court]* on *[date of order]*.

Along with this notice there is attached a copy of the application and the order.

SIGNED ..... DATE.....

**WHAT YOU SHOULD DO**

**\* YOU MUST COMPLY WITH THE ORDER AND ANY AUTHORISATION, REQUIREMENT OR DIRECTION CONTAINED WITHIN IT. FAILURE TO COMPLY IS AN OFFENCE UNDER SECTION 59 OF THE CHILDREN'S HEARINGS (SCOTLAND) ACT 2011 AND COULD LEAD TO YOU BEING FINED.**

*\*delete as appropriate*

**\*YOU MAY WISH TO OBTAIN ADVICE FROM A SOLICITOR OR LOCAL ADVICE AGENCY OR LAW CENTRE.** You may be entitled to legal aid. Advice about legal aid is available from any solicitor, advice agency or law centre.

**\*You may be able to contest or vary the order, and in such circumstances you should obtain legal advice without delay.**

## LINKS TO LEAFLETS

Forms for children and young people explaining about investigations, case conferences, etc. are available from: <http://www.safershetland.com/for-children-and-young-people> – at end of webpage

Leaflets for parents and carers are available from:  
<http://www.safershetland.com/for-parents-and-carers>

Link to GIRFEC leaflets: [http://www.shetland.gov.uk/children\\_and\\_families/GIRFEC.asp](http://www.shetland.gov.uk/children_and_families/GIRFEC.asp)

**SECTION TWO – APPENDICIES:**

**Appendix 1** Child Protection Order Applications

**Appendix 2** Appeal against the Decision of a Child Protection Case Conference

**Appendix 3** Managing a Disclosure of Abuse

## Appendix 1

### Child Protection Order Applications

#### Guidance Notes for the Completion of Relevant Forms

##### Introduction

- 1.1 A Child Protection Order (CPO) may be granted where the Sheriff is satisfied either:
- that there are reasonable grounds to **believe** that a child is being so treated (or neglected) that s/he is suffering significant harm; or will suffer such harm if not removed to, or kept in, a safe place; and that an order is necessary (section 57(1)); or
  - that the local authority has reasonable grounds to **suspect** that a child is suffering or will suffer significant harm **and** that enquiries being carried out to verify this are being frustrated by access to the child being denied (section 57(2)).
- 1.2 Although the term 'suspect' does not require the same level of evidence as the term 'believe', where it cannot be shown that the local authority's enquiries into whether a child is, or is likely to suffer significant harm are being frustrated by denial of access, then section 57(2) will not be appropriate.
- 1.3 A CPO should only be considered when all possible voluntary alternatives have been explored, or when it is impracticable, for reasons of immediate safety, to do so.
- 1.4 Consideration must be given to the views of the child and to the likely impact on the child of the granting of an order.
- 1.5 These notes are to assist with completing the relevant forms for CPO applications to the Sheriff and should be read in conjunction with departmental child protection procedures.
- 1.6 [Form 48](#) is the application form for a CPO for any person other than an employee of Shetland Islands Council. The paragraph numbers in these guidance notes refer to the paragraphs in Form 48. If you are a local authority employee you need a slightly different form which is available from the Council's Legal Section or from the Scottish Courts website.
- 1.7 [Form 50](#) is the notice to the child that a CPO has been obtained.
- 1.8 [Form 51](#) is the notice to the named person (parent, carer, etc.) that a CPO has been obtained.

**The Reporter must be notified, by copy of the application and order, immediately an application for a CPO has been granted; however, in practice wherever possible, the Reporter should be informed of the intention of the Social Care Service to make an application.**

---

**A. [Form 48](#) – Application for a Child Protection Order (not for Local Authority – [see 1.6 above](#))**

**Part 1 Details of applicant and other persons who the applicant believes should receive notice of the application**

**Para**

**1.1** N/A

**1.2** The child's name, address, date of birth and gender should be entered here. The parent will receive a copy of the application and of the CPO when s/he is notified of the granting of the order. There may be occasions, e.g. when the order is to prevent removal of a child from the place where s/he is, that it may be desirable for the child's whereabouts to be withheld; in these circumstances this section should be left blank, and para 3.4 completed, giving reasons for the request.

**1.3** Insert the name and address, and, under the heading 'status', the basis of the person being a 'relevant person'. For the purposes of this application, relevant person means:

- any parent enjoying parental responsibilities or rights. This includes the natural father who is not married to the mother but whose name appears on the birth certificate if the child is born after 4 May 2006;
- any person in whom parental responsibilities or rights have been vested; and
- any person who appears to be a person who ordinarily has charge of, or control over, the child (this excludes people caring for a child by reason of employment, but could for example be a step-parent).

N.B. Consideration will need to be given to absent parents; both divorced parents will usually retain parental responsibilities and rights. Before considering an application for a CPO it is likely that the possibility of the absent parent taking charge of the child will have been explored. If it is believed that the child cannot remain safely with either parent, then notice of the application will have to be served on both.

**1.4** Insert name, address, telephone and fax numbers of any safeguarder appointed by a children's hearing or court in respect of the child.

**1.5** N/A

**1.6** For example, the natural father (if he is not a relevant person): insert name, address and telephone number, and provide details of their interest in the application.

## **Part 2 Information about the application and orders sought**

### **Para**

**2.1** N/A

**2.2** Insert details of any other applications or orders made which affect or are relevant to the child who is the subject of this application.

**2.3** List reports, statements, affidavits or other evidence produced. It may not be sufficient merely to speak to the application, and some preparation will be necessary prior to presenting the case to the Sheriff; this could include bringing along witnesses to give direct evidence. However, if the social worker's evidence is all that is available, and if a CPO is believed to be necessary, then the application should proceed and the Sheriff will make his/her decision.

If a request is being made (at para 3.4) to withhold the whereabouts of the child from the parent, or if restrictions as to contact or other requests are being made (para 3.3), the reasons and supporting evidence should be set out here.

## **Part 3 Details of order sought and any terms, conditions or directions**

### **Para**

**3.1** Insert name of child subject to the application.

**3.2** Delete those bullet points which do not apply.

**3.3** Parents of children who are subject to Child Protection Orders retain all parental rights and responsibilities. This means that any medical examination, treatment or interview can only be carried out with a parent's permission. If such permission is unlikely to be forthcoming, and if it is considered essential that any such interview occur, then the parental rights to do so must be applied for at the time of the CPO application. Insert here details of the direction(s) sought.

Contact between child and parent(s) should normally be encouraged and facilitated. If restricted contact (e.g. supervised only) or no contact is considered necessary to protect the best interests of the child, a direction should be sought here, with reasons and supporting evidence entered at para 2.3

- 3.4** If the whereabouts of the child are to be kept from the parent (or other 'relevant person'), their names should be listed here, and reasons given.

Provision is made in the rules for the child to receive a copy of the application, the CPO and an explanatory notice (Form 50); however, it is possible to request that the child receives Form 50 only. For all children under eight years, the request to serve Form 50 only will be made, the reason being the child's age and understanding; this reason should be entered here. For children between the ages of eight and twelve years, the question of whether to request restricted service will be discussed between social worker and Senior Social Worker/Service Manager (with legal advice where required). Requests to restrict service on children over twelve years will only be made in exceptional circumstances.

Delete that option which is not required; if neither is required, delete both.

#### **Part 4 Details of first order sought from the Sheriff**

##### **Para**

- 4.1** Insert the child's name; if directions are not being sought as per paragraphs 3.3 and 3.4, then all after \* should be deleted. However, it is likely that most applications will seek some directions at this stage.
- 4.2** The applicant is responsible for serving on both the child and the relevant person, a copy of the application, the CPO and the notice (Form 50 for the child and Form 51 for the relevant person). If it is felt that the child should receive only a copy of the notice, then delete at subparagraph i. : "the child, together with a notice in form 50," and list below the documents which are to be served.
- 4.3** If the application includes the request that the child's whereabouts are not disclosed to the parent, the child's name should be inserted here.
- 4.4** If the application includes the request not to serve a copy of the application/order on either the child or the parent/other relevant person, list the reasons here.

Delete those paragraphs which do not apply.

**B. [Form 50 – Notice of Child Protection Order to Child](#)**

This form should be completed with:

- i. the child's name;
- ii. in simple language the order(s) and any directions granted and their effect on the child; and
- iii. examples of what changes the child might want to ask the court to grant, e.g. to allow more contact with certain members of the family, etc.

N.B. Form 50 must always be served on the child subject to a CPO; it is important, however, that the social worker serving the notice also explains in age-appropriate language what is happening to the child, what the child's rights are, how the child will be helped to exercise his/her rights, and the likely course of events in the short-term, who will be looking after the child, what contact with family will be, who will be making decisions about the child, his/her contribution to the decision-making, likely timescales, etc. It is important not to assume a level of understanding sufficient for comprehension of the forms, and every effort must be made to assist the child in understanding what is happening to him/her and who can help.

**C. [Form 51 – Notice of Child Protection Order to a Named Person](#)**

This form should be completed with:

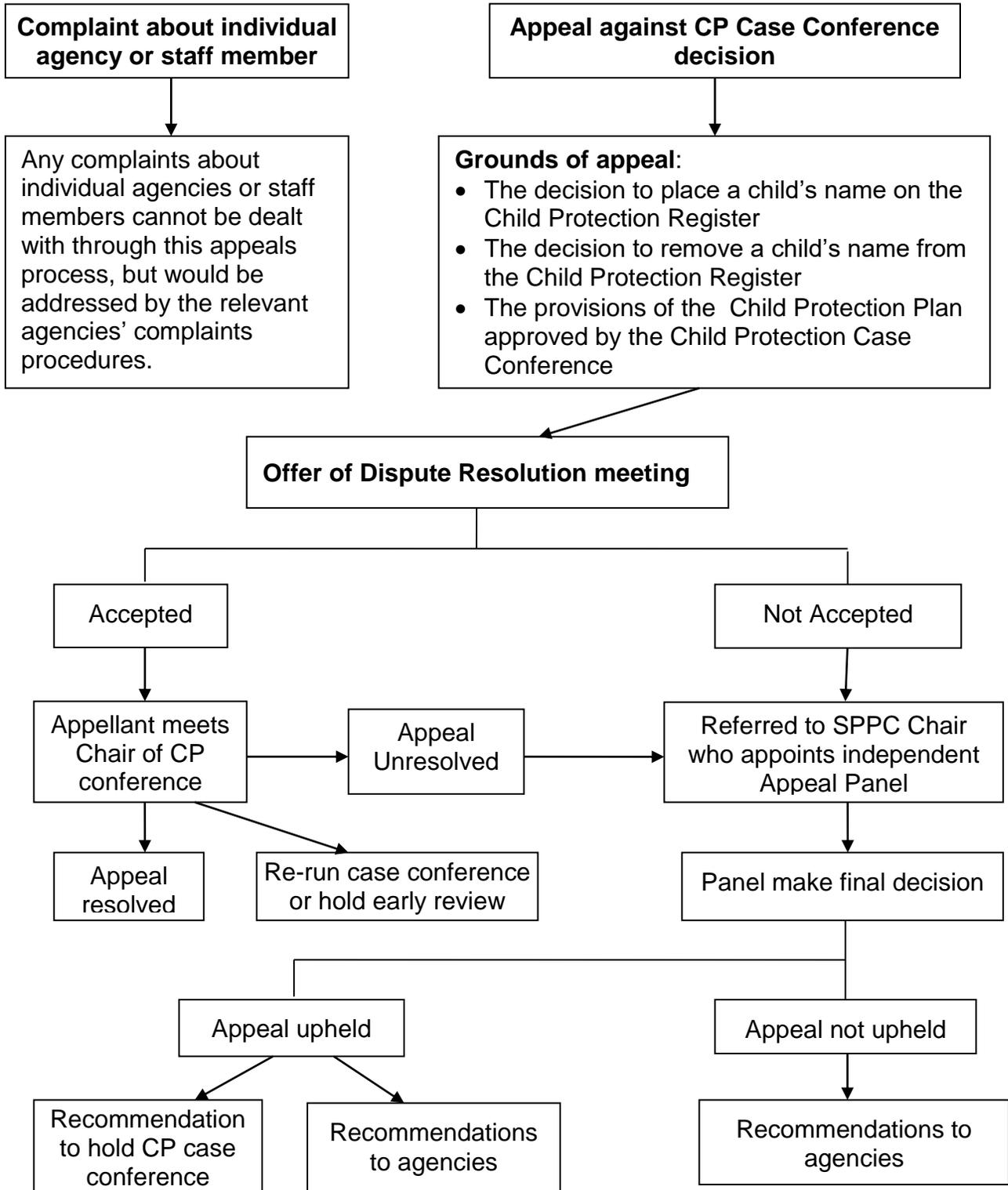
- i. the relevant person's name and address;
- ii. the child's name, address, DoB and gender;
- iii. the date of the granting of the CPO.

N.B. It is the responsibility of the applicant to serve form 51 on the relevant person, together with a copy of the CPO and the application to the Sheriff. The exception to this is when the Sheriff has granted the applicant's request not to divulge the whereabouts of the child to the relevant person, in which case the child's location may be withheld.

**Whenever possible assistance should be sought from Legal Services. If this is not possible, you should refer to the appropriate rules of court (Act of Sederunt (Child Care and Maintenance Rules) 1997 R.3.29-33)**

## Appendix 2

### Appeal against the Decision of a Child Protection Case Conference



## **Process**

1. Any Parent, Carer, Child or Young person who has either attended or been excluded from attending an Initial, Pre-Birth, Review or Transfer Child Protection Case Conference can use this process to challenge the decision of the child protection case conference.
2. The appeal process is in relation to decisions of the Child Protection Case conference. The decisions which can be appealed are therefore as follows:
  - The decision to place a child's name on the Child Protection Register
  - The decision to remove a child's name from the Child Protection Register
  - The provisions of the Child Protection Plan approved by the Child Protection Case Conference.
3. It is always important to address any concerns and seek to resolve them. They often provide good opportunities for agencies involved in child protection work to learn and improve. However this process must not detract from the need to focus on the safety of a child and any protection plans put in place to reduce risk will be adhered to whilst the appeal process is ongoing and until a Review Child Protection Case Conference makes a decision which changes the protection plan.
4. Child Protection Case Conferences are interagency meetings. If a parent, carer, child or young person has a concern about the information shared at the case conference by a particular person representing their agency or the professional conduct of a staff member then the agencies individual complaints procedure should be used to raise this. The Chair of the Child Protection Case Conference can provide advice on who to contact and how to go about making a complaint.
5. Child Protection Case Conferences can be stressful and upsetting for families and support and help to assist them to participate fully and understand why a case conference has been called and has reached a particular decision is the shared responsibility of the Team Leader in Children and Families Social Work, The Lead Professional and the Chair of the case conference. If following informal discussions the parent, carer, child or young person remains dissatisfied and wants to pursue an appeal, they should be referred to the Chair of the Case Conference for advice on this appeal process.

6. There are two grounds for appealing a decision to either place a child's name on the child protection register or remove a child's name:
  - The criteria for registration or de-registration have not been met. The criteria for registration are that the child is assessed as being or likely to be at risk of significant harm. The criteria for de-registration are that the child is no longer at risk of significant harm
  - That the process was sufficiently unfair to invalidate the outcome. This may refer to, but is not limited to, the way in which the meeting was chaired, not following proper procedure as laid down in the Shetland Interagency Child Protection Procedures, the opportunities for parents, carers, children and young people to participate, the way in which the decision about registration was reached or the information shared at the conference that influenced the decision.
7. The grounds for appealing the Child Protection Plan are that the terms of the plan do not protect and promote the best interests of the child.
8. If possible the person making the appeal should write or e mail the Chair of the conference stating the decision they wish to appeal and the grounds for their appeal. If this is difficult then the Chair can have a preliminary meeting with the person making the appeal to clarify and record their reasons.
9. On the receipt of an appeal the Chair will offer to arrange a formal Dispute Resolution meeting. The appellant can refuse a Dispute Resolution meeting and proceed with an appeal to the Appeal Panel. People making an appeal can bring a supporter or an advocate to the Dispute Resolution meeting to assist them. The Chair will arrange for the minutes and reports considered at the case conference to be available at the Dispute Resolution meeting. The Dispute Resolution meeting should be minuted and copies of the minutes provided to everyone who attends, unless to do so may place the child or any other person at risk. This process should take place within 20 working days of the Chair of the case conference being notified that an appeal has been made.
10. The outcome of the Dispute will be one of the following:
  - The matter is resolved and the appeal closed
  - There are grounds to uphold the appeal and a review Child Protection Case Conference should take place or some other agreement is reached with the appellant.
  - The appellant remains dissatisfied and seeks a formal appeal.

It should be noted that a Dispute Resolution Meeting cannot change the decision of the Child Protection Case Conference.

11. Following the meeting, the Chair should write to the person making the appeal outlining the outcome of the Dispute Resolution meeting and any next steps.
12. In the event that there is to be a Review Child Protection Case Conference, in most cases it will be appropriate that the same person should chair the Review conference, but in some situations it may be helpful to have a different chair, particularly if the fairness of the original conference is in question. The Chief Social Work Officer will decide who should chair the Review Child Protection Case Conference and will have due regard to the view of the person who appealed when making this decision.
13. If there has been a change of circumstances identified at the time of the Dispute Resolution meeting, so that there is new or emerging information that indicates the level of risk to the child is changing and either a new initial case conference to consider increased risk or an early review to consider reducing risk is appropriate a case conference will be arranged in accordance with usual child protection procedures.
14. The Chair of Shetland Public Protection Committee (which fulfil all responsibilities of a child protection committee) will convene a three member Appeal Panel from members of SPPC. The Panel will be chaired by the SPPC Chair or their nominee. The Panel members should represent as far as possible the membership of SPPC.
15. The Lead Officer for Adult and Child Protection will act as Clerk to the Appeal Panel unless they have already acted as the Chair at the disputed Child Protection Case Conference in which case another officer of the Council will take the Clerk's role.
16. The appellant shall be invited to the Appeal Panel Hearing and shall be entitled to submit a short written statement in support of his or her appeal in advance of the meeting. The appellant shall be entitled to be heard by the Appeal Panel and may be accompanied by a friend advocate or supporter at the discretion of the Appeal Panel.
17. The Chair of the disputed case conference shall be invited to the Appeal Panel Hearing and shall provide the minutes of the case conference and any Dispute Resolution meeting to the Appeal Panel. The Chair of the disputed case conference shall be entitled to submit a short written statement in explanation of his or her views in advance of the meeting and shall be entitled to be heard by the Appeal Panel.
18. The Chair of the Appeal Panel shall regulate the hearing as he or she thinks fit. The Appeal Panel may deal with the matter in the absence of the appellant or any other person.

19. The Appeal Panel can decide that either:
  - The decision of the disputed Case Conference is not upheld and further action is recommended to one of the partner agencies. The Appeal Panel can recommend that a Child Protection Case Conference is held to reconsider the decision made by the disputed case conference. The Appeal Panel cannot register or de-register a child.
  - The decision of the disputed Case Conference is upheld and no further action is required or recommendations for improvement are made to one of the partner agencies or the SPPC.
20. The Clerk to the Appeal Panel shall arrange for the decision of the Panel and the reasons for that decision to be sent to the appellant in writing within 7 days of the date of the hearing.
21. The Appeal Panel's concludes the inter-agency Child Protection Case Conference Appeal's procedure.

## Appendix 3

### Managing a Disclosure of abuse

#### 1. Listening to a disclosure of abuse

- 1.1 Children and young people will often choose a trusted adult to confide in. It is important to take what the child says seriously and to react calmly, no matter how you may be feeling. A calm reassuring approach will help the child.
- 1.2 Research tells us that children and young people usually tell the truth about experiences of abuse. Children are the victims of abuse never the cause – sometimes they may feel that they are the cause and if a child does feel this or express this, it is important to be clear that they are not to blame.
- 1.3 Always take what a child says seriously and make a child protection referral following the Stepwise Guide in these procedures. Do not delay.

#### 2. Asking Questions

- 2.1 It is not your role to investigate but it still may be appropriate to check out with the child your understanding of what has happened, especially if you are not clear whether what the child is telling you amounts to a cause for concern or not. You can do this by asking open ended questions.
  - **Open ended questions** are questions designed to avoid suggesting the answer to the child or putting the child under pressure. Only one question should be asked at a time, and simple construction should be used, e.g. “Tell me what happened next?” and “How did you get there?”
  - **Specific yet non leading questions** are more focused questions that allow for the extension and clarification of **previously provided information**. Certain facts can be referred to, but be careful to avoid implying the answer. For example, once a child has said “George made me do something” you can ask “What did George make you do?”
  - **Closed and leading questions should NOT be used.** Leading questions are those that suggest the answer and should be avoided at all costs. The danger of leading questions is that people listening to the child’s disclosure can then be accused of coaching them or encouraging them to be untruthful. This could make it more difficult to protect the child and prosecute the alleged abuser at a later date. Closed questions tend to elicit yes/no answers for example, “Was it George that hit you in the tummy?” which would prompt a reply in the way an open question would not.

### **3. After a disclosure**

- 3.1 Once a child has disclosed abuse, it is important to tell the child what will happen next and to whom you need to pass on the information. Take the time you need to reassure and explain – rushing out of the door the moment a child speaks may not be helpful to them.

Bear in mind the following points:

- Do not promise confidentiality and do not make promises that you cannot keep. You may want to say ‘I’ll make sure that never happens again to you’, but you cannot promise that.
- A fuller exploration of the concerns raised by the child should be postponed until social workers and police officers can speak to the child more fully.
- You will need to speak to the designated person in your organisation to pass the concerns on. No-one else should question the child about what they have said. Follow the Stepwise Guide in these procedures.
- As soon as possible make a detailed written note of what the child has said, using the child’s own words i.e. the particular words and phrases that they have used, even if you would not put things that way. It may sometimes be possible to note things down at the time the child says them, but only do this if it can be done in a way that does not distract you from what the child is saying.
- Remember that a child or young person has placed their trust in you, and that puts a responsibility on you to begin the process designed to protect the child.

### **4. Further help**

- 4.1 It is not possible in a set of Procedures such as these to cover every eventuality. Training at various levels and on various topics is available through the Shetland Public Protection Committee, and may be provided by your own organisation. The Lead Officer maintains an extensive library of child protection related guidance and research, and can provide information about training available and the latest national best practice guidance.
- 4.2 The Lead Officer for Adult and Child Protection can be contacted on 01595 74 4435 or via [www.safershetland.com](http://www.safershetland.com) website.

- 4.3 For all queries about specific children, for example where you are not certain if something raises a child protection issue, please speak to the Duty Social Worker as soon as you can.
- 4.4 To make a child protection referral, contact the Duty Children's social work service, following the procedure in [Chapter 6](#). ([The numbers to ring are at the front of these procedures](#)). The police can also be contacted where their immediate assistance is required.
- 4.5 Look after yourself - it can be distressing to hear a first-hand account from a child who has been harmed. Seek support from your line manager and colleagues and remember that in following the child protection procedures and this guidance you will have done your best to support and protect a child.

**SECTION THREE – PROTOCOLS:**

1. [Protocol 1 - Guidance for becoming aware of under age sexual activity](#)
2. [Links between Child Protection Case Conferences and the Scottish Children's Reporter Authority](#)
3. [Individual Procedure for the Exchange of Information between Shetland Islands Council and NHS Shetland Accident & Emergency Department](#)
4. [Protecting Children & Young People affected by adults with problem substance use](#)
5. [Managing Significant Case Reviews](#)
6. [Working with Children and Young People who display sexually harmful behaviour](#)
7. [Shetland Multi Agency Procedure for National and Local Missing Children/Family Alerts](#)
8. [Unseen Child and Working with Non-Engaging Families](#)
9. [Safe Use of the Internet](#)
10. [Supporting Children and Young People who self-harm](#)
11. [Vulnerable Young Persons' Protocol \(16-18 years\)](#)
12. [Child Sexual Exploitation](#)

## Protocol 1

### Guidance for those who become aware of under-age sexual activity

Developed for use with the Shetland Inter-Agency Child Protection Procedures

#### 1. Introduction

- 1.1 Increasing numbers of young people (30% of young men and 26% of young women according to 2010 Scottish Government information) are engaging in a range of sexual activities before the age of 16. The reasons behind this behaviour will vary considerably. In some cases the activity will be wholly consensual, in others it will happen as a response to peer pressure or as a result of child abuse or exploitation. Young people who are sexually active will therefore have differing needs so practitioners must provide a range of responses.

Where practitioners working with young people become aware of situations where under-age sexual activity has taken place they have a duty to consider the impact that this has on that child or young person, and whether this behaviour is indicative of a wider child care or child protection concern. All practitioners have a duty of care to ensure that the young person's health and emotional needs are addressed, and to assess whether the sexual activity is of an abusive or exploitative nature.

#### 2. Circumstances when a Child Protection Referral **MUST** be made

- 2.1 A child protection referral must be made if:-

- The child or the child's partner, has not reached their 13<sup>th</sup> birthday;
- The child or their partner is currently 13 years of age or over, but under the age of 13 when the sexual activity took place;
- If there is any evidence to suggest that the child or young person is involved in child sexual exploitation (please see [Protocol 12](#) for more information), the making and distributing of child abuse images or pornography;
- If the young person is at immediate risk;
- Where the other person is in a position of trust in relation to the young person.

### **3. Legal considerations**

3.1 Within Scotland the law is clear that society does not encourage sexual intercourse in young people under the age of 16. The Sexual Offences (Scotland) Act 2009, is clear that the age of consent for both young men and young women is 16 years.

3.2 The Sexual Offences (Scotland) Act introduced significant changes to the law regarding sexual offences:-

- Defined consent as “free agreement”;
- Introduced new offences;
- Is not gender specific – so, for example, a man can be charged with the rape of another man, and if two young people engage in sexual activity between the ages of 13 and 16 years they both commit an offence regardless of gender;
- Introduced offences designed to offer greater protection to young people sexually harmed by someone who holds a position of trust and those people who, through mental health problems and/or learning disabilities may not have the capacity to give full consent.

### **4. Lesbian, Gay, Bisexual and Transgender (LGBT)**

4.1 Practitioners working with young people must recognise the rights, needs and aspirations of lesbian, gay, bisexual and transgender young people. There is often a perception that a young person’s LGBT identity in and by itself may constitute a child protection concern. This perception is wrong and any concern about underage sexual activity between same sex, bisexual or transgender young people should be assessed in the light of this protocol, whilst recognising the additional vulnerabilities and discrimination that LGBT young people can experience.

### **5. Assessing Situations – Guidance for staff aware of under-age sexual activity**

5.1 This model is based on a reference to trigger factors rather than a checklist or questionnaire. Each of the areas should be addressed. Sufficient information should be obtained and recorded to enable a properly informed judgement to be made. This will also assist should a decision be called into question later

5.2 The following broad areas should be considered and information on each recorded;

- Characteristics of the young person;
- Social factors;
- Characteristics of the partner;
- Consent issues;
- Context of sexual activity.

5.3 These areas may be further broken down as follows. Consideration should be given to each aspect:-

5.3.1 Characteristics of the young person:-

- Age, development and level of maturity;
- Level of emotional development;
- Vulnerability;
- Self-esteem and self-image;
- Loneliness and isolation;
- Intelligence;
- Knowledge and level of understanding – appropriate/inappropriate sexual knowledge;
- Exposed to sexual contact or information that has affected normal sexual development e.g. a young child with knowledge beyond their years;
- Whether in a group more likely to experience discrimination e.g. a young person from a different cultural/religious background;
- Additional support needs.

5.3.2 Social Factors:-

- Parenting;
- Family background;
- Previous contact with social work services, health services;
- Looked after children;
- Homelessness.

5.3.3 Characteristics of Partner:-

- Age difference;
- How they met;
- Does the partner have more knowledge;
- Is there potential for exploitation?;
- Known to agencies/the police.

5.3.4 Context Issues:-

- How was consent given?;
- Does the young person understand he/she has a choice?;
- Was consent expressly sought?;
- Does the young person understand that not saying no is not the same as consenting?;
- Is it genuine expressed and active consent or just passive acceptance?;

- Was it freely given or was the young person co-erced/bribed/even assaulted?;
- Did the young person have control/understand?;
- Was it sufficiently informed consent i.e. with knowledge of possible consequences? (Remember that even with consent it is still illegal to engage in sexual activity with someone under the age of 16)

5.3.5 Context of the sexual activity:-

- Ongoing relationship?
- Alcohol/drugs;
- Risk-taking behaviour;
- Was it a one-off or on-going sexual activity?;
- Influence of social group/peer-group pressure;
- Is consideration given to contraception/sexual health issues?;
- Did it occur within a relationship of trust?

5.4 All cases need to be looked at on their own facts and circumstances. However, the following facts and circumstances may raise concern about the risk the young person may be at:-

- Age or Power imbalances (where the child is under 13 then that fact alone requires a child protection referral to be made) e.g. in a position of authority or trust;
- Overt aggression;
- Coercion/bribery;
- The misuse of substances as a disinhibitor;
- Whether the child's own behaviour, because of the misuse of substances, places him or her at risk so that he or she is unable to make informed choices about a sexual activity;
- Whether any attempts to secure secrecy have been made by the sexual partner, beyond what would be considered usual in a teenage relationship;
- Whether the sexual partner is known by one of the agencies;
- Whether the child denies, minimises or accepts concerns; and
- Whether the methods used are consistent with grooming;
- Whether the facts could amount to sexual exploitation (sex in exchange for something e.g. a lift home or a new mobile phone).
- Trafficking of young people to provide sexual services. This can be trafficked into the United Kingdom, within Scotland and has also happened between different areas of Shetland.

5.5 It should be noted that the Scottish Legal System is unique and has developed in such a way that there are fundamental and significant differences with other jurisdictions. Accordingly, no reliance can be placed

on any experience an individual may have which has been gained from working in another jurisdiction.

- 5.6 Once information has been gathered and considered then it should be possible to decide what is the appropriate response to the young person, and for practitioners to be clear that they are:-
- Not needing to refer out of their own agency but will need to ensure that the young person's sexual health needs are being met;
  - Needing to refer to another agency with the young person's consent as there is some level of concern about their behaviour or vulnerability that would require a GIRFEC type response;
  - The situation is one where the young person is or could be at risk of significant risk harm and a child protection referral needs to be made. It would always be good practice to inform the young person about this decision unless to do so would increase the risk.
- 5.7 All decisions should be recorded, as renewed concern about under age sexual activity may require the situation to be reassessed.
- 5.8 If, having gathered information, staff are unsure about the best course of action then advice and guidance can be sought from the Duty Social Worker. A decision about the need to make a child protection referral can be made through discussion.

## **6. Sexual Health Guidance for Young People**

A confidential sexual health service is essential for the welfare of children and young people. Concern about confidentiality is the biggest deterrent to young people asking for sexual health advice. That in turn presents dangers to young people's own health and to that of the community, particularly other young people.

### **Information**

Under the United Nations Convention on the Rights of the Child, children and young people should be able to access information (Article 17). This means that practitioners should ensure that all children and young people are provided with, and not denied, accurate and age-appropriate information on how to protect their sexual health and well-being and practice healthy sexual behaviour.

## **Medical treatment**

The law allows a young person under the age of 16 to give consent for treatment themselves if a suitably qualified health professional deems they are capable of understanding what is being proposed.

### **7. The Fraser Guidelines**

These arose from a legal judgement where the Law Lord, Lord Fraser, offered a set of criteria which must apply when medical practitioners are offering contraceptive services to under-16s without parental knowledge or consent. They have proved a useful tool and have been adopted by many agencies offering sexual health services as a guideline for best practice. All the requirements listed here should be fulfilled:

- 7.7.1 The young person understands the advice being given;
- 7.7.2 The young person cannot be convinced to involve parents/carers or allow the medical practitioner to do so on their behalf;
- 7.7.3 It is likely that the young person will begin or continue having intercourse with or without treatment/contraception;
- 7.7.4 Unless he or she receives treatment/contraception their physical or mental health (or both) is likely to suffer;
- 7.7.5 The young person's best interests require contraceptive advice, treatment or supplies to be given without parental consent.

Even when these criteria apply, and treatment/contraception is being provided without parental knowledge, consideration should also be given to the above factors in deciding whether a child protection referral should be made.

### **8. Protection for health practitioners providing sexual health services and information**

- 8.1 Practitioners can and should provide sexual health advice, information and services as appropriate for under 16s. Under the Sexual Offences (Scotland) Act 2010 - <http://www.legislation.gov.uk/asp/2009/9>, - a person is *not guilty* of being involved in offences under Part 4 (Children) or 5 (Abuse of a position of trust) if they are working to:-

- Protect another person / child from sexually transmitted infection,
- Protect the physical safety of another person / child
- Prevent another person / child from becoming pregnant

- Promote another person / child's emotional well-being by the giving of advice.

(but not for the purposes of obtaining sexual gratification; humiliating, distressing or alarming another person / child; or causing or encouraging the activity constituting the offence or another person / child's participation in it).

## **9. Respecting confidentiality where there are no child protection concerns**

9.1 If the practitioner has assessed that the sexual behaviour is consensual teenage sexual activity where there are no concerns of abuse or exploitation, the practitioner should:

- Uphold the confidentiality rights of the young person; and
- Provide practical assistance and advice as required.

Practitioners not qualified to provide this should signpost young people to the appropriate local services (e.g. sexual health services).

9.2 If the practitioner has assessed that the sexual behaviour is not abusive or exploitative, but that there remain concerns about the young person's behaviour e.g. their ability to assess risk, their use of drugs/alcohol, the environment in which they seek sexual contacts etc, then the practitioner should:

- Uphold the confidentiality rights of the young person; and
- Provide practical assistance and advice as required within their own agency or, with their permission, refer them to the appropriate clinical or support services, including forensic or sexual health services.

In both these scenarios, a single-agency decision-making process is normally appropriate.

9.3 The General Medical Council has guidance for doctors in terms of disclosing patient's personal information for the purposes of reporting criminal activity. GMC guidance for doctors says that a patients' personal information may be disclosed if it is in the public interest; and this would be if it is likely to protect individuals or society from risks of serious harm, such as serious communicable diseases or *serious crime*, to reduce the risk of death or serious harm to the patient or a third party. Consensual sexual activity between two teenagers is unlikely to be considered as a serious crime in this context.

## **10. Further guidance**

Practitioners should also bear in mind that there may be opportunities to discuss concerns relating to under-age sexual activity on an informal, 'hypothetical' basis - whether for general advice on procedures and processes, or to ascertain whether information they hold should be shared on a wider basis. These types of discussion can help increase knowledge and skills base, and help promote the development of inter-agency relations and understanding. Such discussions may be within the practitioners own organisation; with local child protection advisors or with professional bodies such as the General Medical Council, Royal College of Nursing and medical defence organisations. The duty social worker may also be of assistance.

## Protocol 2

### **Links between Child Protection Case Conferences and the Scottish Children's Reporter Administration (SCRA)**

SCRA employs a Reporter in Shetland to receive and assess referrals in respect of any child who may require compulsory measures of supervision.

The local Shetland Reporter should be invited to every initial and review Child Protection Case Conference as per the Shetland Inter Agency Child Protection Procedures. The decision to attend is at the discretion of the Reporter however it is likely attendance will not be routine but may depend on whether the Reporter has information to contribute to the discussion and the assessment of risk or the Reporter is gathering information to assist in making a decision about the requirement for compulsory measures in respect of a child who has already been referred.

The Executive Manager, Children's Social Work or the Team Leader can specifically request the Reporter to attend a Child Protection Case Conference if, in their opinion, this is required, due to the nature and seriousness of the case.

All initial and review Child Protection Case Conferences should consider the need for compulsory measures, and only in the cases where a referral to the Reporter is decided upon should the minutes and reports available to the conference be sent to the Reporter to accompany a referral. However, reports and minutes can be shared with the Reporter if the child is subsequently referred or the Reporter requests information following a referral. For example, a child may be reported to the Reporter by the police for an offence and the fact that the child's name is on the Register and the child is at risk of significant harm would be very important information to share with the Reporter in response to a request for an initial assessment report.

For ease of reference the Grounds of Referral are below or can be accessed by clicking on the following link Children's Hearing (Scotland) Act 2011  
<http://www.legislation.gov.uk/asp/2011/1/contents>

**Children’s Hearing (Scotland) Act 2011**  
**GROUND FOR REFERRAL**

**Meaning of “section 67 ground”**

**67.**

- (1) In this Act “section 67 ground”, in relation to a child, means any of the grounds mentioned in subsection (2)
- (2) The grounds are that –
  - (a) the child is likely to suffer unnecessarily, or the health or development of the child is likely to be seriously impaired, due to a lack of parental care
  - (b) a schedule 1 offence has been committed in respect of the child
  - (c) the child has, or is likely to have, a close connection with a person who has committed a schedule 1 offence
  - (d) the child is, or is likely to become, a member of the same household as a child in respect of whom a schedule 1 offence has been committed
  - (e) the child is being, or is likely to be, exposed to persons whose conduct is (or has been) such that it is likely that –
    - (i) the child will be abused or harmed, or
    - (ii) the child’s health, safety or development will be seriously adversely affected
  - (f) the child has, or is likely to have, a close connection with a person who has carried out domestic abuse
  - (g) the child has, or is likely to have, a close connection with a person who has committed an offence under Part 1, 4 or 5 of the Sexual Offences (Scotland) Act 2009 (asp9)
  - (h) the child is being provided with accommodation by a local authority under section 25 of the 1995 Act and special measures are needed to support the child
  - (i) a permanence order is in force in respect of the child and special measures are needed to support the child
  - (j) the child has committed an offence
  - (k) the child has misused alcohol
  - (l) the child has misused a drug (whether or not a controlled drug)
  - (m) the child’s conduct has had, or is likely to have, a serious adverse effect on the health, safety or development of the child or another person
  - (n) the child is beyond the control of the relevant person
  - (o) the child has failed without reasonable excuse to attend regularly at school
  - (p) the child –
    - (i) is being, or is likely to be, subject to physical, emotional or other pressure to enter into a marriage or civil partnership, or
    - (ii) is, or is likely to become, a member of the same household as such a child
- (3) For the purposes of paragraphs (c), (f) and (g) of subsection (2), a child is to be taken to have a close connection with a person if –
  - (a) the child is a member of the same household as the person, or
  - (b) the child is not a member of the same household as the person but the child has significant contact with the person.

## Protocol 3

### **Individual Procedure for Exchange of Information Between Shetland Islands Council and NHS Shetland Accident & Emergency Department, Gilbert Bain Hospital**

#### **1. General Introduction**

This is an Individual Procedure supported by the Shetland Islands Council Protocol for Sharing Personal Information (the Protocol). The Protocol forms part of this Individual Procedure. All parties to this Individual Procedure have formally approved the Protocol and agree to adhere to its terms.

#### **2. Purpose**

The purpose of this Individual Procedure is to facilitate the use of Shetland's Child Protection Register (CPR) in the Accident & Emergency Department at the Gilbert Bain Hospital, Lerwick, Shetland (A&E). Evidence shows that patterns of attendance at A&E are one of the known risk factors for children at risk of abuse.

This Individual Procedure augments, but does not override, the Shetland inter-agency Child Protection Procedures. Where any parties to this procedure have an immediate concern about the safety of a child, a child protection referral must be made in line with the Shetland inter-agency Child Protection Procedures.

**The fact of the child or young person's name being on the CPR is a reminder to exercise extra vigilance, and should NEVER be a reason for not making an immediate further child protection referral in accordance with the Shetland inter-agency Child Protection Procedures where the circumstances warrant it.**

This procedure is written to ensure that information about attendance is shared whether or not a Child Protection referral is made.

All parties signed up to this Individual Procedure recognise the importance of sharing information with each other in order to ensure that children are protected, since the welfare of a child is the paramount consideration.

### **3. Information to be Shared**

The Keeper of Shetland's Child Protection Register (the Register) is within Children's Services, Shetland Islands Council (the Council). The Register contains personal details about children assessed as being at risk of abuse.

#### **Information to be Shared by the Council**

The Children and Families administrative support will e-mail designated officers in NHS Shetland to advise that the Child Protection Register has been updated.

The updated list of names is accessed through SWIFT and NHS Shetland update their records accordingly.

#### **Information to be Shared by NHS Shetland**

A&E staff will advise Duty Children's social work that a child on the Register has attended A&E immediately and before the child leaves the Gilbert Bain Hospital.

Additionally, a further Child Protection Referral should be made whenever there is suspicion of a new instance of abuse.

Notification should also include any of the following relevant information:

- (i) Details of any accident involving the child.
- (ii) Whether the child is to be admitted to hospital.
- (iii) Any other concerns held by A&E Staff.

### **4. How and When is the Information Shared?**

#### **Information to be Shared by the Council**

Only designated officers in NHS Shetland have access to the SWIFT system on a read only basis.

The Keeper of the Register will provide the List to the Designated Officer within NHS Shetland. The List will be stored as a file in a particular folder in the Council computer network. The Keeper of the Register will telephone the Designated Officer within NHS Shetland every time that the List is updated. Once notification of update has been received, the Designated Officer will retrieve a copy of the file using the web access procedure set up by Council and NHS IT Departments. The List will be provided to the Designated Officer within NHS Shetland each time the Register is updated or amended.

The web access procedure will be configured such that the file passes directly between the Council network and the NHS network by means of a private fibre-

optic cable linking the two networks. The folder within each site will be maintained by their respective IT departments such that only the Keeper of the Register, the Keeper's delegates, the Designated Officer and the Designated Officer's delegates have access rights.

The Designated Officer within NHS Shetland is the Board's Information Manager or their nominee. Any such nominee will be a permanent member of the Information Department Staff and will have had an enhanced check by Disclosure Scotland, or equivalent check under the Protecting Vulnerable Groups Act 2007 when introduced.

### **Information to be Shared by NHS Shetland**

A&E Staff will advise Duty Children's Social Work immediately and before the child leaves the Gilbert Bain Hospital that a child has attended A&E by telephone using the following numbers:

During Working Hours Monday to Friday (9 am to 5 pm) Tel: (01595) 744421

Out of Hours Duty Social Work Tel: (01595) 695611

The information will be recorded and retained in accordance with section 5.

## **5. Use, Retention & Storage of the Information**

### **Information used, retained and stored by NHS Shetland**

The Designated Officer within NHS Shetland will enter the details from the List into a confidential area of the Gilbert Bain Hospital's Information Technology system (the IT system). This includes flagging the electronic record of the children on the List.

Once this information has been transferred into the IT system, the Designated Officer will print the file to produce a paper copy of the List which will be stored in a locked filing cabinet within a locked office. This most recent version will be kept for back-up purposes in line with these procedures should the IT system fail. Upon receipt of the most recent version, the Designated Officer will destroy the previous version by immediate shredding.

The IT system will display a 'flag' to A&E Staff who input names of those attending A&E that are contained within the Register. A&E Staff will move to a private area before opening the 'flag'. A&E Staff will then have access to the following information, namely that the child's name is on the Register.

Information received from NHS Shetland under this Procedure is stored by the Council on the child's file. The information will be shared with the Core Group of

professionals involved in the Protection Plan and may be shared at a Child Protection Case Conference convened in accordance with the Shetland inter-agency Child Protection Procedures.

A copy of the List will be provided to the NHS Shetland's Nurse Advisor Child and Adult Protection and will be kept securely in line with Board procedures.

## **6. Consent**

Best practice dictates that we should always seek consent from a parent to share or disclose information, but child protection is recognised as an exception where the absence of consent may be overruled in the interests of the child.

Information may be disclosed without seeking consent where this is justifiable on the grounds of child protection.

This procedure explains the circumstances in which information should be shared whether or not consent is sought or given, for child protection purposes, as explained in Section 3.

If the decision is made to share information without consent, this should be recorded in the case notes.

The Keeper does not seek consent from the child or parent/carer/guardian before the information from the Register is shared with NHS Shetland. This information is shared on the basis that it is necessary to ensure the protection of children and to safeguard their welfare.

## **7. Complaints & Breaches**

Initial complaints must be referred to either NHS Shetland or Shetland Islands Council internal complaints review procedures.

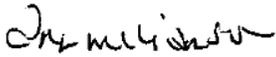
## **8. Review**

This Individual Procedure will be reviewed every five years or more regularly if necessary due to changes in legislation; guidance or good practice. The review will be organised by Shetland Public Protection Committee.

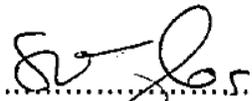
Signed:

  
.....  
(Data Controller, Shetland Islands Council)

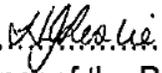
14/06/10  
.....  
(Date)

  
.....  
(Chief Social Work Officer)

8.6.2010  
.....  
(Date)

  
.....  
(Caldicott Guardian, NHS Shetland)

4.06.10  
.....  
(Date)

  
.....  
(The Keeper of the Register)

10.06.2010  
.....  
(Date)

## **Protocol 4**

### **Protecting children and young people affected by adults with problem substance use**

#### **Introduction**

This Protocol is aimed at all professional staff working with children and adults. It is designed to provide basic information about substance misuse and the impact that parental substance misuse has on children and young people. It should also help staff identify those situations that would require a response under child protection processes and when wellbeing concerns can be addressed through GIRFEC and contact with Named Person.

It is divided into 3 sections as outlined below

- Section 1 Introduction and national and local information
- Section 2 information about and definitions of substance misuse and how children and young people can be affected by parental misuse
- Section 3 Information about GIRFEC, guidance for staff working with adults and children
- References

#### **SECTION ONE**

All agencies in Shetland - those working with children and families and those providing services to adults - have a responsibility to care for and protect children and young people as laid out in the National Guidance for Child Protection in Scotland 2014

“This guidance is for all services, agencies, professional bodies and organisations, and for individuals working within an adult and child service context who face, or could face, child protection issues”

An approach that unites services for children and adults to mitigate the effects of parental substance misuse on children is vital as for many years being affected by parental substance misuse has been the most frequently recorded reason for children’s names being placed in the child protection register in Shetland. This has consistently been the case since the system of recording reasons for registration was introduced in 2010. It is difficult to estimate the numbers of children in Shetland who are affected by parental substance misuse; however it has been recognised as a serious issue and is a priority for action in the Shetland Partnership Plan.

<https://www.shetland.gov.uk/communityplanning/documents/180801SPPforWebFINAL.pdf>

Additionally the Scottish Government has provided guidance specifically focussed on the needs of children affected by adult substance misuse, "Getting our Priorities Right" (GOPR) was revised and reissued in 2013 (<http://www.scotland.gov.uk/Publications/2013/04/2305>)

"Adults can recover from problematic alcohol or drug use while being effective parents and carers for children. However, where parental alcohol and/or drug use becomes a problem this can have significant and damaging consequences for any dependent children. This can result in risks to their wellbeing and impair an adult's capacity to parent well. Where children are affected as a result, they are entitled to effective help, support and protection, within their own families wherever possible. Parents too will often need strong support from services to tackle and overcome their problems and help them to promote their child's full potential." (paragraph 2 GOPR p13 2013)

"Getting Our Priorities Right" makes it clear that early intervention through Getting It Right For Every Child (GIRFEC) should be used wherever possible to identify and support children and families with the aim of improving outcomes for children and managing risk so as to reduce the likelihood of child protection measures being required. GIRFEC is based on the wellbeing of children and the importance of every child being safe, healthy, active, nurtured, achieving, respected, responsible and included (SHANARRI). GIRFEC provides the foundation and framework for supporting children who are affected by parental substance misuse and who do not need a response under child protection procedures. Early intervention is about seeking consent to work cooperatively with families. Further information is available in Section 3.

The agencies represented at the Shetland Alcohol and Drug Partnership, Shetland Public Protection Committee and Children and Young Persons Integrated Strategy Group, as the lead partners, recognise that in line with national and local guidance:

- all agencies and practitioners in contact with adults with problem substance use have a responsibility to work together to promote and protect the welfare of children;
- all practitioners are in a position to identify these children and should be knowledgeable about the action they need to take to protect children;
- Staff are expected to attend either level 1, level 2 or level 3 Child Protection Training;
- Staff are expected to be familiar with the GIRFEC policy and procedures and have attended at least the basic half-day awareness training;
- all agencies providing care, support and treatment for adults with problem substance use will ensure that services are properly co-ordinated, supervised and regularly reviewed;
- all agencies will ensure that staff are clear about what is expected of them and monitor regularly the standards of practice based on these guidelines.

The lead partners agree to adhere to the terms of these guidelines as a minimum standard of practice in the wider context of the Shetland inter-agency Child Protection Procedures and Shetland Guidance on Getting it Right for Every Child. Agencies must adhere to the following guiding principle:

**The welfare of the child is paramount and will always override the needs of the parents.**

## **SECTION TWO**

### **Background Information**

#### **2.1 What is problematic substance misuse?**

Problematic substance misuse is defined in different ways, but refers to situations where the physical, psychological, emotional, social and practical aspects of life and work are being interfered with due to the regular use of alcohol, legal or illegal drugs. This affects relationships and the ability to nurture and meet the needs of children.

It is important to understand that it is not the level of substance misuse that is the issue - it is the effect on the child. Parents who may not view themselves as having problematic use may still be having a significant effect on their child's emotional and psychological wellbeing. For example the parent that is placing children at risk by driving under the influence of alcohol or prescribed medication, the child whose parent is "absent" due to using substances and not able to support them at school or their sports club. Adults may or may not recognise that their use of substances is affecting them and those close to them.

#### **2.1.1 Drugs**

The Advisory Council on the Misuse of Drugs (ACMD) defined 'problem drug use' in *Hidden Harm* (2003) as any drug use which has serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them. ACMD further described this drug use as normally heavy, with features of dependence, and typically involves the use of one or more of the following drugs:

- opiates (e.g. heroin and illicit methadone use);
- illicit use of benzodiazepines (e.g. diazepam); and
- stimulants (e.g. crack cocaine and amphetamines).

Problem drug use can also include other drugs, including the misuse of over the counter drugs or prescribed medicines and increasingly counterfeit medicines. Drug use in pregnancy can cause harm to babies.

Recreational drug use also cause harm to the people who are using drugs and to those around them.

### **2.1.2 Alcohol**

Alcohol is by far the most popular substance in Shetland and Scotland. Low risk drinking guidelines for men and women are far lower than most people think. The recommended guideline is that men and women should not regularly drink more than 2-3 units per day. Guidelines also recommend that everyone should have at least 2 alcohol free days per week, and should spread their drinking over at least 3 days, to avoid binge drinking (Chief Medical Officer, 2019). 14 units per week is the recommended maximum alcohol intake for adults.

Three types of problem drinking are defined by the Scottish Intercollegiate Guidelines Network: 'hazardous/risky drinking'; 'harmful drinking'; and 'alcohol dependence'.

- Hazardous/risky drinking refers to any consumption above the low risk level that may cause harm in the future, but does not currently appear to be causing harm.
- Harmful drinking is defined as a pattern of drinking that is currently causing evidence of damage to physical or mental health.
- Alcohol/drug dependence is characterised by a strong desire to take the substance, difficulties in controlling its use, persisting in its use despite harmful consequences and a higher priority given to substance use than to other activities and obligations, increased tolerance to the substance and a physical withdrawal state. Relapse (or reinstatement of problem drinking or drug-taking after a period of abstinence) is also a common feature.

Practitioners should take into account the combined effect of the use of different substances at any one time – and over time – when considering an adult's ability to care for their child and parent effectively. Practitioners should also be aware of adults who are involved in poly substance misuse.

It is important to remember that the level of drug or alcohol misuse may not be significant in health terms for the adult, but still may pose risks to children and young people, for example an adult driving with children in the car whilst over the alcohol limits. Another example would be children placed at risk due to unsafe access to illegal or prescribed drugs in a family home. It is also important to remember that although substance misuse may not be a direct cause of domestic abuse it is often a feature of abusive and controlling situations.

## **2.2 The Impact of parental substance misuse on children of different ages**

(the following is adapted from "Getting our Priorities Right")

### **2.2.1 Pre-conception and pregnancy**

Guidance at these stages tends to highlight lower thresholds of adult problematic alcohol and/or drug use before services should consider interventions to protect children.

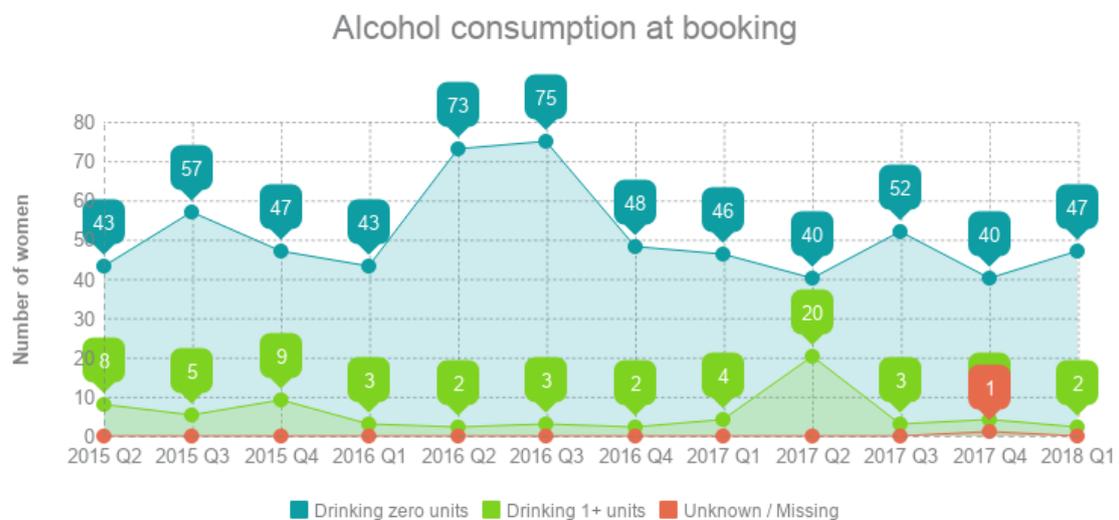
- Pre-conception and pregnancy are the earliest, and most critical, of these stages at which services can put in place effective interventions that will prevent long-term harm to children and families. For example, 'Improving Maternal and Infant Nutrition: A Framework for Action' states that “in addition to advice before pregnancy, during pregnancy women are advised to avoid alcohol completely.” Drug use, at these critical stages, would be considered problematic, for example, where any woman reported regular use (i.e. more than once a week).
- Women and their partners are often incentivised to improve their problematic drug and alcohol use when either trying to conceive or are about to become parents. Maternal alcohol and/or drug use can harm unborn babies in different ways at different times during pregnancy, increasing the risk of complications such as low birth weight, miscarriage, prematurity and stillbirth.
- Some babies are born dependent on alcohol and drugs and can develop withdrawal symptoms – known as Neonatal Abstinence Syndrome (NAS). Neonatal withdrawal symptoms vary in onset, duration and severity. Some babies can be very unwell for days or weeks and can require close observation and special medical and nursing care.
- NAS can also have an impact on attachment, parent-infant interactions, and the infant’s longer-term growth and development.

### **2.2.2 Fetal Alcohol Spectrum Disorder**

The term fetal alcohol spectrum disorder (FASD) describes the range of effects that can occur in a baby whose mother used alcohol during pregnancy. In 2013, prevalence statistics suggested that one in 100 children and young people had FASD – similar to those for autistic spectrum disorders (Carpenter et al 2013) FASD describes a full range of disabilities that may result from prenatal alcohol exposure. There are no specific diagnostic tests, but a triad of clinical manifestations including facial abnormalities, growth retardation and neuro developmental abnormalities along with a history of maternal alcohol use. FASD is completely preventable; it is not hereditary or genetic. Problems associated with FASD do not improve with age, they last a lifetime. There is no known safe level of alcohol consumption during pregnancy. Experts do not know how much alcohol it takes to cause damage to an unborn baby, they do know that alcohol can potentially cause serious damage.

Data from NHS National Services Scotland Discovery

The chart below shows the number of women identified as drinking at booking with maternity in early pregnancy, where the average weekly consumption over the last three months has been one or more unit of alcohol. The figures are taken from the last three complete years available – April 2015 to March 2018. The rates of mothers drinking in pregnancy are on average 3% higher than Scotland over the same period. Analysis by age shows that younger women are more likely to drink while pregnant and by Scottish Indicators of Multiple Deprivation (SIMD) suggests that those aged 20-24 in the most deprived SIMD areas in Shetland are more likely to drink whilst pregnant.



### 2.2.3 Babies and infants

Babies are particularly vulnerable to the effects of physical and emotional neglect or injury. This can have damaging effects on their long-term development. The following examples illustrate possible harms to babies where parental problematic alcohol and/or drug use is a factor.

- Neglect can occur while the parent/carer is under the influence of substances, unaware of what is going on around him/her. Children may have their physical needs neglected; for example, they may be unfed or unwashed.
- Unhappiness, tension and irritability of parents under the influence of substances – coupled with a lack of commitment to parenting when preoccupied with substance use – may lead to poor parenting.
- Poor or inconsistent parenting may damage the attachment process between parent and child.
- Poor childcare, little stimulation or inconsistent and unpredictable parental behaviour may hinder the child’s cognitive and emotional development.
- Lack of contact with other children, when attendance at nursery is irregular or erratic, may compound other problems in social and emotional development. Emotional difficulties should be addressed early to avoid more serious mental health issues from developing.
- Children can become withdrawn and isolated and develop an inability to form relationships.
- The financial demands of problematic alcohol and/or drug use may mean that the child’s material environment is poor.

- They may be subjected to direct physical violence by parents, and learn inappropriate behaviour through witnessing domestic abuse.
- They may be exposed to other substance misusing adults who associate with their parents and this can include adults who are a risk to children - for example who may be seeking to sexually abuse children.

#### **2.2.4 Children of primary school age**

At primary school age, children:

- may be at increased risk of injury, and show symptoms of extreme anxiety and fear of hostility;
- may develop poor self-esteem and blame themselves for their parents' problems;
- may be harmed by parental neglect or disinterest, especially with regards to how well they do at school;
- may feel embarrassment and shame; and
- may take on too much responsibility for themselves, their parents and younger siblings.

#### **2.2.5 Older children**

In addition to the impacts set out above, young people aged 16 – 18 may be at increased risk of the following:

- greater risk of injury by parents as a result of becoming out of their parents control;
- there is an increase of emotional disturbance and conduct disorders, including bullying.
- young people in families – where other family members misuse drugs and/or alcohol may develop early problems with drugs and alcohol themselves.
- young people may end up providing care for parents who are affected by substance misuse and also caring for siblings
- If there are concerns about young people aged 16-18 then please see Protocol 11 below in these Procedures, regarding Vulnerable Young People.

## **2.2.6 Adverse Childhood Experiences**

Internationally there is growing understanding of what harms children and young people in their childhood also goes on to affect their physical and mental health as adults and as parents in their own right. Growing up in a household affected by parental substance misuse is identified as an adverse childhood experience. Breaking the cycle of adversity and intervening early to reduce harm and support resiliencies should be the aim. For more information about ACES in Scotland please see the Scottish Public Health Network report “Polishing the Diamond” [https://www.scotphn.net/wp-content/uploads/2016/06/2016\\_05\\_26-ACE-Report-Final-AF.pdf](https://www.scotphn.net/wp-content/uploads/2016/06/2016_05_26-ACE-Report-Final-AF.pdf)

## **SECTION THREE**

### **Guidance for all staff in assessing situations where children may be affected by adults who misuse substances**

Problem substance misuse by parents does not always automatically indicate that children are at risk of abuse or neglect, but it is highly likely to have negative consequences for a child, who at the very least may experience the “absence” – either actual or emotional – of a parent who is misusing substances. It is also true that parents and children hide problems – sometimes very serious ones, for example, children are often wary of talking about their needs for fear of losing their parents. Parents may also have concerns about their children being taken into care. Generally, where substance use is identified, this should act as a prompt for all services – whether in an adult or child care setting – to consider how this might impact on any dependent child. Children and young people living with adults who have problems with substance misuse often find themselves in the role of carers to their parent and to siblings too. This level of responsibility can affect their schooling, mental wellbeing and health and be far too much for a young person to cope with. Recognising the needs of young carers is important and indicates that the family will require additional support.

Significant case reviews and child protection research indicates that parental substance misuse is linked to high risks for children – especially for very young children. From the 20 Scottish SCRS reviewed between 2012 and 2015 by the Care Inspectorate 11 involved harm to children caused by parental substance misuse. Children can be at risk of serious neglect, physical harm and emotional and psychological harm. The “toxic trio” of substance misuse, domestic abuse and mental health issues has been identified as being particularly concerning for children. Any professional who identifies parental substance misuse linked with domestic abuse and mental health issues should consider that children may be at risk of significant harm and seek advice from the Duty Social Worker. The following web link is to the most recent summary of learning from significant case reviews in Scotland conducted by the Care Inspectorate:

<http://www.careinspectorate.com/images/documents/3352/Learning%20from%20Significant%20Case%20Reviews%20in%20Scotland%202012%20-%202015>

Risk of significant harm is not just linked to individual incidents, but an accumulation of incidents, a history of neglect and emotional abuse, a parent unwilling or unable to change can mean that the threshold of risk of significant harm is reached over a period of time. Good chronologies are essential in being able to record such incidents and concerns and allowing damaging patterns to be recognised.

A comprehensive assessment of the whole situation will allow professionals to draw conclusions about the level of risk, the ability of the adults to accept help and change and the ways in which the needs of the child are being met – or not. The Shetland GIRFEC guidance provides the framework for assessing children and families (<http://www.scotland.gov.uk/Resource/0039/00394308.pdf>). The National Risk assessment toolkit (<http://www.scotland.gov.uk/Publications/2012/11/7143/0>) is also helpful.

### **3.1 GIRFEC, the role of the Named Person, Lead Professional and the Child's Plan.**

Getting it Right for Every Child aims to improve outcomes for all children and young people.

'Getting it right for every child' puts the wellbeing of children and young people at the centre. A common coordinated framework for assessment, planning and action across all agencies is used to address needs. Getting it right for every child recognises that children, young people and their parents / carers have the right to be consulted about decisions that affect them. It promotes a shared approach that:

- Builds solutions with and around children and families
- Enables children to get the help they need when they need it
- Supports a positive shift in culture, systems and practice
- Involves working together to make things better

Getting it right for every child is the foundation for our work with all children and young people, including adult services where parents are involved.

Every child from birth to 18 has a Named Person who has specific role in being a point of contact for parents and children and any professional who may have a concern about a child. They will trigger additional help for a child or their family if required.

The Named Person holds basic information about the child and family and has a basic chronology. If information is shared with the Named Person by parents or any agency or professional that indicates concerns about a child's wellbeing then the Named Person can begin an assessment of the situation. If a child's plan is required, a Lead Professional will be appointed who will coordinate the plan and provide support to the family and the child. Further information is available at the following web link:

[http://www.shetland.gov.uk/children\\_and\\_families/GIRFEC.asp](http://www.shetland.gov.uk/children_and_families/GIRFEC.asp)

## Who is the Named Person?

Age of child or young person	Named Person
Pre birth - 10 days	Midwife
10 days - Primary School entry to P1	Health Visitor
Primary School P1 - P7	Head Teacher or designated other; this is likely to be a Depute Head Teacher or Principal Teacher
Secondary School up to the age of 18	Head Teacher or designated; Depute Head Teacher, Pupil Support or Principal ASN Teacher
Young people aged 16-18 who are not in school	Shetland Island Council Youth Work Services
Young People 16 – 26 who are or who have been Looked After	Through Care and After Care Team

The presenting problems that may trigger a Named Person to begin a GIRFEC assessment and child's plan may not initially be about parental substance misuse and this issue may come to light as a result of work with the family. For example the child who is always late to school and whose appearance is causing some concern for school staff may be living with a parent who, due to alcohol misuse, finds morning routines a problem. A child who is assessed as needing additional support beyond that which the Named Person can provide will have a Lead Professional who will work closely with them and their family and will be responsible for completing an assessment and drawing up a child's plan.

### **3.2 Guidance for staff working with adults**

All staff working in Shetland assessing the needs of adults seeking help with substance misuse problems will identify if the adult has any child care responsibilities. It is good practice for staff and agencies working with adults to have clear policy and procedures in relation to the children of adults using their services which can be honestly and openly explained to service users.

Adults may have sole or shared responsibility for their own children or live with their partner's children. They may have contact with their own or other family member's children or may be seeking to re-establish contact with their own children. They may be planning to have family or could be at risk of becoming pregnant in an unplanned way. Helping the adult to understand the effect that their substance misuse has had on their children and what the adult can do to change or improve the situation for the child are important in helping adults to make some different and safer choices.

Staff working with adults should have a good basic understanding of GIRFEC and the role of Named Person and Lead Professional and discuss this with the adult – do they know who the Named Person is for their child? Is there already a Lead Professional and child's plan in place to support their child and have they been a part of that process? Some parents with parental responsibility may have been excluded from the process if there are issues of substance misuse and family breakdown. Where parents/carers are accessing substance misuse and

recovery services and staff providing support to them assess there are wellbeing concerns about their children they can, with the consent of the parent/carer, contact the child's Named Person to share those concerns. Seeking advice from line managers would be appropriate if an adult refuses consent and the staff member feels unable to share information about the wellbeing concerns for the child.

If staff providing support to adults with substance misuse issues have concerns that children for whom the adult is responsible are at risk of significant harm then they should make a child protection referral following these procedures. Consent is not required to make a referral see 3.4 below.

It is also worth remembering that children can be referred to the Reporter to the Children's Hearing and such referrals do not need to meet the threshold of at risk of significant harm. Anyone can refer to the Reporter and there is no need to seek consent to make such a referral.

Living with a parent who has a substance misuse problem is recognised as an adverse childhood experience likely to pose psychological and emotional consequences for a child of any age. This guidance would encourage staff working with adults to factor this into their work with substance misusing parents.

### **3.3 Guidance for Staff working in Children's Services**

Staff working in universal services for children may identify a concern about a child. Using the GIRFEC guidance this information should be shared with the Named Person (see above and web link to GIRFEC [http://www.shetland.gov.uk/children\\_and\\_families/GIRFEC.asp](http://www.shetland.gov.uk/children_and_families/GIRFEC.asp)).

Any information that a child is being affected by parents who misuse substances should be taken seriously and acted on - either as a wellbeing concern by sharing information with the Named Person or if there is a risk of significant harm by making a child protection referral.

### **3.4 Child Protection Referrals**

A child protection referral should always be made if assessments of both a child and family situation or of an adult seeking help for a substance misuse problem indicates that there is a risk of significant harm to a child. Parental substance misuse linked to domestic abuse and parental mental ill health would be a particular source of concern for the child.

Significant harm is defined by the National Guidance for Child Protection in Scotland as follows:

"Harm means the ill treatment or the impairment of the health or development of the child, including, for example, impairment suffered as a result of seeing or hearing the ill treatment of another. In this context "development" can mean physical, intellectual, emotional, social or behavioural development and "health" can mean physical or mental health" (paragraph 42, page 13 of the [National Child Protection Guidance 2014 for Scotland](#))

Additionally children who live in families where there is parental substance misuse can become targets for sexual abuse and exploitation. For example some adults will allow their homes to be used for drug or alcohol misuse by other people and this can expose resident children to high risks. Some sexual abusers will target families where children are being neglected or not supervised properly.

### **3.5 Confidentiality, Consent and Data Sharing**

When using this protocol staff may assess that a child is at risk of significant harm and a child protection referral needs to be made using the Stepwise Guide in these procedures. Significant harm can result from a serious incident or an accumulation of incidents or neglect or emotional harm over a period of time. Consent from a parent is not required to make a child protection referral. Consent is not required for agencies to share relevant and proportionate information when making a child protection referral or taking part in other child protection processes (sharing information at a Child Protection Case Conference for e.g)

If it is assessed that the child is not at risk of significant harm, but there remains wellbeing concerns and a need for further assessment and possible future support then this can be offered through the Named Person and GIRFEC. Agreement to participate in the process of assessing children under GIRFEC and creating a Child's Plan should be sought from parents and carers. Agreement to participate should be informed and everyone should understand fully what the process will involve. Further information about Named People and GIRFEC is available from [https://www.shetland.gov.uk/children\\_and\\_families/GIRFEC.asp](https://www.shetland.gov.uk/children_and_families/GIRFEC.asp)

### **3.6 Indicators of high risks to children and protective factors**

#### **Risk factors**

There are a number of issues that can indicate a higher risk of harm and although no checklist can be completely definitive or exhaustive they are worth bearing in mind.

- The age of the child - high risk for new babies and small children
- Children with additional support needs/disabilities
- The nature of the drug /alcohol use – chaotic, poly-drug and alcohol use, injecting equipment, unsafe storage
- The adult is the sole carer
- Both parents are using to excess
- Money is being diverted from bills and food to fund substances
- Physical conditions in the home are dangerous and unhygienic
- Other substance misusing adults have access to the child's home
- Adults are not truthful about their drug use (most people who misuse substances will initially be in denial and will minimise – but experienced drug and alcohol workers can assess this and when it becomes more of an issue)
- A Non engaging family that does not accept that there is any problem
- Children displaying self-harm, serious developmental delay or untreated health problems

- Disruption to schooling
- Older children taking high levels of caring responsibilities for parents and siblings
- Assessments indicate that parental substance misuse is linked with domestic abuse and parental mental health problems

### **Preventative and protective factors**

Some of the impacts on children and families described above can be counterbalanced by other factors. Children and young people need support in dealing with what are often confused feelings and emotions towards their parents and families. They need strategies to help them cope with the various consequences of their parent's problematic alcohol and/or drug use.

Resilience has been viewed as “normal development under difficult conditions”. Focusing on the positives and the strengths in a child's life is likely to help improve outcomes by building the protective network around the child and the self-protective potentials within the child. At the same time, it is important to be alert to factors of adversity or vulnerability, which may potentially impact upon the child's wellbeing and the interaction of these factors with any identified resilience and protective aspects. The second core component of the National Risk Framework to Support the Assessment of Children and Young People (<http://www.gov.scot/Publications/2012/11/7143/0>) builds upon the Resilience/Vulnerability Matrix within the GIRFEC Practice Model. A set of Matrix Related Indicators have been developed here to support practitioners explore the key concepts of adversity/protective factors and vulnerability/resilience. All staff whether working with adults or children have a duty to respect confidentiality, share relevant, proportionate and appropriate information where necessary. Recording information and storing it securely in accordance with their agencies policy is also important.

### References

Carpenter B Blackburn C and Egerton 2013 J Fetal Alcohol Spectrum Disorders: Interdisciplinary perspectives Routledge Oxon.

“Getting our Priorities Right” Scottish Government 2013  
<http://www.scotland.gov.uk/Publications/2013/04/2305>)

Audit and Analysis of Significant Case Reviews Scottish Government 2012-2015

<http://www.careinspectorate.com/images/documents/3352/Learning%20from%20Significant%20Case%20Reviews%20in%20Scotland%202012%20-%202015.pdf>

Fetal Alcohol Spectrum Disorder Awareness Toolkit Scottish Government 2013

<http://www.scotland.gov.uk/Resource/0043/00435992.pdf>

## Protocol 5

### Managing Initial Case Reviews and Significant Case Reviews

#### 1. Introduction- Criteria for ICR/SCR

##### 1. Introduction

1.1 In 2015, the Scottish Government published a guide for Child Protection Committees for conducting Significant Case Reviews (SCR) <http://www.gov.scot/Resource/0047/00474570.pdf>

1.2 When a child dies or is significantly harmed (please see criteria below) Shetland Public Protection Committee - which fulfils all the functions of a Child Protection Committee - may decide to conduct an Initial Case review to gather information and any concerns. From the Initial Case Review, a decision will be made by SPPC about the need to conduct a full Significant Case Review. SPPC will also draw up a remit for this in depth piece of work, and either, appoint a local inter-agency professional team, or an independent person to conduct the SCR. The aim of an SCR is to identify learning and improve practice.

1.3 The Chair of SPPC or the Lead Officer can be contacted by any senior manager in any agency or organisation in Shetland with a request that an ICR be conducted to consider the requirement for an SCR in respect of a specific case. This request should be made in writing giving clear reasons for the request. The Chair will respond **within 14 days** and further discussion will then follow.

1.4 Initial Case Reviews and SCR's will be conducted in accordance with Scottish Government Guidance.

#### 2 **Criteria for SCR**

##### 2.1 **Criteria**

***When a child dies and*** the incident or accumulation of incidents (a case) gives rise to significant/serious concerns about professional and/or service involvement or lack of involvement, and ***one or more of the following apply:***

- Abuse or neglect is known or suspected to be a factor in the child's death;
- The child is on, or has been on, the Child Protection Register (CPR) or a sibling is or was on the CPR. This is regardless of whether or not abuse or neglect is known or suspected to be a factor in the child's death unless it is absolutely clear to the Child Protection Committee that the child having been on the CPR has no bearing on the case;

- The death is by suicide or accidental death;
- The death is by alleged murder, culpable homicide, reckless conduct, or act of violence;
- At the time of their death the child was looked after by, or was receiving aftercare or continuing care from, the local authority

## 2.2 Criteria

***When a child has not died but*** has sustained **significant** harm or risk of significant harm as defined in the [National Child Protection Guidance 2014 for Scotland](#), **and** in addition to this, the incident or accumulation of incidents (a case) gives rise to serious concerns about professional and/or service involvement or lack of involvement, and the relevant Child Protection Committee determines that there may be learning to be gained through conducting a Significant Case Review.

- 2.3 Any senior manager from any agency can request that a case, which they assess as meeting the above criteria, be the subject of an Initial Case Review. The purpose of an Initial Case Review is to gather information to inform a decision about the requirement for a Significant Case Review (or another type of practice learning review).
- 2.4 The process of ICR/SCR/Learning review is to learn from experience and to improve the practice of agencies in supporting families and protecting children.

## 3. Notification and Conducting Initial Case Review (ICR)

- 3.1 Any Senior Manager who wishes to request an ICR should complete the ICR form in the National Guidance and send that to the Lead Officer with information about the case and the reason why the manager thinks that it meets the criteria outlined above and what maybe the benefit of conducting an ICR. The Lead Officer will inform the Chair of SPPC and respond to the request within 14 working days. The Lead Officer should also notify the chair of the Chief Officer's Group that such a request has been made within 14 working days.
- 3.2 The SPPC Chair, assisted by the Lead Officer, will convene a Case Review Subcommittee. This should include the Vice Chair of SPPC and reflect the membership of SPPC by having representatives from Police Scotland, Shetland Islands Council Social Work, SIC Schools, NHS Shetland and the third sector. The remit of the case review subcommittee is;
- 3.2.1 To come together solely for the purpose of conducting an ICR/SCR following national guidance
- 3.2.2 To recommend to SPPC (and to inform SPPC's recommendations to Chief Officers Group) if the ICR should proceed to an SCR or a practice learning review or other form of learning from experience.

- 3.2.3 If the subcommittee recommends proceeding to an SCR or practice learning review then they should give clear reasons for this decision, some initial thoughts about a remit for the review (by identifying key questions that an SCR or practice learning review needs to address) and give some thought to the way in which further work could be carried out. This may include the subcommittee themselves undertaking the work or creating a short life interagency working group to carry out the detailed work or considering the need for an external independent reviewer.
- 3.2.4 The Lead Officer has the responsibility of supporting the Case Review Subcommittee and the SPPC Chair will chair it.
- 3.2.5 To consider the methodology that an SCR should use. Scottish Government identify a number of appropriate methodologies - the SCIE Learning Together approach, Critical Path Analysis or the proportionate approach to Serious Case Reviews taken by the Welsh Government.

It should be noted that there is a Senior Interagency Operational Group that meets regularly and the SPPC Chair may wish to co-opt that group to be the SPPC Case Review Sub-Committee This decision is at the discretion of the Chair and the members of the Senior Interagency Operational Group.

- 3.3 Prior to the case review subcommittee meeting the Lead Officer will request information on the case from all agencies using the ICR format in the National Guidance. The Lead Officer will also prepare an interagency chronology for the case review sub- committee.
- 3.4 There may be occasions when the conducting of an ICR is sufficient in itself to identify and share learning and no SCR or practice learning review is required. In this situation the Case Review Subcommittee will identify for SPPC the key learning points.

#### **4. Decision by SPPC**

- 4.1 The Case Review Subcommittee will conduct the ICR on behalf of SPPC and a report outlining the case, any concerns identified and the recommendations as to the next steps will be made to SPPC.
- 4.2 SPPC's role is to discuss the ICR conducted by the Case Review Group and decide if the recommendation made by the Case Review Subcommittee is appropriate and well founded.
- 4.3 SPPC will either support or change the recommendations made by the Case Review Subcommittee. SPPC should also comment on any draft remit for an SCR or practice learning review. SPPC should also assist

with planning how an SCR or practice learning review can be carried through.

- 4.4 SPPC will in turn recommend to Chief Officers the way forward for the case that has been the subject of the ICR
- 4.5 The Lead Officer has the responsibility for notifying the Care Inspectorate of the outcome of the ICR and submitting information about the ICR or any subsequent SCR.

## **5. Decision by the Chief Officers Group**

- 5.1 Chief Officers Group will make the final decision about the requirement for an SCR or practice learning review and will comment on the remit. Chief Officers will set timescales for an SCR or practice learning review.
- 5.2 Chief Officers retain the responsibility for overseeing the ICR/SCR or practice learning review process. Chief Officers may need to identify funding if it is decided that an independent external reviewer is required.

## **6. Conducting and Reporting an SCR or Practice Learning Review and follow up.**

- 6.1 SCRs or practice learning review may be conducted by an internal team, or an internal team lead by a suitably qualified and experienced external reviewer or by a single reviewer internal or external depending on the nature or complexity of the case. The Lead Officer will have a role in supporting the work and providing clerical help to the SCR or practice learning process.
- 6.2 When an SCR or practice learning review is conducted all agencies should make available information and case records as requested by the Lead Officer for the purposes of the SCR or practice learning review. Information requested will be relevant and proportionate, kept securely and used only for the SCR or practice learning review. Once the SCR report has been finalised any information received will either be returned or destroyed.
- 6.3 Consideration needs to be given as to how to inform and involve the child, young person or family who are the subjects of the review. National Guidance should be followed in this respect and appropriate members of the review team should be given the responsibility of seeking the views of the child, young person and family and feeding back to them any outcomes.
- 6.4 For staff working with the case that is the subject of an SCR or practice learning review there can be anxieties about what will happen and the impact on them and their practice. An open, honest, learning “no

blame” approach that seeks to understand the circumstances in place at the time and avoids hindsight bias as much as possible should be adopted by the individual or the group carrying out the SCR or practice learning review. Staff will require support and guidance from first line managers.

- 6.5 It will be appropriate for the SCR or practice learning review to include interviews with key staff using an agreed and consistent approach and questions. Interviews with staff should be proportionate - so it is likely that an SCR will need to involve more comprehensive interviews and numbers of staff than a practice learning review.
- 6.6 Once the SCR or practice learning review has completed it should be presented to SPPC and Chief Officers.
- 6.7 Depending on how the report is structured there will be recommendations and learning points to be cascaded. Whilst Individual agencies will have the responsibility of cascading learning and to implement any recommendation, SPPC and the Chair should retain the oversight of this process and be satisfied that learning has been put into practice. Chief Officers will also need to be satisfied that this process is robust and effective in the longer term.

## Protocol 6

# Working with Children and Young People who display sexually harmful behaviour

### 1. Introduction

This document sets out Shetland's inter-agency policy and procedures for working with children and young people whose problematic sexual behaviour poses a risk to themselves and others. The focus is on managing the risk, reducing the potential for harm and meeting the needs of the young person displaying the behaviour. This protocol sits as an appendix to Shetland inter-agency Child Protection Procedures.

This Protocol is divided into three sections;

- **Section 1:** Statement of principle and the broader GIRFEC framework
- **Section 2:** Recognising behaviour that could be sexually harmful - the traffic light tool, children who harm siblings, the impact of social media.
- **Section 3:** Responses to behaviour – responding to “red, amber and green”. Child Protection processes and specialist interaction for young people who sexually harm others.
- Appendix 1 - Management of risk in schools.
- Appendix 2 - Brook Traffic Light Tool
- Appendix 3 - Sexual behaviour reporting format and resource list - useful websites for reference

### Section 1:

#### 1.1 Statement of principles

- The responsibility for managing the risk to children and young people has to be held within a multi-agency perspective. In most cases Childrens Social Work Services will take the lead in working with children who display sexually harmful behaviour.
- That the motivation for children and young people who display sexually harmful behaviour to others – whether or not that leads to any criminal charges – is often significantly different to adult sex offenders; Interventions that are focused appropriately are likely to succeed in preventing further abuse. Earlier studies show recidivism rates at between 3 – 14% (Prentky, et al. 2000). Another study showed a 5% recidivism following treatment within a six-year follow up period. (Worling, 2001). These figures are low and important to consider, as there can

be a tendency for professionals to over emphasise risk of recidivism concerning children with sexually harmful behaviours.

- Supporting and involving parents and carers in work with children and young people is vital to the success of any intervention designed to address sexually harmful behaviours and manage risk on a day to day basis
- Research shows that appropriate work with young people addressing their behaviour and their own needs can lead to a positive outcome and lessen the risk of future offending;
- In assessing risk not only are static factors important it must be recognised that other factors are dynamic and may change quickly. Risk needs to be reassessed and reviewed.
- The environment that a young person is growing up in has a huge influence on them and may make risks more or less manageable;
- Viewing risks in terms of its manageability is often a tangible means for responding to it;
- All inter-agency work with children and young people who display sexually harmful behaviour towards others will be dealt with in accordance with the overarching policy set out in the Shetland inter-agency Child Protection Procedures.

## **1.2 GIRFEC**

Getting It Right for Every Child provides the framework for assessing any child who requires additional support and whose family may need assistance from universal and specialist services in order that children can be safe, healthy, active nurtured, achieving, respected, responsible and included.

For children and young people who display sexually harmful behaviour there is a responsibility to assess both risk and need and to ensure the right specialist services are available to that child.

The GIRFEC (Getting it right for every child) approach requires practitioners to view their work in the context of the whole child when assessing and managing risk, viewing risks in the short term but equally considering the impact of those risks on children's wellbeing in the long term. The National Practice Model and National Risk Framework (NRF) (2012) provide guidance and tools to support holistic assessment.

Within both the NRF and the National Practice Model the need, at times, for more focused assessment is recognised. This Protocol recommends using sexual behaviour specific assessment tools as an additional and integral part of a child's broader assessment and single plan, for example AIM2 or MARR. Social work staff in Shetland are trained to use Aim 2 and would provide specialist support for some children who display sexually harmful behaviours to self or others. (AIM 2 Will be updated to Aim 3 in 2019)

The Whole Systems Approach in Youth Justice in Scotland involves putting in place a streamlined and consistent planning, assessment and decision making process for young people involved in offending to ensure they receive the right help at the right time. This approach works across all systems and agencies.

FRAME: The Framework for Risk Assessment, Management and Evaluation for Children and Young People under the age of 18 (2014) is part of that approach. FRAME highlights the need for local care and risk management processes to be in place for those children presenting a risk of serious harm.

FRAME highlights “Undertaking different depths of assessment in response to different levels of risk presented by individuals is vitally important”. It describes risk management processes being transparent, proportionate, rights-based, risks, and needs being considered holistically. This Risk Management Protocol reflects the principles advised by FRAME and ensures the integration of assessment and intervention with risk management. It offers a clear structure that captures the complex processes described above. In addition, the protocol also recognises the need for younger children with different types of sexual behaviour to also have Risk Management processes around them. In Shetland the Care and Risk Management (CARM) process led by Children and Families Social work has been introduced to provide a clear plan when a child or young person has been identified as presenting a risk of serious harm to themselves or others.

## **Section 2:**

### **2.1 Recognising harmful behaviour**

Children and young people develop sexually throughout childhood. Children and young people may display sexual behaviours that are connected with normal development and exploratory behaviour and as such do not need a response under this protocol. Being able to respond in a proportionate and appropriate way to support normal sexual development and being able to recognise when sexual behaviours may be more harmful or inappropriate is important. Children and young People may require some guidance about what is socially acceptable even if the behaviour is not concerning. The Brook’s “Traffic Light Tool” is a good way of assisting staff in identifying what behaviour may require a more significant response. This is reproduced at appendix 2 and the following web link gives more detailed information.

<https://www.brook.org.uk/our-work/the-sexual-behaviours-traffic-light-tool>

### **2.2 Children who sexually harm a sibling**

A child or young person causing sexual harm to a sibling is a distressing and difficult situation for all involved. Information that a sibling has been sexually harmed - perhaps from a disclosure made by the sibling - should be treated seriously and be subject to an immediate Child Protection referral to Duty Children’s Social Work. Child Protection processes will be followed to investigate the concern and then a series of decisions will need to be taken about the best way to protect the sibling who has been harmed, to understand the family context within which this has occurred and the future issues and to assess and assist the child who has caused the harm. Children’s Social Work will provide the Lead Professional in such situations.

**Potential outcomes where a young person is alleged to have sexually abused a sibling:**

1. Supervision - family remains intact with supervision and supportive strategies in place
2. Living apart – where children live apart but continue to have contact. It may be possible to reunify child and family when risk has reduced.
3. Separation of the children – complete separation with no contact. It may be safe to resume contact when risks have reduced.
4. The Child or Young Person may be reported to the Reporter or the PF for sexual offences and legal processes will also need to be factored into planning for the child and family.

Both children should be identified as children at risk and in need of support

**Guidelines to assist decision making:**

- Decisions about placement, contact and intervention should weigh up the needs and interests of all the family
- Family evaluation and victim assessment should occur as quickly as possible to inform decision making
- If reunification/restoration is not safe services should be explicit as to why this is the outcome
- If children are removed, services/supports should be put in place to address the issues impacting on the child not being able to stay at home
- Intervention should promote accountability, responsibility and healing in sibling relationships where it is appropriate and safe to do so
- Wherever possible and when it is safe to do so the full participation of parents in assessment and intervention is essential
- Completion of treatment should not be a requirement for children to stay together or to have contact however the welfare of the child is the paramount consideration and assessing and managing risk is key
- The child or young person's views should be taken into account in decisions that affect their lives

**Examples of strengths within home environment**

- Parents expressing feelings about behaviours and managing those
- Parents expressing concerns for both children
- Family functions in positive caring manner
- Good parent child expectations and boundaries
- Responding positively to safety plans
- Good communication between parents and children

**Examples of concerns:**

- High levels of family chaos/dysfunction
- Family stress
- Parental denial of behaviour
- Parental unwillingness to participate in work
- Parental substance misuse

- Parental mental health
- Lack of boundaries/unclear roles

### **Examples of victim impact concerns**

#### **Strengths:**

- Victim able to talk about thoughts and feelings re behaviours
- Victim not feeling responsible or scared of sibling
- Parents responsive and open to working with professionals
- Minimal impact on victim
- Child responsible not showing hostility or aggression towards victim

#### **Concerns**

- Victim blaming self
- Parents unable to communicate that behaviours happened
- More significant impact on victim
- Sexualised relationship between children and difficulties in stopping this

### **2.3 The impact of social media**

The development of the internet and social media has brought with it different types of behaviour problems. Children and young people have to “navigate challenges emerging from fast-paced technological change: digital reputation, pornography, sexting and an unprecedented exposure to images and media” (Parker 2014)

Children and young people may cause harm to others or themselves by

- Creating and sharing sexual images either of themselves or of other children.
- Sexting sexually explicit text messages

Sharing sexual images or texting should be responded to as a child protection issue and child protection referrals made as soon as possible. Some behaviours seen on social media are likely to be associated with developing sexuality in teenagers and risk taking, as well as conforming to peer pressure and what may be seen as a social norm. There may be occasions where it is linked to more worrying abusive behaviour. Repeat instances of creating and sharing naked image or sexting or one child putting pressure on another to create naked images would all be more serious causes for concern.

### **Section 3:**

#### **3 Responding to behaviour that poses a sexual risk to others**

3.1 Any agency which is working with or providing services to children and young people (third sector agencies, schools, sports and youth club settings) may become aware of inappropriate sexual behaviour.

- 3.2 Children’s Social Work has the lead responsibility for the implementation of this protocol. The effectiveness of the protocol will however depend on the ability of all agencies coming together to share the responsibility for the management of risk and the meeting of individual needs of all the children and young people concerned.
- 3.3 This protocol offers an inter-agency framework to manage the risks associated with sexually harmful behaviour more effectively and to meet the needs of young people displaying sexually harmful behaviour. An inter-agency team will come together to assess and monitor risk and meet needs.
- 3.4 The Child Protection processes will be followed as laid out in the Stepwise Guide to investigate information that suggests a child or young person has sexually harmed another child or young person. ([Stepwise section](#))
- 3.5 Police Scotland have the responsibility for interviewing any young person against whom allegations of sexual abuse have been made in accordance with the Criminal Justice Act (Scotland) 2016 Interviews should be conducted sensitively, bearing in mind the young person may be a victim as well as someone who has caused harm. Young people under 16 should have access to legal advice and the presence of a supportive adult or parent. Young people over the age of 16 who have identified learning disabilities or mental health problems require a trained Appropriate Adult and legal representation and cannot waive their right to this support.

The outcome of any enquiries the police have carried out in connection with the young person responsible for the harm to others will be reported in the usual way to the Reporter and the Procurator Fiscal.

- 3.6 In addition to completing a Child Protection referral the more detailed “sexual behaviours” form attached at appendix 2 gives very detailed information that will assist in assessing risk and should be used by those making a referral.
- 3.7 Following the conclusion of a Child Protection investigation a debrief Interagency Referral Discussion will be held. This needs to focus on both the child who was the victim of the sexually harmful behaviour and the child who caused the harm. Particular care will be required when children are siblings or living in the same household. The following outcomes will follow from the debrief Inter Agency Referral Discussion (as outlined in the Stepwise Guide section of these procedures)
- No evidence of harm and no or limited follow up is required - possibly the behaviour has been assessed as falling within the “green” light.
  - Wellbeing concerns about the victim of the sexual harm and / or the child who caused the harm. This may require further assessment by the Named Person or by an allocated social worker and the development of a child plan - this may be a useful approach behaviour is assessed as being an “amber” light.

- There is a risk of significant harm to the victim and an Initial Child Protection Case Conference is required. This may be in situations where the children are member of the same household and when behaviour is assessed as being “amber or “red” light.
- There needs to be detailed risk assessment using an appropriate assessment and treatment framework (aim 2, MARR) of the child who displayed sexually harmful behaviour. An interagency risk management team should also be in place with a social worker acting as lead professional.
- There may be circumstances when the child or young person causing the harm is at risk themselves for e.g. if they have experienced sexual abuse and have re-played their experiences with another child. Consideration of the need to hold an Initial Child Protection Case Conference will be required

3.8 Clear risk management policies and specific work with young people who sexually harm others will be held by children and families social work who will establish and lead a multiagency team. All agencies will be expected to be part of the team around the child that is focused on reducing risk, meeting needs and supporting the child or young person not to behave in sexually harmful ways to others in future.

## **Appendix 1 - Management of Risk in Schools**

The following provides additional and more specific guidance for managing risk within schools. It has been adapted from Carol Carson and the Aim Project, 2002.

The majority of children and young people who display sexually harmful behaviours can be educated and managed within a school. The management of their behaviours in school needs to be considered on a whole school basis as well as on an individual level with the child or young person. However, the overall management of risk needs to be from a multi agency perspective with family involvement as appropriate.

The responsibility for developing a risk management plan lies with the Child Protection Case Conference/core group or risk management team as a whole, with appropriate input from the school (normally through the Head Teacher).

Within the school setting the Head Teacher has the prime responsibility for ensuring implementation of the relevant parts of the risk management plan, with appropriate support from other agencies. If at any time concerns about the child or young person escalate, the school can contact the key worker or Lead Professional and request an early review meeting.

### **Whole school basis**

To assist in the effective management of risk the following should be considered on a whole school basis:

- The culture and ethos of the school should reinforce positive behaviours and respect for others and create an environment that encourages children to tell if someone is doing anything to them that makes them feel uncomfortable.
- Consider the inclusion of problem sexual behaviours into other appropriate school policies and personal safety programmes. This aspect of behaviour would not then be seen as something separate from the overall work of the school.
- Training for staff increasing their understanding in: the development of problem sexual behaviours; different types of behaviours; risk; risk management and needs of children and young people with these behaviours.
- Contact points for advice and support for staff. This may be from a named person in the Children's Social Work Team, School Designated Person for Child Protection and/or the Head Teacher.
- Ensuring a clear knowledge of procedures.
- The regular reviewing of the physical structure of the school to identify areas where sexual behaviours may occur and strategies put in place to make them safer. Often it is the same areas where children bully other children.
- The identification of children and young people with sexually inappropriate or harmful behaviours to key personnel within the establishment. This will often include ancillary staff.

## **Individual Level: Managing Risk and Meeting Needs**

Effective management of risk cannot be separated from identifying and meeting the individual child's needs particularly in relation to skills deficits. The education setting has a crucial role to play in promoting the development of skills to improve these deficits and thus can greatly assist in making risk more manageable.

### **Managing Risk**

Every young person's behaviour and risk needs to be considered separately and informed by a risk assessment. However it is possible to identify some general strategies that can be used for managing risk:

- Discussing the behaviours in a meaningful way with the child
- Articulating clearly the behaviours that are not acceptable
- Being clear about the times and places where behaviours have happened and targeting resources in an attempt to reduce risk
- Employing behaviour management strategies that include boundaries and consequences
- Child-focused observation and analysis to inform ongoing assessment of risk
- Supervision and monitoring. Agree with the child the areas that he or she is allowed to go, for example, at break and lunch times. This may need to start with close supervision
- Using of positive behaviour strategies
- To work closely with other agencies to ensure that information is shared appropriately
- Recording appropriately.

### **Meeting Needs**

Specific strategies that schools can use to meet needs are as follows:

- The development of individual programmes, for example, on problem solving, communication, social skills and sex education. Most children and young people with sexually harmful behaviours have significant deficits in these areas. A young person's level of skills and insights into these areas can offer part of an overall risk prediction.
- The development of safe boundaries. Many young people with sexually harmful behaviours need adults to take control of managing their risk until they are able to do so themselves. The setting of clear and safe boundaries can be both supportive and helpful for them.
- Dedicating the time and attention of a significant adult in the school. This could be a class teacher or someone from pupil support.
- Identifying specific activities to help children develop new skills.
- Giving assistance to help them integrate with other pupils and form healthy relationships.

## **Protection of children targeted**

Specific arrangements need to be made to ensure that any children who have been targeted feel safe. This should be done in conjunction with their families. Their views on how to feel safe should be sought and considered. The needs of the child should be assessed and individual work and support offered to the child as appropriate.

## **Education Management Decisions**

In a school setting there is always the need to balance meeting the needs of an individual pupil with the responsibilities owed to all pupils.

There may be circumstances where excluding from school a child who has displayed sexually harmful behaviour needs to be considered. This decision should be taken as part of a multi-disciplinary discussion which takes place either as part of a child protection process or in cases that meet the criteria for Care and Risk Management through that process. Although Schools Service ultimately has the power to exclude a pupil, making this decision in isolation is not appropriate.

Where a child or young person has transferred from another school or authority with a previous history of sexually harmful behaviour the educational establishment must contact social work to discuss whether multi-agency involvement is required.

In considering the need for exclusion or transfer to another educational establishment it is important to take account of the following:

- Whether the sexual problematic behaviours occurred in the school setting
- Where the behaviours did not occur in the school setting, but the victim attends the same school
- The views of the victim and his or her family
- The known risks of further occurrences happening in the school
- Whether complaints have been made previously against this child by parents of other children
- The school's ability to provide adequate supervision and support to manage risk while enabling the child to continue with his/her education. This would be informed through ongoing risk management meetings either through child in need or child protection systems.
- That a decision to exclude may increase the risk in other settings. A decision to exclude should be in consultation with other agencies- see above

These matters should be considered on an inter-agency basis with involvement from the Head of Schools and the Head Teacher of any school, transfer to which is being considered.

**Appendix 2**  
**Sexually Harmful Behaviour Reporting Form**

The more detail about sexual behaviours the more informed the analysis will be. Please complete this form for each incident of sexual behaviours. This information should be collated from information already held. The child/young person should not be interviewed further only for the purpose of completing this form.

**Name of Child:**

**Name of person completing form:**

**Date:**

**Type of behaviour:** describe in as much detail as possible what the child/yp did or said:

**Context of the behaviour:** describe what preceded the behaviour e.g. where did the behaviour occur, what was the child/young person doing immediately prior to the behaviour, was the behaviour spontaneous or planned, what was the atmosphere of the environment? If another young person/child was involved was there use of force, coercion or threats?

**Relationship between the child/yp involved:** e.g. are they of a similar age, would they normally associate with each other; is there anything to suggest that one child/young person may be more in control than the other e.g. size, ability, status, strength differences?

**Response of other children/yp involved:** e.g. did they engage freely? Where they uncomfortable? Were they anxious or fearful?

**Response of the child/young person:** e.g. were they defensive, denying, aggressive, angry, or were they passive; or were they embarrassed, regretful and taking responsibility?

**What was attempted to address the behaviour and what was the child/young person's response to that?** E.g. could the child/young person be easily focused on another task, or were they difficult to distract and kept returning to the behaviour. Did they respond to the boundaries that were set?

Appendix 3



**SEXUAL BEHAVIOURS**  
●●● **TRAFFIC LIGHT TOOL**

**Behaviours: age 0 to 5 years**

All green, amber and red behaviours require some form of attention and response. It is the level of intervention that will vary.

**Green behaviours**

- holding or playing with own genitals
- attempting to touch or curiosity about other children's genitals
- attempting to touch or curiosity about breasts, bottoms or genitals of adults
- games e.g. mummies and daddies, doctors and nurses
- enjoying nakedness
- interest in body parts and what they do
- curiosity about the differences between boys and girls

**Amber behaviours**

- preoccupation with adult sexual behaviour
- pulling other children's pants down/skirts up/trousers down against their will
- talking about sex using adult slang
- preoccupation with touching the genitals of other people
- following others into toilets or changing rooms to look at them or touch them
- talking about sexual activities seen on TV/online

**Red behaviours**

- persistently touching the genitals of other children
- persistent attempts to touch the genitals of adults
- simulation of sexual activity in play
- sexual behaviour between young children involving penetration with objects
- forcing other children to engage in sexual play

**What is green behaviour?**

Green behaviours reflect safe and healthy sexual development. They are:

- displayed between children or young people of similar age or developmental ability
- reflective of natural curiosity, experimentation, consensual activities and positive choices

**What is amber behaviour?**

Amber behaviours have the potential to be outside of safe and healthy behaviour. They may be:

- unusual for that particular child or young person
- of potential concern due to age, or developmental differences
- of potential concern due to activity type, frequency, duration or context in which they occur

**What is red behaviour?**

Red behaviours are outside of safe and healthy behaviour. They may be:

- excessive, secretive, compulsive, coercive, degrading or threatening
- involving significant age, developmental, or power differences
- of concern due to the activity type, frequency, duration or the context in which they occur

**What can you do?**

Green behaviours provide opportunities to give positive feedback and additional information.

**What can you do?**

Amber behaviours signal the need to take notice and gather information to assess the appropriate action.

**What can you do?**

Red behaviours indicate a need for immediate intervention and action.

Brook has taken every care to ensure that the information contained in this publication is accurate and up-to-date at the time of being published. As information and knowledge is constantly changing, readers are strongly advised to use this information for up to one month from print date. Brook accepts no responsibility for difficulties that may arise as a result of an individual acting on the advice and recommendations it contains.

Brook Sexual Behaviours Traffic Light Tool adapted with permission from True Relationships & Reproductive Health, (2012). Traffic Lights guide to sexual behaviours in children and young people: identify, understand and respond. Brisbane: True Relationships & Reproductive Health, Australia.

Limited Company registered in England and Wales, number 2466940. Registered Charity in England and Wales, number 703015. Registered Charity in Scotland, number SC045788.



## SEXUAL BEHAVIOURS

●●● TRAFFIC LIGHT TOOL

### Behaviours: age 5 to 9 years

All green, amber and red behaviours require some form of attention and response. It is the level of intervention that will vary.

#### ● Green behaviours

- feeling and touching own genitals
- curiosity about other children's genitals
- curiosity about sex and relationships, e.g. differences between boys and girls, how sex happens, where babies come from, same-sex relationships
- sense of privacy about bodies
- telling stories or asking questions using swear and slang words for parts of the body

#### ● Amber behaviours

- questions about sexual activity which persist or are repeated frequently, despite an answer having been given
- sexual bullying face to face or through texts or online messaging
- engaging in mutual masturbation
- persistent sexual images and ideas in talk, play and art
- use of adult slang language to discuss sex

#### ● Red behaviours

- frequent masturbation in front of others
- sexual behaviour engaging significantly younger or less able children
- forcing other children to take part in sexual activities
- simulation of oral or penetrative sex
- sourcing pornographic material online

#### What is green behaviour?

Green behaviours reflect safe and healthy sexual development. They are:

- displayed between children or young people of similar age or developmental ability
- reflective of natural curiosity, experimentation, consensual activities and positive choices

#### What is amber behaviour?

Amber behaviours have the potential to be outside of safe and healthy behaviour. They may be:

- unusual for that particular child or young person
- of potential concern due to age, or developmental differences
- of potential concern due to activity type, frequency, duration or context in which they occur

#### What is red behaviour?

Red behaviours are outside of safe and healthy behaviour. They may be:

- excessive, secretive, compulsive, coercive, degrading or threatening
- involving significant age, developmental, or power differences
- of concern due to the activity type, frequency, duration or the context in which they occur

#### What can you do?

Green behaviours provide opportunities to give positive feedback and additional information.

#### What can you do?

Amber behaviours signal the need to take notice and gather information to assess the appropriate action.

#### What can you do?

Red behaviours indicate a need for immediate intervention and action.

Brook has taken every care to ensure that the information contained in this publication is accurate and up-to-date at the time of being published. As information and knowledge is constantly changing, readers are strongly advised to use this information for up to one month from print date. Brook accepts no responsibility for difficulties that may arise as a result of an individual acting on the advice and recommendations it contains.

Brook Sexual Behaviours Traffic Light Tool adapted with permission from True Relationships & Reproductive Health, (2012). Traffic Lights guide to sexual behaviours in children and young people: identify, understand and respond. Brisbane: True Relationships & Reproductive Health, Australia.

Limited Company registered in England and Wales, number 2466940. Registered Charity in England and Wales, number 703015. Registered Charity in Scotland, number SC045788.



# SEXUAL BEHAVIOURS



## Behaviours: age 9 to 13 years

All green, amber and red behaviours require some form of attention and response. It is the level of intervention that will vary.

### Green behaviours

- solitary masturbation
- use of sexual language including swear and slang words
- having girl/boyfriends who are of the same, opposite or any gender
- interest in popular culture, e.g. fashion, music, media, online games, chatting online
- need for privacy
- consensual kissing, hugging, holding hands with peer

### Amber behaviours

- uncharacteristic and risk-related behaviour, e.g. sudden and/or provocative changes in dress, withdrawal from friends, mixing with new or older people, having more or less money than usual, going missing
- verbal, physical or cyber/virtual sexual bullying involving sexual aggression
- LGBT (lesbian, gay, bisexual, transgender) targeted bullying
- exhibitionism, e.g. flashing or mooning
- giving out contact details online
- viewing pornographic material
- worrying about being pregnant or having STIs

### Red behaviours

- exposing genitals or masturbating in public
- distributing naked or sexually provocative images of self or others
- sexually explicit talk with younger children
- sexual harassment
- arranging to meet with an online acquaintance in secret
- genital injury to self or others
- forcing other children of same age, younger or less able to take part in sexual activities
- sexual activity e.g. oral sex or intercourse
- presence of sexually transmitted infection (STI)
- evidence of pregnancy

#### What is green behaviour?

Green behaviours reflect safe and healthy sexual development. They are:

- displayed between children or young people of similar age or developmental ability
- reflective of natural curiosity, experimentation, consensual activities and positive choices

#### What can you do?

Green behaviours provide opportunities to give positive feedback and additional information.

#### What is amber behaviour?

Amber behaviours have the potential to be outside of safe and healthy behaviour. They may be:

- unusual for that particular child or young person
- of potential concern due to age, or developmental differences
- of potential concern due to activity type, frequency, duration or context in which they occur

#### What can you do?

Amber behaviours signal the need to take notice and gather information to assess the appropriate action.

#### What is red behaviour?

Red behaviours are outside of safe and healthy behaviour. They may be:

- excessive, secretive, compulsive, coercive, degrading or threatening
- involving significant age, developmental, or power differences
- of concern due to the activity type, frequency, duration or the context in which they occur

#### What can you do?

Red behaviours indicate a need for immediate intervention and action.

Brook has taken every care to ensure that the information contained in this publication is accurate and up-to-date at the time of being published. As information and knowledge is constantly changing, readers are strongly advised to use this information for up to one month from print date. Brook accepts no responsibility for difficulties that may arise as a result of an individual acting on the advice and recommendations it contains.

Brook Sexual Behaviours Traffic Light Tool adapted with permission from True Relationships & Reproductive Health, (2012). Traffic Lights guide to sexual behaviours in children and young people: identify, understand and respond. Brisbane: True Relationships & Reproductive Health, Australia.

Limited Company registered in England and Wales, number 2466940. Registered Charity in England and Wales, number 703015. Registered Charity in Scotland, number SC045788.

## Behaviours: age 13 to 17 years

All green, amber and red behaviours require some form of attention and response. It is the level of intervention that will vary.

### ● Green behaviours

- solitary masturbation
- sexually explicit conversations with peers
- obscenities and jokes within the current cultural norm
- interest in erotica/pornography
- use of internet/e-media to chat online
- having sexual or non-sexual relationships
- sexual activity including hugging, kissing, holding hands
- consenting oral and/or penetrative sex with others of the same or opposite gender who are of similar age and developmental ability
- choosing not to be sexually active

### ● Amber behaviours

- accessing exploitative or violent pornography
- uncharacteristic and risk-related behaviour, e.g. sudden and/or provocative changes in dress, withdrawal from friends, mixing with new or older people, having more or less money than usual, going missing
- concern about body image
- taking and sending naked or sexually provocative images of self or others
- single occurrence of peeping, exposing, mooning or obscene gestures
- giving out contact details online
- joining adult-only social networking sites and giving false personal information
- arranging a face to face meeting with an online contact alone

### ● Red behaviours

- exposing genitals or masturbating in public
- preoccupation with sex, which interferes with daily function
- sexual degradation/humiliation of self or others
- attempting/forcing others to expose genitals
- sexually aggressive/exploitative behaviour
- sexually explicit talk with younger children
- sexual harassment
- non-consensual sexual activity
- use of/acceptance of power and control in sexual relationships
- genital injury to self or others
- sexual contact with others where there is a big difference in age or ability
- sexual activity with someone in authority and in a position of trust
- sexual activity with family members
- involvement in sexual exploitation and/or trafficking
- sexual contact with animals
- receipt of gifts or money in exchange for sex

#### What is green behaviour?

Green behaviours reflect safe and healthy sexual development. They are:

- displayed between children or young people of similar age or developmental ability
- reflective of natural curiosity, experimentation, consensual activities and positive choices

#### What can you do?

Green behaviours provide opportunities to give positive feedback and additional information.

#### What is amber behaviour?

Amber behaviours have the potential to be outside of safe and healthy behaviour. They may be:

- unusual for that particular child or young person
- of potential concern due to age, or developmental differences
- of potential concern due to activity type, frequency, duration or context in which they occur

#### What can you do?

Amber behaviours signal the need to take notice and gather information to assess the appropriate action.

#### What is red behaviour?

Red behaviours are outside of safe and healthy behaviour. They may be:

- excessive, secretive, compulsive, coercive, degrading or threatening
- involving significant age, developmental, or power differences
- of concern due to the activity type, frequency, duration or the context in which they occur

#### What can you do?

Red behaviours indicate a need for immediate intervention and action.

Brook has taken every care to ensure that the information contained in this publication is accurate and up-to-date at the time of being published. As information and knowledge is constantly changing, readers are strongly advised to use this information for up to one month from print date. Brook accepts no responsibility for difficulties that may arise as a result of an individual acting on the advice and recommendations it contains.

Brook Sexual Behaviours Traffic Light Tool adapted with permission from True Relationships & Reproductive Health. (2012). Traffic Lights guide to sexual behaviours in children and young people: identify, understand and respond. Brisbane: True Relationships & Reproductive Health, Australia.

Limited Company registered in England and Wales, number 2466940. Registered Charity in England and Wales, number 703015. Registered Charity in Scotland, number SC045788.

## Protocol 7

# Shetland Multi Agency Procedure For National and Local Missing Children/Family Alerts

### 1. Introduction

The Shetland Multi Agency Working Group for Missing Children and Families was created at the request of the Shetland Child Protection Committee (item 11 CPC Business Plan 2008-09). The remit of the Working Group was to create a multi agency procedure with clear roles and responsibilities for handling national and local requests for information regarding children or families who are regarded as missing from a known address (referred to as 'alerts' in this document).

There are currently two national processes established in Scotland:

- 1) Children Missing in Education, ScotXed and
- 2) Missing Family Alert Protocol, Health Department

These processes appear to be robust and effective for information within the Schools service and NHS, for Scottish alerts.

There was however an outstanding requirement to clarify the process for requesting information when single agency searches fail, having clear roles, responsibilities and methods for passing on information to all partner public agencies in Shetland.

### 2. Purpose

To provide a clear process for public agencies in Shetland:

- to request searches from other Shetland agencies,
- inform agencies of outcomes, and,
- where necessary, initiate national searches, on missing children and families alerts.

### 3. National alerts

Each agency in Shetland receives national alerts in different ways. National alerts are usually sent via agencies, e.g. NHS, Education, Children's Social Work.

As described above, NHS and Education in Scotland have developed standard national processes for the handling of their national alerts. However, alerts are still received from English authorities which have not come through these national frameworks.

Agencies which have not developed national processes receive alerts directly from other authorities in Scotland and England.

Alerts which are received outwith the Scottish national frameworks do not have a consistent format. It can even be difficult to tell from the information if it is in relation to a child or an adult. The originators are often sending the alerts out to different mailing lists.

This procedure can be used when an individual agency receives a national alert and have not located the missing child or person on their own system.

#### **4. Local alerts**

Each agency in Shetland had developed their own methods for managing local alerts. Some are more formal than others. NHS and SIC Schools Service follow national processes.

Although each agency in Shetland will pro-actively contact other agencies there was no consistent approach for doing so and no consistent approach for informing outcomes.

More importantly there was no consistent process for managing the escalation of a search where none of the agencies in Shetland can locate a missing child or family.

#### **5. Triggering the process**

Each agency will continue to use their own internal methods for searching for a child or family.

##### **5.1 Shetland alerts:**

When the practitioner responsible for that search is not satisfied with the outcome of that search they can start the process by asking their internal co-ordinator to contact the Shetland Children's Social Work Duty Assistant providing the following information:

First name  
Middle name(s)  
Surname  
Other name(s)  
Date of Birth  
Last known address  
Date of initial search  
Parents names, other names, maiden names etc. DoB, address, previous addresses  
Guardians names, other names, maiden names etc., DoB, address, previous addresses  
Siblings names, other names, maiden names, DoB, address, previous addresses.

## 5.2 National alerts:

When the receiving agency internal co-ordinator cannot locate the missing child/person they can forward the alert to the Shetland Children's Social Work Duty Assistant and initiate the Shetland multi agency process.

## 6 The Process (Appendix 1)

6.1 The Shetland Children's Social Work Duty Assistant checks if the alert is local or national. If local, check and if necessary request level of risk for child. Distribute the local or national alert to the named contacts in each agency and records it on the Shetland Islands Council Social Care SWIFT system. (Named contacts for each agency attached in [Appendix 3](#) and will be reviewed annually by the Shetland Children's Social Work Duty Assistant.)

6.2 The Missing Children and Missing Families co-ordinators in each agency will check their systems for the persons identified on the form, children and adults. Where internal search procedures exist, these will be followed. The time frame for checking and responding will be determined by the level of risk indicated on the search request.

6.3 If the child or linked persons named on form are found:

6.3.1 Agency co-ordinator sends response to the Shetland Children's Social Work Duty Assistant, stating that they are recorded on this agency's system and the last recorded date of contact.

6.4 Child or linked person found and contact established:

6.4.1 The Shetland Children's Social Work Duty Assistant informs the originator of the agency and contact who responded with child or linked person found.

6.4.2 Originator and contact negotiate further information sharing based on risk assessment and using existing procedures for dealing with the agreed level of risk.

6.4.3 The Shetland Children's Social Work Duty Assistant informs all other agencies that contact has been established, no further information given.

6.5 Child or linked person found on system but no contact since date of alert:

6.5.1 Shetland Children's Social Work Duty Assistant informs originator of which agency and contact has record of the child.

6.5.2 Originator and contact carry out joint risk assessment and agree next steps.

6.5.3 The Shetland Children's Social Work Duty Assistant updates the SWIFT system with 'Record found, no contact'. Inform all other agencies of this status.

6.6 Child not found on any agency system and no contact known from date of alert:

6.6.1 For local alerts:

- a) Shetland Children's Social Work Duty Assistant reports the nil outcome to all agencies.
- b) Originator carries out a risk assessment and determines:

(i) Child is identified as **vulnerable** –

Request the Shetland Children's Social Work Duty Assistant to check the national missing people databases:

<http://www.missingpeople.org.uk/>

<http://uk.missingkids.com/missingkids/servlet/PublicHomeServlet>

<http://www.npia.police.uk/en/10200.htm>

IF the child is not found the originator collates the information required for a national search, by completing the form attached in [Appendix 2](#). Forwards the forms to the Shetland Children's Social Work Duty Assistant and requests that the Shetland Children's Social Work Duty Assistant initiates the national search.

The Shetland Children's Social Work Duty Assistant initiates a national search by sending the completed 'Request for a National Search' to:

SIC Children's Social Work, MIS Assistant – who initiate CME.

Shetland NHS, Public Health Administration – who initiate NHS Missing Family Alert Protocol  
Police Informs all Shetland agencies that a national search has been initiated.

(ii) Child is **not** categorised as **vulnerable**, originator follows own plan as determined by the risk assessment.

## 7. Information Sharing

7.1 One of the Shetland Personal Information Sharing Policy objectives is:

“To provide a framework for the secure and confidential sharing of information between partner organisations to enable them to meet the needs of individuals and groups for their care, protection, support and delivery of services in accordance with government expectations and legislative requirements”

7.2 Information sharing requirements to initiate this process are covered by the Shetland Personal Information Sharing Policy.

[http://www.shetland.gov.uk/children\\_and\\_families/documents/InformationSharingProcedure.pdf](http://www.shetland.gov.uk/children_and_families/documents/InformationSharingProcedure.pdf) from:

[http://www.shetland.gov.uk/children\\_and\\_families/GIRFEC.asp](http://www.shetland.gov.uk/children_and_families/GIRFEC.asp)

The sharing of some key personal identifiers, as laid out in [Appendix 1](#), will fall under the 'overriding justification' as described in Section 5.4 of the Policy. The person responsible for taking the decision to proceed with this process will record the information required in the Policy as part of their Risk Assessment leading up to the initiation of this process:

- 7.2.1. Personal information must not be disclosed without the consent of the person concerned, unless there are statutory grounds or an overriding justification for so doing.
  - 7.2.2. Each organisation will therefore appoint or identify a person or persons who has the authority and knowledge to take responsibility for such a decision. This authority will be available at all times, to enable emergency situations to be dealt with.
  - 7.2.3. If information is disclosed without consent, then full details will be recorded about the information disclosed, the reasons why the decision to disclose was taken, the person who authorised the disclosure and the person(s) to whom it was disclosed. Individual procedures will specify the person(s) responsible for ensuring this happens.
  - 7.2.4. Recipients of the information will be made aware that it has been disclosed without consent and will put agreed security procedures in place.
- 7.3 If a decision is made to share further information between separate agencies as part of this process, existing procedures should be used. The appropriate procedure will be determined by the outcome of the risk assessment and the circumstances of engagement.

Shetland has the following inter agency procedures in place:

Shetland Child Protection Procedures –  
<http://www.safershetland.com/child-protection>

Getting it Right for Every Child (GIRFEC) –  
[http://www.shetland.gov.uk/children\\_and\\_families/GIRFEC.asp](http://www.shetland.gov.uk/children_and_families/GIRFEC.asp)

With You For You (for over 16's where GIRFEC is not appropriate) –  
[http://www.shetland.gov.uk/community\\_care/with\\_you\\_for\\_you.asp](http://www.shetland.gov.uk/community_care/with_you_for_you.asp)

## **8. Records Management – Retention and Storage**

- 8.1 Each party to this procedure is responsible for ensuring all personal information they hold in relation to missing children and linked persons is stored and destroyed in accordance with their own Data Protection and/or Retention and Destruction policy.

8.2 Shetland Islands Council is responsible for removing all information relating to this procedure held on the Social Care SWIFT system in accordance with their corporate Retention and Destruction policy.

## **9. Complaints and Breaches**

9.1 All parties to this procedure are responsible for ensuring that their staff follow the procedure and adhere to it.

9.2 All parties to this procedure are individually responsible for ensuring that all supporting policies and procedures necessary to comply with this procedure are implemented within their own organisation.

9.3 Any breaches of this procedure must be brought with immediate attention to the Data Controller and missing children/families co-ordinator within the agency where the breach occurred.

9.4 Any person wishing to make a complaint regarding how their personal information has been handled in the carrying out of this procedure should do so through the complaints procedure of the agency that has caused concern.

## **10. Review of this procedure**

10.1 This procedure was reviewed in 2019.

## Request for a National Search Shetland Multi Agency Procedure for National and Local Missing Children/Family Alerts – Appendix 2

### Case Details

Please give the following details for the originator of this request.

Name:	<input type="text"/>
Designation:	<input type="text"/>
School:	<input type="text"/>
Telephone number:	<input type="text"/>
Email:	<input type="text"/>

### Details of local investigations for all children in this case to be included in the search

Local searches completed	Date carried out and by whom	Outcome
Enquiries made with other children in the class	<input type="text"/>	<input type="text"/>
Enquiries made with other school staff	<input type="text"/>	<input type="text"/>
Enquiries made with other establishments where siblings are known to be or where siblings were enrolled	<input type="text"/>	<input type="text"/>
Home contact attempted		
– by phone	<input type="text"/>	<input type="text"/>
– by letter	<input type="text"/>	<input type="text"/>
– by visit	<input type="text"/>	<input type="text"/>
Contact made with relatives/emergency contact	<input type="text"/>	<input type="text"/>
Contact made with parent's last known employer	<input type="text"/>	<input type="text"/>
Contact made with other agencies:		
- Social Work	<input type="text"/>	<input type="text"/>
- Housing Dept/Housing Agency	<input type="text"/>	<input type="text"/>
- Health	<input type="text"/>	<input type="text"/>
- Voluntary Agencies	<input type="text"/>	<input type="text"/>
- Police	<input type="text"/>	<input type="text"/>
Other	<input type="text"/>	<input type="text"/>

**Local Authority Details**

Local Authority:

Name of Shetland search co-ordinator:

Designation:

Telephone number:

Email address:

How many sets of child details are being sent with this referral?

Date:

**Please ensure you complete**

- a case details sheet
- a family sheet
- one or more child sheets

**Family Details**

Family surname:

Last known address:

Other names the family has been known by:

Mother's first and maiden name (if known)

Father's name:

Is either parent in the military?

Is anyone in this family an asylum seeker?

Is anyone in this family a refugee?

Other known family whereabouts and telephone numbers:

Emergency contact and telephone number:

**Any other background information**

Please include in this section any other background information about why this case has been referred and/or any other relevant details e.g. medical issues, confidentiality etc.

## **Appendix 3**

### **Missing Children/Family Co-ordinators Named Agency Contacts**

NHS Shetland:

Public Health Administration –

Email [kimgovier@nhs.net](mailto:kimgovier@nhs.net)

Telephone 01595 743340

SIC Schools Service:

Management Information Systems Assistants –

Email [Gail.Burgess@shetland.gov.uk](mailto:Gail.Burgess@shetland.gov.uk)

[Anna.Hutcheon@shetland.gov.uk](mailto:Anna.Hutcheon@shetland.gov.uk)

Telephone 01595 744000

SIC Children's Social Work

Fieldwork Assistants –

Email [childrens&families-intake@shetland.gov.uk](mailto:childrens&families-intake@shetland.gov.uk)

Telephone 01595 744000

SIC Housing Service:–

Email [Shirley.Mills@shetland.gov.uk](mailto:Shirley.Mills@shetland.gov.uk)

[Ian.Bray@shetland.gov.uk](mailto:Ian.Bray@shetland.gov.uk)

Telephone 01595 744360

## Protocol 8

# Unseen Child and Working with Non – Engaging Families

### 1. Introduction

#### 1.1 Definitions

- 1.1.1 Unseen children and non-engaging families can be issues that come together – the family that does not want to engage with professional staff and so prevents access to the child. However there are situations where parents or carers will allow a child to be seen, but refuse to engage in any meaningful work. A child may be compromised in being able to build helping relationships with practitioners if they know that they do not have parental support and approval. A parent may allow access to the child, but refuse to engage in work that will assist them – so, for example, not keeping appointments with the mental health worker who is trying to assist the adult.
- 1.1.2 Following initial information gathering in respect of an unseen child or non-engaging family, it may be established that the family are actually missing. In this case [Shetland Multi Agency Procedure](#) for National and Local Missing Children/Family Alerts ([Protocol 7](#)) should be followed.
- 1.1.3 Pregnant women who disengage with maternity services – particularly if there are concerns for their welfare or the welfare or safety of their unborn baby – will require rapid follow up to re-establish contact wherever possible. NHS Scotland “Guidance for Health Professionals Responding to Missing Families and Unborn Babies for whom there are concerns” should be followed and if necessary child protection referrals made.

#### 1.2 Unseen Children

##### 1.2.1 **What do we mean by an Unseen child?**

A child who is not seen by one of the practitioners (from universal, specialist, third sector etc. agencies) involved with the child's family, even when an appointment has been made to see the child either at home, school or in a medical centre. Sometimes access to the family home may be gained and other members of the household are seen. More concerning would be a situation where the parents refuse to say where the child is.

- 1.2.2 A child does not have to be named on the Child Protection Register in order for this procedure to apply. This procedure applies in the case of any child who should be seen by one practitioner or another, but who it seems is, effectively, being kept hidden from view.

1.2.3 Not all agencies with responsibilities for child welfare will visit a child at home, but for those who do it is good practice to include both planned and unplanned home visits in their contact with families; observe the child and his/her interaction with the parents, and gather information about daily routines and sleeping arrangements for the child.

1.2.4 For children who repeatedly fail to attend medical and dental appointments, NHS Shetland have a local Protocol for the Management of Non-responders and Non-attendeers for Health Service Appointments which should be used by Health staff in Shetland.

### **1.3 Purpose of this Protocol**

1.3.1 The purpose of this multi-agency protocol is to ensure that all practitioners know what to do in situations where a child is “unseen” or in situations where families are not engaging with services. Whenever a pattern begins to emerge in which a child is not being seen, concern should be heightened and action taken to ensure that the child is seen.

1.3.2 This protocol applies equally in cases where a practitioner’s focus of work is with an adult in the household and when it is known, or believed, that there are children also in the home. Practitioners working with adults may not be required to assess the child's circumstances for the purposes of their work, but if they form a view that any child in the house is deliberately being kept out of their view, they need to act on this concern.

1.3.3 This protocol applies to any situation where practitioners are offering services to children and families.

For the absence of any doubt this protocol applies to

- children accessing universal services – Health visiting, Dental Services, Schools, etc., who start to be missed
- Children for whom there is a Child’s Plan (in Shetland commonly referred to as a GIRFEC plan) with a Lead Professional coordinating the Child’s Plan. This also covers children whose names are on the Child Protection Register and whose Child’s Plan is also a protection plan and children who are Looked After.

1.3.4 In general the process for gaining access to children is one of movement from negotiation to increased use of authority. Practitioners working together must be mindful that a pattern may be created if, over a period, a number of them have failed to see the child on one or two occasions. Good communication and information-sharing between practitioners is vital to establish if a pattern of not engaging is emerging.

1.3.5 Every child's circumstances are unique and what constitutes a concerning pattern of not being seen is a matter for professional decision-making, led by good management and supervision. The important point is that every professional remains alert to such a pattern emerging and acts whenever

that happens. It will be the case that, for some children, the Child's Plan will specify the regularity and frequency with which the child must be seen. For other children the Child's Plan may not specify the regularity of contact, but may specify the need to meet with medical professionals or specialists as part of assessing need or progressing a Child's Plan.

1.3.6 This protocol:

- informs staff about what to do if they are worried that a child is not being seen;
- facilitates decision-making when concerns are raised about a non-engaging family or that access to child is being denied or frustrated. The process is summarised in a flow chart at [Appendix 1](#).

## 2 **Non-Engaging Families**

(The following is adapted from the National Guidance for Child Protection in Scotland 2014):

- 2.1 Evidence shows that some adults will deliberately evade practitioner interventions aimed at supporting or protecting a child. In many cases of child abuse and neglect, this is a clear and deliberate strategy adopted by one or more of the adults with responsibility for the care of a child. It is also the case that the nature of child protection work can result in parents/carers behaving in a negative and hostile way towards practitioners.
- 2.2 The terms 'non-engagement' and 'non-compliance' are used to describe a range of deliberate behaviour and attitudes, such as:
- failure to enable necessary contact (for example missing appointments) or refusing to allow access to the child or to the home;
  - active non-compliance with the actions set out in the Child's Plan (or Child Protection Plan contained therein);
  - disguised non-compliance, where the parent/carer appears to co-operate without actually carrying out actions or enabling them to be effective; and
  - threats of violence or other intimidation towards practitioners.
- 2.3 Consideration needs to be given to determining which family member(s) is or are stopping engagement from taking place and why. For example, it may be the case that one partner is 'silencing' the other and that domestic abuse is a factor. Service users may find it easier to work with some practitioners than others. For example, young parents may agree to work with a health visitor, but not a social worker.
- 2.4 If there are risk factors associated with the care of children, risk is likely to be increased where any of the responsible adults with caring responsibilities fail to engage or comply with the child's plan or child protection services. Non-engagement and non-compliance, including

disguised compliance, should be taken account of in information collection and assessment. Non-engagement and non-compliance may point to a need for compulsory or emergency measures under the Children's Hearing Act (Scotland) Act 2011 or Children's (Scotland) Act 1995.

### **3. Planned and Unplanned Visits**

- 3.1 Making appointments – by letter, text, e mail and card – or making the next appointment, having seen the family, are all routine ways of working with children and families. It is important to be clear with families from the beginning, when establishing a working relationship (either as part of a Child's Plan or as part of single agency support to child or family), what is expected and why professionals want to work with parents and see and assess children. Discussing what may be the best times and places to see the child and family are important. If English is not the family's first language, then using the language line or any other means to ensure good communication is important.
- 3.2 So that the genuinely forgotten or missed appointment does not escalate responses, it is helpful to ask parent and carers for a second contact number – a relative, friend or neighbour. There will be times when unplanned visits are appropriate in response to the need to check on wellbeing or safety.
- 3.3 Good record keeping of visits and appropriate – both successful and unsuccessful – will help establish any significant patterns.

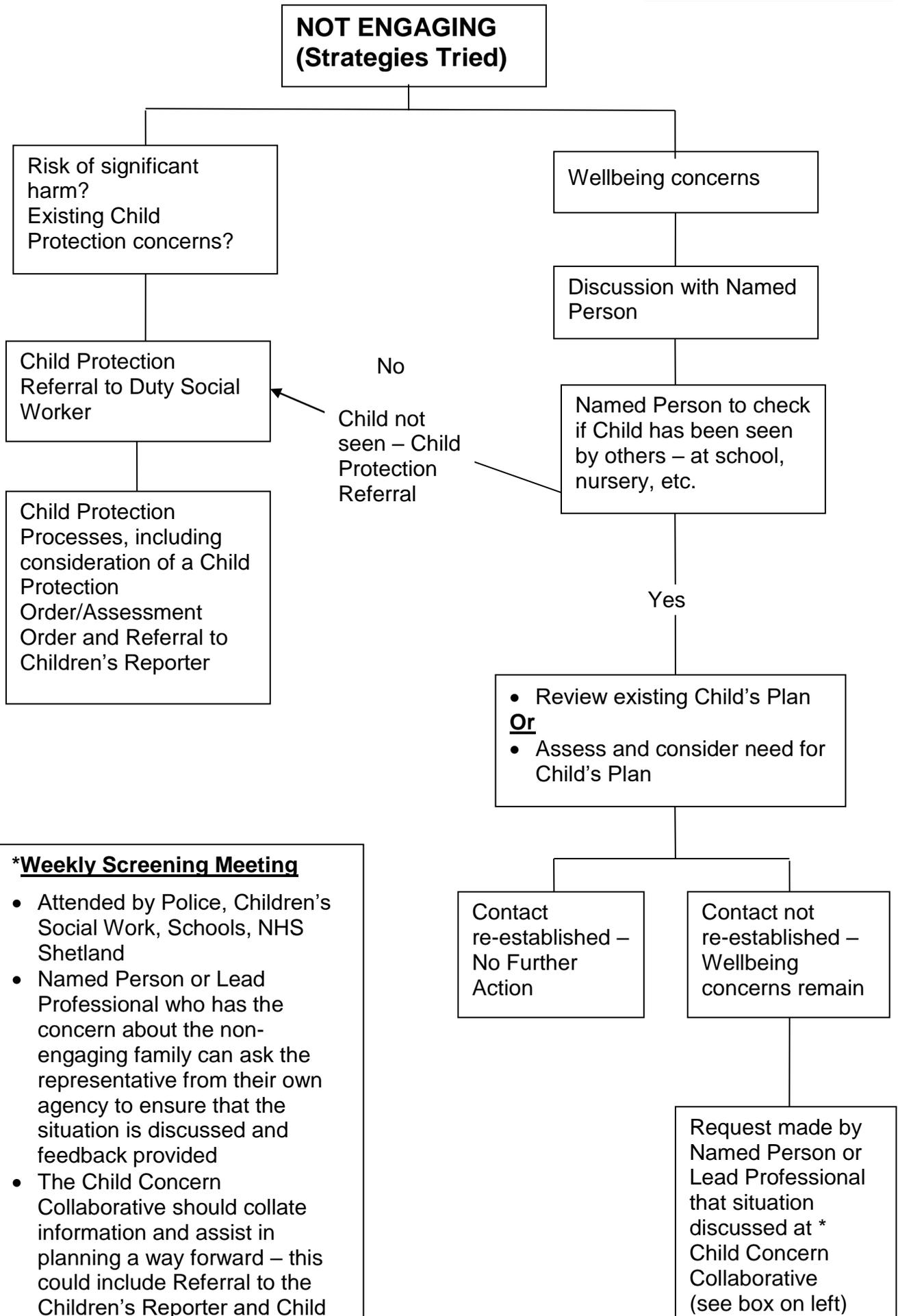
### **4. Acting in response to concerns about a child being unseen or a family not engaging**

- 4.1 Responses to a child being unseen, or a family being unable or unwilling to engage with services, will need to be appropriate to the circumstances and reason for the involvement with the family. Interagency communication is key to establishing if there is a need for urgent action or if a more measured response can be made. For example, if the Health Visitor acting as Lead Professional has not been able to see a child to undertake work outlined as part of a Child's Plan, it would be sensible to check with the nursery or playgroup to find out if they have seen the child. If the child has been attending and seen by staff that could be reassuring and the best way forward may be to convene a review of the Child's Plan.
- 4.2 Attempting to understand why the parent or family has not supported access to the child and what can be done to improve that or reassure parents is helpful. Using the GIRFEC notification process to alert the Named Person to missed appointments and concerns about non-engagement would be important. Writing to parents to encourage cooperation and being clear what the consequence could be if contact is not re-established is appropriate.

- 4.3 When considering non-compliance or lack of cooperation by a parent or carer, it is important to consider if concerns have been explained clearly taking account of language, culture, disability and literacy. Practitioners will need to assess if all possible strategies have been tried to establish partnership working with the parent or carer: i.e. a change of worker, use of another agency – for example a young parent may accept help from a health visitor, but not be willing to work with a social worker.
- 4.4 If contact with a child is not re-established or the family continues to be disengaged and if this indicates that there could be a risk of significant harm, then a child protection referral should be made to the Duty Social Worker. **This is particularly important if there has been a history of or concerns about parental substance misuse, mental illness or domestic abuse.**
- 4.5 If the child's name is already on the Child Protection Register or the child is Looked After, then Children's Social Work would need to consider immediate action. Visiting with the police is one option. Applications for a Child Protection Order or Assessment Order will also need to be considered. Any agency can refer the child to the Reporter for consideration of the need for compulsory measures and this is appropriate in situations where working on a voluntary basis has broken down.
- 4.6 If contact is not re-established and the concern is about the child's wellbeing, rather than a risk of significant harm, practitioners should notify the Named Person using the GIRFEC Notification Form. The Named Person for the child can request that the situation is discussed at the Child Concern Collaborative. Children's Social Work, NHS Shetland, Schools Service and Police Scotland meet to discuss any child for whom there is a concern. Practitioners and Named Persons can ask the representative from their agency to share information about an unseen child or non-engaging family and seek information from others. This meeting can also make a plan of how to address this issue.
- 4.7 Practitioners working in the Third Sector can refer back to the professional who referred the child or family to their service, or notify the Named Person.
- 4.8 It is difficult to give any professional exact guidance for every situation, but advice can always be sought from the Duty Social Worker. Striking a balance between over reacting to missed appointments that may have an explanation and not taking action to protect a child is not always easy, but the main principle of this guidance is to ensure effective interagency information sharing and response. Being persistent and supportive is important, but, equally, not allowing situations to drift on for weeks without a child being seen, or being able to work effectively with parents and carers, is not safe.

**5. Safety of Staff**

- 5.1 Non-engagement and refusal to allow a professional to see a child may be accompanied by threats and aggressive behaviour. Some parents can be very intimidating towards staff. Staff safety is important and, if any agency is aware of aggressive or violent behaviour, then sharing that information urgently with other agencies is important. A professional planning meeting to discuss how to take matters forward without placing staff at risk would need to be convened, either by the Named Person or through Duty Social Work.
- 5.2 Staff safety is important. It is also vital to remember that if staff are frightened and intimidated, then children may not be safe.



**\*Weekly Screening Meeting**

- Attended by Police, Children's Social Work, Schools, NHS Shetland
- Named Person or Lead Professional who has the concern about the non-engaging family can ask the representative from their own agency to ensure that the situation is discussed and feedback provided
- The Child Concern Collaborative should collate information and assist in planning a way forward – this could include Referral to the Children's Reporter and Child Protection processes.

## Protocol 9

### Safe Use of the Internet

#### 1. INTRODUCTION

This protocol is aimed at all practitioners in Shetland who are working with and providing services to children and young people

- to promote and encourage the safe use of the internet,
- to prevent children and young people being affected by online abuse,
- to recognise when children and young people may be at risk of significant harm and child protection processes need to be put in place,
- to share information both to protect children and disrupt online offending.

This protocol relates primarily to the risk of sexual abuse or exploitation of children and young people through the use of internet and mobile technology. It is also important to recognise that children and young people can be groomed or subject to influences which seek to radicalise them (for more information please see [Section 1, Chapter 7, Child Protection in Special Circumstances](#)) However the principles of using social media and internet safely should help prevent other situations that may cause distress to a child.

The protocol gives some background information including definitions of the terms used and gives guidance on how to promote safe internet usage in order to prevent children and young people being harmed or distressed. It also gives guidance about those situations where child protection referrals would be appropriate.

This protocol is broadly designed to protect children and young people up to the age of 18 and is consistent with the Children and Young Persons (Scotland) Act 2014. Young people who are Looked After or entitled to a Through Care and Aftercare service would also be covered by this protocol.

Working with children and young people who are vulnerable to this type of exploitation is complex and no single policy or procedure can be expected to cover all eventualities. For this reason it is very important that in every case there is discussion between professionals regarding children and young people who are considered to be at risk.

## **2. BACKGROUND INFORMATION**

### **2.1 Definitions**

#### **2.1.1 Online Abuse**

(Adapted from 2018 How Safe Are Our Children?)

Online abuse is abuse that is facilitated using internet-connected technology. It may take place through social media, online games or other channels of digital communication. Children can also be re-victimised if evidence of their abuse is recorded or uploaded online. Technology can facilitate a number of illegal abusive behaviours including, but not limited to: harassment; stalking; threatening behaviour; child sexual abuse material; inciting a child to sexual activity; sexual exploitation; grooming; sexual communication with a child; and, causing a child to view images or watch videos of a sexual act. Using technology to facilitate any of the above activities is online abuse.

Children can be at risk of online abuse from people they know as well as from strangers. Abuse may begin online and move into the real world - for example grooming that then moves on to contact sexual abuse. Online abuse may be a continuation of abuse that is already taking place in the real world - for example bullying. In some situations the abuse only happens online - for example persuading children to take part in sexual activity online.

Children and young people can feel like there is no escape from online abuse - abusers can contact them at any time of the day or night, the abuse can come into safe places like their bedrooms, and images and videos can be stored and shared with other people.

#### **2.1.2 Online Child Sexual Abuse**

This has been described as:

- The production, distribution, downloading and viewing of child abuse material (both still and video images).
- The online solicitation of children and young people to produce self-generated child abuse material, to engage them in sexual chat or other online sexual activity, or to arrange an offline meeting for the purposes of sexual activity, also known as grooming or luring.
- The facilitation of any of the above.

These activities will often constitute a criminal offence. However, even if an offence is not committed, or there is insufficient evidence to prosecute, a child or young person may be considered to be at risk of significant harm due to the activity and a child protection referral should be made.

'Child abuse images' are often referred to as 'child pornography'. Nevertheless, the term 'child abuse image' is preferred. 'Child pornography' can suggest legitimacy, with the child or young person being a willing participant. It can also suggest images of children or young people posing in 'provocative' positions rather than being subject to sexual abuse.

## **2.2 How Children and Young People Use the Internet**

Children and young people may use the internet in a range of ways, including:

### **Social Networking**

Social Networking websites and Apps help connect friends using a number of tools such as blogs, profiles, internal email systems and photos. The popularity of certain sites change over time and the easiest way to stay up to date is to use a Google search for the most popular networking sites. In 2018 How Safe Are Our Children report found that 23% of children aged 8-11 and 74% of young people aged 12-15 have a social media account. 7% of under 13s have been asked for a sexual image or message and 24% of young people have experienced an adult that they don't know in real life trying to contact them online. According to recent NSPCC research, more than one in seven children aged 11-18 (15 per cent) have been asked to send sexual messages or images of themselves. One in ten girls aged 13 or under had received a request. Groomers are able to exploit the design of social networks, using friend and follower suggestions to infiltrate peer networks, and to establish contact with children that can quickly escalate into requests for sexual messages. Seven per cent of 11-16 year olds say they have shared a naked or semi-naked image of themselves.

### **Chat and Instant Messaging**

Instant messaging (IM) is a form of real-time text-based communication conveyed over a network, such as the internet. IM technologies often include features that make them even more popular such as having the ability to talk directly for free; to share files; or to view the other party through a webcam. New types of technology, notably livestreaming, provide new opportunities for abusers to control and coerce children into increasingly extreme forms of abuse.

### **Gaming**

Video games are amongst the most popular leisure pursuits for young people. These include Massively Multiplayer Online Role-playing Games (MMORPGs) which involve a large number of players interacting with one another in a virtual online world. These games often have a science fiction or fantasy theme. Other sites, such as Moshi Monsters or Disney Club Penguin are aimed at younger children and have a social networking element.

### **Downloading and Uploading**

Children and young people increasingly access music through sites such as iTunes, and listen to the radio or watch TV online. Sites such as YouTube allow contributors to create video content and upload it. Blogs are a sort of online diary or reflections on a subject. They are usually maintained by an individual or a small group, and readers can comment on entries.

### **Education/Research**

Increasingly, schools are using websites to manage homework, and support study. Children and young people can also use other public sites such as Wikipedia for research.

Children and young people access the internet at home, in public places such as schools and libraries, and on smart phones. The setting itself can add to either risk or protective factors.

## 2.3 Risks of Sexual Abuse/Exploitation

### 2.3.1 Who is at Risk?

*Action and interaction online may have an impact on children's sense of self and be particular risk to those who are already vulnerable in the offline world.*

All children and young people may engage in risky behaviour when using the internet, whether due to lack of confidence and experience in the online world, or high exposure due to increased accessibility. 2018 How Safe Are Our Children Online identified that of the 2059 children and young people involved in Young People's Experiences Online research 15.5% of young people aged 11 to 18 had received a request for a sexual image or message. CEOPS estimated in 2012 that there were 50,000 individuals in the UK involved in downloading and sharing indecent images of children and young people.

Parents and carers and others supervising children's online activity should take appropriate measures to create a safe environment, and inform children about safe practices online. There is a lot of information available for children, young people, parents and carers, which can be found in [Appendix 2 – Key Safety Messages](#).

There are specific risks for the most vulnerable children and young people. For example, children or young people with poor parental relationships and lower satisfaction in life may seek out sensation experiences and greater online communication from friends or strangers.

There are other factors that contribute to individual children or young people's abilities to benefit and manage risks from the online world:

- Biological predisposition (neuro-developmental profiles, temperament) including additional developmental support needs and disabilities.
- Psychological factors (attitudes, thoughts, emotions) i.e. existing issues of self harm behaviours, emotional distress and body image.
- Socio cultural context (models of behaviour going on around the child or young person – beliefs, attitudes, ideology) i.e. issues of violence or abuse in the child or young person's world may be validated or normalised by access to inappropriate violent or sexual content or contact.

Whittle et al (2013) identify the following risk factors:

	<b>Individual risk factors</b>	<b>Family factors</b>	<b>Community factors</b>
<b>Offline and online</b>	Adolescents Being female Confusion around sexual orientation Low self esteem Mental health problems Social isolation / Loneliness Risk taking behaviours Personality traits Previous victimisation	Conflict with parents Single parent or reconstituted family Low satisfaction with family Parental substance abuse Lack of family cohesion Poor family relationships	Social isolation Possibly problems with school Possibly dissatisfaction with school Possibly additional support needs Weak or limited peer support
<b>Online only</b>	Adolescents Frequent internet access	Parental failure to monitor online activity Lack of parental involvement with the Internet	Possibly rural location - but largely unknown

However, the online world can also provide significant opportunities for other vulnerable groups of children and young people. For example children with disabilities or those who can be socially isolated may benefit from increased opportunities to build and sustain relationships.

It is important then that we weigh up the risks with the benefits that the online world can bring to children and young people.

### **2.3.2 Where does the risk come from?**

The risks to children and young people in relation to sexual abuse / exploitation have been categorised as:

- Content – i.e. accessing pornographic or unwelcome sexual content
- Contact – i.e. being targeted by a stranger who develops a relationship with the intent of sexual exploitation
- Conduct – i.e. creating, uploading or seeking out sexually inappropriate material

#### **Content Risk**

In a survey of children and young people:

- 38% exposed to pornographic pop-up advert
- 36% stumbled on pornographic website
- 25% receiving unsolicited pornographic material by email or instant messaging
- 10% purposely sought out pornographic websites

Over half of 9-19 year olds report coming into contact with online pornography or indecent images. A minority of children, particularly boys and older children, seek out sexually explicit material. For a quarter of those surveyed, this is the issue they are most concerned about on the internet. Many children and young people report that they are distressed, disgusted and offended by sexually explicit material, although few report it to parents.

### **Contact Risk**

In surveys with children and young people:

- 31% of 9-19 year olds with weekly online use report having received unwanted sexual comments via email, chat, instant or text messaging
- 12-14 year olds tend to talk to strangers online more than older teenagers
- 25% of UK children have met someone offline, who they first met online

Children and young people often form relationships online. An abuser will create a persona, often posing as another child or young person, in order to develop a friendship. The abuse may take place online, or the abuser may persuade the child or young person to meet up, and abuse them.

The abuser will take time to build trust and invest in the child or young person. In some cases, when they reveal their true identity the child or young person is so invested in the relationship they will accept this. Alternatively the abuser may have obtained information from the child or young person that they use as a means of coercion. This may include indecent images that the child or young person has given them.

Children or young people in foster or residential care may make contact with birth families through social networking, which can be problematic. **If this occurs, the matter should be referred to the child or young person's social worker or carer's link worker.**

### **Conduct Risk**

In surveys of children:

- Only 40% of children set their social networking profiles to private – leaving 60% with personal information exposed
- 27% of children have posted others information or photographs online without consent

Children and young people themselves may take photographs or create videos that they share with other friends. Once this content is on line it can be taken by other people and used out of context. Children and young people need to be aware that indecent images they produce or distribute may be illegal. Such images may also be used by others to bully or exploit them.

### **Combinations of Risk**

Content, Contact and Conduct risks are intrinsically linked, and children can behave in different roles at different times. This needs to be considered when undertaking any assessment. In particular the questions should be considered what risks are posed to the child or young person and what risks (if any) the child or young person poses to others.

Hasebrink et al identify the following ways that content, contact and conduct risks may occur:

	<b>Content Child as participant</b>	<b>Contact Child as actor</b>	<b>Conduct Child as actor</b>
<b>Aggressive</b>	Violent/gory content	Being bullied or stalked	Bullying or harassing
<b>Sexual</b>	Pornography, unwelcome sexual content	Grooming, unwanted sexual comments	Sexual harassment
<b>Values</b>	Racist/hate	Ideological persuasion	Self harm
<b>Commercial</b>	Embedded marketing	Privacy/data abuse	Illegal downloads, gambling, hacking

### 2.3.3 Risk perception of adults

A significant factor in identifying and assessing risk is the different understanding of the use of the internet between children and young people, and adults. Adults have become familiar with using the internet for information gathering and lifestyle support; for example shopping, keeping contact with friends and other recreational interests that supplement their “real life”.

Parents and carers are often more concerned about risks to their children in the real world and do not always appreciate that there can be risks online. A child sitting in their bedroom using the internet may be considered by a parent to be in a safe place as opposed to child who is out playing in the street.

Children and young people generally do not see a distinction between the online world and real life; the two are more fully integrated. For example, they may form relationships with people they have met through social networking or gaming sites, who they consider to be friends, although they have never met one another. This means they can be very open in sharing personal information, and not consider the need to take precautionary measures when meeting up. In addition, they are more likely to create content and upload it, rather than simply downloading. This distinction in internet use has been described as Web 1.0 and 2.0.

This difference in experience and knowledge can create barriers to understanding, reducing confidence of practitioners in supporting children and young people to benefit from the Web whilst keeping them safe.

## 3. PROMOTING SAFE USE OF THE INTERNET AND PREVENTING ABUSE

Curriculum for Excellence (CfE) recognises that being skilled in using information and communications technology (ICT) is essential if children and young people are to be effective contributors able to communicate and interact on a global scale. They need to be equipped with the learning and employability skills required for the 21<sup>st</sup> century. It also acknowledges that there is a need for children and young people to develop the skills and knowledge to keep themselves safe in what is a potentially unsafe environment, with the expectation that all children will achieve the following CfE outcome: ‘I am developing my knowledge and use of safe and acceptable

conduct as I use different technologies to interact and share experiences, ideas and information with others' (TCH1-08a/ TCH 2-08a).

Education of children, young people, parents and carers and practitioners is important. The following resources are currently in place and Shetland Public Protection Committee would urge everyone to make use of these resources:

- Network of Child Exploitation and Online Protection Service (CEOP) trained trainers to deliver sessions to groups of children or adults about keeping safe online
- Local leaflets (<https://www.safershetland.com/assets/files/do-you-know-how-to-stay-safe-online2019.pdf>)
- PSE session delivered by School Staff and Peer Educators
- Online resources are included in [Appendix 2](#)

#### **4. RECOGNISE AND RESPOND TO CONCERNS THAT A CHILD OR YOUNG PERSON MAY BE AT RISK OF SIGNIFICANT HARM AND CHILD PROTECTION PROCESSES NEED TO BE PUT IN PLACE**

Whenever there is any suspicion that a child or young person may be at risk of abuse through the internet, this should be treated as a child protection concern, and progressed under local child protection procedures.

If there is a concern that the child or young person may themselves be posing a risk, or have engaged in illegal activity, this should be considered alongside the question of what protection they may need themselves. Shetland Inter-agency Child Protection Procedures make it clear that any child or young person who poses a risk to other children should also have their own needs assessed. (*Please see [Section 1, Chapter 7, Child Protection in Special Circumstances](#) – Shetland Inter-Agency Child Protection Procedures*) Where appropriate, they should be supported to access legal advice.

In particular, in order to preserve evidence:

- Do not delete any information found on computers/mobile phones.
- Take a note of any websites, email addresses or telephone numbers.
- Note any names, addresses or other contact details.
- Print out/take a screen shot of any concerning materials.

It should be remembered that children will often not consider themselves to be a victim of abuse or exploitation, and may well consider their abuser to be someone who loves or cares for them. Adults working with children therefore need to be particularly sensitive in engaging with children or young people where there is a suspicion they are being abused or groomed online.

## References

Bentley, H. et al (2018) How safe are our children? The most comprehensive overview of child protection in the UK 2018. London: NSPCC.  
<https://www.nspcc.org.uk/globalassets/documents/research-reports/how-safe-children-2018-report.pdf>

Baines, V. (2008) *Online Child Sexual Abuse: The Law Enforcement Response*. ECPAT: London.  
[http://www.ecpat.net/worldcongressIII/PDF/Publications/ICT\\_Law/Thematic\\_Paper\\_ICTLAW\\_ENG.pdf](http://www.ecpat.net/worldcongressIII/PDF/Publications/ICT_Law/Thematic_Paper_ICTLAW_ENG.pdf)

Byron, T. (2008) *Safer Children in a Digital World: Report of the Byron Review*. DCSF: London.  
<http://media.education.gov.uk/assets/files/pdf/s/safer%20children%20in%20a%20digital%20world%20the%202008%20byron%20review.pdf>

CEOP (2007) *Strategic Overview 2006–7*.  
[http://www.educationscotland.gov.uk/Images/all\\_experiences\\_outcomes\\_tcm4-539562.pdf](http://www.educationscotland.gov.uk/Images/all_experiences_outcomes_tcm4-539562.pdf), p.303

[http://www.educationscotland.gov.uk/Images/all\\_experiences\\_outcomes\\_tcm4-539562.pdf](http://www.educationscotland.gov.uk/Images/all_experiences_outcomes_tcm4-539562.pdf), p.310

Get Safe Online (2007) *Social networkers and wireless networks users provide “rich pickings” for criminals*. (Press release). Available at:  
[http://www.getsafeonline.org/nqcontent.cfm?a\\_id=1469](http://www.getsafeonline.org/nqcontent.cfm?a_id=1469)

Hasebrink, U., Livingstone, S., Haddon, L. and Ólafsson, K. (2009) *Comparing children’s online opportunities and risks across Europe: Cross-national comparisons for EU Kids Online*. LSE, London: EU Kids Online

Hinduja, S. and J. Patchin, J. W. Personal Information of Adolescents on the Internet: A Quantitative Content Analysis of MySpace. *Journal of Adolescence*, 31 (2008) 125–146.  
<http://sfcs.cals.arizona.edu/azsearch/sites/sfcs.cals.arizona.edu/azsearch/files/Hinduja,%202008.pdf>

Ibid, p47

Lilley C, Ball R and Vernon H (2014) “The Experiences of 11-16 year olds on social networking sites” London NSPCC

Livingstone, S. & Bober, M. (2005) *UK Children Go Online: Final report of key project findings*. ESCR: London.  
[http://www.lse.ac.uk/collections/children-go-online/UKCGO\\_Final\\_report.pdf](http://www.lse.ac.uk/collections/children-go-online/UKCGO_Final_report.pdf)

Millwood Hargrave, A. & Livingstone, S. (2006). *Harm and Offence in Media Content: A review of the evidence*. Intellect: Bristol.

Peter, J., Valkenburg, P. and Schouten, A. (2006) Characteristics and Motives of Adolescents Talking with Strangers on the Internet. *CyberPsychology & Behavior*, 9 (5), pp. 526-530

Whittle, H., Hamilton-Giachritsis, C., Beech, A.R., & Collings, G. (2013). A review of young people's vulnerabilities to online grooming. *Aggression and Violent Behavior*, 18, 135-146.

## **Appendix 1 – Legislation**

The following pieces of legislation are particularly relevant in relation to internet child sexual abuse and exploitation.

(from Internet Safety for Children and Young People: National Action Plan)

### **The Communications Act 2003, Section 127**

It is an offence to send a message which is grossly offensive or of an indecent, obscene or menacing character

### **The Civic Government (Scotland) Act 1982, Sections 52 and 52A**

It is an offence to have in your possession or to make, take or distribute indecent images of children

### **The Sexual Offences (Scotland) Act 2009, Sections 6, 23, 24, 33 and 34**

It is an offence to coerce a person, or to cause a child under the age of 16, to view a sexual image or receive a sexual communication, where it is done for the purpose of obtaining sexual gratification or causing the recipient fear, alarm or distress.

### **The Abusive Behaviour and Sexual Harm (Scotland) Act 2016**

When it comes into force, it will criminalise the non-consensual sharing of intimate images of another person.

The 2016 Act will also introduce Sexual Risk Orders (SROs) which will strengthen and streamline the current risk of sexual harm order provisions in the Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005. SROs may be made in relation to a person without a conviction for a sexual offence (or any offence), but who poses a risk of sexual harm. The SRO may be made by the court on application, by the police, where an individual has done an act of a sexual nature, e.g. engaged in sexually explicit conduct or communication with a child or children.

### **Criminal Justice and Licensing (Scotland) Act 2010, Section 38 and 39**

It is an offence for a person to behave in a threatening or abusive manner, where that behaviour would be likely to cause a reasonable person to feel fear or alarm

Depending on the facts and circumstances of the case, it may be possible to use the offence of stalking to prosecute a person who publishes any statement relating to a person or purporting to originate from that person or from another person that causes them to feel fear or alarm

### **Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005, Sections 1, 9, 10 11 and 12**

It is an offence (often referred to as an offence of 'grooming') for a person intentionally to meet, travel with the intention of meeting, or make arrangements with the intention of meeting a child under the age of 16 in any part of the world, if that person has met or communicated with the child on at least one earlier occasion, and

intends to engage in unlawful sexual activity involving the child or in the presence of the child either at the time of the meeting or after the meeting.

It is also an offence to pay for the sexual services of a child or to be involved in facilitating a child's involvement in child pornography.

### **Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005, Sections 2 - 8**

These sections make provision for Risk of Sexual Harm Orders (RSHOs). The purpose of this order is to give courts the power to place conditions on someone who is behaving in such a way which suggests that they pose a risk of sexual harm to a particular child or children generally. RSHOs can be made in respect of any person of any age if it appears to the police that that person has, on at least two occasions, engaged in certain inappropriate sexual conduct or communication with a child or children (under 16), and as a result there is reasonable cause to believe that it is necessary for the order to be made.

### **Offensive Behaviour at Football and Threatening Communications (Scotland) Act 2012, Section 6**

It is an offence to communicate material (including images) to someone that contains or implies a threat or incitement to carry out serious violence against a person or group of people. The communication must be likely to cause a reasonable person fear or alarm and be sent with the intent to, or recklessness as to whether it will, cause fear or alarm

### **Human Trafficking and Exploitation (Scotland) Act 2015 - Section 1**

Section 1 sets out the offence of human trafficking. There are two parts to the offence: the relevant action and an intention to exploit or knowledge of likely exploitation [\[3\]](#); both are needed for an offence to be committed.

The first part of the offence is carrying out a relevant action with regard to another person. It does not matter whether that other person consents to that action being taken.

A relevant action includes any of the following:

- Recruiting another person;
- Transporting or transferring another person;
- Harboring or receiving another person;
- Exchanging control over, or transferring control over another person;
- Arranging or facilitating (without necessarily doing), any of the actions above.

The internet could play a role in these actions.

Travel from one place to another is not a required action for there to be an offence of human trafficking in Scotland, although it can form part of the offence.

Involving a person in the making or production of materials which are classified as obscene under the Civic Government (Scotland) Act 1982 (i.e. 'extreme' or child pornography) is included in the definition of exploitation. The definition also includes circumstances where the person has been the victim of certain sexual offences listed in section 3(5) of the Act, such as rape, sexual assault or child-sex offences.

Where a person has committed the offence of human trafficking against a child, then section 6 of the Act requires a court to take that into account in sentencing and explain what part that consideration played in sentencing. It allows the court to increase the sentence it would have given in respect of the human trafficking, because it was committed against a child. It also requires the conviction to be recorded in a way which highlights the fact that it was committed against a child. In this Act, a child is a person under the age of 18.

(What is currently listed)

## **PROTECTION OF CHILDREN AND PREVENTION OF SEXUAL OFFENCES (SCOTLAND) ACT 2005**

<http://www.legislation.gov.uk/asp/2005/9/contents>

### **Grooming**

Section 1 make it an offence for a person (A) to meet, travel to, or make arrangements to meet another person (B) if:

- A has previously met or been in contact with B;
- A intends to engage in unlawful sexual activity with, or in the presence of B; and
- B is under 16 or B is a police officer.

The course of conduct prior to the meeting that triggers the offence may have an explicitly sexual content, though this need not be the case. The evidence of A's intention to engage in unlawful sexual activity may be drawn from the communications between A and B prior to the meeting, or may be drawn from other circumstances, for example if A travels to the meeting with condoms and lubricants. However, the intended sexual contact does not have to take place for the offence of grooming to take place. It is a defence if A reasonably believed B to be over 16

### **Risk of Sexual Harm Orders**

Section 2 introduces the Risk of Sexual Harm Order (RSHO). The police can apply to a sheriff court in respect of a person who has, on at least two occasions, engaged in sexually explicit conduct or communication with a child/children (under 16) and there is reasonable cause to believe that the order is necessary to protect a child/children in the future.

The application may be made in the sheriffdom where the person lives, is believed to be in, is intending to come to; or where the alleged acts are said to have taken place. The application must generally be made within three months of the second incident, though the sheriff may accept an application outwith this timescale.

The sexual conduct may be:

- engaging in sexual activity involving, or in the presence of a child;
- causing or inciting a child to watch a person engaging in sexual activity or to look at a moving or still image that is sexual;
- giving a child anything that relates to, or contains a reference to sexual activity;
- communicating with a child, where any part of the communication is sexual.

The sexual conduct may amount to a criminal offence, but this need not be the case.

## **CIVIC GOVERNMENT (SCOTLAND) ACT 1982**

<http://www.legislation.gov.uk/ukpga/1982/45>

### **Indecent Child Images**

Section 52 makes it an offence to take, allow, or make any indecent photograph, film or other digital image of a child. It is also an offence to distribute or publish such an image, or to possess one with a view to distributing it.

The image may be a copy, or a file stored on a computer or other storage device.

## **SEXUAL OFFENCES (SCOTLAND) ACT 2009**

<http://www.legislation.gov.uk/asp/2009/9/contents>

### **Coercing a person into looking at a sexual image**

There are three relevant sections for this offence. Section 6 makes it an offence to cause another person, without their consent, to look at a sexual image, if it is done for the sexual gratification of the alleged offender, or to humiliate, distress or alarm the other person. A sexual image is either an image of the sender or someone else engaging in a sexual activity, or an image of the genitalia of the sender or someone else.

Section 23 makes it an offence for anyone to show such an image to a child under 13 years, whether they consent or not.

## APPENDIX 2 - KEY SAFETY MESSAGES

Byron recommended that:

*“Children and young people need to be empowered to keep themselves safe – this isn’t just about a top-down approach. Children will be children – pushing boundaries and taking risks.”*

Children and young people need to be able to

- Explore and use the internet and play video games for **fun, creativity and development**.
- Achieve this in an environment where there is **a reduced risk** of coming across harmful or inappropriate material.
- Manage or be able to find the support to manage risks that are age-appropriate should they encounter them.
- Take **ownership** of their own online safety and gaming and be supported to do so in **environments that encourage and promote safe behaviour** and provide user-friendly safety information and tools.

Ultimately, it is the responsibility of the adults in a child or young person’s life to protect them. This will involve both setting boundaries and overseeing the child or young person’s internet use; and empowering the child or young person to manage themselves safely and to access help if they need it.

Key safety messages for children are available in age appropriate language on the **ThinkUKnow website** – <https://www.thinkuknow.co.uk/>. These include:

- How to have fun
  - Information about the range of applications and programmes
  - How to stay in control
  - Managing your privacy settings
  - Choosing what information to share e.g. personal info, pictures
  - Making contact with people online
- What can go wrong
  - Putting up stuff you wish you hadn’t
  - Seeing things you wish you hadn’t
  - Talking to people who make you feel uncomfortable
  - Feeling pressured to do things you don’t want to
- How to report
  - Talking to a trusted adult
  - Using CEOP Report Abuse Button
  - What will happen next

There are many other useful websites available with information for children, carers and professionals. These include:

**Get Safe Online** provides computer users with advice on using the internet confidently, safely and securely. It covers a wide range of issues, including internet safety for children and young people. <http://www.getsafeonline.org/>

**Childnet** has information for children and young people on how to use the internet constructively and develop “net literacy” skills, as well as information for those working to protect children online.

<https://www.childnet.com/>

**Child Exploitation and Online Protection Service (CEOPs)** is a national police agency, which is engaged in operational police work and intelligence gathering to combat online child abuse and exploitation, as well as training and awareness raising for children, carers and professionals.

<http://ceop.police.uk/>

## APPENDIX 3 – IMPACT OF AGE AND BRAIN DEVELOPMENT ON ABILITY TO MANAGE RISK ONLINE

The following table identifies the benefits and vulnerabilities in relation to Internet use at different ages, and highlights particular support needs.

Age	Brain Development – Key Stages	Benefits	Vulnerabilities	Support needs
<b>Pre-school</b>	Family focused  Forming appropriate adult relationships and developing attachment	Fun – imaginative and role play  Development of responsibility and routine	Difficulty defining fantasy from reality  Vulnerable to violent, sexual, emotional content and contact  Mirroring of negative behaviours observed online	Significant online supervision and restriction to minimise inappropriate exposure.
<b>5-11yrs</b>	Beginning to develop peer friendships  Learning right from wrong  Beginning to understand social rules and norms  Defining reality from fantasy  Experiences inform development of frontal cortex	Opportunity to develop critical evaluation and self management	Impulse controls still inhibited  Immature self regulation  Increasingly pushing boundaries of parental or commercial control  Confusion and emotional harm from poor social judgements  Peak usage age	Management and regulation alongside discussion that creates opportunities for development of evaluation and self regulation
<b>11-14yrs</b>	Significant hormonal, physical and mental changes  Drive for external social interaction  Social identity development  Changes in 'reward' network resulting in increased risk taking behaviours	Opportunity to test behaviours and identity development  Development of peer communication and relationships  Learning opportunities for exploration and experimentation	Increase vulnerability of mental health and esteem issues  Susceptible to social acceptance demands  Increasing restricted access to outdoor socialisation plus drive for social experiences increases likelihood of creating online experiences.	Support to take 'safe' risks and development through collaborative management involving discussion and mediation.  Protective measures to manage drive for risk taking and seeking out age restricted content.
<b>15-18yrs</b>	Near adult brain functioning  Value and belief system development	Opportunity for autonomous decision making and independence, and for identity construction	Changes in the structure and function of the brain from reduced development of key skills caused by extensive online and lack of offline activities and skills development.	Providing opportunity for independent decision making and testing whilst ensuring a supportive and trusting relationship remains available to assist if necessary.

## Protocol 10

# Supporting Children and Young People who Self Harm

### Protocol for staff working with children and young people who self-harm

#### Introduction

This protocol is designed to link with both the Shetland Getting it Right for every Child Guidance and the Shetland Interagency Child Protection Procedures. The purpose of this protocol is to ensure that all agencies working in Shetland provide a consistent, caring and appropriate response to children and young people who are at risk of self-harm and suicide.

It is influenced by the views of young people and what they find helpful. It is also designed to give guidance about assessing levels of risk and what help can be given.

It is divided into 4 sections -

- Section 1 Information about Self harm and suicide
- Section 2 Guidance for Staff
- Section 3 Confidentiality and Information sharing
- Section 4 Useful websites and further information.
- Additionally [Appendix 1](#) contains a table that gives dos and dont's and also a reference list

The aims of this guidance is to:

- ensure the child or young person is seen as central to the whole process and accorded appropriate priority by the agencies involved;
- ensure a consistent response to and understanding of self-harm across all agencies concerned with children and young people;
- provide an agreed set of procedures for dealing with disclosure of self-harm or abusive experiences that are leading to self-harm
- minimise harm and support the emotional health and wellbeing of the child and young person through collaborative working;
- provide children and young people with opportunities and strategies for hope and recovery from the effects of self-harming or attempting suicide
- minimise the risk of future harm;
- support staff to carry out a risk assessment to ensure that if a child or young person is at risk of abuse or suicide then child protection referrals or appropriate requests for medical help can be made

## **Section 1 Information about Self-harm and Suicide**

### **1.1 Introduction**

Self-harm is usually a private expression of personal distress. The National Self-harm network defines it as:

“Self-harm describes any behaviour where someone causes harm to themselves, usually as a way to help cope with difficult or distressing thoughts and feelings it most frequently takes the form of cutting, burning or non-lethal overdoses. However, it can also be any behaviour that causes injury - no matter how minor, or high-risk behaviour. Basically, any behaviour that causes harm or injury to someone as a way to deal with difficult emotions can be seen as self-harm. “

Self-harm is generally a way of coping with overwhelming emotional distress. Most young people who self-harm have no intention of committing suicide. However, research shows that some young people who self-harm can be at higher risk of suicide.

### **1.2 Myths about Self-harm**

The following information has been collated from a range of sources, including the National Self-harm Network, Truth Hurts report, SAMH, NHS Inform and Selfharm.co.uk

#### **Myth 1 Self-harm is attempted suicide**

This is rarely the case. A survey of 758 people who self-harmed carried out by the National Self-Harm network in 2009 showed that 4% of those had suicidal feelings

Self-harm is sometimes viewed as a suicide attempt by people who do not understand it. For many people self-harm is about trying to cope with difficult feelings and circumstances. Some people have described it is a way of staying alive and surviving these difficulties. However, some people who self-harm can feel suicidal and might attempt to take their own life, which is why it must always be taken seriously. (Truth Hurts Report, 2006

*“For me it was never about wanting to kill myself. If anything this temporary relief from desperation actually helped me move on from such thoughts.”  
(SAMH Understanding Self-harm booklet)*

#### **Myth 2 Self-harm is all about attention seeking**

More often than not self-harm is a very private and hidden behaviour that does not involve anyone else. Some individuals who do let people know about their self-harm may do this as they have no other way to communicate how they are feeling. The phrase “attention seeking” is in itself stigmatising. It may be appropriate to say “this person is in need of attention” or “lets pay attention to their needs”

### **Myth 3 The more serious the injury the more serious the problem**

It is important to take all injuries seriously, as the nature of the wound does not represent the extent of the anguish being experienced.

### **Myth 4 They must like the pain**

Self-harm is not about liking pain. It is a way to cope with thoughts and feelings that are depressing or distressing and to regain some control over how you feel. A lot of the time, individuals who self-harm do not actually feel any pain due to adrenaline instead they feel a release.

Self-harm can also be a mechanism that allows individuals to 'feel' something as the feeling of being emotionally numb and empty are common symptoms of depression. Such feelings of pain can also be used to 'ground' oneself in reality when feeling disassociated such as during flashbacks common with Post Traumatic Stress Disorder or manic episodes such as those experienced by individuals with Bi-polar Disorder.

In some cases individuals self-harm to punish themselves. This may be due to feelings of guilt or shame. This is common in cases of sexual abuse and sexual assault. Individuals who self-harm for these reasons are seeking pain but not for gratification

### **Myth 5 Self-harm is a young person's issue**

It is not only the young that self-harm, triggers for self-harm are experienced by people of all ages.

Research has suggested that self-harm is most common among 15-19 year olds, and those suffering from [anxiety](#) and [depression](#). (NHS Inform 2019)

Most young people reported that they started to hurt themselves around the age of 12. (Truth Hurts)

It is more likely that a young person who is still attending school could be identified if they are self-harming. It may be much more difficult to identify older adults who self-harm

### **Myth 6 People who self-harm can stop easily if they want to**

Self-harm is very often a coping mechanism; therefore it is very difficult for someone to stop without learning new ways of coping. Triggers for self-harm such as abuse, bullying etc. are unlikely to be resolved over night. Recovery can be a slow process. It is possible that self-harm can also turn into an addiction. Therefore it can be a great struggle to stop even if you want to, the same way as it would be for somebody trying to give up smoking or drinking to excess. Individuals may need a great deal of support to move away from using self-harm as a method of coping.

### **Myth 7 Self-harm is the problem, if we stop this then the person will be fine**

Self-harm is rarely the problem, but a solution until other issues are resolved. It is the reasons that lay behind individuals self-harm that need to be addressed in order to aid a recovery from self-harm.

### **Myth 8 Only Girls self-harm**

Society holds this image of self-harm just affecting vulnerable young teenage girls, but that is not true. Self-harm can affect everyone and anyone and that means boys and men too.

Statistics vary - some think that for every 2 girls self-harming there is only 1 boy, but actually, the figures could be about the same. Boys have emotions and difficulties every bit the same as every girl their own age. Teenage years are no easier for boys than they are for girls, girls are no more likely to have a rough time at home or school than boys, and girls are no more likely to be unhappy than boys. Boys have feelings, boys hurt, and boys self-harm.

“Girls are thought to be more likely to self-harm than boys, but this could be because boys are more likely to engage in behaviours such as punching a wall, which isn't always recognised as self-harm or doesn't come to the attention of hospitals” (Self-harm .co.uk 2019)

### **1.3 Who self-harms?**

Self-harm is a very private behaviour; therefore it is difficult to know exactly how prevalent self-harm is. In Shetland, pupils are offered a health check in their 3<sup>rd</sup> year of secondary school. The health check covers physical factors like their height and weight as well as questions about lifestyle such as alcohol, smoking, diet, mental wellbeing and physical activity. One of the questions pupils are asked is “*have you ever deliberately injured yourself?* Over the past 3 data sets, the percentage of pupils responding “yes” to this question has decreased from 10.2% in 2015 to 5% in September 2017.

It is estimated around 3.8% of the whole population may self-harm.

(<https://www.time-to-change.org.uk/about-mental-health/types-problems/self-harm>)

There is no such thing as a typical young person who self-harms. **Self-harm is something that can affect anyone.** It is believed that around 10% of young people self-harm, but it could be as high as 20%. If you self-harm, there are a lot of people who also know what you are going through. (MH Foundation)

Any young person may self-harm - sometimes as an isolated incident and sometimes as a result of bullying, abuse or other traumatic event. Self-harm does not discriminate and can affect anyone. Self-harm in young children - lower primary age or pre-school - would always be a warning sign of high risk requiring an immediate child protection response and medical help, as it is more unusual to find self-harming behaviour in young or very young children.

Some groups of young people who may be experiencing emotional distress due to their circumstances can be at increased risk of using self-harm as a way of coping. Young people who have experienced adverse events in their early childhood, have been abused, are Looked After Children (particularly those placed in residential settings) young Asian women coping with societal and cultural pressures and racism, and LGBT young people may all be at greater risk. There is some evidence that children living in more rural and isolated areas and teenage girls can be at increased risk also.

Self-harm often takes place very privately and may not be obvious. It is important to remember that self-harm may be a response to a difficult situation and there may be times when it is appropriate to ask about this in a sensitive and appropriate way.

Children and young people can be influenced by a friend who self-harms or membership of a sub-culture that advocates self-harm. It is important not to just label this as copycat behaviour, but to see that the young person is reacting to peer pressure and still needs some understanding and support.

#### **1.4 How do young people self-harm?**

Self-harm is a very private behaviour and will often be hidden. Most often people think of self-harm as cutting, burning or poisoning. It is important to recognise that some forms of self-harm may be harder to detect because they are seen as being more 'socially or culturally acceptable'.

Some other examples of self-harming behaviours are:

- Taking an overdose of tablets
- Swallowing hazardous materials or substances
- Inserting objects into the body
- Burning chemically
- Over/under-medicating, e.g. misuse of insulin
- Punching/hitting/bruising
- Hair-pulling/skin-picking/head-banging
- Episodes of alcohol/drug abuse
- Risky sexual behaviour
- Over or under-eating at times may be deliberate acts of self-harm (eating disorders can be a significant mental health problem and would require specialist treatment)

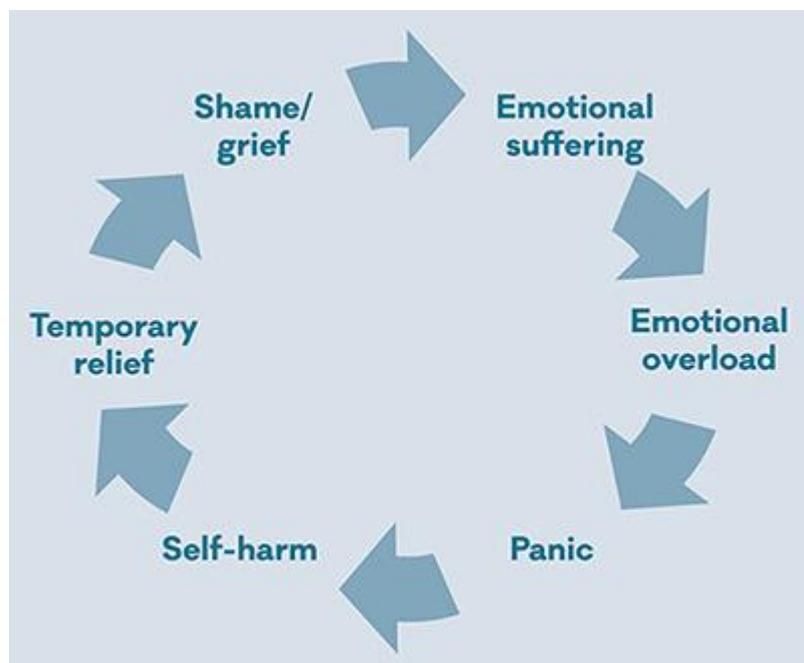
#### **1.5 Why do young people self-harm?**

In trying to understand why some young people may self-harm it is important to understand the physiological and psychological aspects. The physical manifestation of emotional pain can help people cope.

For some people, self-harm may last for a short time. For others, it can become a long-term problem. Some people self-harm, stop for a while, and then return to it months, even years, later, in times of distress.

The reasons people gave for self-harming are varied and include:

- self-harm temporarily relieves intense feelings, pressure or anxiety;
- self-harm provides a sense of being real, being alive - of feeling something other than emotional numbness;
- harming oneself is a way to externalise emotional internal pain - to feel pain on the outside instead of the inside;
- self-harm is a way to control and manage pain – unlike the pain experienced through physical or sexual abuse;
- self-harm is self-soothing behaviour for someone who does not have other means to calm intense emotions;
- self-loathing - some people who self-harm are punishing themselves for having strong feelings (which they were usually not allowed to express as children), or for a sense that somehow they are bad and undeserving (for example, an outgrowth of abuse and a belief that it was deserved);
- self-harm followed by tending to wounds is a way to be self-nurturing, for someone who never was shown by an adult to express self-care;
- harming oneself can be a way to draw attention to the need for help, to ask for assistance in an indirect way;
- on rare occasions self-harm is used to manipulate others: make other people feel guilty or bad, make them care, or make them go away;
- Self-harm can be influenced by alcohol and drug misuse.
- Self-harm can sometimes be seen as part of a 'trend'. This can be related to trends in the local area or may be influenced by trends in the media such as the behaviour of pop stars or celebrities.



The diagram above is taken from “Truth about Self-harm” by the Mental Health Foundation. It shows the cycle of emotions, which can perpetuate the continuation of self-harming behaviours.

**1.6 Biological effects of self-harm:**

- Self-harm can bring its own physical release
- Impact of neurochemicals – endogenous opioids and serotonin
- May generate feelings of calm and well-being
- These neurochemicals are released particularly when the body is injured in any way
- Produce insensitivity to pain
- Body grows to expect a higher level of these chemicals

## **Section 2 Guidance for staff**

### **2.1 Introduction**

This guidance is primarily aimed at supporting staff that are providing services to children and young people up to the age of 18. However, it provides a good practice guide that can be helpful for young adults aged up to 25.

Anyone can make a child protection referral if they are concerned that a child or young person aged under 16 may be at risk of significant harm. For young people aged 16-18 [Protocol 11](#) Vulnerable Young people may be helpful. Children's Social Work will take referrals in respect of young people age up to 18.

### **2.2 How to Respond**

If a young person tells you, they have been self-harming or you see an injury or receive information from others then the most important response is not to panic, but to deal with it calmly. If you see an injury or receive information that young person has been self-harming then speak to them quietly and privately and show that you are concerned for their welfare. If they have a current injury and it is serious or has been done with suicidal intent (the young person may tell you this or have left a message to this effect) then seek medical help quickly by calling an ambulance or going to A+E.

You can also seek medical advice about a less serious injury. This could include contacting NHS 24 on 111 (open 24 hours) or through a nurse or doctor locally.

Staff can find contact details for their local health centre here:

<http://www.shb.scot.nhs.uk/community/index.asp>

Listen carefully to what a young person is telling you. If you feel that speaking to them about self-harming behaviour is beyond your skills or abilities speak immediately to a line manager or someone who can discuss the situation with the child or young person. It is important that any response is helpful and places the child at the centre so if you do need to speak to someone else let the young person know what you are doing and why.

Your core skills and values of empathy, understanding, non-judgmental listening and respect for individuals are all vital in this area.

#### **Do**

- Explain your role and the limits of your confidentiality
- Treat the young person respectfully
- Listen empathically
- Follow first aid procedures when responding to an injury

- Reassure the young person; acknowledge their bravery in talking about self-harm. Let them know what support is available and involve them in decisions about this as far as possible.
- Give reliable information about self-harm in a straight forward and matter of fact manner
- Assess current level of risk to the young person and involve them in this discussion
- Assess whether parents/carers should be informed
- Make appropriate referrals if required

**Be mindful of:**

- The young person's feelings. Common feelings can include guilt, shame, sadness.
- Safety issues such as the risk of infection, nerve damage, illness such as HIV, AIDs, Hepatitis C or even risk of accidental death
- Associated problems such as bullying, bereavement, relationship difficulties, abuse and sexuality
- Whether informing parents/carers could increase the risk of self-harm for the child/young person.

**Don't**

- Tell the young person to stop as this can makes things worse
- Judge the person, use stigmatising language or direct blame or guilt onto them.
- Promise to keep this a secret – you can explain that you will be discrete and only tell the people who need to know to help keep the young person safe.

Take all suicide gestures and thoughts seriously and seek help immediately.

It is vital that the young person retains some control of their situation - is fully aware of who needs to be informed and why, is consulted on their views, is allowed wherever possible to set the pace and make choices. To do otherwise could result in a worsening of the self-harm.

Remember that self-harm is often a way of coping, so stopping the self-harm is not always the best thing to aim for immediately. Safety and understanding are more important in the short term. There is no quick fix.

Some further dos and don'ts are included in the table at [Appendix 1](#)

### **2.3 Social Media**

Today's young people have grown up with the internet and some may use it, not just for entertainment, but also as somewhere to seek information or support.

Child Line, Youth Net (the charity behind TheSite.org), selfharmUK and Young Minds commissioned a poll of 2,000 children and young people between the ages of 11 and 21. Their findings showed that around a third of 11-18 year olds and 69% of 18-21 year olds said they would go online for support and information about self-harm.

Social media in particular is popular with young people, many accounts are visible publicly and this can mean that people are at risk of being exposed to content, which they find distressing. The aforementioned poll found that:

- One in every four 11-14 year olds and seven out of ten of 18-21 year olds said they had seen images online showing someone self-harming
- Of those who had seen an image of someone self-harming, over half of all 11-14 year olds and one in every four 18-21 year olds said they had 'felt like hurting themselves' after seeing these images
- Of those who had seen an image of someone self-harming, nine out of every ten 11-14 year olds and eight out of every ten 18-21 year olds said they had found the images upsetting.
- Of those who had seen an image of someone self-harming, six out of every ten 11-14 year olds and one in ten 18-21 year olds said they had shared images of someone self-harming on social media
- Over half of all 11-21 year olds said they wouldn't know how to report an image of someone self-harming on social media

It is important to take these factors into account so that we can direct young people to safe sources of online support. (See the Resources section for more detail)

## **2.4 Assessing Risk**

Risk assessment needs to consider both the risk that the young person is placing themselves at by the method and frequency of self-harming that they are using and also if the reasons they are self-harming indicate that they may be being abused or at risk of harm from others. For example, we know that young people can be at risk of domestic abuse within relationships. If a young person was self-harming to cope with the emotional effects of being in an abusive relationship then there may be two elements of risk that would need to be considered. It is important to assess the risk, but this needs to be done with care and in a way that does not further distress the child or young person or bombard them with too many questions. Finding a safe and private place to speak is important. Use the following sections of this protocol to think through likely risks

## **2.5 Suicide and Self-Harm**

Self-harming behaviours can increase the risk of attempting suicide. However, most people who self-harm have no intention of suicide and for many, self-harm will be a way of coping and staying alive. However if you are supporting a young person who has self-harmed, it is worth checking out whether they have any suicidal thoughts or feelings.

Sometimes staff may feel anxious about asking a young person if they feel suicidal. **At the root of this anxiety is often the mistaken belief that asking someone about suicide may give them the idea to try it. This is not true. Asking someone if they are feeling suicidal has the potential to save their life.**

Some signs that somebody may be feeling suicidal can include: (*Taken from SMHFA YP Manual p78 – Health Scotland*)

### **Behaviours**

- Actively looking for ways to hurt or kill themselves
- Threatening to hurt or kill themselves
- Seeking access to means of killing self (e.g. pills, weapons etc.)
- Alcohol/drug misuse
- Withdrawal from friends and family
- Prior suicidal behaviour/ recent suicide attempt
- Crying / emotional outbursts

### **Thoughts**

- Talking/planning/writing about suicidal and/or death
- Belief there is no way out
- Feeling that there is no future
- Talking about wanting to escape
- Hopelessness

### **Feelings**

- Sad
- Worthless
- Guilty
- Ashamed
- Helpless
- Hopeless
- Disconnected
- Lonely
- Lacking purpose

### **Situations**

- Bullying
- Abuse
- Relationship problems
- School problems
- Physical/mental health problems
- Trouble with the law
- Family problems
- Isolation

### **Physical Changes**

- Low energy
- Change in sleeping habits

- Change in eating habits
- Increase in minor illnesses

### **Appearing more cheerful after distress**

- This is a difficult one to spot. Sometimes a person may appear more cheerful after a period of distress because they have made the decision to end their life.

The above list is not exhaustive; if you have a gut feeling that the person may feel suicidal, the best thing to do is ask directly.

If you do need to ask a young person if they feel suicidal, do so gently and with compassion. Consider your choice of language to ensure that the young person will be able to understand you and that there will be no ambiguity that suicide is what you are talking about.

It is important to ask the question in a way, which is direct. Talking about suicide is difficult. Asking the person directly can make things a little easier as it allows them to answer with just a “yes” or “no” rather than them having to struggle to find words to describe their situation.

Some examples of ways to ask are:

- Do you feel suicidal?
- Do you want to take your own life?
- Have you made plans to end your life?
- Do you want to die?
- Are you thinking about suicide?

You can also use the symptoms you have observed or things the person has expressed to help you ask the question, for example, *“when you say you wish you hadn’t been born do you mean you feel suicidal?”* or *“I’ve been really worried about you and you seem unhappy and withdrawn. Have you been thinking about suicide?”*

Once you are aware of whether the person feels suicidal, you can then move on to safeguarding.

If they say “yes”, you should refer them to their GP, and make a plan to help keep the young person safe until they can get further support. You should do the same if the young person says “no” but you don’t believe they are being honest.

Asking about suicide can feel uncomfortable and emotional so it is important that you also seek support for yourself from colleagues or your supervisor.

## Local Training:

### ASIST (Applied Suicide Intervention Skills Training)

This is a two-day course designed to help you feel ready, willing and able to ask about suicide and put a first aid plan in place to support the person at risk. For more info contact [shet-hb.healthshetland@nhs.net](mailto:shet-hb.healthshetland@nhs.net)

### 2.6 Child Protection

If the episode of self-harm is associated with sexual abuse, physical abuse, psychological or emotional abuse and the child or young person (or other children or young people) are at risk then follow the Shetland Interagency Child Protection Procedures and contact your line manager and duty social worker. If you are not sure whether this may be child protection or not then you can seek advice from the duty social worker.

### 2.7 Gathering Information

In speaking to a young person about their self-harm, the following may be helpful in assessing why they are self-harming and what may be causing them distress.

- **Health**
  - Ask about other health issues – eating, sleeping, physical and emotional feelings.
  - Mental wellbeing.
- **Other risk taking behaviours**
  - Use of alcohol and drugs.
  - Placing themselves at risk sexually.
- **General Distress**
  - Current level of distress.
  - Ascertain what needs to happen to help the child feel better.
  - What can you do to help them feel better?
  - What support is the child already receiving?
- **Future Support**
  - Ask them “What would you like me to do to help you?”
  - Can harm reduction help keep the young person safer?
  - Elicit current strategies that have been used to resist the urge to self-harm.
  - Who knows about this situation and who can help?
  - Discuss contacting parents if that would be helpful. – Approach with caution as parents may be a contributing factor
  - Discuss around referral to other services.
  - Discuss who you will contact and what you will say.

[Section 3](#) below has more information about consent and confidentiality and may help when considering with the young person who to tell about their self-harming behaviour.

### **2.8 What to do if you suspect self-harm or have third party information**

Staff may have observed a young person behaving in a way that indicates they may be self-harming; Staff may receive third party information from other young people or the young person's parents that the person is self-harming. Staff may be aware of something on social media that indicates self-harm. If observations or third party information indicates high risk- child protection or suicidal intent then staff should always follow procedures and refer on quickly.

If there, is no evidence of immediate high risk then speaking to the child's Named Person and agreeing a way forward is appropriate. (see below for more information on Named Persons) Someone who knows the child or young person well – and that may or may not be the person who had the original concern – should find a quiet and calm time and place to speak to the young person. By indicating that you are not shocked and there are safe places to go to seek help, you may be able to assist the young person. Websites and other information in [Section 4](#) may also be helpful to share.

### **2.9 The role of the Named Person, Lead Professional and the Child's Plan**

Every child from birth to 18 has a Named Person who has specific role in being a point of contact for parents and children and any practitioner who may have a concern about a child. They will trigger additional help for a child or their family if required. Children, young people and families will have clear information about who is the child/young person's named person. The Named Person will be accessible to the child, young person and parent/carer as someone they can talk to about any area affecting their child. The Named Person will remain associated with the child, even if additional help is offered.

The Named Person holds basic information about the child and family. If information is shared with the Named Person by any agency or professional that indicates a child's wellbeing is being affected in some way then the Named Person can begin an assessment of the situation. If required a Lead Professional (who may or may not be the Named Person) will be identified and they will then take a more active role in working closely with parents and children and any agencies or services who are assisting the family or who could assist the family to draw up a child's plan. This plan is based on assessed need and is outcome focussed.

To illustrate how this may work in practice for a primary school aged child the named person will be the Head Teacher/Depute Head Teacher in the school. If, acting on concerns shared about the child, the Head Teacher/Depute Head Teacher decides that the child requires additional support they will start an assessment and identify a Lead Professional. This – for example – could be the child's class teacher who knows the child very well and has an existing relationship with the child's parents. Further information is available at the following web link:

[http://www.shetland.gov.uk/children\\_and\\_families/GIRFEC.asp](http://www.shetland.gov.uk/children_and_families/GIRFEC.asp)

Who is the Named Person?

<b>Age of child or young person</b>	<b>Named Person</b>
Pre birth - 10 days	Midwife
10 days - Primary School entry to P1	Health Visitor
Primary School P1 - P7	Head teacher or designated other; this is likely to be a Depute Head teacher or Principal Teacher
Secondary School up to the age of 18	Head teacher or designated; Depute Head teacher, Pupil Support or Principle ASN Teacher
Young people aged 16-18 who are not in school	Shetland Islands Council Youth Work Services
Young people 16 – 26 who are or who have been Looked After	Through Care and Aftercare Team

The presenting problems that may trigger a Named Person to begin an assessment and Child's Plan may not initially be about self-harming behaviour and this issue may come to light as a result of work with the family. For example, the child who is always late to school, struggling in school and who appears unhappy may, on further assessment, be self-harming due to experiences of bullying or low self-esteem.

## **2.10 Help and Support**

If staff are concerned about the mental health of the child or young person then seeking help through a GP is appropriate. The Child and Adolescent Mental Health Team are available to staff who need some advice about children and young people who self-harm. Most young people who self-harm do not have a mental illness, but some may need more specialised help

### **Positive Staff Attitudes**

Children and Young people's' experiences of services are much more positive when they encounter staff with non-judgmental attitudes who try to understand self-harm behavior. For example, respondents to recent research reported that their experiences were greatly improved when healthcare professionals showed them respect and were calm, reassuring and considerate.

The following quotes are taken from Time to Change:

*“Both A and C were the first teachers I had properly opened up to. Although they had a duty of care, meaning at times they did have to forward on what I said, I still felt like I could trust them. I told A about my self-harm first, and although I knew he'd have to pass it on, he was still very nice and willing to talk to me about it. The key thing was that he was calm and not panicked. I had a similar incident with C, when I was in sixth form, where one of my injuries was bleeding. I went and told her and she dealt with it calmly and kindly – most importantly, she didn't blame me.”*

<https://www.time-to-change.org.uk/blog/teachers-my-corner-made-huge-difference>

*“My mental health breakthroughs happened because of the support I was given at home, conversations with my friends, and letters from my teachers”*

<https://www.time-to-change.org.uk/blog/my-recovery-tied-support-friends-family-and-teachers>

### **Substitutes for self-harm**

If staff are working with young people on a continuing basis, then speaking about alternatives to self-harm may be appropriate. Please note this is not for everyone. The person has to be ready to try these for themselves in their own time. Young people have shared their most successful ones with us, and these are:

#### **Physical**

- Hitting a punch bag to vent anger and frustration
- Hitting pillows or cushions, or having a good scream into a pillow or cushion
- Getting outdoors and having a fast walk
- All other forms of exercise – these are really good at changing your mood and releasing adrenaline

- Making lots of noise, either with a musical instrument or just banging on pots and pans

### **Symbolic**

- Using a red felt tip pen to mark where you might usually cut
- Writing negative feelings on a piece of paper and then ripping it up
- Scribbling on a large piece of paper with a red crayon or pen
- Putting elastic bands on wrists, arms or legs and flicking them instead of cutting or hitting
- Rubbing ice across your skin where you might usually cut, or holding an ice-cube in the crook of your arm or leg

### **Seeking support**

- Talking to a trusted person
- Calling a helpline (see resources page)
- Getting online and looking at self-help websites\*\*

\*\*Websites can contain helpful information but may also be triggering. Make sure that any websites used are safe for the young person to visit before directing them there. There is a list of helpful resources contained within this Protocol.

### **Distraction**

- Keeping a journal
- Calling and talking to a friend (not necessarily about self-harm)
- Collage or artwork – doing something creative
- Listening to music
- Five minute rule

*“I’ve tried so many distraction techniques – from holding an ice-cube, elastic band flicking on the wrist, writing down my thoughts, hitting a pillow, listening to music, writing down pros and cons. But the most helpful to my recovery was the five minutes rule, where if you feel like you want to self-harm you wait for five minutes before you do, then see if you can go another five minutes, and so on till eventually the urge is over”.*

## **Section 3 Consent and Confidentiality**

### **3.1 Child Protection and Risk of Suicide**

Consent is not required for child protection referrals where there are concerns about the risk of significant harm to child. Shetland Interagency Child Protection Procedures should be followed. The following link will take you to the current procedures.

<http://www.safershetland.com/child-protection> - then click on the GREEN button

If a child or young person is at risk of suicide then consent is not required to seek immediate medical help from a GP or from Accident and Emergency.

If the young person is over 16 and it is safe to do so then discussing a referral with them would be good practice. Medical help can be requested if the young person is at risk of suicide. Consent from any parent/carer/guardian would not be needed.

### **3.2 Confidentiality, Consent and Data Sharing**

When using this protocol staff may assess that a child is at risk of significant harm and a child protection referral needs to be made using the Stepwise Guide in these procedures. Significant harm can result from a serious incident or an accumulation of incidents or neglect or emotional harm over a period of time. Consent from a parent is not required to make a child protection referral. Consent is not required for agencies to share relevant and proportionate information when making a child protection referral or taking part in other child protection processes (sharing information at a Child Protection Case Conference for e.g)

If it is assessed that the child is not at risk of significant harm, but there remains wellbeing concerns and a need for further assessment and possible future support then this can be offered through the Names Person and GIRFEC. Agreement to participate in the process of assessing children under GIRFEC and creating a Child's Plan should be sought from parents and carers. Agreement to participate should be informed and everyone should understand fully what the process will involve. Further information about Names People and GIRFEC is available from [https://www.shetland.gov.uk/children\\_and\\_families/GIRFEC.asp](https://www.shetland.gov.uk/children_and_families/GIRFEC.asp)

## Section 4 Useful Resource List

### Training:

**Healthy Shetland (Shetland's Public Health Team)** run a one-day training course on Self-harm Awareness. For further info and enquiries contact: [shet-hb.healthshetland@nhs.net](mailto:shet-hb.healthshetland@nhs.net) or call 01595 807494

### Information & Resources

**National Self-Harm Network** [www.nshn.co.uk](http://www.nshn.co.uk)

The forum provides crisis support, information and resources, advice, discussions and distractions. It is closely monitored with guidance regarding posts, which may be triggering. There is also a section for family/friends.

The aims of this forum are to:

- Support individuals who self-harm to reduce emotional distress and improve their quality of life
- Support and provide information for family and carers of individuals who self-harm
- Raise awareness of the needs of people who self-harm, dispel myths and combat discrimination
- Empower and enable those that self-harm to seek alternatives to self-harm and further help where appropriate

**Young Minds** [www.youngminds.org.uk](http://www.youngminds.org.uk)

Young Minds is the UK's leading charity committed to improving the emotional wellbeing and mental health of children and young people. Driven by their experiences, they campaign, research and influence policy and practice.

They host information on a range of topics, including [self-harm](#). They have a [crisis messenger service](#) and run a [Parents Helpline](#)

**SAMH (Scottish Association for Mental Health)**

<https://www.samh.org.uk/about-mental-health/mental-health-problems/self-harm>

The Scottish Association for Mental Health includes information on a range of issues, which can affect mental health. They have published a guide to Understanding Self-harm, which can be downloaded from their website.

**Mind Your Head** <http://www.mindyourhead.org.uk/info/problems/self-harm>

Mind Your Head are a local mental health charity. They provide information about various mental health issues and do ongoing work to reduce the stigma associated with mental health.

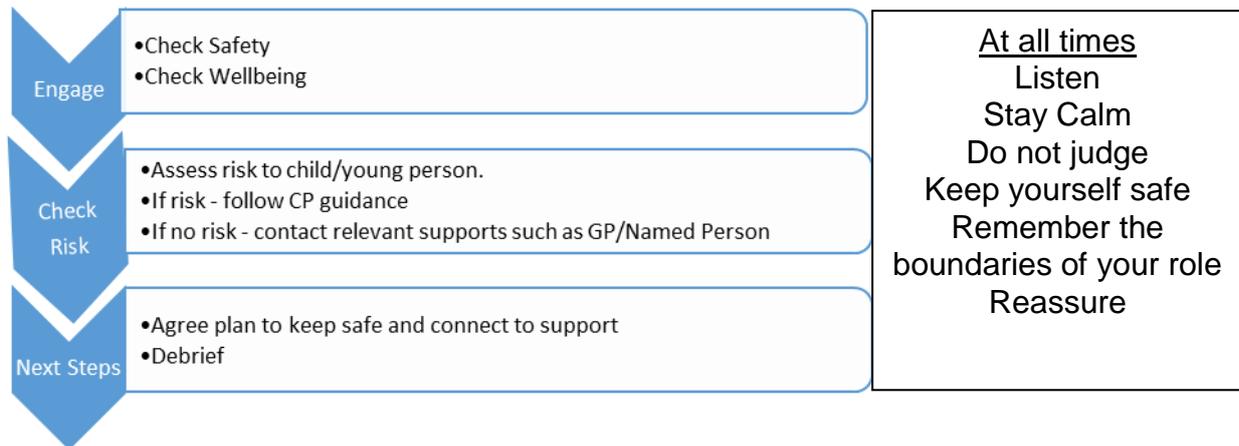
**www.selfharm.co.uk** [Self-harm : www.selfharm.co.uk/home](http://www.selfharm.co.uk/home)

is a project dedicated to supporting young people impacted by self-harm, providing a safe space to talk, ask any questions and be honest about what's going on in your life.

## Appendix 1

The following table gives some simple and clear thought about what to say and do and what not to say or do when working with young people who are self-harming

Don't	Do
<p><b>Panic</b> – Unfortunately many young people self-harm – It is a complex issue and each young person will have a different reason or story behind their behaviour – panicking will not help the young person feel safe and contained.</p> <p><b>send the young person away</b> – Make some time for them – either help them find other ways of coping or support them in getting the right kind of support.</p> <p><b>be judgemental</b> – Keep an open mind about the behaviour and don't refer to it as "attention seeking".</p> <p><b>Work Alone</b> – You may still see a young person alone, but you will need to offload with an appropriate staff member or colleague from another agency. Seek advice and support for yourself- helping young people who self-harm is difficult.</p> <p>Don't offer to take the young person to your home environment. Don't give them your mobile number or your house number – or get into texting the young person. It is more appropriate and professional for you to help the young person identify their supportive network, than for you to take this upon yourself.</p> <p>Self-harming behaviours can be extremely concerning, but remaining calm and supportive and as objective as possible are the best ways to help</p>	<p><b>Stay Calm</b> – Do not show anxiety, disapproval or disgust. Be prepared to be shocked then.....</p> <p><b>Listen</b> – Just being listened to can be a brilliant support and bring great relief to someone particularly if they have never spoken to anyone about their self-harming before.</p> <p><b>Listen Intently</b> – Does not just require ears – Observe the young person's nonverbal clues – look at their body language – does what they say and what you see match up? What is the underlying mood state – Is it anger? Sadness? Frustration?</p> <p><b>Think carefully before you act</b> – What is in the best interest of the young person.</p> <p>Remember most episodes of self-harm have nothing to do with suicide. However, the easiest way to differentiate between suicides and self-harm is by asking the young person what was their intent behind the self-harm behaviours.</p> <p>Treat a suicide intention as an emergency, do not leave the young person alone or in a vulnerable environment – get help and support as soon as possible and remain calm.</p>



### **Self-harm in People with Learning Disabilities**

A three-year research project was undertaken by the Bristol Crisis Service for Women and the Noah Fry Research Centre at the University of Bristol between 2006-2009. A number of recommendations have been made in summary of their findings:

1. Acknowledge self-injury as an issue in its own right and take it seriously
2. Address self-injury in people with learning disabilities as it is addressed in anyone else
3. Acknowledge the importance of choice and control in people's lives, and strive to create conditions in which people can be in control as much as possible
4. Work with people with learning disabilities to help them understand, clarify and manage their emotions
5. Start with the strategies that people are already using to manage their own self-injury and build on these
6. Work individually and creatively with individuals in a person-centred way
7. Consistency is key
8. Put systems in place to help people with learning disabilities explore past experiences
9. Consider support groups for people with learning disabilities who self-injure
10. Practice listening skills, and be mindful of always being non-judgemental, accepting and respectful

A link to the full report and executive summary is below:

<https://www.selfinjurysupport.org.uk/hidden-pain-resources-for-people-with-learning-disabilities>

## References

- National Self-harm Network ([www.nshn.co.uk](http://www.nshn.co.uk)) 2019
- Truth Hurts - Report of the National Inquiry into Self-harm among Young People 2006  
(<https://www.bl.uk/collection-items/truth-hurts-report-of-the-national-inquiry-into-selfharm-among-young-people>)
- Scottish Association for Mental Health – Understanding Self-harm booklet (no date on booklet, accessed online 2019)  
(<https://www.samh.org.uk/about-mental-health/mental-health-problems/self-harm>)
- NHS Inform – 2019 (<https://www.nhsinform.scot/>)
- Self-Harm UK – 2019 (<https://www.selfharm.co.uk/> )
- NHS Shetland – S3 health check data 2015-2017  
(<https://www.shb.scot.nhs.uk/board/documents/icyp-20142017.pdf> )
- Time to Change.org – accessed 2019 (<https://www.time-to-change.org.uk/>)
- Mental Health Foundation (citations from their site dated 2012)  
(<https://www.mentalhealth.org.uk/publications> )
- The Truth about Self-harm – Mental Health Foundation (based on the National Inquiry – 2006?)  
(<https://www.mentalhealth.org.uk/publications/truth-about-self-harm>)
- Scotland’s Mental Health First Aid: Young People manual – Health Scotland  
([http://www.health-in-mind.org.uk/training/our\\_courses\\_and\\_fees/i23/scotlands\\_mental\\_health\\_first\\_aid\\_course\\_young\\_people.aspx](http://www.health-in-mind.org.uk/training/our_courses_and_fees/i23/scotlands_mental_health_first_aid_course_young_people.aspx))
- Child Line (<https://www.childline.org.uk/>)
- Young Minds (<https://youngminds.org.uk/>)
- Hidden Pain report – Self Injury in People with Learning Disabilities - Self Injury Support 2009  
(<https://www.selfinjurysupport.org.uk/hidden-pain-resources-for-people-with-learning-disabilities> )

## Protocol 11

### Vulnerable Young People aged 16-18

#### 1.0 INTRODUCTION

This protocol is designed to work with the Shetland Inter-agency Child Protection Procedures and Shetland Inter-agency Adult Procedures. It is also consistent with Getting It Right for Every Child.

#### 2.0 BACKGROUND

- 2.1 It is recognised that within Shetland there is a small number of young people at risk of causing significant harm to themselves or others. This risk may be as a consequence of their own behaviour or a consequence of others behaviour towards them. The protocol is intended to give guidance for the assessment, decision making and co-ordination of a multi-agency response to the needs of this group of young people.
- 2.2 Work with young people involved in high risk activity/behaviours should be co-ordinated as part of a multiagency protection system.
- 2.3 This protocol will assist agencies and professionals to plan and work together to help reduce risk to the young person or others affected by their behaviour.
- 2.4 Concerns about confidentiality must not obstruct the exchange of information between agencies/organisations which may be essential to the protection of young person's at risk of significant harm to themselves or others.
- 2.5 This protocol is intended to complement the existing Child Protection, Adult Support and Protection and MAPPA Procedures. Additionally [Protocol 6](#) which provides guidance in situations where young people sexually harm others Care and Risk Management processes (CARM) may apply. Decisions on the best way to proceed and protect a vulnerable young person will be taken by Team Leader in Children's Social Work in consideration with other agencies.
- 2.6 The examples given are not an exhaustive list of what can be considered under VYP protocol, professional judgement is required to be used to decide whether it will assist the young person.

### **3.0 AIMS AND OBJECTIVES**

- 3.1 To identify young people who are placing themselves or others at risk of significant harm
- 3.2 To reduce the risk of harm to young persons and others
- 3.3 To undertake a multi-agency integrated risk assessment
- 3.4 To produce and review an outcome based VYP plan

### **4.0 SCOPE OF PROTOCOL**

- 4.1 This inter-agency protocol is for all staff (including voluntary workers) working with young people aged 16-18 years in the Shetland Islands area.
- 4.2 These procedures should be implemented when agencies consider a young person's behaviour to be of a level of concern which could lead to serious physical and/or emotional difficulties to themselves or others. In some instances the level of risk may be life threatening.

### **5.0 CRITERIA FOR REFERRAL**

- 5.1 Two conditions need to be met when someone is considering making a vulnerable young person referral:-

- 5.1.1 There is no existing multi-agency plan and support in place for the Vulnerable Young Person or the referrer considers that the current multi agency support and plan is insufficient to manage the risk that the vulnerable young person poses to themselves or others

and

- 5.1.2 The situation meets one or more of the following criteria:-

- a) He / she regularly goes missing from home or their care placement and where concern has been expressed about their safety and well being (*Consider regularity of absconding, pattern, possible destinations, absconding with others/alone, level of risk*)
- b) He / she is involved in chaotic and/or dependent drug, alcohol or volatile substance misuse. (*A clear deterioration in the overall situation characterised by an increase in substance misuse, evidence of dependency, evidence of beginning to inject, mixing different drugs and alcohol ie polydrug use, poor level of self-awareness, loss of control, health related problems.*)
- c) He / she is sexually exploitative or exploited. Exploitative sexual behaviours are when individual(s) have power over a young person by virtue of one or more of the following – age, emotional maturity, gender, physical strength or intellect. This could be through an emerging pattern of concerning behaviours examples of which could include:

- The exchange of money or other forms of coercion (*a young person may become involved in prostitution and may find themselves having sex in order that they have a bed for the night, food, cigarettes etc. Some young people become involved in abusive relationships which can result in serious emotional difficulties or violence*)
  - A young person is groomed or targeted through technology (*social networking sites, mobile phones, web sites, message boards etc*).
- d) He / she is involved in serious incidents of self-harm. (*Consideration needs to be given to the nature of the incident, pattern of behaviour/seriousness of incident/level of self-awareness/ likelihood of repeated action.*)
- e) His / her offending behaviour places themselves or others at risk of significant harm. (*Any young person who is likely to meet the grounds for being placed in prison / secure accommodation / intensive support and monitoring may have their needs considered by this protocol.*)
- f) His / her violent or abusive behaviour places themselves or others at risk of significant harm. (*Consideration to be given to level of verbal, emotional, physical and sexual aggression, their risk to themselves and others in their homes or in the community*)
- g) He / she has a mental health, additional support needs or learning disability which places themselves or others at significant risk
- h) He / she is involved in an abusive relationship which places themselves or others in danger (*Consideration to be given to level of verbal, emotional, physical and sexual aggression*)

### **Undue Pressure/ Consent/ Capacity**

**The law in Scotland relating to people with mental disorder is** (as defined in Mental Health Care & Treatment Act 2003) designed to strike a balance in protecting those people who do not have the capacity to consent or are vulnerable to the risk of harm, whilst upholding and preserving the rights of those people who do have the necessary capacity to consent.

The Adult Support and Protection (Scotland) Act 2007 permits council officers to investigate circumstances where individuals may have capacity to choose but not the ability to exercise that choice because of **Undue Pressure**.

- Undue Pressure occurs in situations where it appears that harm is being, or is likely to be, inflicted by a person whom the adult has confidence and trust in;
- Undue pressure may also occur in circumstances where the adult at risk is afraid of or being threatened by another person.

## Capacity

The law starts from the assumption that all individuals have capacity. Capacity is a legal test which is decision specific. If someone has a mental disorder this does not mean that they necessarily lack the capacity to consent. **Sect 6** Adults with Incapacity Act states “incapable” means Incapable of –Acting on decisions; making decisions; communicating decisions; retaining the memory of decisions and understanding decisions. For example, with regards to sexual relations, the person needs to understand that a sexual relationship is distinctly different from other forms of relationships. They need to understand the nature of the sexual act and the possible consequences of it as well as being able to communicate their consent or dissent and be able to act on this decision. A decision about whether a person has capacity must be made by a medical practitioner this should involve consultation with those who are involved with the person professionally or in a caring role.

In the case of a child, consent within the context of child abuse is irrelevant. Any concerns that reach the threshold for child protection intervention should be considered under Shetland Interagency Child Protection Procedures.

## Information Sharing

There is nothing in Scottish, United Kingdom or European Law that prevents practitioners from sharing personal information, and in some cases sensitive personal information, where they are worried or concerned about a child or young person’s wellbeing or safety.

### 6.0 REFERRAL PROCESS

6.1 Any worker from an agency or organisation who is concerned about the high risk behaviours of a young person up to the age of 18 should contact the Duty Social Worker in the Children’s Social Work Team.

There may be occasions when the Duty Social Worker may direct the referral to the Through Care and Aftercare Team if the young person is or was a looked after child or to the Criminal Justice Team if the young person is involved in offending.

6.2 The situation of some young people aged 16-18 may meet the three point test for Adult Support and Protection and in this case the Duty Social Worker in the Children’s Social Work Team should liaise with the Duty Senior Social worker in the Community Care Team. Services to young people aged up to 18 are provided by the Children’s Social Work Team, but legal remedies available under the Adult Support and Protection (Scotland) Act 2007 can be used to protect a young person.

6.3 It is good practice to inform the young person unless it is impossible to do so or to do so would increase the risk to the young person or others.

6.4 Decisions regarding involvement of parents / carers should take account of the views of the young person.

- 6.5 If, following discussion, the referrer and the Duty Social Worker agree the criteria for a Vulnerable Young Person has not been met the matter will be managed through existing processes e.g. a multi agency meeting (for children)
- 6.6 If the young person's situation meets the criteria then consultation with other agencies as detailed below should happen. Young people aged 16-18 will have a Named Person who should be notified and involved in interagency discussions. In some cases it will be the Named Person who has made the referral to children and families social work. For young people who are in education their School will provide a Named Person. For those not in schools the Duty Social Worker will know what arrangements have been put in place.
- 6.7 There is nothing in the National Guidance for child protection that prevents an initial Child Protection Case Conference being called for a young person over the age of 16 and their name can be placed on the Child Protection Register. This can be put in place if it is assessed to be in the best interests on the young person.

## **7.0 INTER-AGENCY DISCUSSION**

- 7.1 If the situation of the child or young person suggests that there is immediate high risk then a strategy meeting should be convened and child protection processes – even if the young person is over 16 – should be followed. An Interagency Referral Discussion should put into place an interim safety plan
- 7.2 If the situation is not of immediate risk then the young person's situation should be discussed at the Child Concern Collaborative weekly screening meeting and a plan put in place.
- 7.3 A decision should be made about the need for a vulnerable young person's conference.
- 7.4 A VYP meeting should be held within 10 days of the decision to hold the meeting.
- 7.5 The Named Person for the young person should be notified of this referral and meeting.

## **8.0 VULNERABLE YOUNG PERSON'S MEETING**

- 8.1 The meeting will be chaired by a Team Leader or Senior from the Children's Social Work. This will be convened under GIRFEC processes with the expectation is that the allocated social worker acting as Lead Professional will complete an assessment and draft child's plan.
- 8.2 The young person will be encouraged to attend. If they choose not to attend their views must be sought.

- 8.3 The initial VYP meeting will:
- Share all relevant information.
  - Consider the information in respect of risk and need.
  - Agree what further assessment is required for the review meeting considering any relevant risk assessment tool available, any specialist who can contribute etc.
  - Agree an interim Childs Plan with clear action allocated to professionals.
  - Give the young person's rights full consideration.
- 8.4 The minutes of the meeting will be approved and distributed by the Chair within ten working days.
- 8.5 For young people and/or parents/carers who are difficult to engage professionals need to assess all available information and assess the implications for the failure to receive appropriate support/services. Professionals should take steps to ensure that young people and/or parents are able to make informed choices and be flexible in negotiating alternative means of offering support/services.
- 8.6 If a young person has come under the VYP protocol before the age of 21 years they will remain under the protocol until the group working with the young person agrees they should come off.

## **9.0 VULNERABLE YOUNG PERSON'S (VYP) PLAN**

- 9.1 The Interim Childs Plan with risks and management included will be circulated within three working days of the initial VYP Meeting.
- 9.2 A Lead Professional will be identified and core/review group membership established. Depending on the level of risk identified the Lead Professional is likely to be allocated social worker, but it may be appropriate in some cases for the Lead Professional to come from another agency if that professional has a good working relationship with the young person.
- 9.3 The Interim Child's Plan will identify who is responsible for providing feedback and getting the views of the young person if they did not attend.
- 9.4 The identified lead professional must further develop the Interim Childs Plan to a full outcome based plan for the first core/review group meeting.
- 9.5 The Named Person should be given a copy of the finalised Child Plan by the Lead Professional

## **10.0 CORE GROUP**

- 10.1 The initial core/review group will be held within 21 days of the initial VYP meeting and will be chaired by the Senior or Team Leader from the Children's Social Work Team.

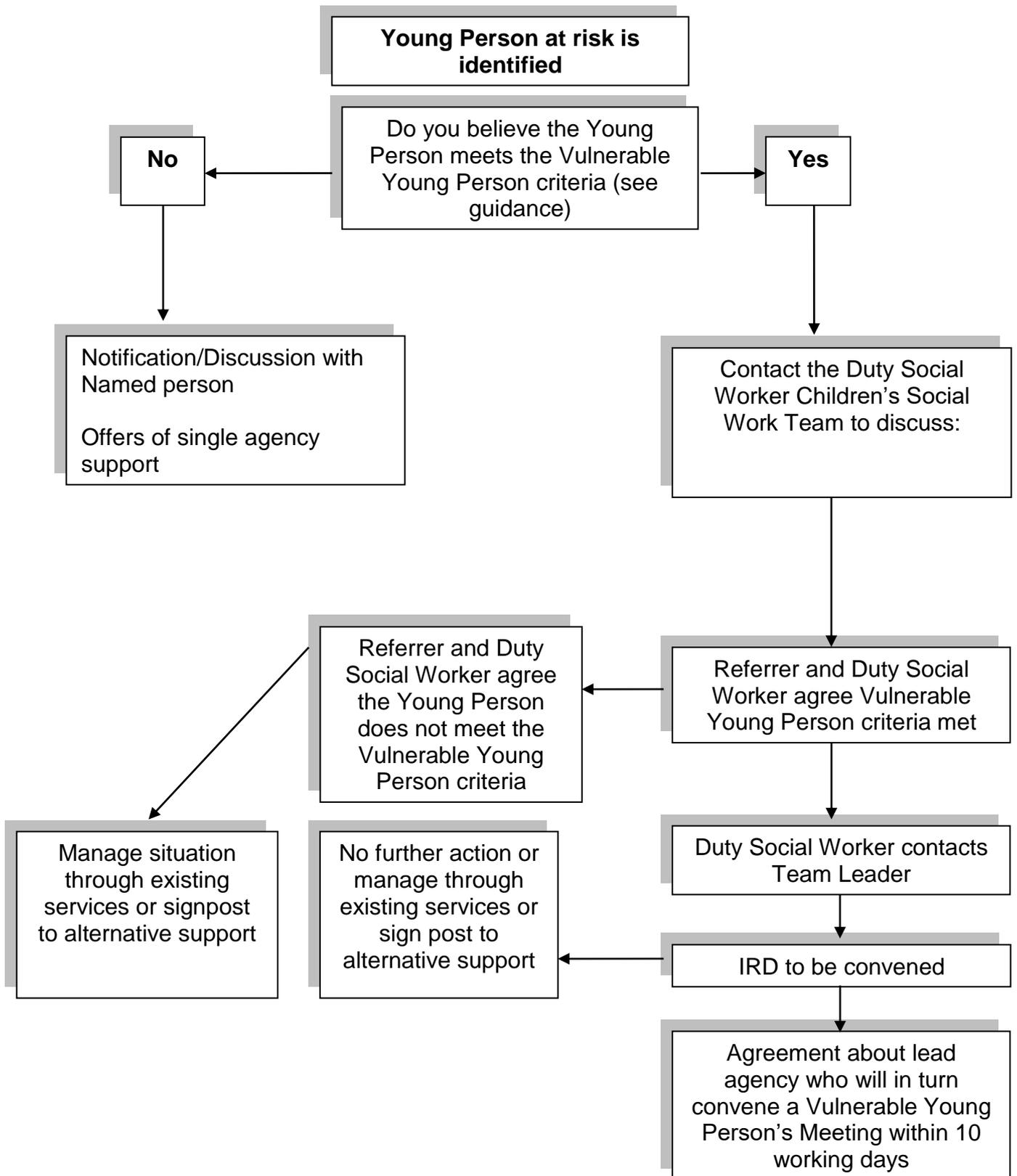
- 10.2 Core/Review groups thereafter will be held 4-6 weekly and will be chaired by the Lead Professional.
- 10.3 All core/review groups must review the current level of risk to the young person.
- 10.4 The core/review group will oversee the implementation of the Childs Plan. They can make amendments to the Childs Plan as agreed. Any significant change must be discussed with the Senior or Team leader from the Children and Families Team
- 10.5 The core/review group can at any time request a review VYP meeting.
- 10.6 All core/review group meetings must be minuted and the minute distributed within ten working days.

## **11.0 REVIEW**

- 11.1 The first VYP Review Meeting will take place within three months and subsequent reviews will be held at six monthly intervals thereafter.
- 11.2 It will be chaired by the same Chair as the Initial meeting, wherever possible.
- 11.3 If required, a comprehensive risk assessment will be completed for the first review VYP meeting
- 11.4 If all are in agreement that the risks have significantly reduced and the child/young person is no longer considered to meet the risk criteria a decision should be made that the child/young person should no longer be subject to a VYP plan. If this is the decision a minimum of one final core/review group must take place following the Review VYP meeting. No agency will end their involvement prior to this core group without full discussion with the other agencies involved.

## **12 WORKING WITH YOUNG PEOPLE**

- 12.1 Young people need to be empowered to participate as fully as possible in this process. They may need assistance from an advocate.
- 12.2 Some vulnerable young people may be very difficult to engage with and whilst every effort should be made to try and work with them there may be times when this is just not possible. A decision to close a case or withdraw support should only ever be a last resort when all attempts have failed and should be taken by a review VYP meeting.



## Protocol 12

# Child Sexual Exploitation

### **Introduction**

This protocol is designed to support staff in all agencies to understand and respond to child sexual exploitation. It is divided as follows:

- Section 1 - Definition of CSE, case examples and information drawn from the experience of responding to CSE in Shetland
- Section 2 - Legislation and policy
- Section 3 - Flow chart, information about which children may be vulnerable to CSE and support and guidance for staff
- Appendices with useful information and websites

This protocol sits within the Shetland Interagency Child Protection Procedures, but links closely with Getting It Right for every Child in Shetland. Some children may be at risk of significant harm and will need a response under child protection, other children and young people may require support and advice or the ongoing help provided by a child's plan without the use of child protection processes. This protocol covers children and young people up to the age of 18.

## **SECTION 1**

### **Definition of Child Sexual Exploitation (CSE)**

#### **Child Sexual Exploitation – National Definition**

In 2016 the Scottish Government published a definition of Child Sexual Exploitation (CSE). This definition provides the context for the Shetland Island's Council CSE protocols and is as follows:

*“Child sexual exploitation is a form of child sexual abuse in which a person(s), of any age takes advantage of a power imbalance to force or entice a child into engaging in sexual activity in return for something received by the child and/or those perpetrating or facilitating the abuse. As with other forms of child sexual abuse, the presence of perceived consent does not undermine the abusive nature of the act.”*

**Applying the definition:** If someone takes advantage of an imbalance of power to get a child/young person to engage in sexual activity, it is CSE if:

1. The child/young person receives, or believes they will receive, something they need or want (tangible or intangible gain or the avoidance of harm) in exchange for the sexual activity.

#### **AND/OR**

2. The perpetrator/facilitator gains financial advantage or enhanced status or power from the abuse.

Where it is the victim who is offered, promised or given something they need or want, the exchange can include both tangible (money, drugs or alcohol, for example) and intangible rewards (status, protection or perceived receipt of love or affection, for example). It is critical to remember the unequal power dynamic within which this exchange occurs and to remember that the receipt of something by a child/young person does not make them any less of a victim. It is also important to note that the prevention of something negative can also fulfil the requirement for exchange, for example a child who engages in sexual activity to stop someone carrying out a threat to harm his/her family.

Where the gain is solely on the part of the perpetrator/facilitator, it must be something more than sexual gratification to constitute CSE (as opposed to another form of sexual abuse). This could be money, other financial advantage (reduced cost drugs/alcohol or discharge of a debt for example), status or power.

#### **What does CSE look like?**

There are many different forms of CSE and this can affect anyone; both males and females can be targeted. CSE can affect all children and young people, including those from minority ethnic backgrounds, children with disabilities and those who identify as lesbian, gay, bisexual or transgender (LGBT).

CSE can include both contact and non-contact sexual activities, and can also occur online (see example 2 below). Using social media to contact, groom or control is an integral part of CSE. CSE can begin through social media and progress to abuse in the real world.

This protocol is part of the interagency child protection procedures so is focussed on children and young people under the age of 18 who are at risk of CSE. There are occasions when adults over 18 may be targeted and if the adult is vulnerable due to mental health or learning disabilities or other problems then consideration of adult protection procedures is important. Younger adults with learning disabilities may be particularly vulnerable. (Barnardos report "Unprotected, Over Protected" is helpful in these situations [https://www.barnardos.org.uk/cse\\_learning\\_and\\_disability\\_report\\_2015a.pdf](https://www.barnardos.org.uk/cse_learning_and_disability_report_2015a.pdf))

**Examples of situations which may meet the criteria for CSE:**

1. A 21 year old male persuading his 17 year old 'girlfriend' to have sex with his friends to pay off his drug debt;
2. A 44 year old female posing as a 17 year old female online and persuading a 12 year old male to send her a sexual image, and then threatening to tell his parents if he didn't continue to send more explicit images;
3. A 14 year old male giving a 17 year old male oral sex because the older male has threatened to tell his parents he is gay if he doesn't do this;
4. A 14 year old female being told she has to have sex with a 16 year old gang member and his two friends if she wants the protection of the gang;
5. A 13 year old female offering and giving an adult male sexual intercourse in return for a lift home in the early hours of the morning;
6. A mother letting other adults abuse her 8 year old child in return for money;
7. A group of men bringing two 17 year old females to a hotel in another town and charging others to have sex with them;
8. Three 15 year old females being taken to party houses and given 'free' alcohol and drugs, then told they have to 'pay' for them by having sex with 6 adult males;
9. A 15 year old female who views a 21 year old male as her 'boyfriend' and engages in sexual activity with him, as he has said he will end the relationship with her if she doesn't;
10. A 15 year old female bringing two other 15 year old females to a party (where they are sexually assaulted) in order to prevent her from being sexually assaulted again.

### **Examples from a local context:**

CSE is an issue which affects children and young people from all backgrounds and areas of the UK, including Shetland. Local examples of concerns identified across Shetland are listed below:

- Numerous joint Social Work and Police interviews in relation to the sharing of indecent images online have been undertaken in recent years. Some young people have been pressurised into providing such images.
- In 2016 during a Police Scotland investigation 22 young people in Shetland were contacted by unknown male adults online.
- Young people being offered lifts by adult males with the intention of either grooming them for future sexual contact or sexually harming them
- Young people hanging around outside a pub in Shetland and being engaged in conversation by adult males who were offering cigarettes, alcohol and use of smart phones.
- Looked After young people being targeted by those who would sexually exploit them.

## **Section 2**

### **National Policy and Legislative Framework**

#### **National Policy:**

This local policy and protocol is set within the context of national policy frameworks including the GIRFEC principles.

The Scottish Government has identified CSE as a national priority and this is reflected in their National Action Plan to Prevent and Tackle Child Sexual Exploitation which can be accessed at:

<http://www.gov.scot/Resource/0049/00497283.pdf>

A coordinated multi-agency approach is required to tackle the complex issue of CSE.

Scottish Government policy and national plan for tackling CSE focusses on the following

- **Awareness and prevention.** Training and supporting staff and agencies to recognise when children and young people may be at risk of CSE and to refer any concerns into child protection processes. Improving the awareness of the risk to children and young people by being able to recognise signs and symptoms in Children's behaviour and activity. Improved awareness also relates to the activities of abusers e.g. cars cruising around schools and residential units, houses where young people may be attracted to gather by the provision of alcohol by adults who would exploit them.

- **Intervention.** Identifying those young people who are or have been harmed, using child protection procedures to refer concerns, interagency discussions and planning.
- **Disruption and Prosecution.** Wherever possible Police Scotland will look to prosecute and disrupt the activities of anyone who is exploiting children and young people. CSE and sexual offences can be difficult to successfully prosecute, so information concerning the possible commission of other offences should also be investigated e.g. driving offences, human trafficking, drugs offences, coercive control under domestic abuse legislation, harbouring young people etc. The Human Trafficking and Exploitation (Scotland) Act 2015 should always be considered when investigating CSE and seeking to disrupt or prosecute perpetrators.
- **Recovery.** Supporting children and young people, their parents and families to be safe in the future and providing trauma sensitive approaches to help them recover and rebuild resilience.

## Legislation

Legislation is complex and there is no statutory offence of child sexual exploitation in Scotland. A number of civil and criminal laws can be used to disrupt and prosecute perpetrators.

Sexual Offences (Scotland) Act 2009. The Protection of Children and Prevention of Sexual Offences Act (Scotland) 2005 and the Human Trafficking and Exploitation (Scotland) Act 2015 together provide a number of sexual and other offences that can be used to prosecute cases of CSE.

Additionally civil orders including sexual offences prevention orders and risk of sexual harm orders can be used to impose prohibitions on individuals involved in CSE.

For agencies involved in a situation where children have been or are at risk of child sexual exploitation it is important, with the support and involvement of Police Scotland, that any planning meetings also focus on the perpetrators of the abuse and ways in which the use of appropriate legislation can disrupt the activities of those who would harm children and young people.

It may not be possible to prosecute adults for sexual offences against children, but it may be possible to stop the harm by using other criminal charges or civil orders.

### **Section 3**

#### **A Shared Responsibility:**

Child Sexual Exploitation is a complex issue which requires a multi-agency approach in order to respond to this effectively. **Anyone concerned that a child or young person is being sexually exploited should follow Child Protection Procedures and make a Child Protection Referral to the Duty Social Worker.** Once a child protection referral has been made, Police and Social Work will take the lead role in investigating and responding to concerns, however this cannot be effective without a sense of shared responsibility and commitment across the statutory and voluntary sectors, and the wider community as a whole. This response is required in order to prevent the abuse and exploitation of children and young people in Shetland.

#### **Recognising CSE**

Whilst understanding that some children and young people may be at increased risk of CSE ( see below) it is important to understand that children and young people may be vulnerable simply because of their age and stage and not because of any intrinsic or family issues. Teenagers who are at the development stage of separating out from their family, looking for peer approval, wanting to take risks and experimenting with relationships may be just as easy to target with false promises of love and affection as any child with recognised vulnerabilities.

#### **Vulnerabilities which may increase the risk of CSE being perpetrated against a child or young person:**

- A history of abuse, neglect and/or disadvantage;
- Being looked after, or formerly looked after;
- Disrupted family life, including family breakdown, domestic abuse and/or parenting difficulties;
- Poor health and wellbeing, social isolation, bullying or low self-esteem;
- Disengagement from education and isolation from other support mechanisms;
- Going missing from home or care environments;
- Drug or alcohol misuse;
- Poverty or homelessness;
- Having a disability

#### **Risk Indicators which may suggest the presence of CSE:**

- Leaving home/care without permission;
- Inappropriate sexualised behaviour for age; children under 13 years asking for sexual health advice;

- Physical symptoms or infections e.g. bruising, bite marks, sexually transmitted infections;
- Evidence of/suspicion of physical or sexual assault; disclosure of assault followed by withdrawal of an allegation;
- Multiple callers (unknown adults/peers);
- Frequenting areas known for adult prostitution;
- Peers abused through sexual exploitation;
- Concerning use of the internet or other social media;
- Increasing secretiveness around behaviours;
- Relationships with controlling individuals;
- Change in personal hygiene (greater attention or less);
- Self-harm and other expressions of despair.

### **Risks associated with the Internet in terms of child sexual exploitation**

- Grooming children online for sexual abuse offline;
- Children viewing abusive images of children/pornographic images;
- Children persuaded/coerced into making indecent images of themselves;
- Selling children online for abuse offline;
- Making abusive images of children;
- Viewing abusive images of children;
- Access to chat lines via the internet or mobile phones;
- Sexting

### **Disrupting CSE- Reporting concerns about unusual activity**

In addition to being able to recognise signs that a child or young person may be at risk of CSE it is important to be vigilant about any suspicious activity that could indicate that this may be happening. For example, noting cars that cruise around various areas, young people being collected by vehicles from school or other places, adults hanging around and engaging with younger people, fast food vans or stalls that may attract young people and adults who want to make contact with them, suspicious activity around a particular house or premises – different adults and young people coming and going during the day when children should be in school or late at night. Whilst it is difficult to be exact about what may constitute suspicious activity it would always be worth passing information onto Police Scotland or the Duty Children's Social Worker as this may link with other information and allow a fuller assessment of any risks to be made.

### **Child Protection Investigations in cases of CSE**

All child protection referrals relating to CSE should be conducted following the Stepwise guide in these procedures. Planning such investigations should involve a child protection planning meeting as care will be needed to investigate the circumstances of the child or young person involved. The following may be useful points to consider:

- Conducting Joint Interviews. Many young people who have been subjected to CSE are controlled by their abuser and may also be fearful that as they have, for e.g., shared naked images or used illicit drugs that they will be in trouble – this will be part of the control. They may not be willing to speak to a social worker and police officer at all.
- In contrast to other Joint Interviews time to build up a relationship involving more than one meeting and good rapport may be needed- defensible decision making and good recording as to why a different approach has been taken will be important in order not just to protect the young person but to not lose the possibility of prosecution
- Involving others who know the young person at the planning stage to ensure that even small pieces of information are gathered e.g. the teacher who noticed the child coming back to school wearing different clothing, the key worker for a looked after child who saw them getting into a particular car
- Police intelligence and information about possible perpetrators and how their activities could be disrupted
- Links to a number of young people, links to particular addresses e.g. the house where all the young people who truant from school gather need to be considered
- If initial child protection planning meetings start to identify complex networks of abuse or numbers of perpetrators then advice and support from appropriate senior staff in Police Scotland and Executive Manager Children's Social Work should be sought.

**Categories of Risk and Associated Actions**

	Indicators of risk	Description	Associated actions	Shetland Interagency response for referral
Category 1 Not at risk	Some young people may have identified vulnerabilities others may just be at a normal stage of teenage development	A child or young person who may be 'in need' but who is not currently at risk of being groomed for sexual exploitation.	Educate to stay safe. Review risk following any significant change in circumstances. Information provided to all parents and schools in respect of staying safe and identifying CSE	Information through schools and youth work services to educate children and young people about CSE and how to stay safe. Linking this topic with other related topics - internet safety, positive relationships etc. For children with some vulnerabilities (e.g. ASN) may be useful to have individual sessions
Category 2 Mild risk	Multiple vulnerabilities. One or two risk indicators may also be present.  Information received by Named Person or concerned parent that indicates a possible CSE risk.	A vulnerable child or young person who may be at risk of being groomed for sexual exploitation.	Consider multi-agency meeting to share information and agree a plan to address risk and/or need. Work on risk awareness and staying safe should be undertaken with this child/young person. Review risk following any significant change in circumstances.	Notify Named Person for the Child and Duty Children's Social Worker. May be helpful to discuss the child at the Weekly Child Concern Collaborative meeting to discuss on a multiagency basis. Representatives from Health, Children's Social Work, Schools Service and Police attend and any staff member can contact their agency representative and ask for a child's situation to be discussed due to concerns about CSE.
Category 3 Moderate risk	Multiple vulnerabilities and risk	A child or young person who may be targeted for	Convene multi-agency meeting under local	Any child with a moderate risk of CSE must be

	<p>indicators present.</p> <p>Clear disclosure / information from third party / allegations of CSE.</p>	<p>opportunistic abuse through exchange of sex for drugs, accommodation (overnight stays) and goods etc.</p>	<p>procedures for sexually exploited children and young people to ensure effective exchange of information with multi-agency colleagues and agree safety plan. At least one review meeting to be convened. Formulation of a Child's Plan and identification of a Lead Professional is required</p> <p>Work should be undertaken with this child/young person around risk reduction and keeping safe.</p>	<p>referred under child protection procedures to the Duty Children's Social Worker. In some cases following discussion and the gathering of interagency information it may be decided that the child's situation meets the child protection threshold of risk of significant harm and child protection processes need to be put in place. Joint Investigative Interview may be required.</p>
<p>Category 4 Significant risk</p>	<p>Multiple vulnerabilities and risk indicators. One or more significant risk indicators also likely.</p> <p>Clear evidence of CSE happening to the child or young person. They may or may not be willing to speak about what is happening.</p>	<p>Indication that a child or young person is at significant risk of or is already being sexually exploited. Sexual exploitation is likely to be habitual, often self-denied and coercion/control is implicit.</p>	<p>Progress to Initial Child Protection Case Conference (ICPCC) in line with local procedures in order to formulate a Child's Plan. Procedures for sexually exploited children and young people to ensure effective exchange of information with multi-agency colleagues and agree safety plan, including regular review meetings.</p> <p>Protection plan should include</p>	<p>Follow Shetland Inter-agency Child Protection Procedures and make a child protection referral</p>

			long-term intensive direct work with the child or young person.	
Moderate or Significant risk	As above.	Young person aged <b>16 years</b> or above.	Where a young person is aged 16 years or over and not subject to statutory measures, the associated action in relation to Moderate and Significant risk: sexual exploitation should be addressed as an issue in relation to this young person through liaison between Social Work and Police Public Protection Unit to address the young person's protection. Consult with Vulnerable Young Persons Protocols to consider if these criteria are met.	A child protection referral can be made in respect of a young person over the age of 16, but under 18. Consideration by Duty Children's Social work and Senior will be given to whether it is best to convene a child protection case conference or to follow the vulnerable young person protocol.

### Training and support to staff

CSE workshops have been developed in line with national and local policy and procedure and are offered as additional child protection training. Staff should look out for these and book onto them. The workshops are for all staff and volunteers working with children and young people in any organisation, but will be especially useful for staff working with groups of children and young people who are identified as being vulnerable- those with Additional Support needs, Looked After children and Through Care and After care.

## APPENDIX 1

### Useful Contacts

#### Local Contacts:

Victim Support Services – 91 St Olaf Street, Shetland – 01595 744524

Women's Aid – Shetland – 01595 692070

Rape Crisis Shetland- 01595 747174

#### Useful Websites

<https://www.childline.org.uk/> Telephone: 08001111

<http://csethesigns.scot/>

[www.safershetland.com](http://www.safershetland.com) Access to electronic copy of Shetland Interagency Child Protection Procedures plus information on adult protection, domestic abuse and pages for professional staff, parents children and young people (which were improved in 2015 following consultation with young people)

[www.nspcc.org.uk/inform](http://www.nspcc.org.uk/inform) Online library of excellent resources on many topics - online safety, physical and sexual abuse, neglect, emotional harm etc New research always being published and you can sign up to weekly CASPER alert to new information

<https://learning.nspcc.org.uk/Search?term=Child+Sexual+Exploitation>

[www.children1st.org.uk](http://www.children1st.org.uk) National Scottish Voluntary organisation with some good resources and information about child protection

[www.ceops.gov.uk](http://www.ceops.gov.uk) Child Exploitation and Online Protection Service. A very good website, with excellent information about keeping children safe online and good training resources.

[www.thinkuknow.co.uk](http://www.thinkuknow.co.uk) These training materials have been developed by CEOPS and work well for all ages of children, parents and professional staff.

[www.barnardos.org.uk](http://www.barnardos.org.uk) A UK wide voluntary organisation with good resources available on their website. In recent years Barnardos have developed training and information about child sexual exploitation

[https://www.barnardos.org.uk/what we do/our work/sexual exploitation.htm](https://www.barnardos.org.uk/what_we_do/our_work/sexual_exploitation.htm)

[www.scotland.gov.uk](http://www.scotland.gov.uk) Scottish Government website - best place to access National Guidance and other national documents

<http://www.gov.scot/Publications/2014/05/3052> 2014 National Guidance. Section 4 has a wealth of information about many topics related to child protection e.g. domestic abuse, FGM, parental substance misuse etc

<http://www.scie.org.uk/> Social Care Institute for Excellence. Has some useful information about children in care and child protection - usually referred to as safeguarding as this organisation is based in England

<http://www.iriss.org.uk/resources> Scottish based organisation that promotes excellence across social care and social work and a good resource.

<http://www.saia.org.uk/> Scottish Attachment in Action - how to put an understanding of attachment into practice to help children recover from abuse and neglect

<http://www.youngminds.org.uk/> UK organisation that addresses issues of mental well being for young people

<http://www.nshn.co.uk/> National Self harm Network. Good information and resources about self-harm and how to help people experiencing self -harm

<https://www.net-aware.org.uk/> Information about safe use of the internet

[http://lrsrb.proceduresonline.com/chapters/g\\_adult\\_men\\_hlth.html](http://lrsrb.proceduresonline.com/chapters/g_adult_men_hlth.html)

Leicestershire Children's Safeguarding Board guidance re protecting children affected by parental mental illness

<http://www.saferinternet.org.uk/safer-internet-day/2016> Good resource for information on safer internet work - has short films that are useful in working with children and young people

## Appendix 2

### Appendices

[11] Risk Indicators which may suggest the presence of CSE:

- Acquisition of money, clothes, mobile phone etc. without plausible explanation;
- Drugs/alcohol misuse;
- Isolation from peers/social networks;
- Exclusion or unexplained absences from school, college or work;
- Leaving home/care without permission;
- Persistently going missing or returning late;
- Receiving lots of texts/phone calls prior to leaving;
- Agitated/stressed prior to leaving home/care;
- Returning distraught/dishevelled or under the influence of substances;
- Unplanned pregnancy; requesting the morning after pill - or other sexual health needs - upon return;
- Inappropriate sexualised behaviour for age; children under 13 years asking for sexual health advice;
- Physical symptoms or infections e.g. bruising, bite marks, sexually transmitted infections;
- Evidence of/ suspicion of physical or sexual assault; disclosure of assault followed by withdrawal of an allegation;
- Relationships with controlling individuals;
- Multiple callers (unknown adults/peers);
- Frequenting areas known for adult prostitution;
- Peers abused through sexual exploitation;
- Concerning use of the internet or other social media;
- Increasing secretiveness around behaviours;
- Change in personal hygiene (greater attention or less);
- Self-harm and other expressions of despair.

[12] Vulnerabilities which may increase the risk of CSE being perpetrated against a child or young person:

- A history of abuse, neglect and/or disadvantage;
- Being looked after, or formerly looked after;
- Disrupted family life, including family breakdown, domestic abuse and/or parenting difficulties;
- Disengagement from education and isolation from other support mechanisms;
- Going missing from home or care environments;
- Drug or alcohol misuse;
- Poverty or homelessness;
- Poor health and wellbeing, social isolation, bullying or low self-esteem;
- Having a disability