SHETLAND
INTER-AGENCY CHILD PROTECTION PROCEDURES

Safeguarding Children and Young People in Shetland

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http://www.childprotectionshetland.com

June 2012
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:-*

<table>
<thead>
<tr>
<th>Duty Social Work Service</th>
<th>Telephone</th>
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<tbody>
<tr>
<td>Monday to Friday 9 am – 5 pm</td>
<td></td>
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<tr>
<td>Duty Working Hours</td>
<td>01595 744 421</td>
</tr>
<tr>
<td>Duty Out of Hours Service (outwith above times)</td>
<td>01595 695611</td>
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<tr>
<th>Children and Families Social Work</th>
<th>Telephone</th>
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<tr>
<td>Monday to Friday 9 am – 5 pm</td>
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<tr>
<td>Executive Manager, Children &amp; Families Social Work</td>
<td>01595 744 400</td>
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<tr>
<td>Team Leader</td>
<td>01595 744 400</td>
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<tr>
<th>Police</th>
<th>Telephone</th>
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<tr>
<td>24 hour cover</td>
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<tr>
<td>Lerwick Police Station</td>
<td>01595 692110</td>
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<tr>
<th>Scottish Children’s Reporter Administration</th>
<th>Telephone</th>
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<tr>
<td>Monday to Friday 9 am – 5 pm</td>
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<tr>
<td>Reporter</td>
<td>0300 200 2200</td>
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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 and families may benefit from further assessments and support through GIRFEC.

Referral to duty social worker raising child protection concerns

Does the situation require an immediate response to protect the child?

Police use powers to remove child
Social Work seeks child protection order

Duty Social Worker and Managers complete checks outlined in 7.2.4

Strategy discussion or meeting
Decision to proceed under CP procedures or not

Joint Interview with child

Debrief meeting/discussion following investigation

Yes
Risk of significant harm?

No
No further action

Initial Child Protection Case Conference and Protection Plan (if required)

Further assessment and support - GIRFEC

Practitioners working with Children/adults
Public and family members

Information sought from all other agencies

Health to inform discussion about health needs and requirement for medical

No action required

Further assessment and Support – GIRFEC

Single agency investigation by police or social work
CONTENTS:

What to do if you are worried about a child – **See information inside front cover**

Page No.

**Explanation of Terminology** ........................................................................................................ i

**How to Open Hyperlinks** ........................................................................................................ i

**Glossary** ..................................................................................................................................... i

**Membership Of Shetland Child Protection Committee** ........................................................ ii

**SECTION ONE – PROCEDURES:**

Chapters

1. **Introduction** ......................................................................................................................... 1
   1.2 **Getting it Right for Every Child** .................................................................................... 1
   1.3 **Young People Aged 16-18** ....................................................................................... 2

2. **Policy** .................................................................................................................................. 5

3. **Roles and Responsibilities** .................................................................................................. 6

4. **Definition** ............................................................................................................................ 8

5. **Recognition** .......................................................................................................................... 11

6. **Referral** ............................................................................................................................... 16

7. **Immediate Response** .......................................................................................................... 18

8. **Child Protection Strategy**, Planning and Debriefing Discussions............................... 40

9. **Special Circumstances**, ..................................................................................................... 45

10. **Investigative Interviewing** – Police and Social Work................................................. 53

11. **Health Assessment** and Medical Examinations............................................................ 54

12. **Parents** ............................................................................................................................... 62

13. **Child Protection Case Conferences** .................................................................................. 64

14. **Legal Action** ....................................................................................................................... 94

15. **Child Protection Register** – Administration................................................................. 106

June 2012
SECTION TWO – APPENDICIES:

**Appendix 1**
- **Part 1**
  Further Guidance
- **Part 2**
  Working with children and families in cultural and ethnic minority groups

**Appendix 2**
- Roles and Responsibilities of Staff Working in Organisations that provide services to Children and Young People

**Appendix 3**
- Guidance notes for preparing a Report for a Child Protection Case Conference

**Appendix 4**
- Guidance Notes – Child Protection Orders

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 and Emergency Department](#)
4. [Protecting Children and Young People affected by adults with problem substance misuse](#)
5. [Information about 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](#)
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 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. 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.

For ease of reference, the terms ‘child’ and ‘children’ are used throughout this document. These terms refer to all children and young people up to the age of 16 years.

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
CPO - Child Protection Order
CPU - Child Protection Unit (Northern Constabulary)
CME - Children Missing from Education
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 (Northern Constabulary)
LGBT - Lesbian, Gay, Bisexual and Transgender
NHS - National Health Service
SWIFT - Social Work Information System
MEMBERSHIP OF SHETLAND CHILD PROTECTION COMMITTEE

<table>
<thead>
<tr>
<th>POSITION</th>
<th>AGENCY</th>
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<tbody>
<tr>
<td>Director of Public Health</td>
<td>NHS Shetland</td>
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<tr>
<td>Nurse Advisor (Protection)</td>
<td>NHS Shetland</td>
</tr>
<tr>
<td>Local Clinician in Children’s Health</td>
<td>NHS Shetland</td>
</tr>
<tr>
<td>Area Commander or Nominated Representative</td>
<td>Northern Constabulary</td>
</tr>
<tr>
<td>Locality Reporter Manager</td>
<td>Scottish Children’s Reporter Administration</td>
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<tr>
<td>Director of Children’s Services</td>
<td>Children’s Services Department</td>
</tr>
<tr>
<td>Executive Manager – Children and Families Incorporating Chief Social Work Officer</td>
<td>Children’s Services Department</td>
</tr>
<tr>
<td>Executive Manager – Criminal Justice Unit</td>
<td>Community Services Department</td>
</tr>
<tr>
<td>Principal Educational Psychologist</td>
<td>Children’s Services Department</td>
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<tr>
<td>Executive Manager – Quality Improvement</td>
<td>Children’s Services Department</td>
</tr>
<tr>
<td>Executive Manager – Housing</td>
<td>Development Services Department</td>
</tr>
<tr>
<td>Chairperson – Shetland Children’s Panel</td>
<td>Shetland Children’s Panel</td>
</tr>
<tr>
<td>Procurator Fiscal</td>
<td>Crown Office – Procurator Fiscal Service, Highlands and Islands Area</td>
</tr>
<tr>
<td>Nominated Representative</td>
<td>Voluntary Action Shetland</td>
</tr>
</tbody>
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In attendance:

Lead Officer – Adult and Child Protection
Child Protection Training Co-ordinator

*Agency representation is Shetland Islands Council unless otherwise stated*
1. Introduction


1.2 CPC is made up of representatives from a range of organisations including the statutory agencies with responsibility for the welfare of children and young people. Membership of CPC is set out at page (ii) of these procedures. CPC’s Constitution is approved by the Chief Officers of Shetland NHS Board and Shetland Islands Council and the Chief Constable, Northern Constabulary.

1.3 Shetland Islands Council, Shetland NHS Board and the Northern Constabulary have approved this document. The policy, procedures and practice guidance that follow apply to all statutory agencies represented at CPC, and must be followed irrespective of the source of the referral or its first point of contact.

1.4 Voluntary and non-statutory sector organisations providing services to children are represented at CPC. They are invited to link into these procedures as part of their child welfare policies.

1.5 Further protocols may be developed to provide additional guidance on specific areas of child protection work. Once approved by CPC 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. Child protection services in Shetland will ensure that they operate in fair, consistent and reliable ways with an emphasis on participation, respect and inclusion.

1.2 Getting it Right for Every Child (GIRFEC)

1.2.1 Early intervention and the provision of co-ordinated inter-agency support to children and families is the focus of children’s services planning in Shetland. Good support to vulnerable children and their parents should, through time, improve outcomes for children and hopefully avoid the necessity for some child protection interventions.

1.2.2 Practitioners involved in GIRFEC assessments and care planning need to understand the links with child protection. Long term support that achieves no measurable change for children may need to be
reconsidered as a trigger for a child protection referral, as the cumulative effects of neglect and emotional abuse can reach the threshold of significant harm. Equally, assessing need does involve assessing possible risks and in some situations child protection concerns will come to light.

1.3 Young People Aged 16 – 18

1.3.1 Young peoples’ names cannot remain on the Child Protection Register beyond the age of 16, and it would be good practice to arrange a review child protection case conference at least one month before their sixteenth birthday to consider the need for further support, risks to the young person, and if the young person’s situation should be considered under the Adult Support and Protection Procedures.

1.3.2 Good practice advice to professional staff working with 16 – 18 year olds would be to refer to social work if they consider that a young person is at risk of significant harm. Referrals should be made with the consent of the young person, but can be made without consent, if there is a high risk of harm. Consideration would need to be given to the risks to other
children, for example, younger siblings of a young person who disclosed abuse.

1.3.3 For most young people between the ages of 16 and 18, Shetland Inter-Agency Adult Support and Protection Procedures would apply wherever concerns or allegations are made. However, any referral received indicating that a young person aged 16 – 18 was at risk of significant harm should be discussed by the Designated Manager for Child Protection (DMCP) and the Designated Manager for Community Services (DMCS) in consultation with police and health colleagues, and a decision made about how to proceed either under Child Protection or Adult Protection Procedures. The Adult Support and Protection Procedures can be accessed through the following link - [http://www.shetland.gov.uk/community_care/documents/ASPProcedures-Nov.2011.pdf](http://www.shetland.gov.uk/community_care/documents/ASPProcedures-Nov.2011.pdf)

1.3.4 The only exception would be when a young person between the ages of 16 and 18 is already subject to a Supervision Requirement under the Children (Scotland) Act 1995 - [http://www.legislation.gov.uk/ukpga/1995/36](http://www.legislation.gov.uk/ukpga/1995/36). It is possible for a young person to remain on a Supervision Requirement up to the age of 18, if they are already subject to a Supervision Requirement on their 16th birthday. A young person who is subject to a Supervision Requirement is classed as a child for the purposes of the remedies available under the 1995 Act, such as, a Child Protection order. A Supervision Requirement 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 Council’s legal services, if required.

1.3.5 A young person between the ages of 16 and 18 who is being provided with a short term refuge under Section 38 of the Children (Scotland) Act 1995 is not regarded as a child for the purposes of the Child Protection remedies available under the Act. Such a young person should be dealt with under the Adult Support and Protection Procedures. Any young person under 16 in receipt of a refuge service is a child and subject to the Child Protection Procedures.

1.3.6 There is a risk that vulnerable 16 – 18 year olds can fall between gaps in services – they may have been assessed as being a child in need of protection prior to their 16th birthday, but do not meet the criteria of an adult at risk as laid down in the Adult Support and Protection Act.
Services need to work together to support young people, and the Children (Scotland) Act 1995 provides a framework for services to be provided by the local authority to young people - http://www.legislation.gov.uk/ukpga/1995/36.
2. **Policy**

2.1 All children 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 are best cared for in their own families, except where consideration for their safety and welfare dictates otherwise.

2.3 The welfare of children must be the paramount consideration in all decisions concerning them; all decisions must be based on children’s best interests.

2.4 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.

2.5 The highest priority will be given to the protection of children 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.

2.6 Children have the right to be listened to and to be taken seriously; interview and other procedures will focus on the child, and will reflect his/her rights, wishes and needs.

2.7 All concerns that children may have been or are being abused will be investigated in accordance with agreed inter-agency procedures.

2.8 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.

2.9 All children will be provided with appropriate support in accordance with their particular needs.


2.11 This policy has been approved by Shetlands Islands Council, Shetland NHS Board, and the Northern Constabulary and adopted by all other organisations represented on Shetland CPC.
3. Roles and Responsibilities

3.1 The statutory responsibility for the investigation of suspected abuse of a child lies with three agencies:

**Police**
The Council through its Children’s Services
**Reporter**

3.2 The **Police** - [http://www.northern.police.uk/Divisions/shetland.html](http://www.northern.police.uk/Divisions/shetland.html) - 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 to the Reporter if they believe that a child 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.

3.3 The **Children and Families Social Work Team** located within Shetland Islands Council Children’s Services - [http://www.shetland.gov.uk/](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 may be in need of compulsory measures of supervision, to refer the case to the Reporter.

3.4 The **Reporter** - [http://www.scra.gov.uk/home/](http://www.scra.gov.uk/home/) - has a duty to investigate referrals to him/her and to refer a child to a Children’s Hearing if s/he is satisfied that it is in the child’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.

3.5 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.

3.6 The **Procurator Fiscal** - [http://www.copfs.gov.uk/](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 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;

c) Set up contact with the child witness where there is prosecution, in consultation with other agencies;

d) Assess with the help of professional colleagues, the most appropriate way for the child to give evidence in any criminal court proceedings and to make appropriate applications to the court;

e) Work with the Reporter; and

f) Go to Child Protection Case Conferences, if this is appropriate.

3.7 **Shetland NHS Board** - [http://www.shb.scot.nhs.uk/](http://www.shb.scot.nhs.uk/) - also 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.

3.8 For further information about the roles and responsibilities of NHS staff in Shetland, please see Appendix 2.

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 as well as the development of their well being.

3.10 For further information about the roles and responsibilities of pre-school and school based staff, please see Appendix 2. Additionally, part 2 of the National Guidance 2010 provides more detailed guidance.

4. Definition

4.1 Child abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting, or by failing to act to prevent, significant harm to the child. Children 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 can be abused.

4.2 The National Guidance for Child Protection in Scotland 2010 (‘the National Guidance’) - http://www.scotland.gov.uk/Resource/Doc/334290/0109279.pdf states that the following definitions show some of the ways in which abuse may be experienced by a child but they are not exhaustive, as the individual circumstances of abuse will vary from child to child.

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 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 emotional development. It may involve conveying to a child 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. It may involve causing children to feel frightened or in danger, or exploiting or corrupting children. Some level of emotional abuse is present in all types of ill treatment of a child; it can also occur independently of other forms of abuse.

Sexual abuse
Sexual abuse is any act that involves the child in any activity for the sexual gratification of another person, whether or not it is claimed that the child either consented or assented. Sexual abuse involves forcing or enticing a child to take part in sexual activities, whether or not the child 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 in looking at, or in the production of, pornographic material or in watching sexual activities,
using sexual language towards a child or encouraging children to behave in sexually inappropriate ways.

**Neglect**

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, to protect a child 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 basic emotional needs. Neglect may also result in the child 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 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**

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 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 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.
4.4 Organisations working with children owe them a duty of care and have specific responsibilities towards them. Everyone has a responsibility to make sure children 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 at 9.4 below.)

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.scotland.gov.uk/Resource/Doc/334290/0109279.pdf

(For further information on this, see the following chapter (chapter 5) of these procedures, and in the National Guidance).
5. Recognition

5.1 There are a number of signs which may indicate that a child 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 whole situation, and in combination with a range of other information related to the child’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 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, and emotional abuse or neglect. 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 young children (under 1 year);
- Delay in parents and/or carers seeking medical attention for their child;
- Children 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 physical or emotional needs;
- Inappropriate behaviour (including sexualised play or activity) or demeanour of the child or parent;
• Unusual illness suggestive of a fictitious origin; and
• Child’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 (bruises 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

If concerned about unusual bruising the advice would be always contact Children and Families Social Work in the first instance as they can liaise with Health colleagues in order that appropriate medical assessment can be made.

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;
• 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;
• Marked contrast in material provision afforded to other siblings;
• Isolation from normal social experiences preventing the child forming friendships;
• Requesting the child be removed from the home or highlighting difficulties in coping with a child 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 also being physically abused can also be a concern.

Child’s Behaviour

• Frozen watchfulness;
• Fear of carers;
• Refusal to speak; and
• Severe hostility or aggression towards other children.
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 are all issues that can affect a child’s situation to the extent that they are being abused or neglected.

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;
- Unhygienic home conditions;
- Lack of protection or exposure to dangers involving moral danger, or Lack of supervision appropriate to the child’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 who arrives early and appears reluctant to go home;
- Failure to keep routine medical, dental and health visiting appointments.

**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 **Chapter 9** gives some further information about specific circumstances that may be helpful. **Appendix 1, Part 1 and Part 2** of these procedures also provide information on a number of topics relating to child protection.
6. Referral

6.1 All allegations of child abuse will be treated seriously. This does not mean that all allegations will necessarily be accepted as true, but staff must be aware of the seriousness of such allegations and the consequent need to examine and test these.

6.2 These child protection procedures are designed to direct referrals to the Duty social work service (within the Children's Services Department of Shetland Islands Council) and/or the Police, who may in turn make a referral to the Reporter. This does not affect the statutory right of any individual to refer a case directly to the Reporter.

6.3 Staff from all agencies working with children should know how to recognise child abuse, and how to refer such a case to one of the investigating agencies in accordance with these procedures.

6.4 Staff may seek an explanation for an obvious injury to the child, either from the child, or from his/her parents. If a child begins to speak about concerns, it is important to listen carefully and note exactly what is said. In seeking to clarify the information being given, and gather basic details to establish the need for a referral, staff should take care not to ask leading questions (questions that suggest an answer) and not to engage in an investigative interview, which will be undertaken by the investigating agencies. Although not involved in interviewing, staff may find it helpful to refer to the examples of open and closed questions in Appendix 1, Part 1, paragraph 10 in order to fully appreciate this point.

6.5 The timing and nature of further contact with parents must be decided by the investigating agencies, following referral. The referrer will normally be kept informed.

6.6 When making a referral, it is important for the fullest and most accurate information to be given. To help ensure this, and to establish a simple chain of communication, either:

- Wherever possible, the referral should be made by the person with firsthand knowledge of the situation, or
- The person with first-hand knowledge may be spoken to before an investigation is started;

6.7 All referrals should make a clear distinction between fact and opinion.

6.8 Staff from all agencies should all be sufficiently familiar with these procedures to enable them to inform members of the public who refer
cases of suspected abuse of the actions and responsibilities of each agency.

6.9 **Chapter 7** of these procedures details the actions required of staff from each statutory agency, and which should be taken by other organisations, in the event of suspected abuse of a child.

6.10 Shetland is too small to have a waking 24 hour social work response team but urgent help 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/social work manager, who will call you back. You will need to provide a number for this purpose. However, if you are unable to give a number, provide as much information as you can to the operator, who will pass it on. However, please be aware that in that case the emergency help that can be offered may be more limited than if the social worker were able to speak to you direct.

6.11 If you are making an enquiry of the Child Protection Register the duty social worker will need to check your identity e.g. by calling you on your work number.

6.12 **In the event of any difficulty in contacting the Duty social work service, where there is an allegation of a crime, or if immediate assistance is required, a child protection referral can be made direct to the police, in an emergency by dialling 999.**
7. **Immediate Response**

7.1 **Immediate Response - Shetland Islands Council Duty social work service.**

7.1.1 On receipt of information suggesting that a child may have been abused, or may be at risk of being abused, social work staff will:

(a) Record all relevant details that are available regarding

- the child/ren concerned;
- the alleged abuse;
- the alleged perpetrator;
- the child’s family;
- the informant;

(b) Notify the Designated Manager for Child Protection (DMCP). It is the responsibility of the Chief Social Work Officer to nominate social work managers to fulfil this function and to ensure relevant staff know who they are.

7.1.2 The DMCP will assume management responsibility for any child protection referral, and instigate any immediate action required to protect the child on an emergency basis. The DMCP who is first notified of a referral will hold responsibility until another DMCP assumes that responsibility. The time of handover must be recorded by them both, and if an investigating social worker has been appointed under 7.1.8 below, it is the responsibility of the DMCP assuming responsibility to notify them of the handover.

7.1.3 The DMCP will ensure that the following checks are made:

- Social work records;
- Child Protection Register;
- Police;
- Health visitor;
- Head teacher;
- General practitioner;
- Clinical psychological services;
- Information on GIRFEC Plans and Assessments;
- Criminal Justice Unit;
- Local authority for any recent last known address;
- Others as appear relevant.

In any case where there is a referral received expressly as a child protection referral, checks will be made of relevant agencies before a
decision is made that a child protection investigation is unnecessary. This will include anonymous referrals.

7.1.4 The DMCP will consider the available information and determine whether an initial investigation should be instigated. Where a child protection referral is received out of hours it is likely that not all the checks can be carried out immediately. The DMCP on duty out of hours will ensure as many checks as possible are carried out and the outcome recorded. If the above checks have not been completed, the DMCP on duty the next working day will ensure they are completed before a decision is made that progressing the matter further under child protection procedures is unnecessary.

7.1.5 Should the DMCP need further support, the Executive Manager, Children and Families Social Work, and the Director of Children’s Services are available for consultation.

7.1.6 The DMCP will ensure that each child concerned is seen by an appropriate professional, preferably a social worker, and that the immediate well-being of the child is established, unless satisfied that this has already been done. The need for any immediate protective action must always be considered.

7.1.7 If, following a child protection strategy discussion, the matter is proceeding as child protection (whether joint investigation or single agency enquiry) the child must be seen by a social worker. If not proceeding as child protection, then arrange that if the child has not been seen by a professional since the incident/concern leading to the referral they are now seen by a known professional (providing guidance who this might be and confirm they can re-refer into child protection if it looks like this may be needed. The professional may also consider the need for further assessment through GIRFEC). Any decision to take no further action must be provisional only until this has happened, and the outcome reported to social work and further decision(s) made as to appropriateness of response.

7.1.8 In the event of a child protection investigation being considered unnecessary, the reasons for this decision will be recorded by the DMCP. If unmet needs are identified GIRFEC is the route through which these should be considered.

7.1.9 The DMCP will identify a social worker to act as the investigating social worker for any investigation, and will make contact with the police to arrange an initial strategy discussion.
7.1.10 A social work Manager and the investigating social worker will attend the strategy discussion with the police, health and any other agencies it has been agreed should be involved. See chapter 8 below.

7.1.11 The investigating social worker will complete the Record of Action Taken - Child Protection Referral. An example of the form to be used can be found on the next page – Form 3.

7.1.12 The investigating social worker, or the duty social worker where a decision is reached not to undertake a child protection investigation, will provide appropriate feedback to a referrer, to include information as to the stage of the Procedures reached, within 48 hours of receipt of the referral, and this will be confirmed in writing within 7 days of the conclusion of the investigation, except in the case where the referrer has confirmed they would be compromised by this, e.g. a family member.
# Record of Action Taken - Child Protection Referral

## Referral

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Method</th>
<th>Source</th>
</tr>
</thead>
</table>

## Name of Child

- **Home Address**

## Date of Birth

- **Address of Current Placement**

## Date of Incident

- **Type of Current Placement**

## Family Composition

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Age/DoB</th>
<th>Address</th>
<th>On Reg?</th>
</tr>
</thead>
</table>

## Checks

<table>
<thead>
<tr>
<th>CP Register</th>
<th>Date</th>
<th>Known/Not Known</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other social work records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Visitor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schools (H Teacher/other)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP</td>
<td></td>
<td></td>
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<tr>
<td>Psychological services</td>
<td></td>
<td></td>
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<tr>
<td>GIRFEC Project Manager</td>
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<tr>
<td>Criminal Justice Unit</td>
<td></td>
<td></td>
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<tr>
<td>Previous Local Authority</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other relevant (specify) e.g. Youth Services, Voluntary services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Has child been seen?

- **By whom?**

## Outcome:
Record of Action Taken - Child Protection Referral cont

<table>
<thead>
<tr>
<th>Name of Child</th>
<th>D.O.B</th>
</tr>
</thead>
</table>

Consultation with Designated Manager for Child Protection  
(state date, time and name)

Action Taken

Initial Risk Assessment

<table>
<thead>
<tr>
<th>Decision (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NFA, further assessment, emergency protection action, child protection case conference, other (please specify)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature</th>
<th>Signature (Team Leader/ Executive Manager)</th>
</tr>
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<table>
<thead>
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<th>Name</th>
<th>Name</th>
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<tbody>
<tr>
<td>Designation</td>
<td>Designation</td>
</tr>
<tr>
<td>Date</td>
<td>Date</td>
</tr>
</tbody>
</table>

Feedback

Information provided to referrer: (date)  
Confirmed in writing: (date)

<table>
<thead>
<tr>
<th>Signature</th>
<th>Signature (TL/EM)</th>
</tr>
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<td>Designation</td>
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<td>Date</td>
<td>Date</td>
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</table>
7.2 Immediate Response – Northern Constabulary Shetland Command

7.2.1 When an allegation is made or information passed to the police from an agency or other source that a child has been or may be at risk of abuse or neglect, the officer receiving the information must let the on call Designated Officer in the Command Area know through the chain of command.

7.2.2 A nominated police officer is the Designated Officer for the purposes of communication between agencies, and has a particular responsibility for child abuse investigations.

7.2.3 The Designated Officer will consider the information and source and contact Shetland Islands Council’s DMCP (see 7.1) or Executive Manager, Children and Families Social Work. If the contact is necessary out of office hours, the duty social worker will be contacted, and if he/she is unavailable the DMCP will be contacted. They will exchange information on the circumstances, and decide on the most appropriate course of action to follow.

7.2.4 The Designated Officer will complete Child Protection review sheet CR/56/37 following the exchange of information and ensure that background checks for the victim(s) and suspect(s) are carried out. Such checks will include:-

a) Child Protection Register  
b) Scottish Criminal Records Office (SCRO)  
c) Police National Computer (PNC)  
d) Child Protection database (HOLMES)  
e) Scottish Intelligence Database (SID)  
f) Incident Text searches (IMPACT)

7.2.5 When an enquiry is necessary the Designated Officer will appoint an officer specifically trained in child protection matters as investigating officer. (All area commands have a number of trained Local Child Protection Officers (LCPOs) who are available to carry out such enquiries). The dedicated Child Protection Unit (CPU) is based at Police Head Quarters in Inverness, and when requested by the Designated Officer will support the LCPOs. The unit will deal with complicated child protection cases, which involve serious allegations, multiple victims or multiple accused.

7.2.6 The Designated Officer will attend the strategy discussion with the investigating officer, a social work manager and the investigating social worker, and any other agencies it has been agreed should be involved. (See chapter 8 below.)
7.2.7 Where any child is at risk of harm, this factor will always over ride Northern Constabulary’s requirements to keep information confidential. The Designated Officer will acknowledge the requirement to act in a child’s best interest, as the Children (Scotland) Act 1995 - http://www.scotland.gov.uk/Resource/Doc/26350/0023700.pdf - supersedes the right to family life requirement in the Human Rights Act - http://www.legislation.gov.uk/ssi/2000/301/contents/made. The duties defined in the Children (Scotland) Act take primacy. Full details of the results of checks stipulated under paragraph 7.2.4 will be disclosed to the investigating social worker in order that an accurate joint risk assessment between the police and social work services is carried out.

7.2.8 It may be necessary for Police Officers to interview the person to whom a child has disclosed. If this is necessary it will be discussed at the strategy meeting and appropriate arrangements made.

7.2.9 Should a child make an allegation directly to a police officer, the officer will not enter into an exploratory interview, but the information will be referred to the Designated Officer as above.

7.3 Immediate Response – Children’s Services – Schools Staff

7.3.1 Wherever there is an indication that a child has suffered a physical injury or is being neglected (see chapter 5 above) or a child makes an allegation that s/he has been subject to any form of abuse, whether recent or not, the staff member must immediately contact the Head Teacher, the Head of Establishment or depute, who are the Designated Persons for child protection.

7.3.2 The Head Teacher, Head of Establishment or depute must immediately refer the case to the Duty social work service, without further discussion with the child. See page at the front of these procedures for contact numbers.

7.3.3 Staff may seek an explanation for an obvious injury to the child, either from the child or from his/her parents; however, Schools service staff must not interview the child, beyond gathering basic details to establish the need for a referral. The timing and nature of further contact with parents must be decided by the investigating agencies, following referral.

7.3.4 A child may choose a member of school or other establishment staff to speak of abuse, which has happened to him/her. It is important to acknowledge the trust that the child is placing in the staff member without
becoming drawn into an interview. If a child begins to speak about concerns, it is important to listen carefully and note exactly what is said. In seeking to clarify the information being given, and gather basic details to establish the need for a referral, staff should take care not to ask leading questions (questions that suggest an answer) and **not to engage in an investigative interview, which will be undertaken by the investigating agencies**. Although not involved in interviewing, staff may find it helpful to refer to the examples of open and closed questions in **Appendix 1, Part 1, paragraph 10** in order to fully appreciate this point.

7.3.5 The child will need to understand that:

- The importance of what the child has said is recognised;
- S/he is being taken seriously;
- The staff member is willing to help; and
- In order to help, the information must be shared with others.

7.3.6 **Staff cannot** give the child a guarantee of confidentiality, but should assist the child as far as possible to understand what will happen next.

7.3.7 If the child has sustained an injury priority should be given to meeting immediate medical needs. Confirmation should be obtained from social work staff as to the medical arrangements, and co-operation given as required with arrangements to take the child to hospital or to his/her GP. It is the responsibility of social work staff to make these arrangements in consultation with parents. (Social work staff will liaise with the police regarding the necessity for involvement of a Police Surgeon.)

7.3.8 In circumstances where staff have general concerns about a child, but no clear sign of injury and no allegation from the child, this should be discussed with the Head Teacher, Head of Establishment or depute. Paragraph 7.3.3 also applies in these circumstances.

7.3.9 The Head Teacher, Head of Establishment or depute will decide, whether a child protection referral should be made.

7.3.10 A written record of concerns, allegations and actions taken must be kept.

7.3.11 If the initial contact with the Duty social work service or police was made by telephone, in addition to taking a written record as at 7.3.10 above, the Director of Children’s Services must be notified in writing, with a copy to the Executive Manager, Children and Families Social Work. A [form for notification](#) is at page 28.

7.3.12 If the Head Teacher, Head of Establishment or depute is not available, or if the staff member is not satisfied with the action taken s/he may contact
the Duty social work service directly, but must then comply with paragraph 7.3.11 above.

7.3.13 In case of any difficulty in contacting Duty social work, see also 6.1.2 above.

7.4 Immediate Response - Shetland Islands Council Children’s Services (other than Duty social work)

7.4.1 Wherever there is an indication that a child has suffered a physical injury or is being neglected (see chapter 5 above) or a child makes an allegation that s/he has been subject to any form of abuse, whether recent or not, the staff member must immediately contact his/her Designated Person for child protection.

7.4.2 The Designated Person must immediately refer the case to the Duty social work service without further discussion with the child. See page at the front of these procedures for contact numbers. An example of the referral form can be found at the end of this chapter – Form 2.

7.4.3 Staff may seek an explanation for an obvious injury to the child, either from the child or from his/her parents; however, staff must not interview the child, beyond gathering basic details to establish the need for a referral. The timing and nature of further contact with parents must be decided by the investigating agencies, following referral.

7.4.4 A child may choose a social worker, youth worker, or other trusted person to disclose to. It is important to acknowledge the trust that the child is placing in the staff member without becoming drawn into an interview. If a child begins to speak about concerns, it is important to listen carefully and note exactly what is said. In seeking to clarify the information being given, and gather basic details to establish the need for a referral, staff should take care not to ask leading questions (questions that suggest an answer) and not to engage in an investigative interview, which will be undertaken by the investigating agencies. Although not involved in interviewing, staff may find it helpful to refer to the examples of open and closed questions in Appendix 1, Part 1, paragraph 10 in order to fully appreciate this point.

7.4.5 The child will need to understand that:

- The importance of what the child has said is recognised;
- S/he is being taken seriously;
- The staff member is willing to help; and
- In order to help, the information must be shared with others.
7.4.6 Staff cannot give the child a guarantee of confidentiality, but should assist the child as far as possible to understand what will happen next.

7.4.7 If the child has sustained an injury that requires medical attention, confirmation should be obtained from social work staff as to the medical arrangements, and co-operation given as required with arrangements to take the child to hospital or to his/her GP. It is the responsibility of social work staff to make these arrangements in consultation with parents. (Social work staff will liaise with the police regarding the necessity for involvement of a Police Surgeon.)

7.4.8 In circumstances where staff have general concerns about a child, but no clear sign of injury and no allegation from the child, this should be discussed with the Designated Person. Paragraph 7.4.3 also applies in these circumstances.

7.4.9 The Designated Person will decide whether a child protection referral should be made.

7.4.10 A written record of concerns, allegations and actions taken must be kept.

7.4.11 If the initial contact with the Duty social work service or police was made by telephone, in addition to taking a written record as at 7.4.10 above, the Director of Children’s Services must be notified in writing, with a copy to the Executive Manager, Children and Families Social Work. A form for notification is at page 28.

7.4.12 If the Designated Person is not available, or if the staff member is not satisfied with the action taken, s/he may contact the duty social worker directly, but must then comply with paragraph 7.4.11 above.

7.4.13 In case of any difficulty in contacting duty social work, see also 6.1.2 above.

Note: All staff should have been informed during induction of the identity of their Designated Person for child protection. Designated Persons must undertake as a minimum the CPC’s Foundation Level (2 ½ day) child protection course and regular updates. Anyone who does not know who their Designated Person is should contact their Line Manager.

7.4.14 Referral Proforma – Form 2 as follows should be used to make a child protection referral. Referrals should always be made by telephone and then followed up in writing using this pro-forma.
Form 2

Referring agency: Shetland Islands Council*
Education and Families
Schools service*
Children’s Resources*
Housing service*
Other SIC department or service (please state)*
Other organisation (please state)*

Child Protection

CONFIDENTIAL

To: Executive Manager, Children and Families and Families
Copy to: Executive Manager – Quality Improvement*
Director of Children’s Services*
Executive Manager - Housing *
(* delete as appropriate)
Designated Person for Organisation (please state):

From: Name, Designation/post held and name & address of
School/Club/Centre etc

Child’s Name:

Date of Birth:

Address:

Name and Address of Parent or Guardian:

Date and time of initial contact with member of staff:

Reasons for concern:
(clearly indicate whether this refers to an incident, suspicion or allegation by the child)
Date and time of contact with the Duty social work service:

Advice received from the Duty social work service:

Any other comments:

Signed: Date:

Please attach a copy of your agency’s chronology if available
7.5 Immediate Response – NHS Shetland

7.5.1 All cases where there is knowledge or suspicion that a child has suffered or is at risk of suffering abuse must be reported to the Duty social work service. There does not need to be a particular incident with substantial evidence.

7.5.2 The following reporting arrangements apply:

7.5.2.1 Staff whose role specifically includes child protection practice e.g. Health Visitors and/or staff who have undertaken the CPC’s child protection Foundation training course refer directly to the Duty social work service (or police as above).

7.5.2.2 Other staff refer through line manager or through the Nurse Advisor (Protection) (see below). All referrals should be advised to line manager.

7.5.2.3 Where a concern is reported to a line manager or the Nurse Advisor (Protection), that person must decide whether a child protection issue is being raised and ensure that the referral is made where appropriate and recorded appropriately. An example of the referral form can be found at the end of this part of the chapter on page 33 – Form 1.

7.5.3 If any staff member is in need of advice regarding the appropriateness of reporting, they may discuss the matter with the Nurse Advisor (Protection) or other relevant professional, provided this will not cause delay.

7.5.4 The referral will need to be immediate and should be made verbally to the duty social worker. See page at the front of these procedures for contact numbers.

7.5.5 Telephone contact must be followed up in writing by completing the form at page 33, and sending it to the Executive Manager, Children and Families Social Work at Hayfield House, Hayfield Lane, Lerwick, ZE1 0QD.

7.5.6 A copy of the referral form must be sent to the Nurse Advisor (Protection), Community Health Partnership Office, Breiwick House, South Road, Lerwick ZE1 0TG marked ‘CONFIDENTIAL’, the child’s GP, the Health Visitor where appropriate, and a copy kept on the referrer’s file for the child.
7.5.7 A written record of concerns, allegations and actions taken must be kept using Clinical Incident/Risk Management forms.

7.5.8 In circumstances where there are general concerns about a child, but no clear sign of injury and no allegation from the child, this should be discussed with a senior colleague, and in case of doubt the duty social worker should be consulted. The outcome should be noted in the child’s medical record.

7.5.9 In case of any difficulty in contacting Duty social work, see also 6.1.2 above.

7.5.10 A check may be made of social work records and the Child Protection Register. It is important to realise that the fact that a child’s name is not yet on the Child Protection Register does not indicate that they are not at risk. For further information about the link between Accident & Emergency and the Child Protection Register, please refer to Protocol No. 3 of these procedures.

7.5.11 Where children present to medical practitioners with an injury or complaint, practitioners should be alert to the possibility of child abuse or neglect, should ensure that full histories are taken and recorded, and should treat as suspicious inconsistencies in such histories. They must consider what information is available from their own or other agencies before they rule out the possibility of continuing risk.

7.5.12 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 child protection referral should be made (see 7.5.1 above).

7.5.13 The issue of a forensic medical examination will then be discussed at the appropriate strategy discussion. (See chapters 8 and 11 below).

7.5.14 For a doctor to continue with more detailed examination in such a case may involve intrusive examination procedures, and would be of limited value in forensic/legal terms. The only circumstance where it should be considered is where it is necessary to provide urgent treatment to the child.
7.5.15 Health professionals will be invited to Child Protection Case Conferences where they are needed, and are expected to attend. (See chapter 13). In every case they should provide the meeting with a written report on the child, even if this is only to record their lack of prior involvement; this is particularly essential if, exceptionally, they are unable to attend. Professionals should bear in mind that even if they have not had prior involvement with a child, their attendance may be required in order to consider what contribution they can make to a child protection plan if the child is or remains registered.

7.5.16 The following table details those who have specific roles in relation to child protection:

| Lead Clinician | (i) GP with a Special Interest in Child Health (supported by Director of Public Health).  
|                | (ii) On-call specialist advice from Grampian on-call Paediatrician.  
|                | (iii) Specialist advice from Consultant with Specific Responsibility for Child Protection at Aberdeen Children’s Hospital, NHS Grampian. |
| Lead Manager   | Director of Public Health |
| Child Protection Advisors | During working hours: Assistant Director of Nursing (Community) Assistant Director of Nursing (Hospitals) Nurse Advisor (Protection)  
| (for advice on Child Protection procedures or issues of concern) | Out of hours: Director of Public Health. On-call Consultant Paediatrician at Aberdeen Children’s Hospital, NHS Grampian. |

7.5.17 Referral Proforma – please use Form 1 as follows for NHS staff. It would be good practice to make a child protection referral by telephone and then follow that up in writing.
NHS Shetland
Child Protection

Referral to social work service

To: Name: ...................................................................................................................
Address: ...................................................................................................................

I refer to your attention

Name: ............................................................  Date of Birth: ..................................
Address: ..................................................................................................................
Parent/Guardian Address if different from above: .....................................................
Telephone Number: ..................................................................................................
Name of General Practitioner: ..................................................................................
Address of General Practitioner: ............................................................................... 
Telephone Number: ..................................................................................................
Name of Health Visitor: .............................................................................................
Address of Health Visitor: .........................................................................................
Telephone Number: ..................................................................................................
School/Nursery Attended: ..........................................................................................

Is there an open GIRFEC on this child?                       Yes/No

Account of Circumstances Leading to Referral

1  From Referrer:

..........................................................................................................................
..........................................................................................................................
..........................................................................................................................

Name: ...............................   Position: .................................  Date: ....................

- 33 -
2 From Accompanying Adult:
............................................................................................................................
............................................................................................................................
............................................................................................................................
Name: ...............................   Position: .................................  Date: ....................

3 From the Child:
............................................................................................................................
............................................................................................................................
............................................................................................................................
Signed:................................................. Name: (Block Capitals) ................................
Designation:.................................................................................  Date: ....................
Address: ......................................................................................................................
Contact Telephone No: .............................................................................................

Please attach a copy of your agency’s chronology if available
7.6 **Immediate Response - Shetland Islands Council, Housing Service**

7.6.1 Housing staff may become aware of child protection issues in a number of ways:-

- Direct information disclosed by child, family or young person;
- Observations of house conditions;
- Information from other tenants or local communities that may raise concerns for a child’s safety. For example, allegations of regular noise and disturbance may possibly affect children in that household.

Information coming to the attention of housing staff indicating that a child has been injured, neglected or at risk in some way, whether recently or not, should be brought to the attention of the Designated Manager.

7.6.2 The Designated Person for child protection must immediately refer the case to the Duty social work service *without* further discussion with the child. See page at the front of these procedures for contact numbers.

7.6.3 Staff may seek an explanation for an obvious injury to the child, either from the child or from his/her parents; however, **Housing staff must not interview the child, beyond gathering basic details to establish the need for a referral. The timing and nature of further contact with parents must be decided by the investigating agencies, following referral.**

7.6.4 A child may choose a support worker or other Housing staff to speak of abuse, which has happened to him/her. It is important to acknowledge the trust that the child is placing in the staff member without becoming drawn into an interview. If a child begins to speak about concerns, it is important to listen carefully and note exactly what is said. In seeking to clarify the information being given, and gather basic details to establish the need for a referral, staff should take care not to ask leading questions (questions that suggest an answer) and **not to engage in an investigative interview, which will be undertaken by the investigating agencies.** Although not involved in interviewing, staff may find it helpful to refer to the examples of open and closed questions in Appendix 1, Part 1, paragraph 10 of these procedures.

7.6.5 The child will need to understand that:

- The importance of what the child has said is recognised;
- S/he is being taken seriously;
- The staff member is willing to help; and
- In order to help, the information must be shared with others.
7.6.6 Staff **cannot** give the child a guarantee of confidentiality, but should assist the child as far as possible to understand what will happen next.

7.6.7 If the child has sustained an injury that requires medical attention, confirmation should be obtained from social work staff as to the medical arrangements, and co-operation given as required with arrangements to take the child to hospital or to his/her GP. It is the responsibility of social work staff to make these arrangements in consultation with parents. (Social work staff will liaise with the police regarding the necessity for involvement of a Police Surgeon.)

7.6.8 In circumstances where staff have general concerns about a child, but no clear sign of injury and no allegation from the child, this should be discussed with the Designated Person for child protection. Paragraph 7.6.3 also applies in these circumstances unless and until the decision is made to progress the concern through the Getting it Right for Every Child process.

7.6.9 The Designated Person for child protection will decide whether a child protection referral should be made.

7.6.10 A written record of concerns, allegations and actions taken must be kept.

7.6.11 If the initial contact with the Duty social work service or the police was made by telephone, in addition to taking a written record as at 7.6.10 above, the Executive Manager - Housing must be notified in writing, with a copy to the Executive Manager, Children and Families Social Work. A [form for notification](#) is on page 28.

7.6.12 If the Designated Person for child protection is not available, or if the staff member is not satisfied with the action taken, s/he may contact the Duty social work service directly, but must then comply with paragraph 7.6.11 above.

7.6.13 If an allegation is made during the course of a homeless interview, the referral to the Duty social work service should indicate that the household is presenting as homeless.

7.6.14 The homeless assessment should continue to ensure the provision of secure, safe accommodation, in accordance with the Council’s obligations under relevant legislation.

7.6.15 Housing staff will liaise with social work staff with regard to the location and suitability of alternative accommodation.

7.6.16 In case of any difficulty in contacting Duty social work, see also 6.1.2 above.
7.7 Immediate Response – Any other organisation;

This part of chapter 7 is applicable to:

- All departments and services within Shetland Islands Council not specifically covered in parts 7.1, 7.3, 7.4 or 7.6 above;
- All agencies and organisations represented on the Child Protection Committee not otherwise specifically covered;
- All independent and voluntary organisations in receipt of funding from Shetland Islands Council or the Shetland Charitable Trust.

It's everyone’s job to keep children and young people safe from abuse and neglect.

7.7.1 Wherever there is an indication that a child has suffered a physical injury or is being neglected (see chapter 5 above) or a child makes an allegation that s/he has been subject to any form of abuse, whether recent or not, an organisation’s staff member or volunteer must immediately contact the organisation’s Designated Person for child protection. If there is no Designated Person or the staff member or volunteer cannot readily find out who it is, or the Designated Person is not available, the staff member or volunteer should make a child protection referral themselves in accordance with 7.7.2 below.

7.7.2 The Designated Person must immediately refer the case to the Duty social work service without further discussion with the child. In the event of any difficulty in contacting the Duty social work service, or where there is an allegation of a crime, a child protection referral can be made direct to the police. See page at the front of these procedures for contact numbers.

7.7.3 You may seek an explanation for an obvious injury to the child, either from the child or from his/her parents; however, you must not interview the child, beyond gathering basic details to establish the need for a referral. The timing and nature of further contact with parents must be decided by the investigating agencies, following referral.

7.7.4 A child may choose a particular member of staff or volunteer or other trusted adult to speak of abuse, which has happened to him/her. It is important to acknowledge the trust that the child is placing in that person without becoming drawn into an interview. If a child begins to speak about concerns, it is important to listen carefully and note exactly what is said. In seeking to clarify the information being given, and gather basic
details to establish the need for a referral, staff should take care not to ask leading questions (questions that suggest an answer) and not to engage in an investigative interview, which will be undertaken by the investigating agencies. Although not involved in interviewing, staff may find it helpful to refer to the examples of open and closed questions in Appendix 1, Part 1, paragraphs 9 and 10 in order to fully appreciate this point.

7.7.5 The child will need to understand that:

- The importance of what the child has said is recognised;
- S/he is being taken seriously;
- You are willing to help; and
- In order to help, the information must be shared with others.

7.7.6 You **cannot** give the child a guarantee of confidentiality, but should assist the child as far as possible to understand what will happen next.

7.7.7 If the child has sustained an injury that requires medical attention, confirmation should be obtained from social work staff as to the medical arrangements, and co-operation given as required with arrangements to take the child to hospital or to his/her GP. It is the responsibility of social work staff to make these arrangements in consultation with parents, although any adult may do what is immediately necessary to ensure the child’s immediate safety. (Social work staff will liaise with the police regarding the necessity for involvement of a Police Surgeon.)

7.7.8 In circumstances where staff or volunteers have general concerns about a child, but there is no clear sign of injury and no allegation from the child, this should be discussed with the organisation’s Designated Person for child protection, if there is one. Paragraph 7.7.3 also applies in these circumstances.

7.7.9 The Designated Person will decide whether a child protection referral should be made, as at 7.7.2 above.

7.7.10 A written record of concerns, allegations and actions taken must be kept.

7.7.11 If the initial contact with the Duty social work service or the police was made by telephone, in addition to taking a written record as at 7.7.10 above, the referral should be confirmed in writing by completing Form 2 on page 28 of these procedures which is suitably adapted for the referring organisation, and showing contact details for the organisation, and sending it to the Children and Families Social Work, Hayfield House, Hayfield Lane, Lerwick, ZE1 0QD.
7.7.12 If the Designated Person is not available, if there is no Designated Person or the staff member or volunteer cannot readily find out who it is, or if the staff member is not satisfied with the action taken s/he may contact the Duty social work service directly, but must then comply with para. 7.7.11 above.

7.7.13 In case of any difficulty in contacting Duty social work, see also 6.1.2 above.

Note: All staff and volunteers should have been informed during induction of the identity of their Designated Person for child protection. Designated Persons should undertake as a minimum the CPC’s Foundation Level (2½ day) child protection course and regular updates.

Where a member of the public has concerns about a child but is not certain whether a child protection referral is required, this may be discussed with senior social workers or social work managers in Children’s Services (see page at the front of these procedures for contact numbers) or with Designated child protection staff in one of the agencies e.g. a school Head Teacher or a Health Visitor.

7.7.14 A proforma for making child protection referrals is included. Please see Form 2 on page 28 above.
8. **Child Protection Strategy, Planning and Debriefing Discussions**

8.1 Police and Social Work will always plan investigations into allegations of child abuse **jointly**. This does not mean that all investigations will be carried out jointly, but their method will be agreed in advance.

8.2 Strategy discussions between all appropriate organisations’ designated officers will normally be face to face, although in some circumstances it may be possible/appropriate for the planning of an investigation to be carried out by telephone, e.g. where it can be agreed at an early stage that either the police or the social work service will begin the enquiry singly.

8.3 The Child Protection Nurse Advisor will always be involved in strategy discussions, and consideration will always be given to the involvement of representatives of other disciplines at any stage of the planning process, particularly for those children with additional support needs. For further advice on this aspect, please also refer to Chapter 9.

8.4 The purpose of the first Strategy Discussion is:

- To collate available information and establish the facts about the circumstances giving rise to concern;
- To agree the nature of the child care enquiries and the criminal investigation; (see chapter 10 below for detailed planning of an investigative interview, and chapter 11 below 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 and any others. (see chapter 14 below for detailed procedures in respect of applications to remove the child, or to take other legal protective action).

8.5 Other than in circumstances where this would be detrimental to the child’s best interests, the child’s parent(s) should be consulted and involved in the planning process. Where the referral is an allegation of a crime, whilst giving paramount consideration to the child’s welfare, there may in some instances, be necessity to restrict the persons present at any strategy discussion.

8.6 In all circumstances, including those where a decision is made to take no further action under child protection procedures, consideration should be given to referral to the Reporter. The social work service will also give consideration to what support services the family may need or whether a GIRFEC assessment is appropriate.
8.7 Further strategy discussions 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.

8.8 At the strategy discussion a record of the discussion and decisions will be made. A signed copy of this document will be disseminated to every other agency in attendance. An example of the form to be completed can be found at the end of this chapter – Form 4.

8.9 Disagreements about the methods of progressing the investigation, if not resolved at the strategy discussion, will be referred to the Chief Social Work Officer and the Chief Inspector of Police, Northern Constabulary Shetland Area Command for consideration.

8.10 A proforma for recording strategy discussions follows on page 42.
Social Work/Police

Record of Child Protection Strategy Discussion

Child Details

<table>
<thead>
<tr>
<th>Surname</th>
<th>Forename</th>
<th>Dob</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Father's Name</th>
<th>Mother's Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Father's DoB</th>
<th>Mother's DoB</th>
</tr>
</thead>
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<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Father's Address (if different)</th>
<th>Mother's Address (if different)</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
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</tbody>
</table>

Other members of household (including DoB):

Other siblings not at this address (including DoB):

School:

GP:

Health Visitor:

Date of Referral: Source of Referral:

Time of Referral:
Initial Strategy Discussion

Date:  
Time:  
Chair:  
Attenders:  
Agency:  
Role:  

NB Consider the involvement of agencies other than the police and social workers where appropriate

Summary of Information Available Indicating Sources

- to establish the facts about the circumstances giving rise to concern;
- to establish whether or not there are grounds for concern;
- to identify sources and levels of risk;
- to establish whether children and families need advice, guidance and assistance without further investigative procedures;
- to consider and plan any necessary protective or other action in relation to the child and others.
### DECISIONS

<table>
<thead>
<tr>
<th>Need for immediate action to protect child?</th>
<th>Refer to Reporter at this stage?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Y/N)</td>
<td>(Y/N)</td>
</tr>
</tbody>
</table>

If Yes, what:

<table>
<thead>
<tr>
<th>Proceed to investigation?</th>
<th>Parents to be involved at this point?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Y/N)</td>
<td>(Y/N)</td>
</tr>
</tbody>
</table>

If not, why not:

<table>
<thead>
<tr>
<th>Social Worker</th>
<th>Police Officer</th>
</tr>
</thead>
</table>

### INVESTIGATION

(To establish what the next steps are which need to be taken, and by whom)

### AGREED FOLLOW UP ACTIONS:

<table>
<thead>
<tr>
<th>How will feedback to be given to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child?</td>
</tr>
<tr>
<td>Family?</td>
</tr>
<tr>
<td>Referrer?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signed: (Social Work):.........................</th>
<th>Date completed:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signed: (Police):..........................</th>
<th>Date:..............................</th>
</tr>
</thead>
</table>
9. **Special Circumstances**

9.1 **Children with additional support needs**

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

9.1.2 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.

9.1.3 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 condition rather than a symptom of abuse – this should be rigorously checked out, taking appropriate specialist advice as needed.

9.1.4 Staff from all agencies working with children 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.

9.1.5 Special consideration must be given prior to the strategy discussion on who are the most appropriate people to attend. These considerations must include issues, such as, whether the child has communication difficulties e.g. Sensory Service, Learning Disabilities Nurse, Social Worker for children affected by disabilities.

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

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

- Principal Teacher - Sensory and Communication Service
- Learning Disabilities Nurse
- Social Worker for children affected by disabilities
- Principal Teacher – Additional Support Needs, Anderson High School
- Depute Head Teacher – Additional Support Needs, Bells Brae Primary School
- Outreach Teacher - Autistic Spectrum Disorder
- Child and Adolescent Mental Health Service (CAMHS)
9.1.8 Should the child 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.

9.1.9 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 strategy discussion.

9.2 Abuse by children and young people

9.2.1 Children and young people who have abused others are in need of support services, help, advice and counselling, and this will be given high priority by all agencies.

9.2.2 Interviews of children who are alleged to have abused a child will not be carried out exclusively by the police without prior agreement at a strategy discussion involving social work services. It must be recognised that should the referral relate to a criminal matter, any delay in enquiry may result in the loss of crucial forensic evidence.

9.2.3 When a young person is alleged to have abused a child, consideration will always be given to referring the young person as well as the child to the Reporter. The police could report the young person for committing offences to the Reporter, if there is sufficient evidence.

9.2.4 Except in exceptional circumstances (recorded in writing) a child protection case conference for any alleged abuser under the age of 16 will be convened, followed by a comprehensive assessment of his/her needs, and a risk management plan will be drawn up where risks to others have been identified. For further guidance regarding sexual abuse please refer to the Protocol regarding working with Children and Young People who display Sexually Harmful Behaviour, which is Protocol 6 of these procedures.

9.3 Organised or multiple abuse

9.3.1 Features of this could include:

- Groups encompassing one or more families, friends, neighbours and wider networks;
- Enticement or intimidation of children for sexual exploitation;
Variations in the degree and form of sexual exploitation, including child pornography;
Close co-operation and defence of common group interests in the face of any inquiry.

9.3.2 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.

9.3.3 Where it appears that organised or multiple abuse may be involved, the Chief Social Work Officer, Chief Inspector, Northern Constabulary Shetland Area Command, and Director of Public Health must be informed, and they will hold the Strategy Discussion. (See chapter 8 above.)

9.3.4 The interests of the children 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 involved.

9.4 Allegations against staff

9.4.1 Any allegation that a child has been abused by a member of staff from any organisation (or volunteer working for any organisation) will be dealt with in accordance with these procedures.

9.4.2 On receipt of an allegation against a member of staff, the Duty Manager must immediately advise the Chief Social Work Officer in order that advice can be offered to the appropriate organisation as to any risks. Where there is an allegation of criminality the Chief Social Work Officer will liaise with the Chief Inspector, Northern Constabulary, Shetland Area Command to ensure that the integrity of the investigation is maintained.

9.4.3 The staff member’s line manager must be informed immediately, as must the Executive Manager Children and Families incorporating the Chief Social Work Officer, Executive Manager - Schools, Director of Children’s Services, Shetland NHS Board Chief Executive and the Chief Inspector of Northern Constabulary. Line managers must not discuss the allegation with the staff member pending decisions of the strategy discussion, but should take any immediate action required for the immediate protection of children.
9.4.4 The Police will invite the relevant Senior Manager for the appropriate agency/organisation together with the relevant Personnel or Executive Manager – Human Resources to the strategy discussion (see chapter 8 above) to either attend or send the most suitable representative. Where it is a criminal investigation, with the potential loss of forensic evidence, strategy discussions should be held at the earliest opportunity. Strategy discussions for criminal matters should not be delayed to accommodate various organisations’ diary commitments.

9.4.5 The strategy discussion will decide (with the exception of allegations against Northern Constabulary staff) who will inform the staff member and how, and will discuss any further steps, such as suspension, that may be needed either to minimise risks or facilitate the investigation. Where the allegations relate to a member of staff employed by Northern Constabulary the Chief Inspector, Shetland Area Command will consult with his/her line manager and the Head of Professional Standards within Northern Constabulary in order to identify actions required. When the allegation pertains to a criminal enquiry, there is a need to ensure that no ‘unique knowledge’ is disclosed to the member of staff. Where such allegations exist, there is a requirement for the strategy discussion to identify and ensure no contamination of knowledge to any suspect.

9.4.6 These child protection procedures should be implemented alongside the organisation’s own procedures, which will include keeping the staff member informed of his/her rights in respect of the investigation, and of any disciplinary procedures and offering appropriate support.

9.4.7 Children’s right to be protected is paramount, but sensitivity is also required to the vulnerability of staff to false allegations.

9.4.8 It must be clearly understood that suspension for a period of time may be required to facilitate the inquiry or to minimise any potential risks based on information available: if an allegation is not upheld, the organisation will support the staff member’s reintegration into the workplace. This will be an internal decision for each individual organisation to address in line with their own policies, standards and guidance.

9.5 Allegations against foster carers

9.5.1 Any allegation that a child has been abused by a foster carer will be dealt with in accordance with these procedures. The Executive Manager – Children and Families Social Work must be informed immediately, and the Executive Manager – Children’s Resources should be involved in the strategy discussion (see chapter 8).
9.5.2 Immediate consideration will be given to whether a change of placement is in the child’s best interests.

9.5.3 Any criminal matter should be discussed with the police Designated Officer prior to informing the foster carer, and the content of any discussion with the foster carer agreed.

9.5.4 The strategy 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.

9.5.5 The Executive Manager, Children and Families Social Work will arrange for a social worker who is not involved in the investigation to act as a support to the foster carer. This role may be undertaken by the Fostering Officer who is already known to the Foster Carers. The Fostering Network may also be able to support the foster carer.

9.5.6 Children’s right to be protected is paramount, but sensitivity is also required to the vulnerability of foster carers to false allegations.

9.6 Disclosure of historical child abuse

9.6.1 An adult or an older young person no longer at risk may disclose abuse that happened to her/him 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 victim/survivor, the police and the Duty 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 strategy meeting must be convened to plan an immediate child protection investigation in accordance with these procedures.

9.6.2 Further guidance on handling disclosures of historical abuse is to be found in the National Guidance for Child Protection in Scotland 2010 at http://www.scotland.gov.uk/Resource/Doc/334290/0109279.pdf under the heading “Historical allegations of abuse”.

9.7. Children living in the same household as abuser(s)

9.7.1 Information that an abuser may be living in the same household as a child should be referred to the Duty social work service immediately, who will consult with the police in order that the risk to the child may be assessed. In the event of any difficulty in contacting the Duty 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. 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 and Schedule 1 of the Sex Offences Act 2003 - http://www.legislation.gov.uk/asp/2009/9/pdfs/asp_20090009_en.pdf 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.

9.8 Anonymous referrals

9.8.1 Anyone receiving an anonymous telephone call about concern for the safety of a child should try to obtain the caller’s number. If this is impossible, full details of the allegation/concern 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 s/he may be interviewed about the allegation.

9.8.2 However, **anonymous callers should not be discouraged from sharing the information they have about a child, 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.

9.8.3 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/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.

9.8.4 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.

9.9 **Children and Young People who place themselves at Risk**

9.9.1 Under the 2010 National Guidance for Child Protection, Child Protection Committees are required to ensure there are multi-agency policies, procedures and systems in place for the identifying, referring and responding to situations where young people place themselves at risk through their own behaviour.

9.9.2 Some children and young people place themselves at risk of significant harm. Concerns about these children and young people can be just as significant as concerns relating to children who are at risk because of their care environment. The main difference is the source of risk, though it should be recognised that at least some of the negative behaviour may stem from experiences of abuse. Where risk is identified, as with other child protection concerns, it is important that a multi-agency response is mobilised and a support plan identified to minimise future risk. The key test for triggering these processes should always be the level of risk to the individual child or young person, and whether the risk is being addressed, not the source of the risk.

9.9.3 While not exhaustive, the following list the different types of concern that may arise:

- Self harm and/or suicide attempts;
- Alcohol and/or drug misuse;
- Running away-going missing;
- Inappropriate sexual behaviour or relationships (for more information, see Protocol 6 of these procedures);
- Sexual Exploitation;
- Problematic or harmful sexual behaviour;
- Violent behaviour; and
- Criminal activity.

9.9.4 Children or young people at immediate risk would need to be referred to the duty social worker who would then initiate child protection procedures, and take any immediate action required. However if practitioners are concerned about a course of conduct that is a cumulative risk to a child or young person then it may be very appropriate to begin a GIRFEC assessment and develop a care plan to support parents and children.

school, misusing alcohol or drugs, misusing volatile substances by inhaling vapours of glue or aerosols or exposed to moral danger (which can be through going missing, associating with adults who would be a risk to them or exploit them) to be referred to the Reporter for consideration of the need for statutory measures. The need for such a referral should be considered when either GIRFEC assessments or child protection interventions are being put in place. The police have a duty to refer any young person under the age of 16 who has committed an offence to the Reporter.
10. Investigative Interviewing - Police and Social Work

10.1 The main purpose of an investigative interview is to gather the information needed to take or plan any necessary action. If a child protection investigation is required the case will be allocated and the investigation commenced within 24 hours of the initial decision being taken.

10.2 The investigation will normally be carried out by an experienced social worker and police officer, one of each gender where possible. There should always be two members of staff involved in the investigation and interviews, to ensure that staff are protected and that there is corroboration of evidence. The investigating social worker and police officer should preferably be child protection trained.

10.3 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 planning meeting.

10.4 A specialist interview suite is available in Lerwick and other premises suitable for carrying out investigative interviews have been identified throughout the isles. A list of suitable venues is held by the Clerical Assistant for Adult and Child Protection. Venues used for visual recording must comply with national guidance on this matter to ensure the recording can be used in later proceedings.

11. Health Assessment and Medical Examinations

11.1 The need for a health assessment

11.1.1 Discussion between medical, nursing, 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 group will ensure that all respect the contribution provided by each service and that the health needs of the child are not overlooked.

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

11.1.3 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 and their family. The health assessment should also aim to identify unmet health and welfare needs in a very vulnerable child 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.

11.1.4 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 social work service of Shetland Islands Council;
- In the event of any difficulty in contacting the Duty social work service, or where there is an allegation of a crime, a child protection referral can be made direct to the police.
11.2 Comprehensive medical assessment

11.2.1 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 will require diagnostic procedures.

11.2.2 The comprehensive medical assessment has five purposes:

- To establish what immediate treatment the child 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 may require; and
- To reassure the child and the family as far as possible that no long-term physical damage or health risk has occurred.

11.2.3 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 10 above) should be made available to the examining doctor(s).

11.3 Arranging a medical examination

11.3.1 The number of examinations to which a child 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.

11.3.2 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, appropriately trained GPs are available for medical examinations through agreement with the paediatrician. The paediatrician or GP involved in the planning discussion should take responsibility for taking the medical assessment forward, supported by the Nurse Advisor (Protection), agreeing with police and social work colleagues the nature, timing and venue for the
examination. In situations where the child is brought initially to the attention of Health, and where there are concerns regarding the welfare or safety of a child, the paediatrician / GP should contact 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.

11.3.3 In instances of physical abuse and neglect, and emotional abuse and neglect, there is a need to identify signs in terms of any observable injuries, lack of care, developmental delay, etc. Medical information is pertinent to the decision-making process, and the need for a medical examination is almost certainly indicated. However, the principle of the best interests of the child will inform decisions on a case-by-case basis.

11.3.4 Failure to thrive is in itself a medical diagnosis, and is therefore likely to be identified by medical staff in the first instance. Where it is suspected by other professionals, a medical examination is essential, not only in terms of a child protection investigation, but with regard to treatment urgently required. The child’s best interests are therefore clearer in these circumstances.

11.4 Specialist paediatric or joint paediatric/forensic examination

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

- The child 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 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 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;
- The child'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.

11.4.2 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.

11.4.3 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 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 for a second opinion to a senior paediatric colleague with specialist experience in child protection.

11.4.4 The specialist paediatric examination provides a comprehensive assessment of the child, 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 and carers. The examination is intended to encompass both the child’s need for medical care and the legal requirement for evidence in a single examination.

11.4.5 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 health and development and ensuring that appropriate arrangements are made for further medical investigation, treatment and follow-up, the forensic physician (also known as forensic medical examiner, child medical examiner, or police casualty surgeon) 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.

11.4.6 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 police Designated Officer will consult the Detective Inspector in charge of the Child Protection Unit, Northern Constabulary, 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 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, 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. (See also chapter 8.)

11.4.7 The strategy discussion should always consider whether a medical examination is required; and, if so, where and when the examination should be carried out. The expectation will be that a health assessment is carried out unless there are specific reasons that it is not necessary.

11.4.8 The GP, and other relevant health staff with first-hand knowledge of the case, may be part of any strategy discussion which is considering the necessity for a medical examination. Health advice should always be sought to inform the strategy discussion, whether or not health staff are in attendance.

11.4.9 The form of the medical examination will be determined not by the nature of the alleged or suspected abuse, but by the agreed need for a corroborating medical witness and full forensic examination.

11.4.10 The police, on behalf of the strategy discussion, should consult specifically with the Procurator Fiscal and a Consultant Paediatrician to determine, in advance of any examination, whether corroboration of the findings is necessary for evidential purposes in any future prosecution.

11.4.11 Account will be taken of the child’s gender and race in making arrangements for a medical examination.

11.4.12 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 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.

11.5 Timing of medical examinations

11.5.1 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 best interests to rush to an immediate examination. It may be more appropriate to wait until the child 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 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.

11.5.2 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.

11.5.3 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.

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

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

11.6 Consent to medical treatment

11.6.1 Consent is required for medical treatment and examination. Parental consent should be sought if the parents have parental rights and responsibilities and the child is under 16, unless this is clearly contrary to the safety and best interests of the child (for example, in urgent circumstances). However, the Age of Legal Capacity (Scotland) Act 1991
- [http://www.legislation.gov.uk/ukpga/1991/50](http://www.legislation.gov.uk/ukpga/1991/50) - allows that a child 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 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.

### 11.6.2

In order to ensure that children 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 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 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 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 14](chapter_14) of these procedures.

### 11.6.3

The Age of Legal Capacity Act - [http://www.legislation.gov.uk/ukpga/1991/50](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 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.

### 11.6.4

If a child 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.**

### 11.6.5

A Child Assessment Order may allow for a medical examination to be carried out without the consent of a parent; however, the child’s consent would still be required by the examining medical practitioner.
11.6.6 To avoid unnecessary re-interviewing at the examination of any child, 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 it may avoid unnecessary additional discomfort.

11.6.7 If the child 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.

11.6.8 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 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.


11.6.10 The doctor should routinely record the results of the medical examination in the child’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.

11.6.11 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 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 asks for a particular person to go with them to the examination, this should be considered;
- The doctor will discuss with the child and parent the medical results of the examination where appropriate.
12. Parents

12.1 Parents with responsibility for the care of children involved in a child abuse investigation will be informed of, and helped to understand, the steps that are being taken. The decision regarding the appropriate organisation to notify the parents will be made at the strategy discussion and recorded as per paragraph 8.8 in chapter 8 of these Procedures. The social work service will confirm all important decisions to parents in writing, both for their own information and, if necessary, to help them instruct their legal representative(s). Where the referral is of a criminal allegation against one of the parents, whilst every effort will be made to comply with paragraph 8.5 in chapter 8 of these Procedures, the strategy discussion will consider the implications of such notification. Discussion at the strategy discussion will consider, in order of importance,

a) The implications for the child.

b) The impact on the criminal enquiry.

Where a decision is made not to inform the parent(s) or guardian, this will be recorded by the designated officers, with the reasons for the decision.

12.2 It is acknowledged that children live in a number of different family settings and it may be appropriate to include carers, guardians, cohabitees and kinship carers as well as those with parental rights and responsibilities in any investigations or subsequent discussions.

12.3 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 for this to occur. The decision will be made at a strategy discussion and the reasons recorded as set out in chapter 8.

12.4 Parents will normally be involved immediately prior to any interview with, or medical examination of, the child, and their support and co-operation sought.

12.5 Every effort will be made to uphold the rights of parents, irrespective of their co-operation.

12.6 At the conclusion of a child protection investigation, as far as necessary, parents and carers should be advised of the outcome and the future actions agreed. The strategy discussion 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. tape with contact details).
13. **Child Protection Case Conferences**

13.1 **General**

13.1.1 The case conference is the main forum for sharing information and concerns, analysing risks, and allocating responsibility for action.

13.1.2 Case conferences are convened by Shetland Islands Children's Services (Social Work) as a delegated function of the Child Protection Committee. The conference chair is accountable to the Chief Social Work Officer.

13.1.3 National guidance recommends the use of four distinct types of case conference:

- The initial child protection case conference;
- The pre-birth child protection case conference;
- The review child protection case conference;
- The transfer child protection case conference.

13.2 **Organisation**

13.2.1 The agency responsible for convening a Child Protection Case Conference is Children's Services Social Work service within Shetland Islands Council, although other agencies may request that a conference is called.

13.2.2 The decision whether an initial case conference is necessary will be made by a Team Leader in the Children and Families Social Work Team, following appropriate discussion with other agencies. If the Team Leader decides not to call a case conference and any professional person disagrees with this decision then an initial discussion with the Executive Manager Children and Families Social Work should take place. If this does not resolve the situation then the professional should refer the matter to the Head of their own agency who, after further discussion with the Executive Manager Children and Families Social Work, may require that a conference is called if they consider it to be in the child's best interests.

13.2.3 Case conferences will be chaired by the Children's Services Improvement Officer or in his/her absence by another trained chair approved by CPC. Exceptionally, if no other chair is available, conferences may also be chaired by the Lead Officer, Adult and Child Protection. All chairs should be of Team Leader grade or above, should have received training for the task and not have had line-management responsibility for the case.

13.2.4 A case conference will usually be convened following an investigation into an allegation of abuse to a child, but will also be necessary when
information is received which suggests that a child may be at risk, e.g. should an abuser join a household (see paragraph 9.7 in chapter 9), when there are escalating or cumulative concerns, or when a child whose name is on the Child Protection Register in another area moves to Shetland. (See below at 13.6 for more about Transfer in conferences.)

13.2.5 Care should be taken not to assume lack of risk based on limited information (the case conference’s main purpose is to share all relevant information to assist in the determination of risk), nor to base the decision on whether to call a case conference on an assumption that registration will not occur.

13.2.6 The manager who makes the decision to hold a conference is responsible for ensuring that the administrative arrangements are made. This includes the booking of a suitable venue, ensuring the availability of a minute-taker and issuing invitations to relevant participants in consultation with the case conference chair. Wherever possible, Child Protection Case Conferences will be held at venues on a list approved by the Children’s Services Improvement Officer.

13.2.7 The lead Professional will complete Form 5 (an example of this form is on page 66 below) and in consultation with the Chair, pass to the Administration Officer for action. (See 13.6.4 regarding decision-making about invitees.)
Form 5

**CHILD PROTECTION CASE CONFERENCE**

Please arrange for a child protection case conference to be convened as follows:

<table>
<thead>
<tr>
<th>Name of Child:</th>
<th>D.O.B.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
</tbody>
</table>

Preferred Date and Time of Conference:

<table>
<thead>
<tr>
<th>Venue:</th>
</tr>
</thead>
</table>

**PARTICIPANTS:** *Invitation list should be agreed with the Conference chair*

<table>
<thead>
<tr>
<th>Agency</th>
<th>Name</th>
<th>Address/Contact No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAMHS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fostering and Adoption</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health -GP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health – Health Visitor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health - Midwife</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schools: Head Teacher</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schools: Pupil Support</td>
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<tr>
<td>Schools: ASN</td>
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<tr>
<td>Educational Psychology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporter</td>
<td></td>
<td>(include only if to be expressly invited – otherwise to be notified only as per protocol)</td>
</tr>
<tr>
<td>Parent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carers</td>
<td></td>
<td></td>
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<tr>
<td>Child</td>
<td></td>
<td></td>
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<tr>
<td>Youth Work</td>
<td></td>
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<tr>
<td>Bridges</td>
<td></td>
<td></td>
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<tr>
<td>Voluntary sector – Advocacy</td>
<td></td>
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<tr>
<td>Children’s Rights</td>
<td></td>
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<tr>
<td>Women’s Aid</td>
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<tr>
<td>CADSS</td>
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</tr>
<tr>
<td>Other as appropriate)</td>
<td></td>
<td></td>
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<tr>
<td>Minute-taker</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A copy of the social work report will be given to the minute-taker at least 24 hours prior to the conference.

Signed: EM Children’s Services (Social Work)/ Senior Social Worker, Ch &Fam Team

Date:       
13.3 Initial Child Protection Case Conference

13.3.1 The purpose of the initial Child Protection Case Conference is:

- To gather together appropriate members of the family and the relevant agencies to share and assess information collected during a child protection investigation or as a result of an accumulation of concerns reaching the risk of significant harm threshold;
- To consider other relevant background information;
- To determine risk and enable multi-agency consideration of cumulative concerns;
- To decide whether to place a child’s name on the Child Protection Register, if they are at risk of significant harm;
- To formulate, or provide the framework for the development of a child protection plan which includes consideration of necessary family support services.

13.3.2 Initial Case Conferences will consider the situation of all the children in the family even if a child protection investigation has been concentrated on the risk to one specific child. A case conference called for a child not currently on the Child Protection Register will be referred to as an ‘initial’ case conference, even where the child named was previously registered, but the social work report must give details of all previous registrations for the child.

13.3.3 The initial Child Protection Case Conference will consider whether to refer the child to the Reporter, for his/her consideration of the necessity for compulsory measures of supervision - if these are not in place, or for a Children’s Hearing review, if the child is subject to a Supervision Requirement.

13.3.4 The Team Leader is responsible for referring the child to the Reporter within 5 days of the decision of the initial case conference that this should be done.

13.3.5 When a case conference is considered necessary it will be convened, where possible, within 10 working days of the child protection referral or of the decision to convene a case conference following cumulative concerns (national guidelines state “no later than 21 calendar days”). In some cases more urgent action may be required.

13.3.6 Consideration will be given to the most appropriate timing of case conferences to optimise the attendance of participants, but the welfare of the child is paramount and invitees are expected to prioritise this work.
Children and Families social work will use a proforma to ensure that the right people are invited to the initial conference.

13.4 Pre Birth Child Protection Case Conference

13.4.1 A Child Protection Case Conference may be convened for an unborn child: this will be done where sufficient concerns exist and indicate a risk of significant harm, prior to the birth of a baby as to require inter-agency intervention and planning.

13.4.2 The pre-birth conference should take place no later than 28 weeks pregnancy, or, in the case of a late notification, always within 21 calendar days of the concern being raised.

13.4.3 If the parents have not chosen a name, 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 10 working days of discharge from hospital.

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

- Where previous children have been removed because of significant harm;
- When a Schedule 1 offender joins the family;
- Where there are concerns about a mother’s 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 immature and vulnerable, or has been or is known to services, and may need an assessment of their own needs.

13.4.5 The assessment and weighing up of vulnerability factors in such cases is an important process and needs to be considered in a wide context that includes:

- Factors specific to the child;
- Factors specific to the adults;
- Adverse stress and environment factors;
- Strengths, supports and protective factors.
13.5 The Review Child Protection Case Conference

13.5.1 The purpose of the child protection review case conference is:

- To review the child and family circumstances;
- To monitor the effectiveness of the child protection plan;
- To consider whether the child continues to be at risk;
- To decide on the appropriateness or otherwise of continued registration;
- To amend the child protection plan where necessary.

13.5.2 The child’s name should be removed from the Register only where the risks have reduced to such an extent that the child’s name would not now be placed on the Register, and a child protection plan is no longer needed. This could be because the child is no longer living in/exposed to the continuing risk of significant harm. Where the child remains at home, care must be taken not to deregister before there is confidence that the diminution in risk is sufficient to protect the child, and likely to be permanent.

13.5.3 The first child protection review case conference will take place within 3 months of the initial case conference. Subsequent review case conferences will take place as required but at maximum intervals of 6 months.

13.5.4 Each Child Protection Review Case Conference will consider the necessity for referral to the Reporter, for his/her consideration of the necessity for compulsory measures of supervision, if these are not in place, or for a Children’s Hearing review, if the child is subject to a Supervision Requirement.

13.5.5 The Team Leader is responsible for referring the child to the Reporter within 5 days of the decision of the review case conference.

13.5.6 Many children and their families will still require support following deregistration. This should be managed, and reviewed, by converting the Child Protection Plan to a Child’s Plan.

13.6 Transfer Child Protection Case Conference

13.6.1 Where a child is on the Child Protection Register of another authority his/her name may initially be placed on the Register in Shetland on a temporary basis.

13.6.2 If the child 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, (national guidelines 21 calendar days). A representative from the original area will be invited and their attendance encouraged and facilitated in person or by video link.

13.6.3 The child’s name should be temporarily registered pending the "transfer-in" conference. Where a child 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.

13.6.4 If the originating authority consider there has/will be a reduction in risk they are responsible for convening a Review Child Protection Case Conference to consider de registration. Social work in Shetland should be invited to attend.

13.6.5 For any child whose name is on Shetland’s Child Protection Register and who moves to another area permanently, the Children and Families Social Work Team Leader would be responsible for notifying the receiving area

13.6.6 Where a child, subject to a protection plan, moves from one local authority to another the child’s case records and /or file need to go with the child.

13.7 Participation

13.7.1 The case conference is not a forum for social work decisions and recommendations to be endorsed. The multi-disciplinary nature of case conferences means that each agency carries responsibility for decisions and recommendations.

13.7.2 The following agencies could be represented at a case conference, on the basis of having specific responsibilities in the child protection process:

- Social Work (including representation from specialist social work services, e.g. criminal justice, mental health);
- Health Visiting/Nursing service;
- Schools;
- Community Development;
- Police;
- Housing Service;
- General Practitioner/examining doctor;
  and, exceptionally:
- Reporter;
- Procurator Fiscal.
Please refer to Protocol No. 2 for arrangements about invitations and notifications to the Reporter.

13.7.3 It may also be appropriate to include non-statutory agency representatives according to the circumstances of individual cases.

13.7.4 Before completing the form as set out at 13.2.7 the Lead Professional should agree the membership of specific case conferences with the Children’s Services Improvement Officer (chair). Since all professionals invited are expected to attend, only those expected to have a contribution to make either to the information being collected, or its analysis, or to the child protection plan (if one is needed) should be invited.

13.7.5 Those attending should be there because they have a significant contribution to make arising from professional expertise, knowledge of the child and family or both. Consideration should be given whether to seek advice from or have present a medical practitioner who can present any medical information in a manner which can be understood by conference attendees and enable such information to be evaluated from a sound evidence base.

13.7.6 Child Protection Case Conferences are interagency meetings and decisions about registration should not be taken by a sole agency. If, at an initial case conference, there is only one agency present, the Chair has the discretion to decide whether or not to proceed. If it is clear from information available that there are immediate and high risks it may be appropriate to register and formulate an interim protection plan, and to arrange an early review conference for other agencies to participate. If more information is needed to decide whether registration is needed, a conference may be deferred under 13.8.4 below, or if the child's name is placed on the Register, a review conference should be convened within a short period, to be determined by the chair, and steps taken to secure the attendance of representatives from other agencies. If at a review case conference there is only one agency present, the case conference should be put off to another day, to be fixed as soon as possible, to allow other agencies to be present and participate in any decisions made about registration. In the meantime the registration and protection plan will continue in force.

13.7.7 Parents or others involved in the care of a child should be included at case conferences as standard practice; and consideration should be given to the attendance of children, depending on their age and understanding, their own wishes, and what would be in their best interests. Parents (and children where attending) may bring someone to help them put their point of view if they wish (a 'supporter'). Parents and children should be given written information about conferences. Exclusion of parents 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.

13.7.8 The decision to exclude a parent before, or during, the conference will be made by the Chair of the Conference.

13.7.9 Justification for any exclusion should be recorded in writing, and include supporting evidence.

13.7.10 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 interests, it is important to encourage and facilitate the expression of the parent(s)' views, in writing, by tape-recording, or by a representative.

13.7.11 Whether or not a child attends, reports for case conferences should include information about any views expressed by the child, and the social worker's reports should expressly include information regarding the child's views about their situation. (See 13.8.1 below).

13.7.12 'Restricted' information may sometimes be made available to a case conference, i.e. information that is not shared with particular participants. Participants should indicate in advance if they wish to share information in this way. The decision rests with the chair, and will be allowed in exceptional circumstances only e.g. where this is considered necessary for personal safety reasons, or where sharing information would prejudice a criminal inquiry. Any such information will be separately minuted.

13.7.13 Parents and the child must be prepared for and fully informed of the purpose and sequence of events in advance of the case conference, in order to minimise anxiety and encourage fullest possible contribution. The Chair will take responsibility for this process. This will generally involve a pre-meeting with the parents and any supporter.

13.7.14 Some parents and children may find it helpful to provide their own written report, which they may be assisted to do by their supporter.

13.7.15 The presence of observers should only be agreed in exceptional circumstances and must be approved beforehand by the chair with the consent of the child and parents, if attending.

13.8 Reports

13.8.1 The investigating social worker (Lead Professional) will provide a written report for the case conference, using the format on page 81. Where decisions are being made about more than one child in a family, there
should be a separate section on each child. Information general to the family should be contained in a separate section. Information regarding each child’s views should normally be included. With care, even very young children can express some feelings about their family situations and where they feel safe.

13.8.2 A copy of the report must be with the chair and with the minute-taker at least 24 hours before the conference. It must be shared with parent(s) a minimum of one full day prior to conference to ensure they have time to consider the information and seek advice if required.

13.8.3 Other agency representatives will also be asked to provide a written report. Such a request should be complied with whenever possible, and a written report MUST be provided if an invitee is unable to attend. Suggested formats follow and guidance notes for preparing these are at Appendix 3. If possible these reports should be made available to the chair and minute-taker at least 24 hours before the conference.

13.8.4 Information should clearly distinguish between fact, observation, allegation, opinion and matters proven in court.
# Report for Initial Child Protection Case Conference

<table>
<thead>
<tr>
<th>Date of Conference</th>
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<tr>
<td>Name of Child</td>
<td>Home Address</td>
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<tr>
<td>Date of Birth</td>
<td>Address of Current Placement</td>
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<td>Date of Incident</td>
<td>Type of Current Placement</td>
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## Family Composition

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<th>Relationship</th>
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## Referral

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## Checks

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<td>CP Register</td>
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<td>Education</td>
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<td>Nurse Advisor (Protection)</td>
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<td>Criminal Justice Unit</td>
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## Consultation/Planning

Action Taken

Child’s Views  (include a separate section for each child)

Risk Assessment  (Follow departmental procedures)
**Recommendation** (if recommendation is to place child’s name on Child Protection Register, include proposed outline protection plan)

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<tr>
<th>Signature</th>
<th>Signature (SSW/SM)</th>
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<td>Name</td>
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1. **Report for Initial Child Protection Case Conference for:**

   [names of all children in respect of whom the conference is being held]

   **to be held on:**

   [date]

   **Report of:**

   [your name and professional role]

2. **Family Composition**

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<tr>
<th>Name</th>
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<th>Relationship to child</th>
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3. **Cause for concern including:**

   (a) **any precipitating incident**

   (b) **any previous concerns**
4. Relevant Family History/Chronology
(Please include here relevant information from your service, that potentially affects all of the children involved, for example, relevant information relating to parents' health/parents' involvement with school – see guidance notes. Please include here information relevant to all of the children involved – please include information specific to only one or some of the children at section 5)

A chronology of my agency's involvement is attached.
5. Past and present involvement regarding: [name and dob of individual child]

From: [your name and professional role]

For case conference on: [date]

Please provide information relevant to your service specific to this child, preferably using a separate page for each child: Please contribute any information you have that will help build up a picture of the child’s circumstances. Include any strengths, and any areas where further support may be needed. Consider in particular any potential areas of risk (see guidance notes).
[please use as many additional pages as required for each child the conference is concerned with]

5. Past and present involvement regarding: [name and dob of individual child]

From: [your name and professional role]

For case conference on: [date]
6. *Summary Statements/Analysis*

- Risk Factors

- Protective factors

- Provisional view on registration

7. *Parents’ views of your report*

8. *Child/Young Person’s view of your report*

9. *Signed:* .................................................................

   *Date:* ........................................................................
# Report for Review Child Protection Case Conference

<table>
<thead>
<tr>
<th>Date of Review Conference</th>
<th>Date of Previous Conference</th>
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<tr>
<td>Name of Child</td>
<td>Home Address</td>
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<td>Date of Incident</td>
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## Decision(s) of Previous Conference

## Dates of Core Group Meetings since Previous Conference

## Progress of Protection Plan

## Child's Views

(include a separate section for each child)

## Risk Assessment

## Recommendation

(if recommendation is to continue registration, include proposed protection plan)

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[names of all children in respect of whom
the conference is being held]

[to be held on:]

[date]

**Report of:**

[your name and professional role]

2. **Family Composition**

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3. **Any significant events since the last report**
4. **Update on Family Circumstances/Chronology**

(Please include here relevant information from your service since the last case conference, that potentially affects all of the children involved, for example, relevant information relating to parents’ health/parents' involvement with school – see guidance notes. Please include here information relevant to all of the children involved – please include information specific to only one or some of the children at section 5)

A chronology of my agency’s involvement since the last case conference is attached.
5. **Update on involvement regarding:**  
   [name and dob of individual child]

**From:**  
[your name and professional role]

**For case conference on:**  
[date]

Please provide information relevant to your service specific to this child, preferably using a separate page for each child: (see guidance notes).
[please use as many additional pages as required for each child the conference is concerned with]

5. **Update on involvement regarding:** [name and dob of individual child]

**From:** [your name and professional role]

**For case conference on:** [date]
6. **Summary Statements/Analysis**

   Evaluation of plan – is it achieving its objectives?

   What is working/ not working?

   Analysis of progress or any blocks to progress, capacity to change, resources needed

   Are the risks reducing?

   Current risk factors

   Current protective factors

   Provisional recommendations to Review conference

7. **Parents’ views of your report**

8. **Child/Young Person’s view of your report**

9. **Signed:** ........................................................................................................

    **Date:** ...........................................................................................................
13.9 Risk Assessment

13.9.1 In reaching a decision on registration, the case conference's primary consideration is assessment of risk to the child, the key question being whether the child is at continuing or potential risk of significant harm.

13.9.2 Key issues in this process include assessment of:

- The nature of the causes of concern, and the factors which have led to the situation;
- The child’s physical and emotional development, health and personality, and the highlighting of any problems the child may have;
- Each parent or partner's background, personality, attitudes, strengths, and problems;
- The couple's relationship;
- Family interactions, and particularly the family's ability to meet the child's needs;
- The nature of the child’s and family's network of relatives and friends, and links with professional or other organisations;
- The quality of attachment/bonding;
- The depth of trauma and the effect on the child psychologically and emotionally of the experience of abuse or neglect.

13.9.3 Key questions in risk assessment are:

- What help will the family require and what is the probable timescale needed for any change to occur?
- What is the degree of acceptance by the parents of their responsibility for the risk to their child?
- Do the parents wish to bring about change, and do they have the ability to do so?
- What are the financial resources and physical environment available to the family?
- Can the family be an acceptable and safe place for the child?

13.9.4 Assessment should include consideration of any risk to the child’s siblings - or other children in the household - who have not been subject to the investigation. They should normally be specifically included as subjects of an initial case conference. In some circumstances siblings may not be included as subjects of the conference, and if this is the decision taken it should be recorded and the position reviewed at the next conference or in the light of any further evidence.
13.10 Registration Criteria

13.10.1 For a child to be registered there must be clear indications that the child has been or is at risk of significant harm, and that a multi-disciplinary child protection plan is required. In deciding whether a plan is needed, the conference should consider whether the child is at continuing risk of significant harm.

13.10.2 Evidence for this will include issues raised by the investigation, and professional judgements.

13.10.3 There may, very exceptionally, be cases where there is insufficient information at the Initial Child Protection Case Conference to register, but the members are not satisfied that registration is unnecessary. In those exceptional circumstances a decision may be made to defer. The chair should identify the missing information, and who will obtain/provide it, and arrange for the conference to be reconvened as quickly as possible, and in any event within 7 days, to consider the missing information and reach a decision on registration.

13.11 Decision

13.11.1 Professionals attending the conference have a collective responsibility to consider whether to register or deregister a child. The chair will elicit the views of all conference members (other than family members and children attending), and try and achieve a consensus. Conference members should be prepared to give reasons for their opinion. If consensus cannot be reached, the chair has the ultimate responsibility to take a decision, while recording conference views.

13.11.2 In the unusual situation that the Chair has had to make a decision regarding registration as no consensus has been reached the decision making needs to be subjected to independent scrutiny by the Executive Manager Children and Families Social Work within 15 working days.

13.11.2 In addition to deciding about the need to place a child’s name on the register, a decision should be made about referral to the Reporter on the basis that the child may require statutory measures.

13.11.3 Consensus should be sought, and, whereas dissent should be recorded, it is essential that, notwithstanding an agency’s or an individual’s dissent, all members of the case conference are committed to participation in the child protection plan.
13.11.4 The Team Leader is responsible for ensuring that, if no officer of the Northern Constabulary is present when such a decision is made, the Northern Constabulary are advised within 24 hours of any child's name being placed on or removed from the Child Protection Register. This will allow the early updating of police national databases.

13.11.5 Regardless of whether parents attended the case conference, the Team Leader will, within 5 working days, inform them in writing whether their child's name was placed on the Child Protection Register, and confirm any other recommendation of the case conference.

13.11.6 A separate letter may be sent to the child when s/he is of an age and maturity for this to be appropriate.

13.11.7 A draft minute will be produced within 3 working days and passed to the chair for approval.

13.11.8 Following the chair's approval, and within 10 working days of the case conference, the minute will be circulated to those persons who were invited. If the decision of the case conference is to refer the child to the Reporter then the referral should be accompanied by the minutes of the Child Protection Case Conference and reports presented to that conference.

13.11.9 If no comments are received by the chair within 5 working days, it will be assumed that the recipient is in agreement with the minute.

13.11.10 The Child Protection Register is maintained in Children's Services premises identified by the Keeper of the Register (see 15.1.2 below). Any member of staff from any agency with a concern about a child should contact the Duty social work service to enquire whether the child's name is on the Register. The information should be supplied provided the caller has a need to know and the caller's identity is established (normally by means of a call back to their workplace), and the query logged as a contact.

13.12 Lead Professional

13.12.1 Following the decision to register a child, the chair will appoint a child protection lead professional

13.12.2 The lead professional must be a social worker, although s/he will not necessarily be the person with the most extensive contact with the child and family.
13.12.3 The lead professional is responsible for:

- Co-ordination and motivation of the inter-agency child protection plan;
- Communication between agencies and family;
- Ensuring full engagement of the child and family in the implementation of the child protection plan.

13.13 Child Protection Plan

13.13.1 A core component of GIRFEC is the Child’s Plan. Within the context of child protection, where the plan includes actions to address the risk of significant harm, it is known as the Child Protection Plan.

13.13.2 Following the decision to register a child, the case conference will produce an outline child protection plan. The main purpose of registration is to ensure that a plan is developed which will lead ultimately to reduce risk, improved outcomes for children and de-registration. Registration in itself will not protect the child. Copies of the outline protection plan will be sent to participants within 5 calendar days.

13.13.3 The outline child protection plan should be clear about whether the expectation is for the child to be living at home during any agreed assessment period. It should provide for a contingency plan if agreed actions are not completed and/or if circumstances change, for example if a caregiver fails to achieve what has been agreed, a court or Hearing application is not successful or a parent remove a child from a place of safety.

13.13.4 The case conference will identify membership of a 'core group'.

13.13.5 The core group will comprise relevant professionals, plus parents and children where age-appropriate, and will be responsible for finalising the details of the child protection plan, actions, timescales, and for interim monitoring arrangements.

13.13.4 The first tasks of the core group are to ensure there is a detailed child protection plan and that a comprehensive family assessment is undertaken (if this has not already been done) - all agencies contributing as required to this process. This will form the basis for future planning, by providing a full understanding of the child and family situation, taking full account of the child’s and family’s views.
13.13.5 Child protection plans need to clearly identify:-

- Key people involved and their responsibilities
- Timescales
- Supports and resources required
- Agreed outcomes for the child
- The longer term needs of the child
- The progress of monitoring and review
- Contingency plans

13.13.8 The core group will be responsible, under the co-ordination of the lead professional, for the implementation of the multi-disciplinary child protection plan.

13.13.9 The detailed protection plan will be produced in writing with copies to all core group members, the Team Leader, Children and Families, the Executive Manager, Children and Families Social Work and the Children's Services Improvement Officer.

13.13.10 The core group will meet within 10 working days (national guidance 15 calendar days) of the conference and thereafter at least once per month to consider the progress of the plan's objectives, unless a different frequency is specified by the chair as part of the outline child protection plan.

13.13.11 Core group arrangements are a delegated function of the Child Protection Committee. It is important for there to be full attendance by the nominated agency representatives.

13.13.12 At each meeting of the core group a decision will be made as to whether the child protection case conference needs to be reconvened. Only a review child protection case conference can make significant changes the child protection plan. Where a core group identifies a need to make a significant change they should notify the Children's Services Improvement Officer (Chair) within 3 calendar days.

13.13.13 Core group meetings should be minuted, preferably by a trained minute taker, if available. The lead professional /chair is responsible for ensuring the accuracy of the minute and distributing this to core group members and to the Children's Services Improvement Officer within 5 working days of the meeting.

13.14 De-registration

13.14.1 A Child Protection Review Case Conference will remove a child's name from the Child Protection Register when an objective
assessment indicates that the risk of abuse has been eliminated or reduced to a level where the child would not have been registered, so that a child protection plan is no longer needed.

13.14.2 The Team Leader is responsible for ensuring that, if no officer of the Northern Constabulary is present when such a decision is made, the Northern Constabulary are advised within 24 hours of any child’s name being placed on or removed from Child Protection Register. This will allow the early updating of police national databases.

13.14.3 As soon as information is received to suggest that a child is to move away from Shetland, the Team Leader will ensure that the local authority for the area to which the child is moving is informed of the registration of the child.

13.14.4 This should be done by telephone in the first instance, but must be followed up by written information, including the most recent child protection case conference minutes and child protection plan.

13.14.5 The child’s name will only be removed from the Shetland Child Protection Register once it is confirmed s/he has left Shetland on a permanent basis and a transfer conference has taken place. Social workers will support receiving authorities by providing information and files promptly and attending their transfer in conferences when appropriate.

13.14.6 If prior to a planned move from Shetland the risks have reduced sufficiently then a review conference should be held in Shetland to consider de-registration.

13.14.7 If the receiving authority have not convened a transfer conference within 4 weeks of that authority receiving notification from Shetland, the social worker should refer the case up through line management with a view to the Shetland Islands Council Executive Manager Children and Families Social Work contacting their equivalent in the receiving authority.

13.14.8 When a child whose name is on the Register is rising 16, a Child Protection Review Case Conference should be convened. This should happen at least one month prior to their 16th birthday to determine what support or protection should remain in place and a plan be drawn up to provide this. Exceptionally, consideration may be required of the need to proceed under the Adult Support and Protection Procedures. Following this review conference the child’s name should be removed from the register, and regular planning
meetings held to ensure the support remains in place as long as needed.

13.14.9 The Team Leader is responsible for ensuring that the administrative tasks in relation to the Child Protection Register are carried out.
14. Legal Action


14.1 General

14.1.1 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 social work department then a referral will be made to the Reporter for consideration of compulsory measures of care. In a situation where a child is at risk of **significant harm** an order to protect the child can be sought from Lerwick Sheriff Court.

14.1.2 There are three forms of emergency court order available for the protection of children under the Children (Scotland) Act 1995.

These orders are:-

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

14.1.3 The Emergency Authorisations under Section 61 of the 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.

14.2 Child Protection Order (S.57)

14.2.1 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 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 social work department.

14.2.2 In the event that some other person than the local authority requires to seek a CPO the application should be in [Form 47](http://www.scotland.gov.uk/Resource/Doc/26350/0023700.pdf) which follows on page 97. 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.

14.2.3 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 50 – 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 51 – see below.

14.2.4 The Reporter needs to be notified immediately of the granting of a CPO so that he or she can organise a Hearing. 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.

14.2.5 More detailed instructions are contained in Appendix 4.

14.3 Child Assessment Order (S.55)

14.3.1 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.

14.3.2 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.

14.3.3 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.

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

14.4 Exclusion Order (S.76)

14.4.1 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.

14.4.2 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.

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

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

14.5 Emergency Protection of Children by a Police Constable (S.61(5))

14.5.1 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.

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

14.5.3 If the child has been removed by the police following authorisation by the Chief Inspector, Shetland command, but without the involvement of the social work department, the police will notify duty 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 Application for a Child Protection Order, Arrangements to Keep You Safe and Notice of a Child Protection Order to a Named Person can be found below.
APPLICATION TO THE SHERIFF AT: Lerwick Sheriff Court

for a Child Protection Order under section 57(1)/57(2)* of the Children (Scotland) Act 1995 (* delete section which does not apply).

1 DETAILS OF APPLICANT AND OTHER PERSONS WHO THE APPLICANT BELIEVES SHOULD RECEIVE NOTICE OF THE APPLICATION

1.1 Applicant: Shetland Islands Council
Hayfield House, Hayfield Land, Lerwick, ZE1 0QD.
Tel: 01595 744400 Fax: 01595 744436

1.2 Child *:
Name: .................................................................
Address: .................................................................
Date of Birth: ..........................................................
Gender: .................................................................

1.3 Relevant Person(s):
Name: .................................................................
Address: .................................................................
Status: .................................................................
1.4 Safeguarder: Name: ..............................................................................
    Address: ................................................................................
            ...........................................................................
    Tel: .................................... Fax: .................................................

1.5 The Principal Reporter: The Principal Reporter
    Ochil House, Springkerse Business Park, Stirling FK7 7XE
    Tel: 01786 459599 Fax: 01786 459 533 **

1.6 Any Other Person who Should receive Notice of the Application:
    Name: ..............................................................................
    Address: ...................................................................................
            ........................................................................
    Tel: ........................................................................................

Note: *Where the applicant does not wish to disclose the address or whereabouts of the child to persons receiving notice of the application, this section should be left blank, and the request made to the Sheriff at para 3.4, with reasons.

** The application should also be copied to the Reporter, 13 Hill Lane, Lerwick ZE1 0HA
    Tel: 01595 692436 Fax: 01595 696763

2 INFORMATION ABOUT THE APPLICATION AND ORDERS SOUGHT

2.1 Grounds for making the application:

* Under section 57(1) of the Children (Scotland) Act 1995 the local authority have reasonable grounds to believe that a child:

    * is being so treated (or neglected) that he is suffering significant harm; or

    * will suffer such harm if he is not removed to and dept in a place of safety, or if he does not remain in the place where he is then being accommodated (whether or not he is resident there); and
* an order under this section is necessary to protect that child from such harm (or such further harm).

**OR**

* Under section 57(2) of the Children (Scotland) Act 1995 the local authority:

  * have reasonable grounds to suspect that a child is being or will be so treated (or neglected) that he is suffering or will suffer significant harm; and

  * are making or causing to be made enquiries to allow them to decide whether they should take any action to safeguard the welfare of the child; and

  * are satisfied that those enquiries are being frustrated by access to the child being unreasonably denied, the authority having reasonable cause to believe that such access is required as a matter of urgency.

[* Delete as appropriate]*

2.2 **Other applications and orders which affect the child:**

..........................................................................................................................................................................................

..........................................................................................................................................................................................

..........................................................................................................................................................................................

2.3 **Supporting evidence:**

The following supporting evidence is produced -

..........................................................................................................................................................................................

..........................................................................................................................................................................................

3 **DETAILS OF ORDER SOUGHT AND ANY TERMS, CONDITIONS OR DIRECTIONS**

3.1 **Order sought:** The applicant requests the Sheriff to make a Child Protection Order in respect of:

.......................................................................................................................................................................................... [Child's Name]
3.2 **Terms and conditions:**
In terms of section 57(4) the applicant seeks an order:

* requiring any person in a position to do so to produce the child to the applicant *

* authorising the removal of the child by the applicant to a place of safety, and the keeping of the child at that place *

* authorising the prevention of the removal of the child from any place where s/he is being accommodated *

[* Delete as appropriate]

3.3 **Terms and conditions to be attached to the order:**
In terms of section 58(4) or (5) the applicant seeks the following direction(s):

* the following parental responsibilities and rights *:

...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................

* an examination as to the physical or mental state of the child *

* an interview of the child as follows *:

...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................

* any treatment of the child arising out of such an examination or assessment *

[* Delete as appropriate]
3.4 **Any other order:**
The applicant also requests the following:

* that the whereabouts of the child are not disclosed to the following relevant persons *:

...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................

* that restricted documents are served on the child *

[* Delete as appropriate]

4 **DETAILS OF FIRST ORDER SOUGHT FROM THE SHERIFF**

The applicant requests the Sheriff to:

4.1 **make a Child Protection Order in respect of** ....................................................
[child's name] 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.

4.2 * 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 order service on the child of the following documents only:

...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................

ii. the persons listed in Part 1 of this application, together with a notice in form 51;
4.3 * order that the address of ................................................................. [child’s name] should not be disclosed in the application;

4.4 * dispense with service on the child or any other person for the following reasons:

..........................................................................................................................
..........................................................................................................................
..........................................................................................................................

4.5 Authorise any service ordered by the Sheriff to be effected orally or in such other manner as the Sheriff directs by a social worker employed by the applicant, in terms of rules 3.15.3 and Rule 3.16.1(c) of the (Act of Sederunt (Child Care and Maintenance Rules) 1997

[* Delete as appropriate]

Signed: ....................................................... Date: .....................................................
Name: ........................................................ Designation: .........................................
Address: ......................................................................................................................
.....................................................................................................................
Tel: .......................................................... Fax: .....................................................
Arrangements to Keep You Safe

Dear ....................................................

I am a social worker, and my name is ................................................................ 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:

.....................................................................................................................................
.....................................................................................................................................
.....................................................................................................................................
.....................................................................................................................................
.....................................................................................................................................
.....................................................................................................................................
.....................................................................................................................................

If you are unhappy with this you can ask the court to change it. For example, you might want to ask the court to allow you:

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.....................................................................................................................................
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.....................................................................................................................................
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Any change must be asked for straightaway.

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. If you want, I can arrange for you to speak to a lawyer.
Remember that if you do not agree with the order or any directions 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 Citizens Advice Bureau 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 0800 317 500 any time between 9.00 am and 5.00 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, 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 that person a copy of the application, and the court’s order.

Signed: ........................................................... Title: ..........................................................

Telephone: Date:
Notice of Child Protection Order made under section of the Children (Scotland) Act 1995 in the Lerwick Sheriff Court

Dear ....................................................  Address .........................................................

You are given notice of the making of a Child Protection Order in respect of the child:

Name .................................................. Address ........................................................

DoB ..................................................... .......................................................

Gender ................................................ .......................................................

by the Sheriff at Lerwick Sheriff Court on: ...................................................................

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

WHAT YOU SHOULD DO
You must comply with the order and any directions contained within it. Failure to comply is an offence under section 81 of the Children (Scotland) Act 1995 and could lead to you being fined.

You may wish to obtain advice from a solicitor or the Citizens Advice Bureau. You may be entitled to legal aid. Advice about legal aid is available from any lawyer or the CAB.

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

Signed: ........................................................... Title: ...................................................

Telephone: ..................................................... Date: .................................................
15 Child Protection Register - Administration

15.1 General

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

15.1.2 The designated Keeper of the Child Protection Register is the Executive Manager – Children and Families Social Work and the Depute Keeper is the Children's Services Improvement Officer.

15.1.3 The Keeper and Depute Keeper are appointed by the Chief Social Work Officer who will advise the Child Protection Committee of any changes; the CPC’s Lead Officer will ensure that the Scottish Government is notified.

15.2 Section 1: Child Details

15.2.1 When a Child Protection Case Conference decides to place a child’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 15.2.4 below.

15.2.2 One form for each child in a family must be completed.

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

15.2.4 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 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.

15.2.5 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 15.3.4 below should be followed.

15.2.6 When a case conference review decides to retain a child'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.
15.2.7 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 (see Protocol No. 3) should be followed.

15.2.8 The case file (one for each child 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 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.

15.2.9 In the event of an enquiry being received by the Children and Families Social Work team regarding a child’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. The registration document must be consulted and a record made that the enquiry has taken place.

15.2.10 Completed referral forms must include an indication that the Register has been checked.

15.2.11 When notification is received that a child whose name is on the Register in another authority is in Shetland a Section 1 form (see 15.2.1 above) must be completed by Duty social work on the day of notification, with as many details as can be obtained; the child’s name should be temporarily registered and a case conference convened in accordance with chapter 13 if the child is moving permanently to Shetland.

15.2.12 In some cases, children whose names are on the Child Protection Register of another local authority may be temporarily resident in Shetland. Details of the child 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 is staying in Shetland for some months.

15.3 Section 2: Closed Child Details

15.3.1 When a case conference review decides to remove a child’s name from the Register the chair is responsible for ensuring that the appropriate form is completed.

15.3.2 One form for each child in a family must be completed.

15.3.3 All sections of the form must be completed wherever possible.
15.3.4  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 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 remains on the register the form is to be shredded and deleted from the system immediately after the conference, and the procedure at 15.2.5 above should be followed.

15.3.5  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 (see Protocol No. 3) is to be followed.

15.3.6  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 has been previously registered.

15.3.7  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.

15.4  **Section 3: Children Reported as Missing**

*Please see Protocol 7.*
APPENDIX 1
Part One: - Further Guidance
Part Two: - Working with Children and Families from Cultural and Ethnic Minority Groups

Part One

1. Introduction

1.1 Listed below are a number of topics related to child protection and wider safeguarding issues for children that are included in Part 4 of the 2010 National Guidance. The list indicates if there is guidance included in the Shetland Inter-Agency Child Protection Procedures that must be followed by all agencies in Shetland. For those topics where there is no local guidance links to the National Guidance and other useful sources of information are given.

1.2 This appendix is designed to be used online with live web links. However, if you are using a hard copy of the procedures or if access to the internet is not easy please contact the Lead Officer for Adult and Child Protection. It is important not to delay taking appropriate action to safeguard a child about whom you are worried.

2. Indicators of Risk

<table>
<thead>
<tr>
<th>Domestic Abuse</th>
<th>Links to Local Inter-Agency Guidance or Protocols</th>
<th>Links to National Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No local inter-agency protocol. NHS Shetland staff have guidance about gender based violence</td>
<td>See section 3 below.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children affected by parental substance misuse</th>
<th>Shetland CPC Protocol 4</th>
<th>Additional national information - Page 107 of the National Guidance – and links below:–</th>
</tr>
</thead>
</table>

Getting our Priorities Right -
The Road to Recovery – A new approach to tackling Scotland’s drug problem -

Changing Scotland’s relationship with alcohol -

**Children with a disability or additional support needs**

Chapter 9 of Section 1 of the Shetland Inter-Agency Child Protection Procedures

Page 109 of the National Guidance and links below

Safeguarding Disabled Children: Practice Guidance

Child Protection and the Needs and Rights of Disabled Children and Young People: A Scoping Study -
http://www.sccpn.stir.ac.uk/view_research.php?id=490

**Non-engaging families**

Page 111 of the National Guidance

**Children and Young People experiencing or affected by a parent with mental health problems or by a parent with learning disabilities**

Please see sections 4 and 5 below.

Page 116 of the National Guidance and links below

**Self harm and/or suicidal behaviour**

Please see section 7 below.

Scottish Good Practice Guidelines for Supporting Parents with Learning Disabilities -

The National Patient Safety Agency Rapid Response Report on Preventing Harm to Children from Parents with Mental Health Needs -
http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59898
<table>
<thead>
<tr>
<th>Children who harm other children</th>
<th>Chapter 9 of Section 1 of the Shetland Inter-Agency Child Protection Procedures.</th>
<th>Page 120 of the National Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Shetland CPC Protocol 6 – Children and Young People who display harmful behaviour or problematic sexual behaviour.</td>
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<tr>
<td>Female Genital Mutilation</td>
<td>Prohibition of Female Genital Mutilation (Scotland) Act 2005 - <a href="http://www.legislation.gov.uk/asp/2005/8/pdfs/asp_20050008_en.pdf">Link</a></td>
<td>Page 122 of the National Guidance, and links below:—</td>
</tr>
<tr>
<td></td>
<td>UNICEF website for Female Genital Mutilation Forward - <a href="http://www.unicef.org.uk/Latest/Publications/Information-Sheet-on-Female-Genital-Mutilation--Cutting">Link</a></td>
<td></td>
</tr>
<tr>
<td>Fabricated or induced Illness</td>
<td>Safeguarding Children in Whom Illness is Fabricated or Induced - <a href="http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008714">Link</a></td>
<td>Page 127 of the National Guidance, and links below</td>
</tr>
<tr>
<td></td>
<td>Fabricated or Induced Illness by Carers - <a href="http://www.scie-socialcareonline.org.uk/profile.asp?guid=ba9efa14-e490-4a8f-b7be-a9de8be34590">Link</a></td>
<td></td>
</tr>
<tr>
<td>Sudden unexpected death in infants and Children</td>
<td>Page 129 of the National Guidance and link below</td>
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<tr>
<td>Sudden Unexpected Death in Infants Guidance - <a href="http://www.sudiscotland.org.uk/">http://www.sudiscotland.org.uk/</a></td>
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</tr>
<tr>
<td>Organised or multiple abuse</td>
<td>Chapter 9 of Section 1 of the Shetland Inter-Agency Child Protection Procedures</td>
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<tr>
<td>Also see “Complex Investigations” - Page 132 of the National Guidance</td>
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<tr>
<td>Historical allegations of abuse</td>
<td>Chapter 9 of Section 1 of the Shetland Inter-Agency Child Protection Procedures</td>
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<tr>
<td>Page 138 of the National Guidance and links below</td>
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<tr>
<td>Children looked after away from home</td>
<td>Chapter 9 of Section 1 of the Shetland Inter-Agency Child Protection Procedures regarding allegations of abuse against carers</td>
<td></td>
</tr>
<tr>
<td>Page 140 of the National Guidance and links below</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interim Guidance on Best Practice in Responding to Allegations Against Foster Carers - <a href="http://www.scotland.gov.uk/Publications/2010/04/26093510/0">http://www.scotland.gov.uk/Publications/2010/04/26093510/0</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Online and mobile phone safety</td>
<td>Page 142 of the National Guidance, also see links below:-</td>
<td></td>
</tr>
<tr>
<td>Child Exploitation and Online Protection Service - <a href="https://www.thinkuknow.co.uk/Teachers/Thinkuknow-FAQ/CEOPs-Thinkuknow-Resources">https://www.thinkuknow.co.uk/Teachers/Thinkuknow-FAQ/CEOPs-Thinkuknow-Resources</a></td>
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</table>
3. **Domestic Abuse**

3.1 Domestic abuse describes any behaviour that involves exerting control using physical, psychological or emotional means over a partner or ex-partners life choices, and that undermines their personal autonomy. Most victims of abuse are women, but men can be affected by domestic abuse too, and it can occur in same sex relationships.

3.2 The impact of living with domestic abuse on a child will vary depending on factors that include the frequency, severity and length of exposure to the abuse and any protective factors in the child’s situation. Domestic abuse is under reported so by the time professional staff become aware of it a child may have lived with it for a long time.

3.3 Early identification, assessment and intervention and the use of routine enquiry by skilled and attentive staff in universal services (e.g. housing and medical staff) can be the best way to keep children and non-abusing parents safe.

3.4 An adult leaving an abusive situation can trigger an even more extreme and controlling response from an abusive partner, and this can increase risk for them and for the children. Good continuing professional support and vigilance at this time are important. One area of critical concern can be contact for the child/children with the perpetrator, which can become a...
way of continuing to abuse. Decisions about contact should be based on
good risk assessments that consider both risk to the child and the non-
abusing carer.

Key Messages for Practice:

- Domestic abuse can have a profound impact on children, both in
  the short and long term;
- Staff need to be alert to the indicators of domestic abuse;
- Supporting the adult victim of domestic abuse ultimately supports
  the child;
- Risk of domestic abuse can increase at the point of separation;
- Contact between the perpetrator and the child should be subject to
  a risk assessment before proceeding.

For more information, see the following:-

- National Domestic Abuse Delivery Plan for Children and Young People
- Safer Lives: Changes Lives – A Shared Approach to Tackling Violence
  against Women in Scotland
- In Partnership, Challenging Domestic Abuse – Joint Protocol between
  the Association of Chief Police Officers in Scotland (ACPOS) and the
  Crown Office and Procurator Fiscal Service
    3547/0000559.pdf
4. **Children and Young People Affected by Parental Mental Health Problems**

4.1 It is not inevitable that living with a parent or carer with mental health issues will have a detrimental effect on a child’s development and many adults who experience mental health problems can parent effectively. However, there is evidence to suggest that many families living in this situation are more vulnerable.

4.2 There are a number of features that can contribute to the risk experienced by the child living with a parent/carer with mental health problems.

The National Guidance for Child Protection in Scotland outlines the following situations as indicators of risk:

- The parent/carer being unable to anticipate the needs of the child or put the needs of the child before their own;
- The child becoming involved in the parent/carer’s delusional system or obsessional compulsive behaviour;
- The child becoming the focus for parental aggression or rejection;
- The child witnessing disturbing behaviour arising from the mental illness (often with little or no explanation);
- The child being separated from a mentally ill parent, for example because the latter is hospitalised; and
- The child taking on caring responsibilities which are inappropriate for his/her age.

4.3 There are also factors which may impact on parenting capacity including:

- Maladaptive coping strategies or misuse of alcohol and/or drugs;
- Lack of insight into the impact of the illness (on both the parent/carer and child); and
- Poor engagement with services or non-compliance with treatment.

4.4 There is stigma associated with mental health problems, and many families are reluctant to seek help, and parents worry that children may be removed from their care.
4.5 Children’s needs should always be considered by services involved with the parent or carer. Joint working across adult and child services is essential to ensuring that children are protected and their needs met.

National resources include:


5. Children Living with Parents who have a Learning Disability

5.1 It is not inevitable that adults who have a learning disability will have difficulty in being good parents. They may need support on a long term basis to assist them and joint assessment and continuing work between services working with the adult and children is key to a good outcome. The use of GIRFEC assessments and care plan will often be very appropriate.

5.2 Women with a learning disability who are expecting a baby will need careful assessment and support and consideration should be given to pre birth planning meetings through GIRFEC or in the case where there may be a risk of significant harm a pre birth Child Protection Case Conference.

5.3 National resources include:


6. Bullying

6.1 Bullying has been found to be a major concern for many children. Many agencies have an anti-bullying policy and most instances of bullying will be dealt with by staff at the facility most closely involved, in line with local anti-bullying guidance, and seeking the support of other agencies as needed, in consultation with parents.

6.2 Where bullying is so severe as to amount to child abuse within the definition set out in these Procedures, or the apparent failure of parents to co-operate in resolving the issue raises a question of neglect, then a referral must be made in accordance with these Procedures.

6.3 All cases of bullying should always be treated seriously. Children and young people who bully as well as those who are bullied should be considered for an assessment of their needs using GIRFEC.
7. **Self-harm and/or suicidal behaviour**

7.1 Self-harm and/or suicidal behaviour can be very distressing for both the young person and the adult who has been informed or witnesses the behaviour. Research states that the responses a young person receives on disclosing self-harm and/or suicidal behaviour is very important in assisting their coping strategies.

7.2 Not all self-harm and/or suicidal behaviour is of a Child Protection nature that would warrant a child protection referral, but consideration should be given to whether an assessment of needs using the GIRFEC would assist.

7.3 Multi-agency guidance is being prepared and further information can be obtained from the Choose Life Co-ordinator on 01595 743003.

8. **Lesbian, Gay, Bisexual and Transgender Young People (LGBT)**

8.1 All practitioners, working with and/or caring for young people, must recognise the rights, needs and aspirations of lesbian, gay, bisexual or transgender (LGBT) young people. This duty is best articulated by The Equality Act 2010. This Act has two main purposes – to harmonise discrimination law and to strengthen the law to support progress on equality and diversity.

8.2 For many LGBT young people, the fear of being ‘outed’ and stigmatised is real and for many, very fearful. Sharing information relating to an LGBT young persons’ sexual orientation and/or gender indentity with another practitioner, service and/or agency can potentially place that young person at a greater risk and should be treated sensitively.

8.3 There is often a perception within mainstream services that a young person’s LGBT identity in and by itself, may constitute a child care and protection concern. **This perception is wrong.** Practitioners must therefore be aware and sensitive to these considerations.

8.4 LGBT Youth Scotland is Scotland's largest youth and community-based lesbian, gay, bisexual and transgender (LGBT) organisation who work to improve the health and wellbeing on LGBT youth and LGBT communities in Scotland. They seek to ensure:-

- LGBT young people can enjoy a safe and supportive upbringing and reach their full potential;
- LGBT young people are empowered to make positive choices about their lives;
• An end to homophobia and transphobia in Scottish schools, colleges and youth groups;

• Better health and wellbeing for LGBT young people and the wider LGBT community; and

• LGBT young people are successful learners, confident individuals, effective contributors and responsible citizens.

Their website contains a wide range of information, advice and factsheets which practitioners may find helpful. The following reports on LGBT issues, particularly as they relate to child protection may also be helpful:-


9. Listening to a disclosure of abuse

9.1 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.

9.2 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.

10. Asking Questions

10.1 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.

11. **After a disclosure**

11.1 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 may 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.

• 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.

12. Further help

12.1 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 Child Protection Committee, and may be provided by your own organisation. Shetland Child Protection Committee’s 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.

12.2 The Lead Officer for Shetland CPC is the Child Protection Co-ordinator who can be contacted for general advice and help at Hayfield House, Hayfield Lane, Lerwick ZE1 0QD or by telephone on 01595 744435.

12.3 For all queries about specific children, for example where you are not certain if something raises a child protection issue, please speak to a Senior Social Worker or Executive Manager in the Children and Families Social Work Team. (The number to ring is at the front of these procedures).

12.4 To make a child protection referral, contact the Duty social work service, following the procedure in chapters 6 and 7. (The numbers to ring are at the front of these procedures). The police can also be contacted where their immediate assistance is required.
APPENDIX 1

Part Two

Working with Children and Families from Cultural and Ethnic Minority Groups

1.1 Care should be taken to deal sensitively with cultural issues; however, child abuse is not acceptable in any culture. All children have the right to be safe from abuse, whatever their race, ethnicity or cultural background. In order to safeguard children, it is important to respond to racial harassment or discrimination, and ensure that when dealing with potential child protection concerns, you are aware of the possibility of institutional racism, cultural misunderstanding or misinterpretation.

1.2 Do not make assumptions – ask or seek appropriate advice. Agencies should ensure that line managers have access to sources of support on these issues. When assessing a child’s needs, agencies should gather information to assist understanding of the child’s cultural background and religion.

1.3 When interviewing or working with a child whose first language is other than English it is particularly important to ensure that he or she can participate as fully as anyone else. Ideally a professional who speaks the child’s first language should undertake this task. Where this is not possible, the services of a suitable interpreter should be secured.

1.4 Similar considerations apply to family members. The need for interpretation will be considered at strategy discussions (see chapter 8). The police have access to interpretation facilities. Although telephone interpreting is available by arrangement with NHS Shetland, this is not considered suitable for in-depth interviews. Agencies should not ask children to interpret for their parents or carers during child protection inquiries, and other adult family members will not normally be appropriate interpreters.’

1.5 When using interpretation facilities it is important to check there is a true language match, and to ensure that the interpreter is independent of the local ethnic community whether in Shetland or abroad. Agencies should ensure that interpreters have skills in interpreting for child protection purposes and are aware of the need to maintain the utmost confidentiality. An appropriate qualification such as the certificate in community interpreting is preferable.
1.6 Agreed arrangements should be put in place in advance with the interpreter and confirmed in writing. These will cover issues such as:

- Confidentiality

- The manner of interpreting – a direct interpretation of the exact words ‘Do you ….?’ Is generally preferable to indirect ‘She is asking if you …?’

- Whether interpreting will be consecutive (necessary for interviewing, requiring pauses whilst translation takes place) or whether the interpreter can translate simultaneously, for example to enable a participant to understand sufficiently what is happening at a meeting

- Any particular technical or specialized words and phrases that may be used, and

- Payment arrangements for the interpreter.
Appendix 2

Roles and Responsibilities of Staff Working in Organisations that provide Services to Children and Young People

1. Health Services

1.1 Health Practitioners

1.2 Health practitioners are responsible for the physical and psychological wellbeing of their patients. In addition to their work in promoting well-being they have a duty to work with statutory agencies when there are concerns about risk of harm to a child. They may be the first to be aware that families are experiencing difficulties in looking after their children and should share information about any concerns arising from suspicions of abuse or neglect with the social work services or the police at an early stage. They will also be asked to help with investigations into alleged or suspected abuse or neglect and will be involved in the joint planning. Health practitioners are an integral part of inter-agency Child Protection Plans and provide support and assistance to families. NHS Shetland has a designated nurse advisor for protection and designated child protection advisory staff who are experienced child protection professionals with a health background.

1.3 The following list of health practitioners is not intended to be exhaustive. All staff working in a healthcare setting should be aware of their responsibilities in identifying and sharing concerns about a child’s care or protection:

2 Maternity services

2.1 Maternity services and midwives in particular, have a significant role in identifying risk factors to the child during pregnancy, birth and in the post-natal period, both in the hospital and the community. Midwives should be alert to risk factors for the mother and the infant including, but not limited to, alcohol and/or drug misuse, domestic abuse and mental health problems such as post-natal depression. Midwives, child health staff, and specialist paediatric staff can assess the attachment of infants to their carers and offer early intervention and support to expectant and new parents.
3 Community nursing services for children

3.1 Health visitors/public health nurses play a key role in the prevention and early identification of child protection and care concerns. After the midwife’s post-natal care ends, a health visitor/public health nurse will become a child’s named person (or, in some cases, their Lead Professional), normally until the child starts full-time primary education. Health visitors/public health nurses provide a consistent, knowledgeable and skilled point of contact for families, assessing children’s development and planning with parents and carers to ensure their needs are met. As a universal service, they are often the first to be aware that families are experiencing difficulties in looking after their children and can play a crucial role in providing support.

3.2 The school nurse can contribute to prevention and early detection of child abuse through a range of health promotion activities. These include: working with teachers on personal, social and health education; monitoring the health of the school population; liaising effectively with teachers and other practitioners; and profiling the health of the school population so that nursing services can be targeted where they are needed most. School nurses continue to monitor the development and health and well-being of all children who have additional health plan indicators from primary 1 onwards for as long as necessary. Where child protection concerns arise, the school nurse should always be alerted and, where appropriate, involved to ensure the child’s health needs are fully identified and met. In Shetland’s rural schools, the Health Visitor acts as the school nurse for these purposes.

4 General practitioners

4.1 The role of the general practitioner (GP) and the practice team in child protection can be critical in detecting potential concerns, since they will often regularly engage with children and families. Their role includes prevention, early recognition and detection of concerns, assessment and ongoing care and treatment. Surgery consultations, home visits, treatment room sessions, child health clinic attendance, drop-in centres and information from staff such as health visitors/public health nurses, midwives, school nurses and practice nurses will all help to build up a picture of the child’s situation and highlight any areas of concern. GPs can provide direct support to children and their families and contribute to the Child’s Plan and specifically, the Child Protection Case Conference and/or the Child Protection Plan. GPs and practices should use the Shetland inter-agency Child Protection Procedures for engaging with other services where child protection concerns arise.
5. **Paediatric Services**

5.1 Paediatricians working in hospitals or in the community (including Visiting Consultants) will come into contact with child abuse in the course of their work. All paediatricians have a duty to identify child abuse and neglect and must therefore maintain their skills in this area and make sure they are familiar with the procedures to be followed where abuse or neglect is suspected.

5.2 Consultant paediatricians, in particular, will be involved in difficult diagnostic situations, where they must differentiate abnormalities resulting from abuse from those with a medical cause. Along with forensic medical examiners, paediatricians with further training will be involved in specialist examinations of children suspected of abuse or neglect. Forensic paediatricians have particular skills, including examination of children who allege sexual abuse, interpretation of injuries, report writing and appearing as expert witnesses. In Shetland, the local GP with Special Interest in Child Health (GPSI) works alongside visiting Consultant Paediatricians from NHS Grampian, and is one of the local Child Protection advisory staff available for advice and support.

6 **Accident and emergency services**

6.1 Accident and emergency staff may be the first point of contact in cases of suspected or actual child abuse and neglect. This may include scenarios where adult carers are presenting with an injury/health problem. The same applies to the Ambulance Service. Emergency Dispatch Centres record and register all calls and can act as an initial hub for emergency medical responses or notifications.

6.2 In Shetland, children presenting to the local hospital are under the care of adult consultant staff, who are expected to liaise with paediatric services in Grampian for specialist advice on the care of children, specifically so for any child protection concerns.

6.3 Carers may seek medical care from a number of sources in order to conceal the fact that a child is being injured regularly. Local arrangements are in place to address this through notification of A&E attendances to the Health Visitor / school nurse. Similarly, staff may notice a child or young person presenting themselves repeatedly, even with slight injuries, in a way that they find worrying. This may include signs of self-harming or of alcohol and/or drug misuse. Arrangements for obtaining medical and nursing advice from the appropriate designated professional/team are in place locally through the GIRFEC process or referral into the Child Protection procedures – see chapter 7 on Immediate Response.
7  NHS 24

7.1  NHS 24 is a special health board providing national services including online, telephone, video and web-based services. NHS 24 provides access to clinical assessment, healthcare advice and information and aims to give customers the assistance and advice they require to meet their health needs. Most calls to NHS 24 are made out-of-hours, when GP surgeries are closed, but the service is available 24 hours a day. When NHS 24 staff identify a child protection issue they will share this information with partners from other agencies locally to ensure that services are alert to the protection needs of the unborn baby, child or young person.

8  Community pharmacy services

8.1 Community pharmacists, pharmacy technicians and pharmacy support staff regularly deal with children and parents/carers including those in ‘at risk’ groups, such as, children of drug misusers in the course of their day to day practice. As such, they have an important role to play in identifying whether a child is at risk of abuse.

9  Mental health services

9.1 Child and adolescent services have an active role to play in identifying concerns about children and young people. Child and adolescent mental health services (CAMHS) may become aware of children and young people who have experienced, or are at risk of, abuse and/or neglect, and are well placed to carry out assessments and provide support. In some cases, adults and older young people may disclose abuse experienced some time ago. Even if they are no longer in the abusive situation, a crime may still have been committed and other children may still be at risk. CAMHS staff can help implement Child Protection Plans, providing therapeutic support to help children recover from the impact of abuse or neglect, build resilience and develop helpful strategies for the future.

9.2 Health practitioners working with adults with mental health problems should always be aware of how those problems might impact on any children in the family. Where they have concerns – for example regarding domestic abuse, drug and /or alcohol misuse – they should liaise with colleagues in children's services via GIRFEC or the Child Protection procedures. If they are concerned that a patient’s mental state could put children at risk of immediate or significant harm, they should make a Child Protection referral in line with local procedures.
10 Adult healthcare providers

10.1 All health staff – including those providing services to adults – have a duty of care to children and young people, and must work to consider and identify their needs. Providers of adult health services are responsible for identifying concerns over a child or young person’s well-being and reporting and responding to those concerns via the Child Protection procedures.

11 Dental care practitioners

11.1 Dental care practitioners will often come into contact with vulnerable children and are in a position to identify possible child abuse or neglect from examinations of injuries or oral hygiene. The dental team should have the knowledge and skills to identify concerns regarding a child’s welfare and know how and with whom to share that information.

12 Other health services

12.1 Other staff are well placed to identify child protection concerns, for example, medical and nursing staff in hospital specialisms such as paediatric surgery, orthopaedics, gynaecology and sexual health services. Staff assessing and treating children and young people may identify unusual patterns of injuries which are not consistent with explanations offered or notice delays in seeking healthcare. Missed appointments may be a reason for concern and should be responded to in line with the NHS Shetland protocol and departmental guidance. All staff can observe behaviour that may be harmful to a child or young person, for example, at visiting times. Medical advice can be sought from the NHS Grampian on-call consultant paediatrician for child protection or from the nurse advisor (protection), or local CP advisory staff as per local arrangements.

13 Substance Misuse services

13.1 Substance Misuse services, whether based within health or social work services or delivered by the community substance misuse service, have an important role to play in the protection of children. Staff from substance misuse services can play a critical role in the ongoing assessment and monitoring of risk by monitoring adults behaviour, sharing information and participating in core groups and other planning meetings. All substance misuse staff should identify where children are living in the same household as and/or are being cared for by adults with alcohol and/or drug use problems. At the point of first assessment, consideration should then be given to how the alcohol and/or drug misuse of the parent or carer impacts on the child, in conjunction with children and family services. For further information, see Shetland CPC Protocol 4 on Parental alcohol and drug misuse.
14 Schools Staff

14.1 Education practitioners, school staff and staff in other learning settings play a crucial role in the support and protection of children as well as the development of their well-being. Teachers are likely to have the greatest level of day-to-day contact with children and so are well placed to observe physical and psychological changes in a child that could indicate abuse and to contribute to the assessment of vulnerable children. Education staff may be the first to be aware that families are experiencing difficulties in looking after their children. They should share information about any concerns with the social work service or the police at an early stage via their established reporting mechanisms. They may also be asked to help with investigations into alleged or suspected abuse or neglect. Children and young people often see teachers as a trusted source of help and support and where the concerns do not constitute a child protection concern the teacher may have a supporting role in developing a Child’s Plan.

14.2 Through Curriculum for Excellence, education practitioners have an important role in equipping children with the knowledge, skills and understanding to keep themselves and others safe. This could include offering advice and guidance on issues such as drugs, alcohol, using e-technology and bullying.

14.3 Children’s Services (Schools) staff work with a range of other agencies, including youth workers and Community Learning and Development. Children’s Services (Schools) staff can provide a range of services and support to meet the needs of a child or young person and education staff can support a child in ongoing planning and support for children, including participation in Child Protection Case Conferences and core groups.

14.4 Where a child goes missing from education, Children’s Services (Schools) staff within local authorities will conduct local investigations to try and locate the child. If these are not successful, the local authority may make a referral to Children Missing From Education (CME). CME (Scotland) can assist local authorities by co-ordinating wider searches across the range of local authorities, other organisations and outside Scotland.

14.5 Children’s Services (Schools) staff also have certain responsibilities towards children educated at home, which can include assessing the educational provision being made. Where a parent elects not to allow access to their home or their child, this should not in itself constitute grounds for concern.
15. **Early Years**

15.1 As part of local authority education services, nursery and partner provider centres share the same responsibilities as their colleagues in schools for identifying and responding to concerns over a child’s welfare. Establishments for the under-fives can offer significant support to vulnerable children and their families and may often be the first to become aware that a family needs additional support or identify concerns about possible harm to a child. They may also be the first point of contact for a parent/carer who needs support. Often they will play a crucial role in providing support and effective intervention to a child and their family once concerns have been identified, as well as monitoring the child’s well-being on an ongoing basis. Family centre staff can play a key role, supervising contact between Looked After Children and their parents, assessing the quality of parent/child interaction, promoting positive parenting and supporting bonding. They make an essential contribution to risk and need assessment and planning. Early Years staff help all children build resilience, and where they are vulnerable, make sense of their situations and recover from trauma.

15.2 Early Years provision can be delivered by private nurseries and day care services including all-day care groups, playgroups, parent and toddler groups and under-5s groups. Many services are provided by third sector organisations but providers may also be private sector or independent groups. Early Years provision can also be delivered by self-employed childminders who must register their services with the Care Commission. As with any service that works directly with children and their families, Early Years providers are often well placed to identify concerns and offer support.

16. **Housing**

16.1 While Housing Service staff will not be directly involved in the investigation of alleged or actual abuse, they may have important information about families to contribute to a child protection investigation or assessment and should be prepared to share this information and to attend conferences as required. The Housing Services may be involved in providing accommodation or advice in situations where, for example, a woman and her child or children become homeless due to domestic abuse or where overcrowding, poor conditions or social isolation contribute to the risk of abuse. Housing services will also often play a key role in the management of risk posed by dangerous offenders. In order to co-ordinate the Housing Service’s role in child protection and management of risk posed by dangerous offenders, a single point of contact approach will be adopted through a Quality and Standards Officer. Where the local authority does not provide the housing service, independent housing
organisations and associations can and should play an active role in supporting and identifying vulnerable children.

17 Cultural and Leisure Services

17.1 Cultural and Leisure services will encompass a number of services that are specially designed for or include children and young people. Services, such as, libraries, play schemes and play facilities, parks and gardens, sport and leisure centres, events and attractions, museums and arts centres all have a responsibility to ensure children and young people’s safety. Such services may be directly provided or purchased or grant-aided by local authorities from voluntary and other organisations and, as such, represent an opportunity to promote child protection across sectors. Those working in sport-related services should be familiar with the National Strategy for Child Protection. In Shetland, cultural and recreational services are provided by the Shetland Recreational Trust, Shetland Arts Trust and Shetland Amenity Trust. These bodies are represented on the Child Protection in the Community Sub Group and have child protection procedures and training in place for staff.

18 Scottish Children’s Reporter Administration

18.1 Children can be referred to the Reporter by anyone where they may require compulsory measures of supervision, either due to concerns over their welfare or in order to address offending behaviour. On receipt of the referral, the Reporter will conduct an investigation, involving an assessment of the evidence supporting the ground for referral, the extent of concerns over the child’s welfare and behaviour and the level of cooperation with agencies, which all leads to an assessment of need for compulsory measures of supervision.

18.2 In making this assessment, the Reporter will rely on information from other agencies, most commonly social work and education services, although health care staff may be asked to contribute. If the Reporter decides that there is sufficient evidence to necessitate supervision measures, the child will be called to a Children’s Hearing. The investigation can take place at the same time as a criminal investigation or court case, but the focus will remain on the needs and welfare of the child or young person.

18.3 A Children’s Hearing is a lay tribunal made up of a panel of three specially trained volunteers from the local community. The Hearing decides on a course of action that it believes is in the child’s best interests, based on reports from a social worker in the local authority and, where appropriate, from the child’s school. Medical, psychological and psychiatric reports may also be requested. The Hearing discusses the child’s circumstances fully with the parents, the child or young person themselves and other
relevant representatives and professionals (most commonly from the
social worker) before reaching a decision.

18.4 Supervision requirements are the most common form of compulsory
supervision made by Children’s Hearings. (Children who are referred on
care and protection grounds, as well as those referred on offence
grounds, can be the subject of a supervision requirement.) Supervision
requirements vary, although the most common involve supervision at
home by a social worker. In other cases, a child could be required to live
away from home, for example, with foster carers, in a local authority home
or in a residential school. It is the statutory responsibility of local
authorities to implement supervision requirements. Where there is no
requirement for compulsory measures of supervision, children and young
people can be dealt with in a number of ways, including: restorative
justice, voluntary measures or tailored programmes to tackle behaviour.

18.5 Even where the Reporter has concluded that evidence is sufficient, there
may not be a requirement for compulsory intervention, for example,
because the incident is entirely out of character, there are no other
significant concerns about the child and the parental response has been
both appropriate and proportionate to the incident. In other
circumstances, compulsion may not be needed because the child and
family have accepted that there is a problem and are already working with
agencies, such as, restorative justice or social work.

18.6 The Reporter also has a role as a legal agent at Sheriff Court. First, if the
child or relevant person denies the grounds for referral at the Hearing, or if
the child is too young to understand the grounds, the matter will require to
go to court for the grounds to be established before the Sheriff. It is the
Reporter’s responsibility to lead the evidence in court and seek to have
the grounds established. Second, if the Hearing’s decision is appealed,
the Reporter will go to court to conduct the appeal on the Hearing’s behalf.

19 Procurator Fiscal Services

19.1 The Crown Office and Procurator Fiscal Service is responsible for the
prosecution of crime in Scotland, the investigation of sudden or suspicious
deaths and complaints against the police. In child protection matters the
police carry out a criminal investigation and submit a report to the local
Procurator Fiscal. The Procurator Fiscal considers this report and decided
whether criminal proceedings should take place. This decision is taken in
the public interest. In taking this decision, the Procurator Fiscal will
consider if there is enough evidence in the case. Where there is, the
Procurator Fiscal will consider a number of additional factors including: the
seriousness of the offence; the length of time since the offence took place;
the interests of the victim and other witnesses; the age of the offender;
any previous convictions and other relevant factors; local community interests or general public concern; and any other factors at his/her discretion according to the facts and circumstance of the case.

19.2 If there is enough evidence, the Procurator Fiscal will then decide what action is appropriate: whether to prosecute, offer an alternative to prosecution or to take no action in the case. In cases that will be considered by a jury, the Procurator Fiscal will interview witnesses and gather and review forensic and other evidence before Crown Counsel makes a final decision on whether to prosecute.

19.3 The Procurator Fiscal has a key role in protecting children in situations where bail conditions can be used to place some control on an alleged offender as to where they live and who they have contact with.

20. **Sports Organisations and Clubs**

20.1 Sports organisations work with a diverse range of children and young people in the community. Some young people may only attend a holiday sport activity, while others may regularly attend and participate in a sports club and a small number are involve in elite sports. All of these activities are run by committed, paid and unpaid coaches and workers who have various degrees of contact with children and young people. These workers will often become significant role models and trusted people in a child’s life. The Safeguarding in Sport service is a partnership between Children 1st [http://www.children1st.org.uk](http://www.children1st.org.uk) and sportscotland - [http://www.sportscotland.org.uk](http://www.sportscotland.org.uk) – which supports sports organisations and individuals across Scotland, including sports governing bodies, clubs, local authorities and parents and carers, to keep children safe in and through sport by providing advice, consultancy, training and support. Organisations and community groups involved in sport activities should familiarise themselves with the National Strategy for Child Protection in Sport - [http://www.scotland.gov.uk/Publications/2010/12/09134441/8](http://www.scotland.gov.uk/Publications/2010/12/09134441/8).

20.2 In Shetland local sporting groups are required to meet grant conditions in respect of having child protection procedures and safe recruitment practices in place. Training for sporting groups is also available.
Appendix 3

Guidance Notes on Report Writing for Child Protection Case Conferences

For both Initial and Review Child Protection Case Conferences it is essential to follow good practice:

- Clarity of language
- Avoidance of professional jargon
- Honesty with parents and carers even when painful issues need to be discussed
- To distinguish fact from opinion
- To make professional assessments based on accurate information
- To think through an assessment of risk and have some thoughts about the need for registration
- Be child focussed and not collusive with the adults

Bear in mind that each child’s information will need to be filed/stored separately. The child may be able to request access when he/she is older/an adult. To save a lot of extra work in separating out reports, it is best practice for information/analysis that is confidential to a particular child to be in a separate section and preferably on a separate sheet, clearly marked with the name and date of birth of the child.

Much of your report will relate to the family as a whole and this need be written out only once, as copies can be put on each child’s file. This outline and the pro-forma show how this can be done.

Remember to seek advice and support from your line manager when thinking through and preparing a report to a Child Protection Case Conference. It may be helpful to have your line manager read through the report. Check when your report is needed - often the Chair of the conference will need it the day before.

Outline of Report to Initial Conference

Title of Report
Give your name and professional title as well as the date of the case conference, whether it is an initial or review conference and the name (s) of the children that are the subject of the conference.
Family Composition
The recommended report form has a table that you should complete with the names, addresses and dates of birth for all family members and significant adults. Care should be taken with accuracy.

(a) Cause for Concern/Precipitating Incident
Only include this if the report writer is the first person to raise the concern or have the incident disclosed to them. If this is the case then include information about what happened/what was observed and the date and time of the incident, place of discovery, any witnesses, anything that the child said at the time and any hearsay or information from other sources.

If there is detailed information relating to only one or some of the children the conference is about you may wish to include this in the separate section on each child at section 6 and cross-reference this here.

(b) Any previous injury or concern
Please check through your agency files for any previous information that may now be relevant to building up a complete picture.

Relevant Family History/Chronology

Please include here information relevant to all the children who are the subject of the conference – put information relevant to each child in the family in a separate section of the report.

Information held by your agency regarding relevant adults, for example:

- language, ethnicity, religious and cultural background of the family;
- social environment including inclusion and participation in the community;
- involvement with services eg school and health;
- any practical difficulties affecting the family (housing, finance, transport etc);
- formal and informal support networks;
- any relevant specific issues such as illness, disability, substance use, domestic abuse, relationship breakdown, bereavement and changes to the household.

Please include all information held by your own agency, indicating when information is known to you personally and when it comes from another professional in your service or agency. You may not have information in all these areas.

A chronology of your service/agency’s involvement, if available, should be attached to the report.
Past and present involvement regarding each child

Please write a separate section for each child known to the service, preferably on a separate page for each child. Please include all information held by your own agency, indicating when information is known to you personally and when it comes from another professional in your service or agency. You may not have information in all these areas.

Information about the child should address the information your agency holds regarding the following topics:

- Health and physical development
- Emotional/behavioural development
- Intellectual development, learning and achieving
- Child’s understanding of and confidence in his/her identity
- Family relationships
- Social and peer-group relationships
- Social presentation, self-care (if appropriate to child’s stage of development)

Summary statement

This section should provide a summary statement about the nature and level of risk to the child based on your knowledge of the child and family. It is also important to include protective factors and those that promote resilience.

If you have had an opportunity to assess parenting skills you should summarise your conclusions here, based on evidence in parts 3-6 of your report.

At this point in the report it would be appropriate to give your preliminary view on registration and this should include your assessment of risk posed to the child. Your views may change at the conference when you hear contributions from other agencies and that is quite appropriate.

You could include here any relevant comments about the family’s level of cooperation with your services, based on section 6 of the report, which may be relevant to the discussion around the possible need for referral to the Reporter for consideration whether compulsory measures may be required.

Child’s parents/carers view of your report

It is important to consider the views of the child in relation to his/her situation and these should be included. The principle here should be that no parent or carer should come to a conference not knowing what is in your report or what you are going to say. Information should be shared honestly and openly. This process
should be seen as an opportunity to talk to people about what the problems facing them are, and what may offer ways forward.

**Child or young person’s view of your report**
This section is relevant to children old/mature enough to express a view. If a child expresses a view this should be recorded even where you do not agree. Record separately for each child.

**Sign and Date**

**Outline of Report to Review Child Protection Case Conference**

Reports to review conferences should give report title etc and family composition as for initial conferences (at 1 and 2) and should then cover the following points.

**Any significant events since the last report**
Changes in family / particular incidents

**Update on family circumstances**
Please include any new information regarding relevant adults (as in 4 above)

**Update on your involvement with each child**
Please include information such as:

Latest centile chart or developmental assessment, progress at school
Work done by you/your agency under the protection plan.

**Summary Statements/Analysis:**

Evaluation of plan – is it achieving its objectives?

What is working/ not working?

Analysis of progress or any blocks to progress, capacity to change, resources needed

Are the risks reducing?

Current risk factors

Current protective factors

Provisional recommendations to Review conference

Remember the decision to remove a child’s name from the register is just as important as the decision to put it on, and any such recommendation should be
based on evidence of changes that you are sufficiently sure are going to be lasting, and which mean that risks have reduced so that the child is no longer at continuing risk of significant harm.

If the plan has not sufficiently reduced the risks, is there a need to change the plan?

Parents’ and Children/Young People’s views as for initial report

Sign and Date
Appendix 4

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 social care staff in completing the relevant forms for CPO applications to the Sheriff; they should be read in conjunction with departmental child protection procedures.

1.6 Form 47 is the application form for a CPO. The paragraph numbers in these guidance notes refer to the paragraphs in form 47.

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 47 - Application for a Child Protection Order**

**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 sub-paragraph 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)*
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 referrals must be made if:-

- The child or the child’s partner, has not reached their 13th 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 prostitution, sexual exploitation, 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;
• Sexualised?;
• 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 – see legal section).

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 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;
• Prostitution.
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 significant risk of 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 made 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](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 patient's 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.
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 and Families 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 (Scotland) Act 1995 - http://www.legislation.gov.uk/ukpga/1995/36/contents (Section 52).
GROUNDS FOR REFERRAL

Children requiring compulsory measures of supervision

52. The question of whether compulsory measures of supervision are necessary in respect of a child arises if at least one of the conditions mentioned in subsection (2) below is satisfied with respect to him.

(2) The conditions referred to in subsection (1) above are that the child –

(a) is beyond the control of any relevant person;

(b) is falling into bad association or is exposed to moral danger;

(c) is likely -
   (i) to suffer unnecessarily; or
   (ii) be impaired seriously in his health or development, due to lack of parental care;

(d) is a child in respect of whom any of the offences mentioned in Schedule 1 of the Criminal Procedure (Scotland) Act 1975 (offences against children to which special provisions apply) has been committed;

(e) is, or is likely to become, a member of the same household as a child in respect of whom any of the offences referred in paragraph (d) above has been committed;

(f) is, or is likely to become, a member of the same household as a person who has committed any of the offences referred to in paragraph (d) above;

(g) is, or is likely to become, a member of the same household as a person in respect of whom an offence under Sections 2A to 2C of the Sexual Offences (Scotland) Act 1976 (incest and intercourse with a child by step-parent or person in position of trust) has been committed by a member of that household;

(h) has failed to attend school regularly without reasonable excuse;

(i) has committed an offence;

(j) has misused alcohol or any drug, whether or not a controlled drug within the meaning of the Misuse of Drugs Act 1971;

(k) has misused a volatile substance by deliberately inhaling its vapour, other than for medicinal purposes;
(I) Is being provided with accommodation by a local authority under section 25, or is the subject of a parental responsibilities order obtained under Section 86, of this Act and, in either case, his behaviour is such that special measures are necessary for his adequate supervision in his interest or the interest of others.
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 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 NHD 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 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 & 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 (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 Child Protection Committee.
Signed:

[Signature]
(Data Controller, Shetland Islands Council)  
14/06/10  
(Date)

[Signature]
(Chief Social Work Officer)  
8/06/2010  
(Date)

[Signature]
(Caldicott Guardian, NHS Shetland)  
4/06/10  
(Date)

[Signature]
(The Keeper of the Register)  
10/06/2010  
(Date)

Amended version approved by CPC on 9 December 2009
Protocol 4

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

Guidelines for agencies in Shetland 2008

FOREWORD

Our collective responsibility to care for and protect children and young people is embedded in the report of the national audit and review of child protection, ‘It’s Everyone’s Job to Make Sure I’m Alright’ (Scottish Executive 2002). Other reports – ‘Getting Our Priorities Right’ (Scottish Executive 2003), ‘Hidden Harm’ (ACMD 2003), ‘Hidden Harm - Next Steps’ (Scottish Executive 2006), ‘Have We Got Our Priorities Right?’ (Aberlour 2006) and ‘A Matter of Substance: Alcohol or Drugs: Does it make a difference to the child?’ (Aberlour and SAADAT January 2007) – highlight the particular issues that confront children and young people affected by problem substance use.

These inter-agency guidelines have been adapted for local use from those originally developed for the Edinburgh, Lothian and Borders Executive Group. They take account of recent child protection reports and inquiries, including Shetland Child Protection Committee’s independent inter-agency child protection audit in 2005. These guidelines augment, but do not replace, the Shetland inter-agency Child Protection Procedures. They aim to enhance and standardise practice across agencies in relation to the welfare and protection of children and young people living in families with problem substance use.

The guidelines build on the good working relationships and the high level of cooperation that exists between agencies and practitioners when working with, and responding to, the needs of potentially vulnerable children and young people and their families. It is important that everyone understands his or her role in this process.

We are keen to ensure that children and young people, whose parents/carers attend drug/alcohol services for help, are more ‘visible’ in future and that their needs are responded to. Equally, we want to encourage parents with problem substance use to make and sustain contact with treatment, rehabilitation and support services to get the help they need so that they can look after their children more effectively. This dual task is challenging, but we believe it can be achieved through greater cooperation, openness and better communication between practitioners and service users. We must get our priorities right.
These guidelines were produced by a working group representing Shetland Alcohol and Drug Action Team (SADAT) and Shetland Child Protection Committee (CPC). They were developed using the document Protecting children living in families with problem substance use – Guidelines for Edinburgh and the Lothians. SADAT and CPC acknowledge with thanks the permission given by Edinburgh, Lothian and Borders Executive Group and Edinburgh, Lothian and Borders Child Protection Office to use this document as a basis for the Shetland guidelines. SADAT and CPC have endorsed this Shetland version for immediate implementation.

Hazel Sutherland
Chair, Shetland Alcohol and Drug Action Team

Chief Inspector Malcolm Bell
Chair, Shetland Child Protection Committee
EXECUTIVE SUMMARY
These guidelines have been adapted from those originally developed for the Edinburgh, Lothian and Borders Executive Group and this version is approved for use in Shetland by SADAT and CPC. They take account of ‘Getting Our Priorities Right’ (Scottish Executive 2003), ‘Hidden Harm - Next Steps’ (Scottish Executive 2006), ‘Have We Got Our Priorities Right?’ (Aberlour 2006) and ‘A Matter of Substance: Alcohol or Drugs: Does it make a difference to the child?’ (Aberlour and SAADAT January 2007) and have been developed as guidelines to support local services dealing with problem substance misuse in implementing the Shetland inter-agency Child Protection Procedures.

These guidelines provide an operational framework applicable to all statutory and voluntary agencies and practitioners, to ensure that they work together to safeguard children and young people affected by problem substance misuse. They outline expectations of staff and agencies in relation to referral, assessment, information sharing, support and intervention for all parents, including expectant parents. (Parent is used throughout this document to refer to all parents, expectant parents and carers who have caring responsibilities for children.)

These guidelines aim to ensure that service users are provided with an appropriate level of care and supervision to enable them, as far as is reasonable and possible, to meet the needs of their children. However, the primary objective is to ensure that children and young people are protected from harm and that families receive the support they require.
1. INTRODUCTION

There is increasing evidence of the negative effects of parental problem substance use on the welfare of children. In particular, parental problem substance use is associated with an increased risk of child abuse and neglect. Parental problem alcohol and drug use can, and does, compromise children's health, development and welfare from conception onwards. Infants, in particular, are vulnerable to the effects of physical and emotional neglect or injury.

A group of drug withdrawal symptoms referred to as Neonatal Abstinence Syndrome (NAS) can occur in infants born to mothers dependent on certain drugs. NAS occurs because, at birth, the infant is cut off from the maternal drug supply to which it has been exposed in utero. The classes of drugs that are known to cause NAS include the opiates, benzodiazepines, alcohol and barbiturates. High alcohol use in pregnancy is also associated with negative consequences such as low birth weight and in some cases babies may be born with Foetal Alcohol Spectrum Disorder.

The risks associated with parental problem substance use can be mitigated by protective factors, which include:

- One or both parents receiving effective treatment and care
- Other responsible adults being involved in the child’s care
- The existence of strong social support networks
- A stable lifestyle with routines and activities maintained
- A safe and stable home environment with adequate financial support.

These guidelines are intended to foster a collective responsibility for promoting the welfare of children and protecting those at risk. By working together, agencies can take many practical steps to protect and improve the health and well being of children affected by parental problem substance use.

It is increasingly recognised that parental problem substance use is detrimental to children whether it is alcohol or other drugs that are being used. In the past, potential harm to children as a result of parental alcohol use, may have been less well recognised by the community and by services, resulting in a delayed response. We are determined to ensure that in future all children get the help they need when they need it.

For some children living with parents/carers with problem substance use, there will be the need to implement the Shetland inter-agency Child Protection Procedures and consider compulsory measures of supervision and other statutory measures to ensure the child or young person’s safety.
2. SCOPE OF DOCUMENT

These guidelines set out the underlying principles and procedures for inter-agency working in Shetland to protect and improve the health and welfare of children living with parents and/or carers with problem substance use. They complement but do not replace the Shetland inter-agency Child Protection Procedures.

These guidelines provide an operational framework applicable to all statutory and voluntary agencies and practitioners to ensure that they work together to safeguard children. They outline expectations of staff and agencies in relation to referral, assessment, information sharing, support and intervention for all parents, including expectant parents. They aim to ensure that service users are provided with an appropriate level of care and supervision to enable them, as far as is reasonable and possible, to meet the needs of their children. However, the primary objective is to ensure that children are protected from harm and that families receive the support they require.

For the purposes of these guidelines, a child is defined as a person less than 18 years of age. Where protective action is believed to be appropriate for persons aged 18 years or over who are vulnerable, such as young people with special needs, the agencies involved may find the underlying principles of these guidelines helpful in considering their roles and responsibilities.

These guidelines will be subject to ongoing review by SADAT and CPC.

These guidelines are for practitioners who work with families where there may be problem substance use. For the purpose of these guidelines, the term practitioner refers to anyone working to deliver services to children and/or parents. It includes individuals who are contractually employed by the agency or work in a volunteering capacity.

3. PRINCIPLES

The welfare of the child is paramount. The main concern of all agencies and practitioners must be to ensure that children are protected from harm and that every opportunity is taken by agencies to work in partnership with each other in order to promote the health and welfare of children.

A child living with a parent with problem substance use will be seen as potentially ‘in need’ and possibly ‘at risk’. The child should therefore be the subject of observation and recording of relevant information and/or concerns, which should be shared, when necessary, between practitioners in extended contact with either the child or family.

Substance use in itself may not have a negative impact on a parent’s capacity to look after their child(ren) properly. It is when substance use adversely affects the
parents’ lifestyle, social behaviour and capacity to discharge their parental responsibilities that it becomes a matter of concern because it adversely affects the quality of care that their child receives and poses a risk to health and development.

Intervention should be carried out as far as possible in partnership with the family, and with the aim of helping them to put the child’s welfare and protection first.

Parents with problem substance use can often be a cause for concern but it should not automatically lead to either child protection procedures or compulsory measures of supervision or intervention. It should, however, lead to careful consideration of their children’s needs.

Equally, parents who stop misusing alcohol or taking drugs should not necessarily be assumed to be better or safer parents, in the absence of other evidence. Some parents who use drugs or use alcohol in harmful ways have poor parenting skills for reasons other than their substance misuse. Any change in patterns of parental substance use will however warrant re-assessment of children’s needs.

Children should be afforded a good start in life, nurtured within a positive, healthy and safe environment and supported to develop constructive relationships within and out-with the family home. Children are best cared for in their own families, except where consideration for their safety and welfare dictates otherwise. In the postnatal period, mother and baby should not be separated unless it is clearly in the best interests of the child to do so.

Parents with problem substance use should be encouraged to make effective use of services at an early stage. Good quality antenatal care from an early stage is known to improve pregnancy outcomes, irrespective of continued drug and alcohol use. All women with problem substance use should be told about the benefits of antenatal care and advised to attend early in pregnancy. At the very least, pregnant women should be enabled to register with a GP so that they and their baby can receive primary health care.

While all agencies have a part to play in safeguarding the welfare and protection of children, it is important for each practitioner to be clear about his or her specific roles and responsibilities in implementing the various elements of these guidelines.
The agencies represented at the Shetland Alcohol and Drug Action Team and Shetland Child Protection Committee, as the lead partners, recognise that:

- 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;
- 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.

Agencies should adhere to the following guiding principle:

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

4. **DEFINITION AND EXPLANATION OF TERMS**

**A Child** under Scottish law carries various definitions between 16 and 18 years depending on different legislation. However, this guidance should be used in relation to all children and young people up to the age of 18. Its principles should also be applied to a young person over that age who is vulnerable.

**A Child ‘in need’** is defined by the Children (Scotland) Act 1995, and covers a child who is in need of care or protection because he or she is unlikely to achieve or maintain a reasonable standard of health or development, or whose health and development is likely to be impaired, without the provision of services by a local authority, or who is disabled or adversely affected by the disability of any other person in the family.

**Child abuse** or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment, or exploitation, resulting in actual or potential harm in the child’s health (adapted from definition in ‘Report on the Consultation on Child Abuse Prevention’, WHO 1999, quoted in ‘World report on violence and health’, WHO 2002). Children can be subjected to more than one form of abuse at a time and different children in a family may be abused in different ways. For further information on categories of Child Abuse, refer to the Shetland inter-agency Child Protection Procedures.
**Parents/expectant parents/carers** refer to service users in any of the following circumstances:

- Who regularly use substances and are considered, following assessment, to be problem substance users, and;
- Are parents and/or have caring responsibilities for children under the age of 18, have children residing with them or are expectant parents (refer to Section 9).

Parent is used throughout these guidelines to refer to all parents, expectant parents, grandparents and carers who have full or part-time caring or guardianship responsibilities for children. It is recognised that a person under 18 years (i.e. a child for these purposes) can also be a parent (or a ‘young carer’ providing care and support to other children). Such persons require the assessment of their own needs, but the welfare of the child takes precedence even when their parent or carer is also under 18.

**Problem substance use** is so defined when the use of alcohol or drugs has a harmful effect on a person’s life. The substance use becomes the person’s central preoccupation taking priority over significant personal relationships and to the detriment of their health and social functioning. Problem substance users who are parents may find that their substance use affects their ability to look after their children and maintain positive relationships with their families.

Problem substance use is often a chronic, relapsing condition, which requires continuous review and long term flexible support in order to respond to the individual’s ongoing needs.

**Problem alcohol use during pregnancy** would include any woman:

- Drinking 21 units or more per week, who is unable to reduce her consumption despite help and advice to do so, or;
- ‘Binge’ drinking (i.e. taking more than six units of alcohol in any one drinking episode) who is unable to reduce her consumption or change her pattern of drinking despite help and advice to do so.

**Problem drug use during pregnancy** is likely to include any woman regularly using:

- Opiates (e.g. heroin, methadone, dihydrocodeine, buprenorphine)
- Benzodiazepines (e.g. diazepam, temazepam)
- Stimulant drugs (e.g. cocaine/crack, amphetamines)
- Hallucinogens (e.g. LSD)
- ‘Designer drugs’ (e.g. ecstasy, ketamine).
Any use of volatile substances (e.g. gas or glue) should be considered problem drug use, as should excessive use of any drug.

The above definitions of problem alcohol and drug use are for guidance only. In some instances, the person may consume less than the stated amounts, but there is still a harmful effect on his/her life. At all times, the professional must exercise judgement on the effect of substance use on the ability to parent.

When a parent consistently places procurement and use of alcohol or drugs over their child’s welfare and fails to meet the child’s physical or emotional needs, the outlook for the child’s health and development is poor. Many problem substance using parents acknowledge this and it is always the duty of all practitioners and professionals to act in the child’s best interests when parents cannot.

Maternal alcohol and drug use during pregnancy may be problematic not only because of any direct effects on foetal growth and development per se, but because of other associated health and social factors related to alcohol and drug use that affect the health and well-being of the baby and parenting capacity. For instance, maternal malnutrition, blood borne viruses (HIV, hepatitis C and hepatitis B), mental health problems, violence and domestic abuse, homelessness or insecure accommodation, poverty and debts, legal problems, failure to attend antenatal care as well as other health and social welfare appointments. Dependent drug or alcohol use by a pregnant woman can cause withdrawal symptoms in the newborn baby.

Because paternal problem alcohol and drug use is associated with many of the above problems and can affect the health and well-being of women and their children, substance using current or prospective fathers should receive good quality care and support as well. This document therefore applies equally to problem substance using men, whether their partner is a problem substance user or not.

5. INFORMATION SHARING

Practitioners in services for children and services coming in contact with problem substance users will work in partnership with each other as well as with parents to achieve the best possible outcome for children and their families. It is good practice to discuss ‘joint working’ with service users at an early stage so that informed consent can be obtained to allow information sharing.

There is a separate information sharing procedure for use by practitioners’ which is provided at annex iii. These guidelines sit within the principles contained within the Multi-Agency Policy for Sharing Personal Information.

There is a general requirement that all practitioners and agencies offering treatment or support should keep information obtained during the course of their
work confidential. Practitioners should, generally, obtain informed consent before sharing information with other agencies. However, there are important exceptions to this.

**Confidentiality is conditional and not absolute.** It is however an important factor in enabling people with problem substance use to engage with treatment and support agencies.

All practitioners working with current and prospective parents with problem substance use should discuss the kinds of situations where they may have to share information, whether or not the person’s consent is forthcoming.

Disclosure and sharing of information without the person’s consent is acceptable in certain circumstances. For example, if there is reasonable cause to suspect or believe that a child may be at risk of harm this will always override a professional or agency requirement to keep information confidential. All practitioners have a responsibility to ensure that confidentiality does not prevent sharing information where a child is in need of protection.

The needs of each child are the primary consideration when practitioners decide how best to share information. All decisions about sharing information and reasons for them must be recorded.

Practitioners will share information on a ‘need to know’ basis. When any agency approaches another to ask for information they should be able to explain:

- What information they already hold;
- What kind of information they need;
- Why they need it;
- What they will do with the information;
- Who else may be informed for the purposes of protecting the child.

Practitioners will provide information with consent but on receiving answers to questions will consider:

- Whether there is any perceived risk to a child which would warrant breaching confidentiality;
- What information the service user has already given permission to share with other professionals;
- Whether they have relevant information to contribute — that is information which has or may have a bearing on the issue of risk to a child or others, which enables another professional to offer appropriate help, assist access to other services, or take any other action necessary to reduce the risk to the child;
• Whether that information is confidential, already in the public domain or could be better provided by another professional or agency, or the parent directly;
• How much information needs to be shared to reduce risk to the child.

The circumstances under which a Child Protection referral must be made are clearly set out in the Shetland inter-agency Child Protection Procedures.

Practitioners who have any concerns about a child’s welfare will, as a minimum, seek advice from one or more of the following:

• A designated member of staff in their agency with responsibility for Child Protection or line manager
• The family’s allocated social worker, if there is one;
• The Duty social work service.

Practitioners should always discuss with parents what is expected of them as parents and inform them what help and support is available. Where a referral to social work services is necessary, practitioners should enable parents to understand that social work services can arrange a range of services to promote the welfare and protection of the child and to keep families together where practicable. All practitioners must refer via the Child Protection Procedures or notify the Duty social work service if they anticipate that an unborn child may be at risk of harm after birth, even if this means breaching their duty of confidentiality to either the mother or father. On receipt of the information the social work service will assess the risk by following the procedures set out in the Shetland inter-agency Child Protection Procedures.

6. RECORDING AND RECORD KEEPING

Maintaining up-to-date, accurate written records is an important part of good practice. All practitioners should make a written legible note in the service user’s file detailing when they share information with another practitioner or agency and the reasons, action taken or to be taken, and if consent from the service user has been obtained. Any concerns that are recorded should be backed up by evidence as far as possible.

Each entry should be dated and signed contemporaneously.

All pregnant women in Shetland now receive a unified multi-professional woman held maternity record. This is normally given to the woman at around 16 weeks’ gestation and she keeps it until she is admitted into hospital for delivery. The woman is encouraged to contribute to her notes if she wishes.

All practitioners involved in antenatal care should ensure that important information is put in writing and included in the woman’s hand held maternity record. If the woman does not want certain information included in her hand held
records (for instance because of concerns about confidentiality) then it should be
equipped in her supplementary notes file which is held in the maternity hospital
where she is booked. All practitioners should send relevant information to the
woman’s named community or hospital midwife so that the information can be
included in the woman’s notes.

All records relating to the welfare of children should be retained and stored
securely by the agency in line with the agency’s policy. These principles apply to
electronic as well as paper records.

7. ROLES AND RESPONSIBILITIES

Gathering information

All practitioners have a part to play in helping to identify problems at an early
stage. Initial assessments of clients should inform practitioners if there is contact
with children.

The role of all agencies is to be alert to the welfare and needs of children living in
families with problem substance use, and respond to any emerging problems.
While a number of parents with problem substance use are known to services,
there are many more who remain unidentified whose children may be ‘in need’ or
‘at risk’. Identifying as many of these adults as possible, and encouraging them
towards treatment programmes is an important contribution to the prevention of
harm to children. Some parents may not disclose (the extent of) their
alcohol/drug use. It is therefore important for practitioners dealing with people
with substance misuse to undertake initial assessments in order to be vigilant for
any indicators of risk (annex ii).

Responsibilities of agencies include:

- Maintaining awareness and vigilance, particularly in relation to changes in
  behaviour/lifestyle/social circumstances/parental health, and the potential
  implications of changes to treatment and rehabilitation regimes, which may
  impact on the ability to parent;
- Gathering information and keeping up-to-date records;
- Knowing who else is involved with the child/parent;
- Seeking advice from and views of other professionals involved with the child or
  adult, and
- Making a child protection referral (see Shetland inter-agency Child Protection
  Procedures) where appropriate.

Antenatal referral to specialist services

All practitioners who become aware that a woman is pregnant should
recommend immediate referral to the woman’s GP.
All pregnant women who disclose problem alcohol or drug use during pregnancy should be assessed for the need for referral to an alcohol/drug service for assessment and treatment if they are not already attending.

All alcohol/drug services should prioritise referrals for pregnant women, and any problem substance using partner, so that they can be assessed and offered appropriate help as early in pregnancy as possible.

Practitioners in specialist alcohol/drug treatment services must liaise closely with staff providing maternity care so that substance use treatment plans are clearly understood and the parents do not receive conflicting advice or help.

**Seeking advice**

Concerns about the care and welfare of children of substance misusing parents may come from a variety of sources/services focused on the adults and/or the child.

Practitioners who are concerned about a child's welfare and are unsure of how or whether to do anything about it, should seek advice from one or more of the following:

- A designated member of staff in their agency with responsibility for Child Protection or line manager
- The family's allocated social worker, if there is one;
- The Duty social work service.

If the matter is one of immediate child protection concern, then the immediate response section of the Shetland inter-agency Child Protection Procedures will be operated.

**Practice Point:-**

Problem substance use by parents does not automatically indicate that children are at risk of abuse or neglect, however there may be children in need of services or additional support and these needs require to be addressed.
8. PROCESS

For a summary of the process, please see the attached flowchart at Annex i. More detail on each stage of the process then follows.

Screen service users

Screening service users is critical in order to prioritise the needs of children.

When seeing a new client for the first time, practitioners working with adult alcohol and/or drug users must, as part of a routine ‘screening’, ascertain whether the client is a parent, expectant parent or carer of children, his or her family circumstances and the extent of contact with other services. All agencies will have reference to child protection in their assessment procedures even if they are primarily services for adults.

Professionals should seek consent to share information with other health and social care professionals as required (i.e. on a ‘need to know’ basis whenever it is in the interests of the mother or child to do so). For a pregnant woman with problem substance use, this should occur when she attends for her booking appointment.

In all cases where there is adult substance misuse and there is contact with children the practitioner must actively discuss this with a designated member of staff in their agency with responsibility for Child Protection or their line manager.

If assessment identifies no concerns then no further action is required.

If concerns are identified then consent must be gained from the adult to refer for support or to begin the process of a GIRFEC Assessment or in the instance of serious concerns a Child Protection Referral.

However, if consent is not given the practitioner needs to revise the assessment, decide if it now becomes a child protection referral and react accordingly.

If you know that:

- a child is on the Child Protection Register, or
- a child protection referral has been made or
- a GIRFEC assessment is ongoing

you MUST provide the Lead Professional/Named social worker or key worker with any information you have that may be relevant to the assessment even if you are not asked for it. You may also be asked to assist with gathering further information where appropriate.
Practice Points:-

• Discuss the situation with line manager.
• Any agency can refer to the Children’s Reporter, irrespective of the views of the local authority.
• Concerns should always be raised if the client has other children who have been taken into care.
• Assessment is an ongoing process.
• Keep parents informed of your actions.
• Communicate with other agencies.
• Clearly record your actions in client’s file.
GLOSSARY OF TERMS

**Agency:** an organisation that provides a service.

**Antenatal care:** care provided to the woman and her unborn child during pregnancy.

**Care pathway:** structured care plans which detail essential steps in the treatment and care of people with a specific illness or condition.

**Children and Families social work:** Comprises qualified social workers, social work assistants, support and managerial staff. It provides assessments of children in need and their families, as well as advice, guidance and support in accordance with individual care plans.

**CPC:** Child Protection Committee

**DCO:** Designated Child Protection Officer

**Foetal:** of the unborn child.

**Gestation:** age of the unborn child.

**GIRFEC:** GIRFEC Assessment

**Intoxication:** a state where the individual has drunk or taken drugs sufficient to significantly impair functions such as speech, thinking, or ability to walk or drive.

**Intrapartum care:** care provided during labour and childbirth.

**In-utero:** in the uterus or womb, unborn.

**Midwifery team:** a small team of midwives, double and triple duty nurses who will share responsibility for care during pregnancy, childbirth and the postnatal period. They will be based both at the Hospital and/or within the community.

**Neonatal abstinence syndrome (NAS):** is a group of drug withdrawal symptoms, which can occur in infants born to mothers dependent on certain drugs. NAS occurs because, at birth, the infant is cut off from the maternal drug supply to which it has been exposed in utero. The classes of drugs that are known to cause NAS include the opiates, benzodiazepines, alcohol and barbiturates.

**Neonatal period:** first 28 days of a baby’s life.

**Perinatal:** around the time of birth.
**Postnatal:** after the birth.

**Postpartum care:** care provided in the period following delivery.

**Practitioner:** for the purposes of these guidelines, the term refers to anyone working to deliver services to children and/or parents and carers.

**SADAT:** Shetland Alcohol and Drug Action Team

**Withdrawal:** the body’s reaction to the sudden absence of alcohol or a drug to which it has adapted.
LEGISLATION AND GUIDANCE
The current legislative framework and some relevant guidance underpinning the provision of services to children and families are contained in the following documents.

Up to date information can be obtained from the Child Protection Co-ordinator (who can be contacted at Hayfield House, Hayfield Lane, Lerwick ZE1 0QD or by telephone on 01595 744435).

Legislation
- Social Work (Scotland) Act 1968
- UN Convention on the Rights of the Child (ratified by UK government in 1991)
- NHS and Community Care Act 1990
- Children (Scotland) Act 1995
- Human Rights Act 1998
- Data Protection Act 1998
Guidance
Department of Health, (1999). Drug misuse and dependence: guidelines on 
Scottish Executive Health Department (2000). Protecting Children – A shared 
Scottish Executive (2003). ‘Getting our priorities right: good practice guidance for 
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professionals in Lothian’, NHS Lothian, Edinburgh.
Geneva.
Annex ii

Guidance for Assessment

Assessing Children’s needs

The following questions provide guidance for assessing the needs of children of substance misusing parents.

General

• Are there any factors which make the child(ren) particularly vulnerable, for example a very young child, or other special needs such as physical disability, behavioural and emotional problems, psychological illness or learning disability?
• Are there any protective factors that may reduce the potential risks to the child?
• Are children usually present at home visits, clinic or office appointments during normal school or nursery hours?
• If so, does the parent need help getting children to school?
• How much money does the family spend on alcohol/drug use?
• Is the income from all sources presently sufficient to feed, clothe and provide for children, in addition to obtaining alcohol/drugs?
• What kind of help do you think the child needs?
• Is there evidence of neglect, injury or abuse, now or in the past? What happened?
• What effect did/does that have on the child?
• Is it likely to recur?
• Is the concern the result of a single incident, a series of events, or accumulation of concerns over a period of time?
• Do the parents perceive any difficulties and how willing are they to accept help and work with professionals?
• Is the child a carer?

Substance Use Specific

• What is the current pattern and level of use?
• Type and amount of alcohol consumed/where/when/alone or with others?
• If with others, with whom?
• When and where does this occur?
• Is this typical of the last three months?
• What arrangements are there for the child(ren) when the parent goes to get illegal drugs or attends for supervised dispensing of prescription drug(s)?
• What do you think might happen to the child?
• What would make this likely or less likely?
• Do parents think that their child knows about their problem alcohol or drug use?
• How do they know?
• What does the child think?
• What do other family members think?
• How do you know?
• Is there a failure on the parent(s) part to maintain contact with helping agencies?
• Is the parents’ substance use associated with violence or domestic abuse, parental disharmony, or criminal behaviour, which is likely to be detrimental to the children?
• Who will look after the child(ren) if the parent is arrested or is in custody?

Gathering information on risk factors
The following questions provide guidance for gathering information on significant risk factors that are likely to affect parenting capacity.

Substance use risk factors
• Regular injecting drug use.
• Daily illicit (non-prescribed) drug use
• Regular stimulant use
• Problem prescription drug use
• Poly-substance misuse (e.g. alcohol use in addition to drug use)
• High alcohol consumption or alcohol dependence
• Repeated episodes of intoxication or withdrawal from alcohol or drugs.

Health risk factors
• Poor maternal physical health/significant illness
• Severe mental health problems
• Cognitive impairment or learning difficulties
• Poor attendance for antenatal care/health care appointments.

Social risk factors
• Living with another problem alcohol/drug user
• Reported or suspected domestic abuse or violence within the home
• Living alone/unsupported pregnancy
• Criminal justice system involvement
• Homelessness/unstable accommodation
• Substantial debts or inadequate financial resources
• Unsuitable accommodation that lacks the necessary material possessions for a baby
• Chaotic lifestyle with no daily routines or activities.

Child-care risk factors
• Recorded history of previous parenting or child-care concerns.
• Recorded history of abuse in previous child.
• Existing children on Child Protection Register.
• Previous children taken into care, fostered or adopted.
• Partner or other household member with history of violence or child abuse.
Annex iii

INDIVIDUAL PROCEDURE FOR EXCHANGE OF INFORMATION

PROTECTING CHILDREN & YOUNG PEOPLE WHO ARE AFFECTED BY ADULTS WITH PROBLEM SUBSTANCE USE

1. General Introduction

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

2. Purpose

The purpose of this Individual Procedure is to facilitate the exchange of information to protect children and young people who are cared for or have contact with an adult who misuses substances.

This Individual Procedure forms part of the Protecting Children & Young People who are affected by adults with problem substance use guidelines.

The Guidelines do not detract in any way from the Shetland inter-agency Child Protection Procedures. If a child is suspected of being at risk of harm the practitioner must refer directly to the Shetland inter-agency Child Protection Procedures.

The following process applies when the child or young person is identified as NOT being at risk of harm. This must be re-assessed at each stage of the process, see the Process diagram contained within the guidelines (page 26).

N.B These guidelines recognise that some practitioners i.e. Consultants, GP’s and other senior clinical staff with relevant roles/training will make child protection referrals in their own right and will use this procedure similarly. All other practitioners MUST consult with their organisation’s designated Child Protection member of staff. This member of staff MUST have completed the 2.5 days Inter-agency Child Protection Training as a minimum.

3. The Process

Screening Service Users

3.1.1 The Practitioner has identified that there is an adult substance misuser (the Service User) and contact with children.

3.1.2 The Practitioner must discuss the case with their organisation’s designated Child Protection member of staff or line manager. The purpose of this discussion is to confirm whether a child is at risk and to
agree the next steps of the process. The outcome of the discussion must be recorded.

3.1.3 If a child is at risk of harm, the Practitioner must follow the Shetland inter-agency Child Protection Procedures.

3.1.4 The Service User’s consent is not required at this stage as information is not being shared out-with the Practitioner’s organisation.

3.2 **Support for the Service User**

3.2.1 The Practitioner should identify the appropriate support for the Service User and discuss a support plan with the Service User.

3.2.2 If the Service User does not agree to engage with the support plan, the Practitioner must re-assess whether this refusal to engage with support services puts a child at risk of harm. If a child is at risk of harm, the Practitioner must follow the Shetland inter-agency Child Protection Procedures.

3.2.3 The Practitioner must discuss the case with their organisation’s designated Child Protection member of staff or line manager as outlined at paragraph 3.1.2.

3.2.4 If the Service User agrees to the support plan, the Practitioner must seek the Service User’s consent to information being shared with the relevant support services to enable the support plan to be established.

3.2.5 If the Service User does not consent to information being shared to establish the support plan, the Service User must re-assess whether this refusal to share information puts a child at risk of harm. If a child is at risk of harm, the Practitioner must follow the Shetland inter-agency Child Protection Procedures.

3.2.6 The Practitioner must discuss the case with their organisation’s designated Child Protection member of staff or line manager as outlined at paragraph 3.1.2.

3.2.7 If the Service User consents to the Practitioner sharing information, the agreed support plan and consent to share information must be recorded.

3.2.8 The Practitioner can then make the necessary referrals to support services and share the appropriate information to enable the support plan to be established. The Practitioner should only share the information required to make a referral to a support service. This information should be shared by:-

(i) Secure e-mail systems.
(ii) Hand delivering information in a sealed envelope, marked “Confidential” and for the attention of a named individual.
(iii) Via telephone (see ‘record keeping’ section of the protocol, Section 6)

3.3 **Support for the Child**

3.3.1 The Practitioner should identify if there is a child who requires support as a result of an adult’s substance misuse.

3.3.2 Where it is identified that a child does not require support, the Practitioner must still discuss the case with their organisation’s designated Child Protection member of staff or line manager. The purpose of this discussion is to confirm that the child does not require support. The outcome of the discussion must be recorded.

3.3.3 The Service User’s consent is not required at this stage as information is not being shared out-with the Practitioner’s organisation.

3.3.4 Where it is identified that a child requires multi-agency support, the Practitioner must refer to and follow the procedures for the GIRFEC Assessment process as someone who has identified a need about a child.

4. **Retention & Destruction**

4.1 The Practitioner’s documentation and records will be stored in a locked filing cabinet within a locked office or on a secure computer network.

4.2 Each Practitioner will store and destroy their documentation and records in line with their organisation’s Retention and Destruction Schedule.

5. **Complaints & Breaches**

5.1 The Caldicott Guardian within NHS Shetland and Data Protection Officers within Shetland Islands Council and other organisations are ultimately responsible for ensuring all staff and volunteers are bound by this procedure and adhere to its terms. They are also individually responsible for ensuring all supporting policies and procedures are implemented within their own organisation.

5.2 Any breaches of the protocol must be brought to the immediate attention of one of the above individuals.

5.3 Complaints will be made through the Practitioner’s organisation’s complaints procedure.
6. **Review & Audit**

6.1 Application of this procedure will be subject to audit and review by Shetland Child Protection Committee.
1. Introduction

1.1 In 2007, the then Scottish Executive published a guide for Child Protection Committees for conducting Significant Case Reviews (SCR) - http://www.scotland.gov.uk/Resource/Doc/174043/0048532.pdf. When a child dies or is significantly harmed (please see the criteria listed below), CPC 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 CPC about the need to conduct a full SCR. CPC 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.

1.2 The Chair of CPC or the Lead Officer can be contacted by any senior manager in any agency or organisation in Shetland with a request that an SCR be considered 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.

1.3 Initial Case Reviews and SCR’s will be conducted in accordance with Scottish Government Guidance and with the best practice approach developed by the Scottish Care Initiative for Excellence in 2010 - http://www.sircc.org.uk/nrcci.

2. Criteria for SCR

2.1 A child has died and:-

- 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 or a sibling is or was on the Child Protection Register. 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 CPC that the child having been on the Child Protection Register has no bearing on the case;
- The death is by suicide or accidental death;
- The death is by murder, culpable homicide, reckless conduct, or act of violence;
- The child was looked after by the local authority 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.

OR

2.2 **A child has not died** but has sustained a serious injury or been significantly harmed by being neglected, sexually or emotionally abused as outlined in section 4.3 of these procedures. In addition to the harm caused to the child there are serious concerns about the services provided or not provided to the child and family and there are some questions about whether more effective intervention could have prevented or ameliorated the harm to the child.

2.3 Anyone requiring further information about significant case reviews please contact the Lead Officer for Child Protection or follow the weblink below:

http://www.scotland.gov.uk/Publications/2003/03/16909/21147
1. **Purpose**

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 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.

2. **Statement of Principles**

- The responsibility for managing the risk to children and young people has to be held within a multi-agency perspective;
- Children and young people who display sexually harmful behaviour to others – whether or not that leads to any criminal charges – need to be recognised as significantly different to adult sex offenders;
- 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;
- Assessing risk is not a static process – it has to be fluid and dynamic and regularly reviewed;
- The environment that a young person is growing up in has a huge influence on them and makes risks more or less manageable;
- Viewing risks in terms of its manageability 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.

3. **Making a referral about a young person displaying sexually harmful behaviour**

3.1 Any agency which is working with or providing services to children and young people (voluntary agencies, schools, sports and youth club settings) may become aware of sexual behaviour. In most instances this will be a developmental stage that children and young people are going through and whilst it may need to be dealt with in terms of acceptable behaviour in that setting there may not be any concern about abuse or harm. Please see Annex 1 for further information about developing sexuality, which may assist in deciding if there needs to be a referral made.
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 risk 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. In some circumstances this will be a core group through child protection procedures and in others it will be a risk management team to support an individual child or young person. This may be co-ordinated through the Getting it Right for Every Child (GIRFEC) process where that is appropriate and available.

4. **Investigating allegations of abuse where young people are alleged offenders and victims**

4.1 Police, Social Work and the Reporter are the investigating agencies and referrals to them should be made following the guidance laid out in the Shetland inter-agency Child Protection Procedures (the CP Procedures).

4.2 The police and social work should carry out the same initial checks and information gathering in respect of the child or young person who may have harmed others as they do in respect of the child or young person who is the subject of the child protection investigation.

4.3 The child protection strategy discussion outlined in the CP Procedures is particularly important. As well as planning child protection investigations and interviews with any victims it needs to focus on the young person who has harmed them. This strategy meeting needs to function as an initial risk assessment meeting. In addition to the matters the discussion meeting needs to consider as outlined in the CP Procedures the following should also be considered:

- The seriousness of the abusive behaviour;
- The vulnerability of the child or young person displaying the behaviour;
- The information so far available;
- The source of the concern;
- The context in which the child or young person is living;
- The continuing risk to the victims that have already been identified and the potential risk to any other children or young people;
- How likely timescales for the investigation may increase or reduce risk to any victim, potential victim or the young person displaying sexually harmful behaviour. Depending on timescales, interim measures to reduce possible risks may need to be considered.

The outcome of this discussion and the plans put in place to investigate the situation should be recorded as outlined in the CP Procedures, and
shared with those who were at the strategy discussion and anyone else who needs to know.

In accordance with the CP Procedures consideration will always be given to the involvement of representatives of other disciplines at any stage of the planning process. Where a child or young person who may have harmed others is at school consideration should be given to the involvement of a Schools service representative at child protection strategy discussions, provided this will not cause delay. An appropriate health representative should also attend.

If, for any reason, agencies involved with a child or young person are not able to be included in an initial child protection strategy discussion, they should be contacted and involved as early as possible. Agencies are entitled to take the initiative themselves by contacting Children’s Services (social work) to seek further information and support.

4.4 The police have the responsibility for interviewing any young person against whom allegations of sexual abuse have been made in accordance with the Criminal Procedure (Scotland) Act 1995. Interviews should be conducted sensitively, bearing in mind the young person may be a victim as well as a perpetrator. The presence of an appropriate adult or legal representation is important. This may be especially needed if the young person has a recognised learning disability.

4.5 Following a child protection enquiry there should be a follow up strategy discussion to review the information gathered in the course of the investigation and to plan the next steps. This meeting will need to consider:

- The outcome of interviews with victims
- The continuing and future risk to victim(s) and whether or not there should be a Child Protection Case Conference arranged to consider the situation of the alleged offender as well as the victims (as per CP Procedures).

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.

4.6 In accordance with the CP Procedures, except in exceptional circumstances (recorded in writing) a Child Protection Case Conference for any alleged abuser under the age of 16 will be convened, followed by a comprehensive assessment of his/her needs and a risk management plan will be drawn up where risks to others have been identified.

4.7 In those exceptional circumstances where there is no Case Conference it may still be necessary for a support plan and risk management plan including all appropriate agencies to be drawn together. Please refer to section 7 for further guidance in such cases.
5. Initial Child Protection Case Conference

5.1 An Initial Child Protection Case Conference arranged to consider the situation of a young person who is an alleged offender or whose sexually harmful behaviour is of grave concern will follow the normal procedures laid down in the CP Procedures.

5.2 In addition to the matters that would normally be addressed in reports to the Initial Child Protection Case Conference it is important that the following are also included:-

- An initial analysis of the problem sexual behaviours;
- Possible routes into the behaviours (child’s history of any adversities);
- The child or young person’s needs;
- The immediate risk to others;
- Family response;
- Community response.

This will assist in the process of determining:

- Short-term risk management requirements;
- The need for referral to the Reporter and legal processes;
- Placement considerations – the young person may need to be accommodated elsewhere either for their own or other’s safety;
- Referral onto other agencies e.g. mental health services;
- The roles and responsibilities of agencies and family members in managing risk and meeting needs;
- The need for disclosing information to third parties.

6. Outcome of the Initial Child Protection Case Conference

6.1 If the Initial Child Protection Case Conference finds the grounds for registration satisfied and decides to place the name of the young person displaying sexually harmful behaviour on the Child Protection Register then a protection plan, key worker and core group will be identified.

6.2 It is imperative that the protection plan includes a risk management plan. It is imperative that the core group also functions as a risk management team when it is reviewing the protection plan and risk management plan.

6.3 If the Conference decides that the name of the young person displaying sexually harmful behaviour does not need to be placed on the Child Protection Register it is still important to identify a support plan and a risk management plan. In such cases it will be necessary to identify a risk management team. The responsibility for establishing the team lies with the Chair of the Child Protection Case Conference.
6.4 In all cases the risk management team or core group will meet within 10 working days of the Initial Child Protection Case Conference and monthly thereafter. It will be the responsibility of the case responsible senior social worker to ensure the meetings are held and to chair them.

6.5 If at a Review Child Protection Case Conference it is decided to remove the child’s name from the register, the conference must consider whether there is a possibility of continuing risk to others, and if so, a risk management team should be established by the Chair, as in 6.3 above.

7. **Children and Young People not on Child Protection Register**

7.1 In the exceptional circumstances where there is no Initial Child Protection Case Conference may still be necessary to identify a support plan and a risk management plan. In such cases the Team Leader, Children’s Services (Social Work) will be responsible for establishing the risk management team, with the chairing responsibilities being held by the case responsible senior social worker.

7.2 The risk management team will meet within 10 working days of being established and monthly thereafter. It will be the responsibility of the case responsible Team Leader to ensure the meetings are held and to chair them.

7.3 Meetings of the risk management team will focus on managing risks and will also ensure that needs are met. The team will develop a plan to manage risks and meet needs which will be reviewed monthly. A keyworker or Lead Professional must be appointed.

7.4 Where the GIRFEC process is available, the work of the risk management team may be coordinated in the GIRFEC process, with the proviso that the Lead Professional in such cases that should normally be a social worker.

7.5 Planning to meet the needs of 16 – 18 year olds involved in sexually harmful behaviour may need to use a number of different systems according to what is happening for the young person:-

- If they are, or have been, prosecuted in the Sheriff Court Criminal Justice social workers and police will be the key agencies for managing risk and meeting need;
- If there is no prosecution and the young person is willing to engage in services then either GIRFEC or ‘With You For You’ may assist in assessing need but care would need to be taken to ensure that risk management was part of this process;
- Young people aged 16 – 18 may still be in school or attending college and management and support in these settings is important;
- Consideration may need to be given to the vulnerabilities of the young person and whether they should be consideration of their needs for protection under the Adult Support and Protection Procedures.
7.6 Whichever approach is taken inter-agency working and risk management are key issues to be addressed.

8. **Review**

This protocol will be reviewed as necessary to ensure it remains compatible with the Multi-Agency Public Protection Arrangements (MAPPA) and in any event will be reviewed within 2 years from its approval by the Child Protection Committee.

9. **Flow chart**

The flow chart attached as Annex 3 is intended to assist in summarising the process, but reference should be made to the protocol itself and in case of doubt the protocol itself should be followed.
Annex 1: Guidance Notes: Identifying Problem Behaviours

Defining normal, problematic or abusive behaviours in children and young people can present difficulties for professionals with responsibility for protecting children. The uncertainty created can sometimes leave workers feeling powerless to respond to behaviours that concern them. This can then result in a failure to respond to the needs of both children displaying the behaviours and their actual or potential victims.

In considering the behaviours of younger children, American Psychologist and leading expert in her field, Toni Cavanah Johnson, has developed sexual behaviour checklists to assist in determining the nature of behaviours. This list describes behaviours indicating concern:

- A child showing an interest in, and knowledge of, sex outwith the developmental norm;
- The sexual behaviours exhibited being significantly different from other children of the same age;
- The child being unable to stop the behaviours after being told to do so;
- The sexual behaviours eliciting complaints from others;
- The sexual behaviours making adults uncomfortable;
- Sexual behaviours that increase in frequency, intensity or intrusiveness;
- When fear, anxiety, deep shame or intense guilt is associated with the behaviours;
- Children who are engaging animals in sexual behaviours;
- Sexual behaviours that are causing physical/emotional pain/discomfort to self or others;
- Children who use sex to hurt others;
- Anger preceding or following or accompanying sexual behaviour;
- Children who use force, bribery, manipulation and threats.

While Johnson’s work concerns younger children, the above may be useful in considering the sexual behaviours of teenagers. However an additional aspect to teenage years is the onset of puberty. This is a stage of major social, emotional and physical change. These include physical maturation, experience of sexual arousal and awareness of orientation, more complex peer interaction, and a greater autonomy around decision making. During this time adolescents need to synthesise a variety of experiences in order to establish a health sexual identity.

Because there is a wider range of sexual behaviours on display in adolescence it can be more difficult to determine what is normal and healthy and what is problematic. The following has been adapted from Ryan and Lane (1991).
Normal Adolescent Behaviours:

- Explicit sexual discussion amongst peers, use of swear words, obscene jokes;
- Interest in erotic material and its use in masturbation;
- Expression through sexual innuendo, flirtation and courtship behaviours;
- Mutually consenting non coital sexual behaviour (kissing, fondling, etc);
- Mutually consenting masturbation;
- Mutually consenting sexual intercourse.

Behaviours that Cause Concern:
(showing escalation in seriousness)

- Sexual preoccupation/anxiety;
- Use of hard core pornography;
- Indiscriminate sexual activity/intercourse;
- Twinning of sexual behaviours with aggression;
- Sexual graffiti relating to individuals or which have disturbing content;
- Single occurrences of exposure, peeping, frottage or obscene telephone calls;
- Compulsive masturbation;
- Persistent or aggressive attempts to expose other’s genitals;
- Chronic use of pornography with sadistic or violent themes;
- Sexually explicit conversations with significantly younger children;
- Touching another’s genitals without permission;
- Sexually explicit threats;
- Persistent obscene telephone calls, voyeurism, exhibitionism and frottage;
- Sexual contact with significantly younger children;
- Forced sexual assault or rape;
- Inflicting genital injury.
Annex 2: 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 with 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 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
- Liaison with other agencies and family on a regular basis
- 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.

Where the Schools service deems it likely that the child will require an immediate exclusion they should urgently convene a multi-agency risk management meeting to inform decision-making. In appropriate circumstances this can be considered at a child protection strategy discussion within the CP Procedures. (See section 4 of this protocol).

Where a child or young person has transferred from another school or authority with a previous history of problem sexual behaviours the educational establishment should 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.

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.
Annex 3 Flowchart – For children and young people up to age 16

Concern about sexual behaviour comes to notice either due to allegations of victim or observations of behaviour that is outside developmental norms

Referral to duty
Social Work as per Child Protection Procedures

Initial information gathering/discussion with agencies

Is the concern Child Protection or should it be dealt with as child in need/GIRFEC? (section 7.1 Shetland inter-agency CP Procedures)

Child in need
GIRFEC process

Social work Lead Professional appointed and GIRFEC assessment undertaken with additional focus on risk to others

GIRFEC meeting and + plan including risk management

GIRFEC review and risk management process

NB some young people may face police investigations and referral to the Procurator Fiscal or Reporter which could result in Sheriff’s Court or Children’s Hearing proceedings. Children and young people aged under 16 can be prosecuted in the Sheriff’s Court for serious sexual offences. These processes may run alongside or replace GIRFEC/Child Protection processes

Child Protection process

Initial strategy discussion + plan for child protection investigation

Initial Child Protection Conference

Not Registered

Risk management plan + team (consider GIRFEC if appropriate)

Monthly meetings to review risk management plan

Registered

Core group includes risk management group

Monthly meetings of protection plan + risk management plan and review CPCCfs (if dereg’d, still possible risks to others, set up risk manag’t team
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, Social Work Services.

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 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 Social Work Duty Assistant and initiate the Shetland multi agency process.

6 The Process (Appendix 1)

6.1 The Shetland 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 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 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 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 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 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 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 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 Social Work Duty Assistant to check the national missing people databases:
   http://www.missingpeople.org.uk/
   http://uk.missingkids.com/missingkids/servlet/PublicHomeServlet

   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 Social Work Duty Assistant and requests that the Shetland Social Work Duty Assistant initiates the national search.

   The Shetland Social Work Duty Assistant initiates a national search by sending the completed ‘Request for a National Search’ to:
   SIC Children’s Service, 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. 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:


Getting it Right for Every Child (GIRFEC) – http://www.shetland.gov.uk/socialwork-health/iafpilot.asp

With You For You (for over 16’s where GIRFEC is not appropriate) – http://www.shetland.gov.uk/socialwork-health/4u.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 will be reviewed in 5 years, or sooner at the request of the Shetland Child Protection Committee.

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