Shetland Child Protection Committee

Shetland inter-agency Child Protection Procedures

Safer Shetland – Safeguarding children and young people in Shetland

www.safershetland.com

August 2015
SHETLAND INTER-AGENCY CHILD PROTECTION PROCEDURES

Safeguarding Children and Young People in Shetland

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http://www.safershetland.com

August 2015
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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<tr>
<td>Monday to Friday 9 am – 5 pm</td>
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</tr>
<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 744 000</td>
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<td>Team Leader</td>
<td>01595 744 000</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>101</td>
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<tr>
<td>In an emergency call 999</td>
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<table>
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<tr>
<th>Other numbers</th>
<th>Telephone</th>
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<tbody>
<tr>
<td>Monday to Friday 9 am – 5 pm</td>
<td></td>
</tr>
<tr>
<td>SCRA Children’s Reporter</td>
<td>0300 200 2200</td>
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The process of responding to child protection concerns is represented in diagrammatic form below. At any stage in the process it can be stopped if it is felt that either the child requires immediate emergency measures to protect them or if the information gathered does not require a response under child protection procedures. Some children, young people and families may benefit from further assessments and support through GIRFEC.

Referral to duty social worker raising child protection concerns

Does the situation require an immediate response to protect the child/young person?

- Police use powers to remove child/young person
- Social Work seeks child protection order

No action required

Further assessment and Support – GIRFEC

Single agency investigation by police or social work

Duty Social Worker and Managers complete checks outlined in Chapter 6 Step 5

Information sought from all other agencies

Health to inform discussion about health needs and requirement for medical

Strategy discussion or meeting

Decision to proceed under CP procedures or not

Joint Interview with child/young person

Debrief meeting/discussion following investigation

Risk of significant harm?

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

- No
  - No further action

Further assessment and support - GIRFEC

Practitioners working with children/young people/adults
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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 and young people. However, for the purposes of this document, the above terms have been used to indicate the activities of all three agencies specifically in respect of child protection.

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

OPENING HYPERLINKS WITHIN THE INTERNET VERSION OF THIS DOCUMENT

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

GLOSSARY:

CPC - Child Protection Committee
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>Children and Families Health Manager</td>
<td>NHS Shetland</td>
</tr>
<tr>
<td>Advanced Practitioner (Protection)</td>
<td>NHS Shetland</td>
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<tr>
<td>Area Commander or Nominated Representative</td>
<td>Police Scotland, Highlands &amp; Islands Division, Shetland Area Command</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 Directorate</td>
</tr>
<tr>
<td>Executive Manager – Children and Families Incorporating Chief Social Work Officer</td>
<td>Children’s Services Directorate</td>
</tr>
<tr>
<td>Executive Manager – Criminal Justice Service</td>
<td>Community Health and Social Care Directorate</td>
</tr>
<tr>
<td>Principal Educational Psychologist</td>
<td>Children’s Services Directorate</td>
</tr>
<tr>
<td>Executive Manager – Quality Improvement</td>
<td>Children’s Services Directorate</td>
</tr>
<tr>
<td>Executive Manager – Housing</td>
<td>Development Services Directorate</td>
</tr>
<tr>
<td>Chair – Shetland Children’s Panel</td>
<td>Shetland Children’s Panel</td>
</tr>
<tr>
<td>Procurator Fiscal or Nominated Representative</td>
<td>Crown Office Procurator Fiscal Service, North Federation</td>
</tr>
<tr>
<td>Executive Officer or Nominated Representative</td>
<td>Voluntary Action Shetland</td>
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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 Inspector, Shetland Area Command, Police Scotland.

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

1.4 Third sector organisations providing services to children and young people are represented at CPC. They are invited to link into these procedures as part of their child and young person welfare policies and further guidance for community groups is available at [http://www.safershetland.com/adult-protection-for-community-groups](http://www.safershetland.com/adult-protection-for-community-groups)

1.5 Further protocols may be developed to provide additional guidance on specific areas of child protection work. Once approved by 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](http://www.legislation.gov.uk/ukpga/2010/15). The guidance is also compatible with the Human Rights Act 1998. Child protection services in Shetland will ensure that they operate in fair, consistent and reliable ways with an emphasis on participation, respect and inclusion.

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

2.1 This guidance is rooted in the GIRFEC approach and the provisions of the Children and Young People (Scotland) Act 2014. Every child and young person in Shetland has a Named Person. Where concerns about the wellbeing of the child or young person require co-ordinated intervention from more than one agency, then a Lead Professional will be identified to take on the coordinating role. Where evidence suggests that a co-ordinated plan to provide “targeted intervention” involving two or more agencies will be necessary, a Child’s Plan will be drawn up. (For further information and to find out who is the Named Person for a specific child or young person please see following web link: [http://www.shetland.gov.uk/children_and_families/GIRFEC.asp](http://www.shetland.gov.uk/children_and_families/GIRFEC.asp)
2.2 Where a child or young person is at risk of significant harm – either due to a specific experience of abuse or an accumulation of concerns over a period of time then the primary concern will be for their safety and child protection procedures should be put into place.

2.3 For children and young people involved in child protection procedures – either at the referral and investigation stage or if their names are recorded on the child protection register – the Lead Professional will be a social worker from the Children and Families Social Work Team. For children and young people whose names are on the child protection register the Child’s Plan will also be the Child Protection Plan.

3 16-18 Year Olds

3.1 Young people age 16 – 18 can be at risk of falling between gaps in services. The Children and Young People Act (Scotland) 2014 is clear that all young people up to the age of 18 should have a Named Person in place that can be a first point of contact if the young person requires advice and assistance.

3.2 For young people aged 16-18 who are still in Education the Schools Service will provide a Named Person. The Duty Social Worker can assist anyone who wants to make contact with the Named Person for a 16-18 year old who is not in school

3.3 To ensure that vulnerable young people aged 16 -18 who may be at risk of significant harm have their situation assessed and responded to, please see the Vulnerable Young Person’s guidance Protocol 11 in Section 3 of these procedures.

3.4 For young people whose names are recorded on the Child Protection Register at their 16th birthday it is appropriate to consider at the next review case conference if their name should continue to be registered or if their need for protection would be better met by using the Adult Support and Protection (Scotland) Act 2007 and the Shetland Inter-agency Adult Protection Procedures.

3.5 It would be unusual to keep a young person’s name on the Child Protection Register beyond their 16th birthday, but there is nothing in the 2014 National Guidance that prohibits this if the agencies felt it was an appropriate response to a risk of significant harm. The cooperation of the young person, a robust Child’s Plan that addresses risk and a positive relationship with the Lead Professional would need to be in place.
3.6 For some young people between the ages of 16 and 18, Shetland Inter-Agency Adult Support and Protection Procedures may apply wherever concerns are raised or allegations are made. The Adult Support and Protection Procedures can be accessed through the following link – http://www.safershetland.com/adult-protection

3.7 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. This means that they are “Looked After” and the local authority has a responsibility for their care and welfare up to the age of 26. A young person who is subject to a 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 Duty Social Worker who can consult with Shetland Island’s Council’s legal services, if required.
2. **Policy**

2.1 All children and young people have a right to protection from abuse and exploitation, and to adequate physical, emotional and social care; parents have the responsibility and the right to provide such care.

2.2 Children and young people are best cared for in their own families, except where consideration for their safety and welfare dictates otherwise.

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

2.4 Each child must be treated as an individual with individual needs, feelings and beliefs.

2.5 Work will be carried out on the basis of partnership with families wherever possible, parents being consulted and involved in all decisions affecting their children, subject to paragraph 2.3 above.

2.6 The highest priority will be given to the protection of children and young people from abuse, and all agencies and organisations will ensure that activities carried out in the name of child protection are child-centred, and give paramountcy to the welfare and interests of children and young people.

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

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

2.9 All agencies are committed to working in an open and collaborative way, together and with parents, whilst recognising the potential for conflict in child protection situations.

2.10 All children and young people will be provided with appropriate support in accordance with their particular needs.


2.12 All Child Protection interventions will be carried out with an understanding of the Human Rights Act and the right to family life, balancing the need to protect children and young people from harm and the rights and responsibilities of parents and carers.
2.13 This policy has been approved by Shetlands Islands Council, Shetland NHS Board, and the Police Scotland and adopted by all other organisations represented on Shetland CPC.
3. **Roles and Responsibilities**

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

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

- **Police**
  - The Council through its Children’s Services
  
- **The Reporter**
  - have a general duty to protect the public and to investigate matters on behalf of the Procurator Fiscal, where they believe that a criminal offence may have been committed. They will give the Procurator Fiscal any information which will help him or her to decide whether a criminal prosecution should take place. The police will refer a child or young person to the Reporter if they believe that a child or young person may be in need of compulsory measures of supervision. The police will also consult and share information with all other appropriate agencies on matters which relate to the well being of a child or young person.

3.3 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 or young person 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 made to the Scottish Children Reporters Administration (SCRA) and to refer a child or young person to a Children’s Hearing if the Reporter is satisfied that it is in the child’s or young person’s interest to provide protection, care, treatment or control on a compulsory basis. The extent and type of investigation is for the Reporter to decide.

3.5 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.
3.7 The Procurator Fiscal - http://www.copfs.gov.uk/ - also has clear statutory responsibilities in relation to the investigation of crime. With regard to child protection matters the Procurator Fiscal has a duty to:

a) Consider the terms of reports sent in by police or other agencies and to instruct them to make appropriate enquiries;

b) Consider bail conditions that may protect a child or young person from an alleged offender

c) Consider whether criminal proceedings are appropriate and if so, to consider how they should be prosecuted taking account of all the circumstances of the offence and the offender;

d) Set up contact with the child or young person witness where there is prosecution, in consultation with other agencies;

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

f) Work with the Reporter; and

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

3.8 Shetland NHS Board – http://www.shb.scot.nhs.uk/ – has a specific role in connection with medical examinations for investigative purposes. Other agencies also have an essential part to play as set out in the following sections of these Procedures.

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

3.10 Children’s Services (School Staff) – staff working in a range of school and pre-school settings play a crucial role in the support and protection of children and young people as well as the development of their well being.

3.11 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 2014 provides more detailed guidance.

3.12 For further detailed information about the respective roles of different agencies please see Part 2 of the National Guidance 2014.
4. Definition

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

4.2 The National Guidance for Child Protection in Scotland 2014 states that the following definitions show some of the ways in which abuse may be experienced by a child or young person but they are not exhaustive, as the individual circumstances of abuse will vary from child to child. [http://www.gov.scot/Resource/0045/00450733.pdf](http://www.gov.scot/Resource/0045/00450733.pdf) [2014]

**Physical abuse**

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

**Emotional abuse**

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

**Sexual abuse**

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

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

4.3 Significant harm

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

The National Guidance gives the following definitions:

‘Harm’ means the ill treatment or the impairment of the health or development of the child, including, for example, impairment suffered as a result of seeing or hearing the ill treatment of another. In this context, “development” can mean physical, intellectual, emotional, social or behavioural development and “health” can mean physical or mental health.

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

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

4.4 Organisations working with children and young people owe them a duty of care and have specific responsibilities towards them. Everyone has a responsibility to make sure children and young people are safe and well cared for, and should never cause them harm. Therefore allegations against members of staff (or volunteers) working for any organisation will be investigated under these Procedures. (See further information in Chapter 7.)

4.5 More information on significant harm and on specific roles and responsibilities for child protection are to be found in the National Guidance, available on the internet at http://www.gov.scot/Resource/0045/00450733.pdf

(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 or young person has been abused.

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

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

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

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

The following gives some information about possible indicators of physical, sexual, 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 and young people brought for medical attention by parent or carer who was not present when the injury was sustained;
- Features of general neglect of the child’s/ young person’s physical or emotional needs;
- Inappropriate behaviour (including sexualised play or activity) or demeanour of the child/young person or parent;
- Unusual illness suggestive of a fictitious origin; and
- Child’s/young person’s name already entered on the Child Protection Register.
5.5 Physical Abuse

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

**Bruises**

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

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

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

The following are uncommon areas for accidental bruising:
- Back;
- Back of legs;
- Buttocks (except occasionally along the bony protuberance of the spine);
- Neck;
- Mouth;
- Cheeks
- Behind the ear;
- Stomach;
- Chest;
- Under arm; and
- Genital or rectal areas
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/young person;
- Acting in a sexually explicit manner e.g. very young child inserting objects into their vagina;
- Sudden changes in behaviour or school performance or attendance;
- Displays of affection which are sexually suggestive;
- Tendency to cling or need constant reassurance;
- Tendency to cry easily;
- Regression to earlier behaviour such as thumb sucking, acting as a baby;
- Distrust of a familiar adult or anxiety about being left with a relative, babysitter or lodger;
- Unexplained gifts or amounts of money;
- Secretive behaviour; and
- Fear of undressing for gym classes or swimming lessons.
5.7 Emotional Abuse

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

Parents’ Behaviour

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

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

Child’s/Young Person’s Behaviour

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

There are factors that can impact on a parent or carer’s ability to provide safe care for their child, including substance misuse, domestic abuse, severe mental illness and learning disabilities. These are all issues that can affect a child's/young person’s situation to the extent that they are being 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/young person’s age which may arise due to familial abuse of substances;
- General failure to achieve developmental milestones;
- Lack of parental involvement, care and interest;
- Lethargy and tiredness; and
- Persistently late to school, not attending school or conversely the child/young person who arrives early and appears reluctant to go home;
- Failure to keep routine medical, dental and health visiting appointments.

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

Introduction

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

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

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

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

**Report/Refer**
Follow child protection procedures.

**Record**
Record all information including actions, discussions and decisions.

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

**Steps 5 to 8** relate to the specific actions that will be taken by the investigating agencies.

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

All allegations of child abuse will be treated seriously and investigated in accordance with these interagency procedures.
STEP 1

Concern or Initial Referral about a Child at Risk

1.1 Person Responsible

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

1.2 Action to Take

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

1.2.2 If the child/young person has an obvious injury, then staff may seek an explanation from the child/young person or from the child’s parents. Even if the explanation indicates an accidental cause then it is always good practice to record that. If a child/young person speaks about experiences of physical harm, neglect, sexual abuse or emotional abuse, then listen carefully, seek basic clarification of what the child/young person is saying and record the information carefully as soon as possible. Further information about how to support a child or young person who discloses abuse is contained in Appendix 1, Part 1, paragraphs 9-11.

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

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

1.2.5 The timing and nature of further contact with parents must be decided by the investigating agencies following the making of a referral.
STEP 2

Consultation with a Manager

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

2.2 **Action to be Taken**

The staff member will discuss the suspected or alleged harm, mistreatment or neglect with the line manager as soon as possible. If the line manager is not available, then the staff member should speak to a suitable alternative manager. NHS staff can seek the advice of the Advanced Nurse Practitioner (Protection). Anyone who is not a staff member or who is not able to speak to a line manager can seek advice from the Duty Social Worker, without the need to make a formal referral at this stage.

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

- The need for immediate action and any consequent risk to the child/young person, for example, if a child/young person has told a teacher that they have been physically abused, then they may be at risk of further harm when school closes and they return home. Delaying making a referral will reduce the time that the investigating agencies (police and social work) have to respond and this potentially increases the risk to the child/young person.

- The need to share full information that the staff member, the line manager and their agency hold about the child/young person, family composition, address, contact numbers.

- The need to consider the risks to other children/young people and possibly adults too. For example, a child/young person may disclose that they have witnessed domestic abuse involving a physical assault to an adult and this poses future risk to the adult as well as the child/young person and any siblings.

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

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

- GPs
- Consultants
- A & E staff
- Health visitors
- Midwives
All of these staff can seek advice and guidance from line managers, but are not obliged to do so before making a referral. It is good practice to ensure that a concern or potential referral is discussed with the Consultant who has overall responsibility for that child in Accident and Emergency or admitted to Wards before a referral is made, and that the consultant is then made aware of any child protection referral.

Good practice would be that a copy of the written referral would follow the telephone referral and would be shared with line managers, the patient’s consultant if made during a hospital stay, and with the Advanced Nurse Practitioner (Protection).

**STEP 3**

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

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

**3.2 Action to be Taken**

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

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

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

**STEP 4**

*Referral to the Duty Social Worker*

**4.1 The Person Responsible**

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

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

The following information should be shared:

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

4.2.2 Once a referral is made by telephone, the Referral Form attached at Chapter 13 should be completed. A copy should be retained for the records of the referring agency. NHS Shetland staff should send a copy to the Advanced Nurse Practitioner (Protection).

STEP 5

Receiving a Child Protection Referral by Duty Social Worker

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

Shetland is too small to have a waking 24 hour social work response team but 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 or Duty Social Work Manager, who will call the referrer back. The referrer will need to provide a number for this purpose. However, if the referrer is unable to give a number, it is important that they provide as much information as possible to the operator, who will pass it on. It is more helpful if the Duty Social worker can speak directly to the person making the referral in order to respond in the best way possible to safeguard a child or young person.
The Duty Social Worker receiving the call will check social work records on SWIFT / O drive and the Child Protection Register to identify if the child or young person is known to the department.

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

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

5.2 **Daytime Duty Response**

Child Protection referrals will normally be dealt with by the Duty Social Worker for the Children and Families Social Work Team. Child Protection referrals must take priority over all other work and referrals must be the subject of an immediate assessment.

5.3 **People Responsible** – the Duty Social Worker receiving the Child Protection referral and the Designated Manager for Child Protection in the Children and Families Social Work (DM) assisting the Duty Social Worker.

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

5.4 **Action to be Taken**

5.4.1 The Duty Social Worker will consult with the DM. The DM will decide, on the basis of the information received, if there is a need to urgently protect the child/young person by calling on the immediate support of police officers or seeking advice from the Shetland Islands Council’s Legal Services about the requirement to apply for a Child Protection Order (please see Chapter 11 about Legal Orders).
5.4.2 The Duty Social Worker will gather relevant background information. The following checks will be made:

- Social Work records – SWIFT
- Child Protection Register
- Health records – GP/Health visitor/Midwife, etc. The Advanced Nurse Practitioner (Protection) will be able to gather relevant information by checking NHS Shetland records and sharing this with the Duty Social Worker.
- School records
- Criminal Justice Unit
- The Named Person and if there is a child’s plan co-ordinated by a Lead Professional

5.4.3 The Duty Social Worker or DM will make contact with the Police Scotland Family Protection Unit in Inverness.

5.4.4 The Family Protection Unit, Police Scotland has an immediate duty to respond to the child protection referral by gathering information as detailed below and participating in an initial referral discussion:

- Check Police Scotland Database for relevant information in respect of the child/young person and family (Scottish Criminal History System, Police National Computer, Police National Database, Vulnerable Persons Database, Scottish Intelligence Database, Incident text searches and where relevant foreign conviction checks can be made)
- Share relevant information with the Duty Social Worker or DM.

5.5 **Decision to Proceed under Child Protection Procedures or Not**

5.5.1 The DM, in consultation with the Designated Detective Inspector Police Scotland will have an Initial Referral Discussion and will decide jointly if the referral received and the information gathered indicates that a Strategy Discussion (which may be conducted as a face to face meeting or via phone or video link) and possible Joint Investigation is required.

5.5.2 If at this stage the DM, in consultation with the Designated Detective Inspector Police Scotland, decides the referral does not need a response under child protection procedures then one of the following decisions will be made:

- No further action
- Single agency investigation by either social work or Police Scotland agreed during the discussion between the DM and Designated Police Inspector
- Further assessment of the child’s/young person’s wellbeing needs by Social Work
- Further assessment of the child’s/young person’s wellbeing needs by the Named Person
- Review of existing Child’s Plan by Lead Professional

The child’s/young person’s situation will be dealt with out with the interagency Child Protection Procedures.
5.5.3 The Duty Team Leader should ensure that:

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

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

5.6 Decision to Proceed under Child Protection Procedures

5.6.1 If following an Initial Referral Discussion the Designated Detective Inspector Police Scotland and the DM decide that the referral needs to be progressed under Child Protection Procedures, then the following actions are required:

- To arrange a Strategy Discussion involving Police Scotland and the Advanced Nurse Practitioner (Protection) and a Quality Improvement Officer from the Schools Service. Other staff as appropriate can be involved – for example Criminal Justice Social Work, Additional Support needs staff or Community Care Adult Services Social work. The timing of the meeting or discussion will be informed by the Initial Risk Assessment.
- The DM and Designated Detective Inspector Police Scotland will identify investigating social worker and police officer who are JITT trained. Wherever possible the investigating social worker and police officer will be included in the Strategy meeting or discussion.

STEP 6

Child Protection Strategy, Planning and Debriefing Discussions

6.1 People Responsible

The Designated Manager from Social work and Designated Detective Inspector from Police Scotland will agree a time for a strategy meeting or discussion. The formal Strategy Discussion will follow on from the Initial Referral Discussion. The timing of the Strategy Discussion will be agreed according to the initial risk assessment. 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 7, Special Circumstances. Wherever possible, the investigating social worker and police officer should be in attendance.
6.2 Action to be taken

6.2.1 The purpose of the first Strategy Discussion is:

- To collate available information and establish the facts about the circumstances giving rise to concern;
- To consider the need for a paediatric or forensic medical as part of the formal child protection investigation.
- To also consider the need for a medical to ensure the wider holistic health needs of the child/young person are being met and identify any unmet need. This will be important in a number of situations, but particularly when there are concerns about neglect or emotional abuse.
- To agree the nature of the child care enquiries and the criminal investigation; (see Step 7 below for detailed planning of an investigative interview, and Chapter 8 for detailed consideration of medical examinations);
- To identify sources and levels of risk;
- To consider and plan any necessary protective action in relation to the child/young person and any others. (See Chapter 11 for detailed procedures in respect of applications to remove the child/young person, or to take other legal protective action).

6.2.2 Other than in circumstances where this would be detrimental to the child’s/young person’s best interests, the child’s parent(s) should be consulted and involved. Where the referral indicates that crime may have been committed, whilst giving paramount consideration to the child’s/young person’s welfare, it may in some instances, be necessary to restrict the persons present at any strategy discussion.

6.2.3 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. A Strategy Discussion may conclude that it is not appropriate to proceed under child protection procedures and in this case consideration should be given to whether there are well being concerns for the child/young person and there needs to be further assessment and possibly a child’s plan put in place. The Named Person and the Lead Professional should be informed of the outcome of the strategy meeting and if they need to take any further action to respond to wellbeing concerns.

6.2.4 Following every child protection investigation there should be a Strategy Debrief Discussion that records outcomes and considers any further action. Debrief meetings need to consider if there should be an initial child protection case conference. Wherever possible debrief meetings should include everyone who has attended the first strategy meeting. However there may be less complex investigations where a discussion at the weekly child protection screening meeting is an acceptable way of conducting a debrief discussion.
6.2.5 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.

6.2.6 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. A form for recording strategy meetings is in Chapter 13.

6.2.7 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 Detective Chief Inspector, Public Protection Policy Unit, Divisional Headquarters, Inverness.

STEP 7

Investigative Interviews

7.1 Persons Responsible

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

7.2 Action to be taken

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

7.2.2 The main purposes of the investigative interview are to:
   - Learn the child’s/young person’s account of the circumstances that prompted the enquiry
   - Gather any information to permit decision making on whether the child/young person in question or any other child, is in need of protection
   - Gather sufficient evidence to suggest whether a crime may have been committed against the child/young person or anyone else
   - Gather evidence which may lead to grounds of referral to a children’s hearing being established.
7.2.3 A specialist interview suite is available in Lerwick and other premises suitable for carrying out investigative interviews have been identified throughout the isles. Venues used for visual recording must comply with national guidance on this matter to ensure the recording can be used in later proceedings. It is important that any venue needs to be suitable for recording equipment and where the child/young person feels comfortable and safe to speak.

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

7.3 The Child at the Centre

Children and young people are not just objects of concern and great care must be taken when planning and carrying through a formal investigative interview. Conducting the interview in as sensitive and child centred a way as possible is vital. The following gives some guidance on this approach:

- Providing age appropriate explanations to children and young people about what is happening (a leaflet for children and young people is available from http://www.safershetland.com/for-children-and-young-people – at the end of webpage)
- Answering questions as honestly as possible
- Considering the best way to communicate with a child/young person of a given age
- Considering if the child/young person has any additional support needs that require more specialist help with communication (please see Chapter 7, paragraph 7.1)
- Considering the support needs of children and young people – especially those who are very young. In some circumstances children and young people may need a parent or trusted adult to be close by while they are being interviewed for reassurance and support and this need should be respected and accommodated.
- Allowing a child or young person to express their views and to participate in the process as fully as possible.
- Explaining what will happen next – especially if the child or young person will be asked to agree to a medical examination.
7. **Child Protection in Special Circumstances**

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

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

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

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

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

7.1.5 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/young person has communication difficulties e.g. Sensory Service, Learning Disabilities Nurse, Social Worker for children affected by disabilities.

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

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

- Principal Teacher - Vision Service
- Teacher-Hearing Impairment 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 – ASN Outreach (Social Communication and Autism Spectrum Disorder)
- Child and Adolescent Mental Health Service (CAMHS)
7.1.8 Should the child/young person be being interviewed as a result of suspected abuse by parents, consideration needs to be given to who would be the most appropriate responsible adult to support them during interview.

7.1.9 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.

7.2 Abuse by Children and Young People

7.2.1 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.

7.2.2 Interviews of children and young people 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.'

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

7.2.4 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 their 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.

7.3 Organised or Multiple Abuse

7.3.1 Features of this could include:
- Groups encompassing one or more families, friends, neighbours and wider networks;
- Enticement or intimidation of children and young people for sexual exploitation;
- Variations in the degree and form of sexual exploitation, including child pornography;
- Close co-operation and defence of common group interests in the face of any inquiry.
7.3.2 If links are established between cases that suggest the possibility of organised abuse, careful planning of each stage of any investigation must include:

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

7.3.3 Where it appears that organised or multiple abuse may be involved, the Chief Social Work Officer, Chief Inspector, Police Scotland Shetland Area Command, and Director of Public Health must be informed, and they will hold the Strategy Discussion. Please see guidance for strategy meetings in Chapter 6 Step 6.

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

7.4 Allegations Against Staff

7.4.1 Any allegation that a child or young person 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.

7.4.2 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, Shetland Area Command Police Scotland to ensure that the integrity of the investigation is maintained.

7.4.3 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, Shetland Area Command Police Scotland. 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 and young people.

7.4.4 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 6 Step 6) 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.
7.4.5 The strategy discussion will decide (with the exception of allegations against Police Scotland 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 Police Scotland, the Chief Inspector, Shetland Area Command will consult with their superior officer and the Head of Professional Standards within Police Scotland 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.

7.4.6 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.

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

7.4.8 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.

7.5 Allegations Against Foster Carers

7.5.1 Any allegation that a child or young person 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 (Chapter 6 Step 6).

7.5.2 Immediate consideration will be given to whether a change of placement is in the child’s or young person’s best interests.

7.5.3 Any criminal matter should be discussed with the Detective Inspector Public Protection Police Scotland prior to informing the foster carer, and the content of any discussion with the foster carer agreed.

7.5.4 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.
7.5.5 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.

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

7.6 Disclosure of Historical Child Abuse

7.6.1 An adult or an older young person no longer at risk may disclose abuse that happened to them as a child. The person may do so by making a complaint direct to the police, or the disclosure may emerge in another context, such as therapeutic work. As well as offering support to the person, the police and the Duty 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.

7.6.2 Further guidance on handling disclosures of historical abuse is to be found in the National Guidance for Child Protection in Scotland 2014 at http://www.gov.scot/Resource/0045/00450733.pdf under the heading “Historical allegations of abuse” (p 149). See also information on historical child abuse in Part 1 of Appendix 1 in Section 2 of these Procedures.

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

7.7.1 Information that an abuser may be living in the same household as a child or young person should be referred to the Duty social work service immediately, who will consult with the police in order that the risk to the child/young person 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/young person. This applies when an adult is known to have been convicted of an offence listed in Schedule 1 of the Criminal Procedure (Scotland) Act 1995 - http://www.legislation.gov.uk/ukpga/1995/46/contents and Schedule 1 of the Sex Offences Act 2003 - 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.
7.8 Anonymous Referrals

7.8.1 Anyone receiving an anonymous telephone call about concern for the safety of a child or young person should try to obtain the caller's number. If this is impossible, full details of the concerns for the child/young person should be recorded carefully in writing. Callers should be encouraged to be as specific as possible. Efforts should be made to identify the anonymous caller in order that they may be interviewed about the allegation.

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

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

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

7.9 Children and Young People who Place Themselves at Risk

7.9.1 The 2014 National Guidance for Child Protection requires that Child Protection Committees have inter-agency policies in place for the identifying, referring and responding to situations where young people place themselves at risk. Shetland Child Protection Committee and the Integrated Child and Young Persons Strategy Group have developed a vulnerable Young Person’s Protocol – Protocol 11 in Section 3 of these procedures.
7.9.2 Whilst accepting that some children and young people can place themselves at risk, it is important to understand that their behaviour can be influenced by experiences of poor care within the family setting and they can be groomed and exploited by adults who wish to use them. Blaming a child or young person or seeing them as mature enough to make genuine choices or failing to understand how they can be manipulated will not assist professional staff in making the right decisions. For example, in cases of child sexual exploitation young women are often drawn into a relationship that they see as loving, but may in reality be exploitative. We need to put the responsibility for exploitation on the adult who is knowingly behaving in this way.

7.9.3 The Children’s Hearing (Scotland) Act 2011 allows anyone to refer a child/young person to the Reporter to the Children’s Panel. Please see Protocol 2 in Section 3 of these Procedures for the Grounds of Referral to the Reporter. The Reporter will make the decision about whether the child/young person may be in need of compulsory measures and that a Children’s Hearing should be convened.

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

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

7.10 Children at Risk of Radicalisation – PREVENT Strategy

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

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

- Notify the Child’s Named Person who can request that the situation is discussed at the Inter-Agency Screening Meeting
  Or
- Make a child protection referral to the Duty Social Worker.
  Or
- Contact the police

Following an initial interagency discussion a plan will be formulated to assist the child or young person and their family. In some cases it may be appropriate to hold a Child Protection Case Conference.

Web link to PREVENT Guidance for Scotland:
8. Health Assessment and Medical Examinations

8.1 The Need for a Health Assessment

8.1.1 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 agency will ensure that all respect the contribution provided by each service and that the health needs of the child or young person are not overlooked.

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

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

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

- The general examination should be completed;
- The examination specifically for abuse should not continue;
- Clinical findings up to the end of the general examination should be recorded;
- A referral should be made to the Duty 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.
8.2 Comprehensive Medical Assessment

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

8.2.2 The comprehensive medical assessment has five purposes:

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

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

8.3 Arranging a Medical Examination

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

8.3.2 Appropriate advice is available on a 24-hour basis, from NHS Grampian paediatricians (day time Child Protection Paediatrician NHS Grampian, out of hours on-call paediatrician). In Shetland, 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 Advanced Nurse Practitioner (Protection), agreeing with police and social work colleagues the nature, timing and venue for the examination. In situations where the child or young person is brought
initially to the attention of Health, and where there are concerns regarding the welfare or safety of a child/young person, the paediatrician or GP should contact social work services or the police before carrying out any medical assessment. Where information is unclear or uncertain, a comprehensive medical assessment may be undertaken to determine the need for a specialist paediatric or joint paediatric/forensic examination. Where it is clear that a forensic opinion will be required – for example, where there is an allegation or observation of serious physical assault or injury or a disclosure of sexual abuse – the forensic examination should also include a comprehensive medical assessment.

8.3.3 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/young person will inform decisions on a case-by-case basis.

8.3.4 Failure to thrive is included in the definition of neglect and 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 or young person’s best interests are therefore clearer in these circumstances.

8.4 Specialist Paediatric or Joint Paediatric/Forensic Examination

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

- The child/young person urgently requires more specialist assessment or treatment at a paediatric department (for example, if they have a head injury or suspected fractures);
- The account of the injuries provided by the carer does not provide an acceptable explanation of the child's/young person's condition;
- The result of the initial assessment is inconclusive and a specialist's opinion is needed to establish the diagnosis;
- Lack of corroboration of the allegation, such as a clear statement from another child/young person or adult witness, indicates that forensic examination, including the taking of photographs, may be necessary to support criminal proceedings against a perpetrator and legal remedies to protect the child/young person;
- The child's/young person’s condition (for example, repeated episodes of unexplained bruising) requires further investigation; and
- In cases of suspected child sexual abuse, as the medical examination has to be carried out by medical practitioners with specialist skills using specialist equipment.
8.4.2 In some cases, the information gathered from an earlier comprehensive medical assessment may be sufficient together with other supportive evidence (for example, corroboration of the incident from an eyewitness) to enable a conclusion to be reached regarding the allegation. In such cases, there will be no need for further examination. Photographic evidence may be obtained by the police or medical photographer as part of their investigative procedures, but the examining doctors should assist by ensuring that all significant injuries are recorded.

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

8.4.4 The specialist paediatric examination provides a comprehensive assessment of the child/young person, establishing the need for immediate treatment and ongoing health care as well as providing a high standard of forensic evidence to sustain any criminal or care proceedings and offering reassurance and advice to the child/young person and carers. The examination is intended to encompass both the child's/young person’s need for medical care and the legal requirement for evidence in a single examination.

8.4.5 The joint paediatric/forensic examination combines a comprehensive medical assessment with the need for corroboration of forensic findings and the taking of appropriate specimens for trace evidence including, for example, semen, blood or transferred fibres. While the paediatrician is responsible for assessing the child’s/young person’s health and development and ensuring that appropriate arrangements are made for further medical investigation, treatment and follow-up, the forensic 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.

8.4.6 In cases of child sexual abuse, the need for a medical examination should be discussed at a strategy discussion involving police, social workers and medical staff. There should be discussion about the kind of medical examination required. In cases of child sexual abuse the Designated Detective Inspector Police Scotland Public Protection will consult with other agencies regarding the type of medical examination required and advice regarding forensic evidence. For example, will it be a general medical examination as carried out by the child’s/young person’s own practitioner, or
will it be the more comprehensive medical examination required for forensic purposes? The decision should be made, bearing in mind the interests of the child/young person, the needs of the criminal and civil investigations, and the likelihood of a forensic medical examination producing useful evidence. All decisions and the reasoning behind them should be recorded in writing.

8.4.7 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.

8.4.8 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.

8.4.9 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.

8.4.10 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.

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

8.4.12 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 or young person’s needs. Where examination in Shetland is not considered appropriate, the medical examination will be arranged out with Shetland via the paediatrician involved in the strategy discussion.

8.5 Timing of Medical Examinations

8.5.1 The timing of the medical examination should be agreed jointly by the medical examiners and the other agencies involved. It may not be in the child’s/young person’s best interests to rush to an immediate examination. It may be more appropriate to wait until the child/young person has had time to rest and prepare; this may also allow for more information to become available. It is expected that in the great majority of cases arising in working hours, a comprehensive medical assessment will be carried out locally and quickly by a doctor who knows the child/young person and/or the family and is competent to carry out such an assessment. The paediatrician responsible for child protection will advise on assessments off island. The decision on how best to proceed should always be made in discussion with the other agencies involved.
8.5.2 In cases of alleged sexual abuse it is expected that the examination will be undertaken by the specialist paediatrician in Grampian. The examination must be carefully planned to take place during working hours when skilled personnel and specialist staff are available. Where the incident is believed to have taken place more recently, care must be taken to ensure that forensic trace evidence is not lost. Particular care should be taken to retain clothing and bedding, and to avoid bathing.

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

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

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

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

8.6 Consent to Medical Treatment

8.6.1 Consent is required for medical treatment and examination. Parental consent should be sought if the parents have parental rights and responsibilities and the child/young person is under 16, unless this is clearly contrary to the safety and best interests of the child/young person (for example, in urgent circumstances). However, the Age of Legal Capacity (Scotland) Act 1991 - http://www.legislation.gov.uk/ukpga/1991/50 - allows that a child/young person under the age 16 can consent to any medical procedure or practice if in the opinion of the attending qualified medical practitioner they are capable of understanding the possible consequences of the proposed examination or procedure. Children and young people who are judged of sufficient capacity to consent can withhold their consent to any part of the medical examination (for example, the taking of blood or a video recording). Clear notes should be taken of which parts of the process have been consented to and by whom.

8.6.2 In order to ensure that children and young people and their families give properly informed consent to medical examinations, the examining doctor, assisted if necessary by the social worker or police officer, should provide
information about any aspect of the procedure and how the results may be used. Where a medical examination is thought necessary for the purposes of obtaining evidence in criminal proceedings but the parents/carers refuse their consent, the Procurator Fiscal may consider obtaining a warrant for this purpose. However, where a child/young person, who has legal capacity to consent declines to do so, the Procurator Fiscal will not seek a warrant. If the local authority believes that a medical examination is required to find out whether concerns about a child’s/young person’s safety or welfare are justified, and parents refuse consent, the local authority may apply to a Sheriff for a Child Assessment Order or a Child Protection Order with a condition of medical examination. A child/young person subject to a Child Protection or Assessment Order may still withhold their consent to examination or assessment if they are deemed to have legal capacity. For further information on Child Protection and Assessment Orders, see Chapter 11 of these procedures.

8.6.3 The Age of Legal Capacity Act - [http://www.legislation.gov.uk/ukpga/1991/50](http://www.legislation.gov.uk/ukpga/1991/50) - does not clarify the position in terms of parents’ rights in this situation. Logic and current health service practice suggest that once the child/young person is considered able to consent on his/her own behalf, the parents’ rights to override that consent should cease. However, it is considered good practice to obtain the consent of parents wherever possible.

8.6.4 If a child or young person is unable to consent to therapeutic medical treatment, and the parents refuse consent, emergency treatment can be authorised by the doctor. This does not allow for medical examination for any other purpose than emergency treatment.

8.6.5 A Child Assessment Order may allow for a medical examination to be carried out without the consent of a parent; however, the child’s or young person’s consent would still be required by the examining medical practitioner.

8.6.6 To avoid unnecessary re-interviewing at the examination of any child/young person, the investigators should tell the examining medical doctor as much about the circumstances of the case as possible. Whilst the medical examiner is required to discuss certain elements with the child/young person it may avoid unnecessary additional discomfort.

8.6.7 If the child/young person refuses to give permission, the medical examination cannot go ahead. However, the examining doctor may submit notes based upon any observation of obvious injury, behaviour and so on.

8.6.8 Physical signs or symptoms may be inconclusive when viewed in isolation, but can provide a clearer picture of abuse or neglect when seen in conjunction with other information. A psychiatric or psychological examination can highlight emotional or behavioural signs of abuse and/or
symptoms of mental distress or illness. In all cases during the investigation stage, staff in all agencies working with children and young people and families must be alert to behaviours that indicate possible abuse. There may be a need for close liaison with child and adolescent mental health services during the investigation. Professionals should also give consideration to issues of self-harm and suicide.


8.6.10 The doctor should routinely record the results of the medical examination in the child’s/young person’s health records, and should provide a short report of the medical examination for the Child Protection investigation. A standard format is available for recording and reporting the health assessment / examination. Information gathered from the examination will be taken back to a strategy discussion to inform the planning of further action.

8.6.11 Any medical examination under these Child Protection Procedures must ensure that the family is treated with dignity at all times. The following points are considered as best practice and will be complied with, unless prevailing circumstances dictate otherwise.

- If the child or young person expresses a preference for a male or female doctor, all organisations must make sure that, whenever possible, the examination is carried out by a doctor of that gender;
- If the child or young person asks for a particular person to go with them to the examination, this should be considered;
- The doctor will discuss with the child/young person and parent the medical results of the examination where appropriate.
9. **Parents and Carers**

9.1 Parents will normally be involved at the earliest stage; however, these Procedures acknowledge that there may be circumstances when it is not in the best interests of the child or young person for this to occur. The decision will be made at a strategy discussion and the reasons recorded as set out in Step 6 of the Stepwise Guide at [Chapter 6](#).

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

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

9.4 Every effort will be made to uphold the rights of parents, irrespective of their co-operation. In some instances it may be helpful for parents to have the support of an advocate.

9.5 At the conclusion of a child protection investigation parents and carers should be advised of the outcome and the future actions agreed. The 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. a recording with contact details). Leaflets for parents are available from the following weblink: [http://www.safershetland.com/for-parents-and-carers](http://www.safershetland.com/for-parents-and-carers) (under the heading “What happens if someone has reported a concern about my child?”)
### Chapter 10. Child Protection Case Conferences

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10.1 Introduction

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

10.1.1 Child Protection Case Conferences (CPCCs) are convened by Shetland Islands Children’s Services – Children and Families Social Work as a delegated function of the Child Protection Committee. The Conference Chair is accountable to the Chief Social Work Officer.

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

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

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

- ensuring that all relevant information held by the Named Person and each service or agency has been shared and analysed on an inter-agency basis;
- assessing the degree of existing and likely future risk to the child or young person;
- considering the views of the child or young person;
- considering the views of parents or carers;
- identifying the child’s/young person’s needs and how these can be met by services and agencies;
- developing and reviewing the Child Protection Plan;
- identifying a Lead Professional;
- deciding whether to place or retain a child’s/young person’s name on the Child Protection Register; and
- considering whether there might be a need for Compulsory Measures of Supervision and whether a referral should be made to the Children’s Reporter if this has not already been done.
10.2 Organising and Chairing Case Conferences

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

10.2.2 The decision to hold a case conference is based on an assessment of risk and a judgement that a child or young person is at risk of significant harm. Following a child protection investigation, the decision to go to conference would usually be made on an inter-agency basis at the debrief strategy meeting. Where there has been an accumulation of concerns leading to an assessment of risk of significant harm, the Team Leader of Children and Families Social Work can decide to hold a conference. Wherever possible it would be appropriate to discuss this with the Inter-agency Screening Group to seek the views of other agencies and to ensure relevant and up to date information about the child/young person and the family is informing the decision.

10.2.3 Case Conferences will be chaired by the Independent Reviewing Officer (IRO). If the IRO is not available the Lead Officer for Adult and Child Protection or the Executive Manager Children Resources or any other trained individual who is of Team Leader grade or above who does not have line management responsibility for the case. Please see 10.11 below for further information about the role of the Chair.

10.2.4 The Seniors or Team Leader in Children and Families Social Work are responsible for ensuring that the administrative arrangements are made – this includes a suitable venue, minute takers, chair and invitations to relevant participants in consultation with the child’s/young person’s social worker and the conference chair. The child’s/young person’s social worker, acting as Lead Professional, should complete Form 4, Chapter 13 and pass to the Administrative Officer for action. It is important at this stage to identify any barriers to communication and participation and to make suitable arrangements to support parents, carers, children and young people to be able to participate fully: for example if the families’ first language is not English, then a translator needs to be made available.

10.2.5 The full participation of children, young people, parents and carers in child protection case conferences should be supported. This will involve planning times that will suit parents and speaking to children and young people and families about what support they may need in order to be able to fully participate.

10.2.6 Named People should be notified using the GIRFEC notification form when a Child Protection Case Conference is being held and also notified of the outcome: http://www.shetland.gov.uk/children_and_families/GIRFEC.asp, direct to form: http://www.shetland.gov.uk/children_and_families/documents/NotificationFormV11.docx
10.3 Timescales

10.3.1 When an initial child protection case conference is considered necessary then it will be convened within 10 days of taking the decision to hold the conference.

10.3.2 For the timing of the pre-birth conference please see 10.5 below.

10.3.3 Review case conferences should be planned well in advance and invitations issued at least 15 working days before the conference.

10.3.4 If a conference decides that a referral to the Reporter to consider the need for compulsory measures is appropriate then the Senior Social Worker or Team Leader should ensure the referral is made within 5 working days of the conference.

10.4 Initial Child Protection Case Conference

10.4.1 The purpose of an initial CPCC is to allow representatives from across services to share information about a child or young person for whom there are child protection concerns, jointly assess that information and the risk to the child/young person and determine whether there is a likelihood of significant harm through abuse or neglect that needs to be addressed through a multi-agency Child Protection Plan. The initial CPCC should also consider whether the child/young person is safe to remain at home or if a referral to the Children’s Reporter is required.

10.4.2 The initial CPCC should be held within 10 working days from the decision being taken that a conference is necessary. During school holidays the Quality Improvement Officer (Schools Service) should be contacted to ensure that initial child protection case conferences have access to information held by schools.

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

10.5 Pre-birth Child Protection Case Conference

10.5.1 The purpose of a pre-birth CPCC is to decide whether serious professional concerns exist about the likelihood of harm through abuse or neglect of an unborn child when they are born. The participants need to prepare an inter-agency plan in advance of the child’s birth.
10.5.2 They will also need to consider actions that may be required at birth, including:
- whether it is safe for the child to go home at birth
- whether there is a need to apply for a Child Protection Order at birth
- whether supervised access is required between the parents and the child and who will provide this if needed
- whether the child’s name should be placed on the Child Protection Register. Where an unborn child is felt to require a Child Protection Plan, their name should be placed on the Register
- whether there should be a discharge meeting from the maternity ward and a handover to community based supports.

10.5.3 The pre-birth CPCC should take place no later than at 28 weeks pregnancy or, in the case of late notification of pregnancy, as soon as possible from the concern being raised but always within 21 calendar days of the concern being raised. There may be exceptions to this where the pregnancy is in the very early stages. However, concerns may still be sufficient to warrant an inter-agency assessment.

10.5.4 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.

10.5.5 The need for an initial pre-birth case conference should be considered:
- where previous children or young people have been removed because of significant harm;
- when 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.

10.5.6 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.
10.6 Review Child Protection Case Conferences

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

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

10.7 Transfer Case Conference

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

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

10.7.3 The child's/young person’s name should be temporarily registered pending the “transfer-in” conference. Where a child/young person is on the register of another authority, great caution should be exercised and rarely would it be appropriate to decline to register in Shetland until all the available information and current circumstances have been carefully assessed.

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

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

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

10.8.1 When a Child's Plan incorporates a Child Protection Plan this should set out in detail:
- the perceived risks and needs;
- what is required to reduce these risks and meet those needs; and
- who is expected to take any tasks forward including parents/carers and the child or young person themselves.
- plans should be specific, measureable, achievable, realistic and time bound (and transparent).

10.8.2 Children and young people and their families need to clearly understand what is being done to support them and why.

10.8.3 In addition, Child Protection Plans need to clearly identify:
- the agreed outcomes for the child or young person using the Barnardos Outcome Framework and the GIRFEC Child Plan
- key people involved and their responsibilities, including the Lead Professional (who will be a social worker for children whose names are placed on child protection register) and named practitioners
- timescales
- supports and resources required (in particular, access to specialist assistance)
- the longer term needs of the child and young person
- the process of monitoring and review
- any contingency plans.

10.8.4 Responsibility is shared for the Child Protection Plan. Each person involved should be clearly identified, and their role and responsibilities set out. To preserve continuity for the child/young person and their parents and carers, arrangements should be made to cover the absence through sickness or holidays of key people. All Child Protection Plans where there are current risks should have specific cover arrangements built in to make sure that work continues to protect the child. Plans should also clearly identify whether there might be a need for Compulsory Measures of Supervision. As part of this continuity, children and young people who are on the Child Protection Register should not be excluded from school unless there is a multi-agency discussion to identify risk factors and strategies to address these. Head teachers are expected to discuss with the Lead Professional and Quality Improvement Officer Schools Service for their school if they are considering excluding a child whose name is currently placed on Shetland’s Child Protection Register.

10.8.5 Participants should receive a copy of the agreed Child Protection Plan along with the minutes of the child protection case conference within five working days of the CPCC. It is recognised that a full comprehensive risk assessment may not be achievable within the timescales of the initial CPCC or the first core group. Therefore, it should be recognised that the early Child Protection Plan may need to be provisional until a fuller assessment can be undertaken.
10.8.6 Under the GIRFEC Guidance the Named Person should receive a copy of the Childs Plan once it is finalised. The Lead Professional for the child/young person has the responsibility to share this with the Named Person.

10.9 Core Groups

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

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

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

10.9.4 The core groups will be chaired by a Senior Social Worker or Team Leader from the Children and Families Social Work Team. If the Core Group identifies that there needs to be an earlier Review Child Protection Case Conference to make significant changes to the protection plan due to changes in the child’s circumstances or level of risk, the Core Group Chair is responsible for organising a Review Case conference within 15 working days.
10.10 Decision to either Place a Child’s Name on the Register or to Remove a Child’s Name from the Register

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

10.10.2 Review and Transfer Case Conferences need to consider if registration needs to be continued or not. A child’s or young person’s name should only be removed from the register when risks have reduced to such an extent that the child’s/young person’s name would not now be placed on the register. Where a child or young person remains at home, care must be taken not to de-register before there is confidence that the reduction of risk is significant enough to protect the child or young person and likely to be permanent.

10.10.3 Following the decision to remove a child’s or young person’s name from the register the child/young person and family may benefit from further support and guidance. A revised Child’s Plan co-ordinated by a Lead Professional, who may or may not be a Social Worker, should then be put in place.

10.11 Role of the Chair

10.11.1 The Chairs role is to:
- in consultation with the Senior Social Worker or Team Leader agree who to invite, who cannot be invited and who should be excluded.
- check that any special arrangements to support the attendance and participation of parents, carers, children and young people have been put in place
- ensure that all persons invited to the CPCC understand its purpose, functions and the relevance of their particular contribution
- meet with parents/carers immediately prior to the conference and explain the nature of the meeting and possible outcomes
- facilitate information-sharing and analysis
- ensure that the parents/carers and child’s or young person’s views are taken into account
- facilitate decision-making
- determine the final decision in cases where there is disagreement
- wherever possible, chair review CPCCs to maintain a level of consistency
- where a child’s or young person’s name is placed on the Register, outline decisions that will help shape the initial Child Protection Plan (to be developed at the first core group meeting)
- identify the Lead Professional (if not already appointed)
- advise parents/carers about local dispute resolution processes
facilitate the identification of risk, needs and protective factors and how strengths can be build on to improve the child’s/young person’s situation
facilitate the identification of a core group of staff responsible for implementing and monitoring the Child Protection Plan
agree review dates
challenge any delays in action being taken by staff or agencies
ensure that timescales are adhered to, including review dates, distribution of minutes and copies of the Child Protection Plan and changes to plans
ensure that any member of staff forming part of the core group who was not present at the case conference is informed immediately about the outcome of the case conference and the decisions made, and that a copy of the Child Protection Plan is sent to them.
ensure that the Named Person receives a notification about the outcome of the conference and a copy of any updated Child’s Plan

10.11.2 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 re-convened on another day. 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.

10.11.3 Decisions about how to restrict information need to be made by the Chair. Restricted access information is information that, by its nature, cannot be shared freely with the child/young person, parents or carers and anyone supporting them. The information will be shared with the other participants at the CPCC. Such information may not be shared with any other person without the explicit permission of the provider.

10.11.4 Restricted information includes:
- Sub-judice information that forms part of legal proceedings and which could compromise those proceedings
- information from a third party that could identify them if shared
- information about an individual that may not be known to others, even close family members, such as medical history and intelligence reports
- information that, if shared, could place any person at risk, such as a home address or school which is unknown to an ex-partner.
10.11.5 Restricted information will normally be shared by agreeing a confidential section of at the beginning of the CPCC. People with whom restricted information cannot be shared – and this includes parents, carers and children and young people – will be excluded from the confidential section of the meeting.

10.11.6 All participants at a CPCC with significant involvement with the child/young person and family have a responsibility to contribute to the decision as to whether or not to place the child’s/young person’s name on the Child Protection Register. Where there is no clear consensus in the discussion, the Chair will use his or her professional judgement to make the final decision, based on an analysis of the issues raised. In these circumstances, the IRO will refer the decision to the Chief Social Work Officer for independent scrutiny. The Chief Social Work Officer can request support from the Lead Officer for Adult and Child Protection if that is appropriate.

10.11.7 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/young person or where bail conditions preclude contact.

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

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

10.11.10 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 or young person’s interests, it is important to encourage and facilitate the expression of the parent(s)’ views, in writing, by a recording to be played at the conference, or by a representative.
10.12 CPC Case Conference Complaints/Comment and Appeals

10.12.1 Dispute resolution is a way of managing:
- challenges about the inter-agency process
- challenges about the decision-making and outcomes
- challenges by children and young people or their parents and carers about the CPCC decisions
- complaints about practitioner behaviour.

10.12.2 Pending the completion of the dispute resolution process all protective actions should continue, the child's/young person’s name should be added to the Child Protection Register and the Child Protection Plan developed as required.

10.12.3 All of the agencies and services involved in child protection work have clear complaints procedures, which should be followed where there is a complaint about an individual practitioner from that agency.

- **Agency representatives** – where a member of staff wishes to raise an issue about the process or disagrees with a CPCC decisions, they should go through their normal line management processes.
- **Parents and carers** – Please see the complaints process at Appendix 5 of these procedures
- **Child** – children and young people should be supported by the Lead Professional to challenge a decision. The Children’s Rights Officer (see [http://www.safershetland.com/for-children-and-young-people](http://www.safershetland.com/for-children-and-young-people)) can be contacted to assist a child or young person to raise a complaint about any aspect of the child protection process and Lead Professionals should assist the child/young person in doing this.

10.12.4 Please see Appendix 5 for more details about an appeals process that can be used by parents and carers if they are unhappy either where they feel that the criteria in child protection procedures has not been met or the process was sufficiently unfair as to invalidate the outcome.
10.13 Reports to Child Protection Case Conferences

10.13.1 The Lead Professional (Social Worker in Child Protection cases) will provide a written report to the conference using the Getting it Right for Every Child assessment and analysis proforma (http://www.shetland.gov.uk/children_and_families/GIRFEC.asp).

10.13.2 For an initial or pre-birth child protection case conference a draft child’s plan should be prepared and for a review conference the current plan should also be made available.

10.13.3 All other agencies are expected to bring a written report

   • For schools, midwives, health visitors and school nurse and any other agencies, please use Form 6 in Chapter 13
   • For GP’s please use Form 5 in Chapter 13

10.13.4 For initial conferences all reports should be shared with the Chair 24 hours before the conference. For review conferences reports should be shared 3 working days before the conference.

10.13.5 It is very important that parents, children and young people have time to read and understand the reports. Professionals should meet with families to share reports at least 24 hours before the conference.

10.14 Participation

Communication with parents, carers, children and young people is key to good participation. Therefore it should be established as soon as possible if anyone requires assistance with this: for example, ensuring the availability of an interpreter if the families’ first language is not English, using a room with a hearing loop, an accessible room or having available someone who can use sign language.

Parents and Carers

10.14.1 Parents, carers or others with parental responsibilities should be invited to the CPCC. They need clear information about practitioner’s concerns if they are to change behaviour which puts the child or young person at risk.

10.14.2 In exceptional circumstances, the Chair may determine that a parent/carer should not be invited to or be excluded from attending the CPCC (for example, where bail conditions preclude contact or there are concerns that they present a significant risk to others attending, including the child or young person). The reason for such a decision needs to be clearly documented. The parent’s views should still be obtained and shared at the meeting and the chair should identify who will notify them of the outcome and the timescale for carrying this out. This should be recorded in the minutes.
10.14.3 The Chair should encourage the parent or carer to express their views, while bearing in mind that they may have negative feelings regarding practitioners’ intervention in their family. The Chair should make certain that parents and carers are informed in advance about how information and discussion will be presented and managed. Parents and carers may need to bring someone to support them when they attend a CPCC. This may be a friend or another family member, at the discretion of the Chair, or an advocacy worker. This person is there solely to support the parent or carer and has no other role within the CPCC.


10.14.5 Reports for conferences should be shared at least 24 hours before a conference with parents and carers.

Children and Young People

10.14.6 Consideration should be given to inviting children and young people to CPCCs. CPCCs can be uncomfortable for children and young people to attend and the child or young person’s age and the emotional impact of attending a meeting must be considered. A decision not to invite the child or young person should be verbally communicated to them, unless there are reasons not to do so. Children and young people attending should be prepared beforehand so that they can participate in a meaningful way, and thought should be given to making the meeting as child- and family-friendly as possible.

10.14.7 Consideration should also be given to the use of an advocate for the child or young person. The Shetland Children’s Rights Service can assist young people in attending conferences and helping them to express their views and the Lead Professional should support a child or young person in making contact with the service. It is crucial that the child’s or young person’s views are obtained, presented, considered and recorded during the meeting, regardless of whether or not they are present. Where the child/young person has additional support needs consideration should be given to whether they will need support to express their views. Where appropriate and agreed the child or young person should be part of the core group.

10.14.8 Reasons for agreeing that older children and young people should or should not attend a CPCC or core group meeting should be noted, along with details of the factors that led to the decision. This should be recorded in the minutes.
10.14.9 The Lead Professional’s report to the Child Protection Case Conference should always contain the child or young person’s views. Even very young children are able to communicate through their behaviour how they are feeling, where and with whom they feel safe.

10.14.10 Shetland Child Protection Committee have developed information for young people and also a format that should be used for a child or young person to express their views directly to the conference even if they are not present: http://www.safershetland.com/for-children-and-young-people

Hard copies of this leaflet are kept by Children and Families Social Work

Agency Representatives

10.14.11 CPCC participants need to include:
- Social Worker from the Children and families Social Work Team;
- education staff where any of the children and young people in the family are of school age or attending pre-five establishments;
- NHS staff, health visitor/school nurse/GP as appropriate, depending on the child’s/young person’s age, and the children’s paediatrician where applicable; and
- police where there has been involvement with the child/young person and/or parents/carers.

10.14.12 Other participants might include other health practitioners (including mental health services), adult services, housing staff, addiction services, educational psychologists, relevant third sector organisations, representatives of the Procurator Fiscal. Following Protocol 2 in Section 3 of these procedures the Children’s Reporter can be asked to attend a child protection case conference in certain circumstances.

10.14.13 There may be occasions when it is appropriate to invite foster carers, home carers, childminders, volunteers or others working with the child/young person or family to the CPCC. The practitioner most closely involved with the person to be invited should brief him or her carefully beforehand. This should include providing information about the purpose of the CPCC and their contribution, the need to keep information shared confidential and advice about the primacy of the child’s/young person’s interests over that of the parents/carers where these conflict.

10.14.14 Participants attending are there to represent their agency/service and share information to ensure that risks can be identified and addressed. They have a responsibility to share information and clarify other information shared as necessary.
10.15 Risk Assessment

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

10.15.2 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/young person’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/young person’s needs;
- The nature of the child’s/young person’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/young person psychologically and emotionally of the experience of abuse or neglect.

10.15.3 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? Identifying strengths – can they be built on?
- What are the financial resources and physical environment available to the family?
- Can the family be an acceptable and safe place for the child/young person?

10.15.4 Assessment should include consideration of any risk to the child’s siblings or other children and young people in the household. The safety and welfare of other children and young people need to be specifically considered at the initial child protection case conference even if they were not the subject of the original investigation.

10.15.5 Using the National Risk Assessment Framework may be very appropriate and helpful in conducting a comprehensive risk assessment: [http://www.gov.scot/Publications/2012/11/7143/0](http://www.gov.scot/Publications/2012/11/7143/0)
11. **Legal Action**

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

11.1 **General**

11.1.1 Legal action is only appropriate when it is not possible to protect a child by working with the family on a voluntary basis. If a family will not work voluntarily with the 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.

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

These orders are:-

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

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

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

11.2.1 A Child Protection Order ("CPO") is an order authorising the removal of a child from the persons with parental rights to a place of safety or to prevent the removal of the child from a place of safety. Such an order can be sought when the child is at **immediate** risk of **significant** harm. Whilst any person 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.

11.2.2 In the event that some other person than the local authority requires to seek a CPO the application should be in Form 48 which follows in Chapter 13 below. If you are a local authority employee you need a slightly different form which is available from the Council’s Legal Section or from the Scottish Courts website. The applicant should contact the Sheriff Clerk on 01595 693914 to arrange for a Sheriff to hear the application. When the Sheriff is
out with Shetland either a video-conference will be arranged by the Sheriff Clerk or an Honorary Sheriff will be contacted. The applicant will need to persuade the Sheriff that the child is at immediate risk of significant harm and that the order is necessary.

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

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

11.2.5 More detailed instructions are contained in Appendix 4.

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

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

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

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

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

11.3.4 Any application for a Child Assessment Order would be sought by the Council’s legal officers on instructions from the social work department.
11.4 Exclusion Order (S.76 of the Children (Scotland) Act 1995)

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

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

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

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

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

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

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

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

11.5.3 If the child has been removed by the police following authorisation by the Chief Inspector, Shetland command, but without the involvement of the 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 Form 48 Application for a Child Protection Order, Form 50 Arrangements to Keep You Safe and Form 51 Notice of a Child Protection Order to a named person can be found in Chapter 13 below.
12. Child Protection Register – Administration

12.1 General

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

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

12.2 Section 1: Child Details

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

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

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

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

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

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

12.2.7 The Register is then updated. Immediately on updating the Register, the procedure set out in the Protocol for use of Shetland’s Child Protection Register in the Accident and Emergency Department at the Gilbert Bain Hospital should be followed (see Protocol 3 in Section 3 of these Procedures).
12.2.8 The case file (one for each child or young person whose name is placed on the Register) must be identified with a removable sticker placed on the outside of the file. When a child’s/young person’s name is placed on the register the 'hazards' tab on the SWIFT system is completed so that a red alert will appear when the file is accessed.

12.2.9 In the event of an enquiry being received by the Children and Families Social Work team regarding a child’s or young person’s registration status, information should only be shared on a need to know basis. This information would not be available to the public. The registration document must be consulted and a record made that the enquiry has taken place.

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

12.2.11 When notification is received that a child or young person whose name is on the Register in another authority is in Shetland, a Section 1 form (see 12.2.1 above) must be completed by Duty social work on the day of notification, with as many details as can be obtained; the child’s/young person’s name should be temporarily registered and a case conference convened in accordance with Chapter 10 if the child/young person is moving permanently to Shetland.

12.2.12 In some cases, children and young people whose names are on the Child Protection Register of another local authority may be temporarily resident in Shetland. Details of the child or young person should be noted as above and any temporary monitoring arrangements requested by the originating local authority complied with. It would usually not be necessary to hold a transfer in conference in such circumstances, however the Team Leader may decide a conference is necessary if a child/young person is staying in Shetland for some months.

12.3 Section 2: Closed Child Details

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

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

12.3.3 All sections of the form must be completed wherever possible.
12.3.4 In the case of Review Child Protection Case Conferences, the minute taker should prepare a Section 2 Closed registration form for the chair to sign at the end of the conference in the event of de-registration. If the child/young person is de-registered, the form must be checked and signed by the chair on the same day as the case conference decision, and placed in the Child Protection Register. If the child/young person remains on the register the form is to be shredded and deleted from the system immediately after the conference, and the procedure at 12.2.5 above should be followed.

12.3.5 The Register is then updated. Immediately on updating the Register, the procedure set out in the Protocol for use of Shetland’s Child Protection Register in the Accident and Emergency Department at the Gilbert Bain Hospital is to be followed (see Protocol 3 in Section 3 of these Procedures).

12.3.6 The identification sticker on the case file must be removed. The status of the ‘hazard’ on the SWIFT system is changed to indicate that the child/young person has been previously registered.

12.3.7 In the event of an enquiry, this section of the Register must be consulted. Information should only be shared on a need to know basis. The information would not be available to the public. The registration document must be consulted and a record made that the enquiry has taken place.

12.4 Section 3: Children Reported as Missing

Please see Protocol 7 in Section 3 of these Procedures.
13. Forms

INDEX OF FORMS AND LEAFLETS:

Referrals:

Form 1: NHS Shetland Referral to Social Work

Form 2: SIC and other agencies (non-NHS) Referral to Social Work

Form 3: Record Of Action Taken On Referral, Including Record Of Strategy Meetings (for Social Work)

Form 4: Arranging Child Protection Case Conference (for Social Work)

Reports to Child Protection Case Conferences:


Form 5: NHS Shetland GPs’ Reports to Child Protection Case Conference

Form 6: Other Agencies’ Reports to Case Conferences

(See Appendix 3 for Guidance re writing Reports to Case Conferences)

Legal Forms:

Form 48: Application for Child Protection Order non Local Authority

Form 50: Notice of Child Protection Order to a child

Form 51: Notice of Child Protection Order to a named person

Links to leaflets
NHS Shetland
Child Protection

Referral to social work service
Please also send a copy of this form, when completed, to the Advanced Nurse Practitioner (Protection)

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: ....................

Back to: Index of Forms
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
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  
Referral to social work service  
CONFIDENTIAL

To: Executive Manager, Children 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.
### Record of Action Taken – Child Protection Referral

**Form 3**

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

#### Category of Concern (tick as appropriate)
- Domestic abuse
- Parental alcohol misuse
- Parental drug misuse
- Non-engaging family
- Parental mental health problems
- Children placing themselves at risk
- Sexual abuse
- Child exploitation
- Physical Abuse
- Emotional Abuse
- Neglect
- Other concern(s)

#### Name of Child:

#### Home Address:

#### Date of Birth:

#### Gender:

#### Address of Current Placement:

#### Date of Incident:

#### Type of Current Placement:

#### Details of Referral

#### Family Composition

<table>
<thead>
<tr>
<th>Name</th>
<th>Dob/Age</th>
<th>Relationship to Child</th>
<th>Employment/School/other</th>
<th>Residence if different</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Back to: Index of Forms
<table>
<thead>
<tr>
<th>Checks</th>
<th>Date</th>
<th>Known/Not Known</th>
</tr>
</thead>
<tbody>
<tr>
<td>CP Register</td>
<td></td>
<td></td>
</tr>
<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>
</tr>
<tr>
<td>Psychological Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GIRFEC Project Manager</td>
<td></td>
<td></td>
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<tr>
<td>Criminal Justice Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous Local Authority</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other relevant agency (specify, e.g. Youth Services, Voluntary services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Named Person</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a current Lead Professional/Child’s Plan in place?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has child been seen?</td>
<td></td>
<td>By Whom?</td>
</tr>
</tbody>
</table>

Consultation with Designated Manager for Child Protection

Decision (NFA, Proceed to Strategy Meeting, Other)

Follow up Information

Initial Strategy Discussion
<table>
<thead>
<tr>
<th>Date:</th>
<th>Time:</th>
<th>Chair:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Attenders:  

Agency:  

Role:  

Form 3  
August 2015
### Minute of Strategy Discussion

<table>
<thead>
<tr>
<th>DECISIONS</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Need for immediate action to protect child?</strong></td>
<td><strong>Refer to Reporter at this stage?</strong></td>
<td></td>
</tr>
<tr>
<td>(Y/N)</td>
<td>(Y/N)</td>
<td></td>
</tr>
<tr>
<td><strong>If Yes, what:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Proceed to investigation?</strong></td>
<td><strong>Parents to be involved at this point?</strong></td>
<td></td>
</tr>
<tr>
<td>(YN)</td>
<td>(Y/N)</td>
<td></td>
</tr>
<tr>
<td><strong>If not, why not:</strong></td>
<td><strong>If not, why not?</strong></td>
<td></td>
</tr>
</tbody>
</table>

- **Social Worker**
- **Police Officer**

### INVESTIGATION (Details of Investigation)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
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</tbody>
</table>
AGREED FOLLOW UP ACTIONS:

How will information be fed back to:

Family?
Child?
Referrer?

<table>
<thead>
<tr>
<th>Name</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
<td>Signature</td>
</tr>
<tr>
<td>Designation (TL/EM)</td>
<td>Designation (TL/EM)</td>
</tr>
<tr>
<td>Date</td>
<td>Date</td>
</tr>
</tbody>
</table>
CHILD PROTECTION CASE CONFERENCE

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

Name of Child:  
D.O.B.:  
Address:  

Preferred Date and Time of Conference:  
Venue:  

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>
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<tr>
<td>Fostering and Adoption</td>
<td></td>
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<tr>
<td>Health -GP</td>
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<tr>
<td>Health – Health Visitor</td>
<td></td>
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<tr>
<td>Health - Midwife</td>
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<tr>
<td>Schools: Head Teacher</td>
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<td></td>
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<tr>
<td>Schools: Pupil Support</td>
<td></td>
<td></td>
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<tr>
<td>Schools: ASN</td>
<td></td>
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<tr>
<td>Educational Psychology</td>
<td></td>
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</tr>
<tr>
<td>Police</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporter</td>
<td></td>
<td></td>
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<tr>
<td>Named Person/Lead Professional</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child</td>
<td></td>
<td></td>
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<tr>
<td>Youth Work</td>
<td></td>
<td></td>
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<tr>
<td>Bridges</td>
<td></td>
<td></td>
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<tr>
<td>Third 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>
<td></td>
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<tr>
<td>CADSS</td>
<td></td>
<td></td>
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<tr>
<td>Other as appropriate)</td>
<td></td>
<td></td>
</tr>
<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:  

Back to: Index of Forms
For Social Workers’ Reports to Child Protection Case Conferences, please see the following GIRFEC link:

NHS Shetland GP Report to Child Protection Case Conference

Please email completed form to Social Work at
childrens.services@shetland.gsx.gov.uk

<table>
<thead>
<tr>
<th>Name of child</th>
<th>Date of Birth</th>
<th>Conference date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>I will / will not be attending the Conference</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I have / have not attempted to share this report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>With ..........................................................</td>
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<td></td>
<td></td>
<td>On .........................................................</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Family Structure</th>
<th>Name</th>
<th>DOB</th>
<th>Relationship</th>
<th>Address</th>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Frequency of Contact** - include opinion whether family makes appropriate use of GP services

<p>| Date and Nature of most recent Contact | |
|----------------------------------------||
|                                        |</p>
<table>
<thead>
<tr>
<th>Nature of other Noteworthy Contacts</th>
<th>e.g. Childhood illnesses, family members significant illnesses, accidents or injuries, referrals to other services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observations about Child’s General Health and Development:</td>
<td>milestones, immunisations etc., where possible</td>
</tr>
<tr>
<td>Observations of Parental Health:</td>
<td>including parent-child relationship, parent illness/disability, substance misuse, domestic violence etc</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date Completed</th>
<th>Signature</th>
<th>Practice Stamp</th>
</tr>
</thead>
</table>
Reports for both Initial and Review Case Conferences

For use by schools, midwives, health visitors and school nurse and any other agencies (GPs see Form 5 above). See guidance for completion in Appendix 3 below.

Please email completed form via secure link to Social Work at: childrens.services@shetland.gsx.gov.uk

1. **Report for Initial/Review 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**

<table>
<thead>
<tr>
<th>Name</th>
<th>D.o.b</th>
<th>Relationship to child</th>
<th>Address</th>
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<tbody>
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</table>

3. **Cause for concern including:** (for Review reports, give an update on any significant events since the last report)

   (a) **any precipitating incident**

   (b) **any previous concerns**
4. **Relevant Family History/Chronology (for Review reports, give an update on family circumstances)**

(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 in Appendix 3 below). 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 in Appendix 3 below).
[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/continuing registration

7. **Parents’ views of your report**

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

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

   **Date:** .................................................................
Application to Sheriff at
for a Child Protection Order under section 57(1) of the Children (Scotland) Act 1995

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

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

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

Part 2. Information about the application and orders sought

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

OTHER APPLICATIONS AND ORDERS WHICH AFFECT THE CHILD
[insert details of any other applications or orders made which affect or are relevant to the child who is the subject of this application]
SUPPORTING EVIDENCE
The following supporting evidence is produced - [list reports, statements, affidavits or other evidence produced]

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

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

*TERMS AND CONDITIONS TO BE ATTACHED TO ORDER
In terms of section 57(4) the applicant seeks an order to [insert details of the order sought].

*DIRECTIONS IN RELATION TO THE EXERCISE OR FULFILMENT OF PARENTAL RESPONSIBILITIES OR PARENTAL RIGHTS
In terms of section 58(4) or (5) the applicant seeks the following direction(s) - [insert details of the direction(s) sought].

*ANY OTHER ORDER(S)
[Insert here details and grounds for any order sought in relation (a) to non-disclosure of address or whereabouts of child; or (b) service of restricted documents on child.]

Part 4. Details of first order sought from the sheriff

The applicant requests the sheriff to:

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

*b. Order the applicant to forthwith serve a copy of the Child Protection Order [and a copy of the application] on,
   i. the child, together with a notice in form 50* or orders service of the following documents only [insert details of documents to be served on child, e.g. notice in form 50 only]; and
   ii. the persons listed in Part 1. of this application, together with a notice in form 51.

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

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

SIGNED ........................................ DATE............................
[name, designation and address telephone, DX and fax numbers]
Notice of Child Protection Order to a child in terms of section 37 of the Children’s Hearings (Scotland) Act 2011

ARRANGEMENTS TO KEEP YOU SAFE

Court ref. no.:

Dear [insert name by which child is known]

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

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

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

Any change must be requested without delay

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

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

In the meantime you must do what the order says.

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

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

SIGNED ........................................... DATE....................
Notice of Child Protection Order to a named person under section 37 of the Children’s Hearings (Scotland) Act 2011

Rule 3.32(b) Court ref. no.:

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

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

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

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

**SIGNED **........................................... DATE.................

**WHAT YOU SHOULD DO**

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

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

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

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

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

Link to GIRFEC leaflets: http://www.shetland.gov.uk/children_and_families/GIRFEC.asp
SECTION TWO – APPENDICIES:

Appendix 1
- Part 1: Further Guidance
- Part 2: Working with children, young people 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

Appendix 5
- Appeals process
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 National Guidance 2014. 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 (telephone 01595 744435). It is important not to delay taking appropriate action to safeguard a child about whom you are worried.

2. Indicators of Risk

When making judgements about the risks and needs of a child, there are a range of indicators that should trigger assessment and, where appropriate, action. In the sections below, indicators of potential risk are considered separately, but they will often occur together, particularly for children in vulnerable circumstances.
For Links to Local and National Information on the following Indicators of Risk, Click on each Indicator below:

- Domestic Abuse
- Children and Young People Affected by Parental Substance Misuse
- Children and Young People with a Disability or Additional Support Needs or whose Parents have Learning Disabilities or Additional Support Needs
- Non Engaging Families
- Children and Young People experiencing mental health problems or affected by a parent with mental health problems including self-harm or suicidal behaviour
- Children And Young People Who Display Harmful Or Problematic Sexual Behaviour
- Female Genital Mutilation
- Honour based Violence and Forced Marriage
- Fabricated or Induced Illness
- Sudden Unexpected Death in Infants and Children
- Organised or Multiple Abuse
- Historical Allegations of Abuse
- Child Sexual Exploitation
- Child Trafficking
- Children and Young People Looked After Away from Home
- Online And Mobile Phone Safety
- Children And Young People Who Place Themselves At Risk
- Children and Young People who are Missing
- Under-age Sexual Activity
- Bullying
- Lesbian, Gay, Bi-sexual and Transgender Young People
- Managing Disclosure Of Abuse

See also the More Detailed Paragraphs below:

- Paragraph 3 – Domestic Abuse
- Paragraph 4 – Children and Young People Affected by Parental Mental Health Problems
- Paragraph 5 – Children Living with Parents who have a Learning Disability
- Paragraph 6 – Bullying
- Paragraph 7 – Self Harm or Suicidal Behaviour
- Paragraph 8 – Lesbian, Gay, Bi-Sexual and Transgender Young People
- Paragraph 9 – Listening to a Disclosure of Abuse
- Paragraph 10 – Asking Questions
- Paragraph 11 – After a Disclosure of Abuse
- Paragraph 12 – Further Help
Domestic Abuse

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Local Information for Professionals on domestic abuse:

- www.safeshetland.com/for-professional - which has links to Shetland Domestic Abuse Partnership

- Paragraph 3 below of Part 1 of Appendix 1 for further links and more detailed information.

- No local inter-agency protocol. NHS Shetland staff have guidance about gender based violence.

National Information for Professionals:


Children Affected by Parental Substance Misuse

Local Information for Professionals:

- Shetland CPC Protocol 4

- Getting It Right For Every Child (GIRFEC)

  Local guidance on GIRFEC procedures and process in Shetland, with links to forms, leaflets for professionals, parents and carers, Scottish Govt leaflets, self-evaluation tools, information sharing, etc.: www.shetland.gov.uk/children_and_families/GIRFEC.asp

National Information for Professionals:


- Children and Young People (Scotland) Act 2014 – GIRFEC Q&A guides for practitioners on the following aspects of GIRFEC: general questions, wellbeing, Named Person, Child’s Plan, information sharing, independent education, Lead Professional and for parents and families: www.gov.scot/Topics/People/Young-People/gettingitright/publications/practitioners-q-and-a

- Children and Young People (Scotland) Act 2014 www.legislation.gov.uk/asp/2014/8/contents/enacted contains provisions which, when fully in place by the end of 2015, will introduce a legal duty on a range of public bodies to share information which is likely to be relevant to their function, with a child’s Named Person.


Children with a disability or additional support needs or whose parents have learning disabilities or additional support needs

Local Information for Professionals:

- **Chapter 7 of Section 1** above of these Shetland inter-agency Child Protection Procedures (2015)

**National Information for Professionals:**

- A disabled child is defined as a child in need under section 93(4) of the Children (Scotland) Act 1995: [www.legislation.gov.uk/ukpga/1995/36/contents](#)
- Triangle [www.triangle.org.uk/](#) is an independent organisation that works directly with children and their families but also offers training and consultancy to practitioners and agencies.
- Capability Scotland [www.capability-scotland.org.uk/](#) is a third sector agency providing education, employment opportunities and support for disabled people.

Non-engaging families

Local Information for Professionals:

- **Shetland CPC Protocol 8** – in Section 3 below of these Shetland inter-agency Child Protection Procedures (2015)

**National Information for Professionals:**

- Scottish Government [National Child Protection Guidance 2014](#): page 121
Children and Young People experiencing mental health problems or affected by a parent with mental health problems including self-harm or suicidal behaviour

Local Information for Professionals re Working with Children:

- Paragraphs 4 and 5 below of Part 1 of Appendix 1 of these Shetland inter-agency Child Protection Procedures (2015)
- Protocol 10 (Children and Young People who self-harm) – in Protocol section of these Shetland inter-agency Child Protection Procedures (2015)

National Information for Professionals re Working with Children:

- The SCIE Report, Think child, think parent, think family www.scie.org.uk/publications/guides/guide30/index.asp identifies the need for a multi-agency approach with senior level commitment and includes recommendations for practice in relation to assessment, care planning/provision and review at practitioner, organisational and strategic level. The guidance covers England and Wales, but is valuable for practitioners working in Scotland.
- www.seemescotland.org/ – Scotland’s national campaign to end stigma and discrimination associated with mental ill health
- The COMPASS mental health team http://www.nhsggc.org.uk/your-health/health-services/compass/ is dedicated to asylum seekers and refugees.
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National Information for Professionals re Working with Parents:


- [www.seemescotland.org/] – Scotland’s national campaign to end stigma and discrimination associated with mental ill health

- The National Patient Safety Agency Rapid Response Report on Preventing Harm to Children from Parents with Mental Health Needs makes a number of recommendations for practice. NHS Boards in Scotland have been asked to consider and review their local arrangements in light of these recommendations: [http://www.nrls.npsa.nhs.uk/alerts/?entryid45=59898]

Children who display harmful or problematic sexual behaviour

Local Information for Professionals:

- [Chapter 7 of Section 1] above of these inter-agency Child Protection Procedures (2015)


National Information for professionals:


- [www.cycj.org.uk/]: the [Centre for Youth and Criminal Justice] supports improvement in youth justice and aims to strengthen the creation, sharing and use of knowledge and expertise, including national practice guidance (June 2015): [www.cycj.org.uk/resource/youth-justice-in-scotland-guide/]


Female Genital Mutilation

Local Information for Professionals:

Female Genital Mutilation is illegal in Scotland. Any concerns that child or young person is likely has been or is likely to be subject to female genital mutilation should be referred to the Duty Social Worker or the police as an immediate child protection concern. This may include situations where arrangements have been made for children to be taken abroad.

National Information for Professionals:

- Page 129 of the Scottish Government National Child Protection Guidance 2014. See also page 143 re child trafficking and page 131 re forced marriage

- Scottish Government information, including Prohibition of Female Genital Mutilation (Scotland) Act 2005, explanatory notes and factsheets in English and other languages: www.gov.scot/Topics/People/Equality/violence-women/MinorityEthnicIssuesPages/FemaleGenitalMutilation


- FORWARD (Foundation for Women's Health Research and Development, women's campaign and support organisation): http://www.forwarduk.org.uk/key-issues/fgm/


- List of UK hospitals and clinics offering specialist female genital mutilation services: www.forwarduk.org.uk/what-we-do/resources/ – click on blue button: “GET HELP AND ADVICE HERE”

- Unicef information: www.unicef.org/protection/

- NSPCC free 24 hour helpline: tel 0808 800 5000 (free to mobiles)
Honour based Violence and Forced Marriage

Local Information for Professionals:

Forced marriage is illegal in Scotland. Any concerns that child or young person is being forced into a marriage (whether legal or not) or subject to honour based violence should be referred to the Duty Social Worker or the police as an immediate child protection concern.

National Information for Professionals:


- http://www.gov.scot/Topics/Justice/law/forced-marriage – Forced Marriage Scotland, links to support organisations, such as: www.shaktiedinburgh.co.uk and free Forced Marriage Helpline on 0800 027 1234, with trained advisors 24 hours a day.

- https://www.gov.uk/forced-marriage#forced-marriage-unit – Foreign & Commonwealth Office and Home Office Forced Marriage Unit, with Information and practice guidelines for professionals protecting, advising and supporting victims, including leaflets.

Fabricated or Induced Illness

Local Information for Professionals:

Any concerns that a parent may be fabricating or inducing illness in a child or young person should be referred to the Duty Social Worker as an immediate child protection concern.

National Information for Professionals:

- Fabricated or Induced Illness by Carers – a Practical Guide for Paediatricians: http://www.rcpch.ac.uk/list-practice-statements - Royal College of Paediatrics and Child Health (click on ‘F’ for ‘Fabricated Illness’)

Sudden Unexpected Death in Infants and Children

National Information for Professionals:

- Sudden Unexpected Death in Infants Scottish Government Toolkit for professionals – www.sudiscotland.org.uk/
- HealthCare Improvement Scotland’s programme of work: www.healthcareimprovementscotland.org/
Organised or Multiple Abuse

Local Information for Professionals:
- Chapter 7 of Section 1 below of these Shetland inter-agency Child Protection Procedures (2015)
- See also Child Sexual Exploitation and Child Trafficking on the following pages of this section of these Shetland inter-agency Child Protection procedures.

National Information for Professionals:
- Page 139 (complex child abuse investigations) of the Scottish Government National Child Protection Guidance 2014. See also page 143 (Child Trafficking).
- The Office of the Children’s Commissioner two year Inquiry into Child Sexual Exploitation in Gangs and Groups (CSEG): http://www.childrenscommissioner.gov.uk/publications
  http://www.childrenscommissioner.gov.uk/sites/default/files/publications/If%20only%20someone%20had%20listened%20CYP.pdf

Historical allegations of abuse

Local Information for Professionals:
- Chapter 7 of Section 1 below of these Shetland inter-agency Child Protection Procedures (2015)

National Information for Professionals:
- Survivor Scotland is a Scottish Government-run website for victims of childhood sexual abuse: http://www.survivorscotland.org.uk/
The sexual exploitation of children and young people is often hidden. In practice, it might involve children and young people being coerced, manipulated, forced or deceived into performing and/or others performing on them, sexual activities in exchange for receiving some form of material goods or other things, such as food, accommodation, drugs, alcohol, cigarettes, gifts, affection. Sexual exploitation can occur through the use of technology and without the child’s immediate recognition. Victims rarely directly disclose abuse, not recognising that they have been exploited and may believe they are in an ‘adult relationship’ with their abuser, due to the sophisticated grooming processes involved. 

Local Information for Professionals:
- Chapter 7 of Section 1 of the Shetland inter-agency Child Protection Procedures (2015). Any concerns that a child may have been sexually exploited should be referred to the Duty Social Worker as an immediate child protection referral.
- Protocol 9 (Safe Internet Use) – in Section 3 of these Child Protection Procedures (2015)
- Protocol 11 (Vulnerable Young People) – in Section 3 of these Child Protection Procedures

National Information for Professionals:
- Pages 145-9 of the Scottish Government National Child Protection Guidance 2014. See also page 109 (supporting child witnesses) and page 153 (online and mobile safety)
- Barnardo’s leaflet for professionals on how to spot the signs of Child Sexual Exploitation: www.barnardos.org.uk/spot_the_signs_professionals.pdf
- Further information from WithScotland and Barnardo’s: http://withscotland.org/resources/search?utf8=%E2%9C%93&query=Child+sexual+exploitation&document_type= www.barnardos.org.uk/what_we_do/policy_research_unit/research_and_publications/sexual_exploitation_research_resources.htm
Child Trafficking

Child trafficking typically exposes children to continuous and severe risk of significant harm. It involves the recruitment, transportation, transfer, harbouring and/or receipt of a child for the purposes of exploitation. This definition holds whether or not there has been any coercion or deception, as children are not considered capable of informed consent to such activity. It applies to activity within a country as well as between countries. The UN Palermo Protocol (2006) broadens the scope of a child to under 18 years.

Local Information for Professionals:

- Chapter 7 of Section 1 of the Shetland inter-agency Child Protection Procedures. Any concerns that a child may have been trafficked should be referred to the Duty Social Worker as an immediate child protection referral or the police contacted.

National Information for Professionals:

- Page 143 of the Scottish Government National Child Protection Guidance 2014. See also page 109 (supporting child witnesses) and page 131 (Honour-based violence and forced marriage)


- Scottish Government Child Trafficking Forms for use alongside Shetland inter-agency Child Protection Procedures:


- NSPCC free helpline for those with concerns, including human trafficking: 0808 800 5000 (free for mobile calls, also)

- The Scottish Guardianship Service provides support to trafficked children who are also seeking asylum: http://www.aberlour.org.uk/how_we_help/services/248_scottish_guardianship_service
List of Contents Indicators of Risk

Children and Young People Looked After away from home

Local Information for Professionals:

- Chapter 7 of Section 1 of the Shetland inter-agency Child Protection Procedures (2015) regarding allegations of abuse against carers

National Information for Professionals:

- Managing Allegations Against Foster Carers and Approved Kinship Carers – How Agencies Should Respond: http://www.gov.scot/Publications/2013/05/7759 
- The Scottish Refugee Council offers advice and support on issues facing separated children: http://www.scottishrefugeecouncil.org.uk/
- The Scottish Guardianship Service offers advice and support on issues to separated children who fall under immigration restrictions (from outside the EU): http://www.aberlour.org.uk/how_we_help/services/248_scottish_guardianship_service

Online and mobile phone safety

Local Information for Professionals:

- Protocol 9 in Section 3 below of these inter-agency Child Protection Procedures (2015)

National Information for Professionals:

- Child Exploitation and Online Protection Centre – https://www.ceop.police.uk/Ceop-Report/ – to make a report. For information and resources, ‘ThinkuKnow’ is CEOP’s education programme: https://www.thinkuknow.co.uk/Teachers/Thinkuknow-FAQ/Advice--Guidance/
- Where a child comes across potentially illegal content online, a report can be submitted to the Internet Watch Foundation: https://www.iwf.org.uk/
- WithScotland’s Keeping Children and Young People Safe Online: Balancing Risk and Opportunity: http://withscotland.org/exchanging-withscotland-briefings - scroll down to ‘K’ and right-click on green ‘download’ button to open pdf document
- Respectme: http://www.respectme.org.uk/ supports schools, authorities and communities to prevent and tackle bullying, including cyber-bullying
Children and Young People who place themselves at risk

Local Information for Professionals:

- Chapter 7 of Section 1 above of Shetland inter-agency Child Protection Procedures (2015)
- Protocol 11 (Vulnerable Young People) in Section 3 below of Shetland inter-agency Child Protection Procedures (2015)
- See also, the earlier paragraphs in this section on: children and young people displaying harmful or problematic sexual behaviour and children and young people with mental health problems, including self harming and Child Sexual Exploitation and the following paragraph on children and young people missing
- Protocol 6 (Working with Young People who display Sexually Harmful Behaviour) in Section 3 below of Shetland inter-agency Child Protection Procedures (2015)

National Information for Professionals:

- Page 155 of the Scottish Government National Child Protection Guidance 2014. See also pages 156 (missing children) and 127 (harmful/problematic sexual behaviour)

Children and Young People who are missing

Local Information for Professionals:

- Protocol 7 in Section 3 below of Shetland inter-agency Child Protection Procedures (2015)
- Protocol 8 in Section 3 below of Shetland inter-agency Child Protection Procedures (2015)

National Information for Professionals:

- Page 156 of the Scottish Government National Child Protection Guidance 2014. See also page 155 (children and young people who place themselves at risk)
- Still Running II – Findings from the Second National Survey (England – The Children’s Society)
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Under-age Sexual Activity

Local Information for Professionals:

- Protocol 1 in Section 1 above of Shetland inter-agency Child Protection Procedures (2015)

National Information for Professionals:

- Page 159 of the Scottish Government National Child Protection Guidance 2014. See also page 155 (children and young people who place themselves at risk)


Bullying

Local Information for Professionals:

- Paragraph 6 below of Part 1 of Appendix 1 of these Shetland inter-agency Child Protection Procedures (2015)

- Protocol 9 (Safe Use of Internet) in Section 1 above of Shetland inter-agency Child Protection Procedures (2015)

National Information for Professionals:


- Respectme: www.respectme.org.uk/ supports schools, authorities and communities to prevent and tackle bullying, including cyber-bullying
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- ChildLine provides help and support for children and young people: 
  www.childline.org.uk/Pages/Home.aspx and for professionals: 

- Parentline, a national, confidential helpline providing advice and support to anyone caring for or concerned about a child or young person: 
  www.children1st.org.uk/parentline

- Cyberbullying – Safe to Learn: Embedding anti-bullying work in schools: 
  www.schools-out.org.uk/policy/docs/DCSF_Homophobic_Bullying/Summary_Safe_to_Learn.pdf

Lesbian, Gay, Bi-sexual and Transgender Young People

Local Information for Professionals:

- Paragraph 8 below of Part 1 of Appendix 1 of these Shetland inter-agency Child Protection Procedures (2015)

- See also information on previous page regarding bullying

National Information for Professionals:

- See pages 25 and 162 (paragraph 633) of the Scottish Government National Child Protection Guidance 2014 re Equality and Diversity

Managing Disclosure of Abuse

Local Information for Professionals:

- Paragraphs 9, 10, 11 and 12 below of Part 1 of Appendix 1 of these Shetland inter-agency Child Protection Procedures (2015)
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.
List of Contents Indicators of Risk

For more information, see the following:-

- **Local information for professionals on domestic abuse:**
  http://www.safershetland.com/for-professional

  **National Information for professionals on domestic abuse:**

  - See page 113 (paragraph 451) of the Scottish Government National Child Protection Guidance 2014


  - The Criminal Justice and Licensing (Scotland) Act 2010, provides for a statutory offence of ‘stalking’ specially criminalising stalking. Conduct which might be described as harassment or stalking can be prosecuted under Scots law as a breach http://www.legislation.gov.uk/asp/2010/13/section/38
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 Please see Protocol 10 in Section 3 below of these Procedures – Supporting children and young people who Self-harm

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 identity 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?”
List of Contents Indicators of Risk

- 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 Chapter 6. (The numbers to ring are at the front of these procedures). The police can also be contacted where their immediate assistance is required.
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 6 Step 7). The police have access to interpretation facilities. Although telephone interpreting is available by contacting the Language Line, 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. Child and Family Health Services

1.1 Midwives

Midwives have a significant role in identifying the risk factors to the unborn child during pregnancy, birth and the post-natal period in hospital and the community. They should be alert to risk factors for the mother and infant including, but not limited to, problematic alcohol and/or drug use, domestic abuse and mental health problems such as post-natal depression. Midwifery and public health nursing services should work collaboratively in addressing the needs of the pregnant woman, unborn child and family as appropriate. In Shetland the midwife is the Named Person for a child for the ten days following birth.

All midwives should consider the needs of the unborn baby, including whether there could be child protection risks after the birth. In Shetland when a pregnant woman is identified as vulnerable she is placed on the Vulnerable Pregnancy pathway. This pathway ensures all vulnerable pregnant women, including those with drug-related problems, learning disabilities or mental health issues, receive appropriate antenatal care and support to maximise both their own and their baby’s health and well-being. It is good practice to regularly share information between all agencies.

1.2 Health Visitors

Health visitors play a pivotal role in the prevention and early identification of concerns about the wellbeing of a child, including more serious protection and care concerns. In Shetland after the post-natal care ends a Health Visitor will become the child’s Named Person until he/she starts full-time primary education. Health Visitors 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.
1.3 **School Nurses**

The school nurse has an important role in promoting the well-being of children and young people and can contribute to prevention and early detection of child abuse through a range of health promotion activities including working with teachers on personal, social and health education; monitoring the health of the school population and profiling the health of the school population so that services can be targeted where they are most needed. School nurses continue to monitor the development, health and well-being of all children and young people with 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, be involved to ensure health needs are fully identified and met.

1.4 **Children’s Nursing and Allied Health Professionals service**

Children with recognised long-term chronic health conditions are cared for in hospital and community by a Children’s Nurse and may be supported by Allied Health Professionals e.g. Physiotherapist, Occupational therapist. These practitioners undertake a multifaceted and complex role having significant input into a child’s care and may be the first professional to recognise a family experiencing difficulties looking after a child accessing appropriate support for them. In Shetland Children’s Nurses and Allied Health Professionals may also be the Lead Professional within the GIRFEC process.

1.5 **General Practitioners**

The role of the General Practitioner (GP) and the practice team in child protection will be critical in detecting potential concerns as they will often regularly engage with children and families. Their role includes prevention, early recognition and detection of concerns, assessments and ongoing care and treatment. Surgery consultations, home visits and treatment room sessions along with information from other health care professionals will all help to build a picture of the child or young person’s situation highlighting any areas of concern. Following GMC guidance GPs must promptly tell an appropriate agency if they are concerned that a child or young person is at risk of or is experiencing abuse or neglect. GPs can provide direct support to children, young people and their families and contribute to the Child’s Plan 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.
1.6 Child Protection Nurse Adviser

In Shetland there is a Child Protection Nurse Adviser. The Child Protection Nurse Adviser will:

- Provide advice and support on child protection to all healthcare staff as well as staff from partner agencies. Be involved in the design, planning and implementation of child protection policies and protocols which includes the work of the Child Protection Committee and relevant subgroups.

- Take a lead role in the planning and delivery of child protection training to all healthcare staff both single and multi-agency. Participate in inter-agency meetings where appropriate e.g. Child Protection Case Conferences, Weekly Screening Meeting.

1.7 Paediatricians

1.7.1 Paediatricians working in the hospital or community setting (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, neglect and a risk to well being and must therefore maintain their skills in this area making sure they are familiar with the procedures to be followed where abuse or neglect is suspected.

1.7.2 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.

1.8 Emergency Medical and Surgical Services

1.8.1 Children or young people with suspected abuse or neglect may be taken to the Accident & Emergency (A&E) department for immediate care or for an opinion about how an injury has been sustained. In addition, children in the care of the Gilbert Bain Hospital for any reason may cause concerns to be raised by staff in relation to potential neglect or abuse. 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.
1.8.2 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. The Named Person must also be informed. 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. If, after examination, healthcare staff suspect a child or young person attending the Gilbert Bain Hospital has experienced, or is at risk of abuse or neglect, they should:

- Provide any immediate medical care required
- Gather information from the child or young person’s medical records and the local child protection register by contacting the duty social worker
- Examine the child for evidence of injuries, remembering that these may be concealed under clothing
- Document carefully all clinical findings including skin condition, bruising, scars, weight and height.
- Information on whether a child is on the local child protection register is available through A&E, but should be only one piece of information to take into consideration in making a decision to refer under the child protection procedures.
- Follow local child protection procedures, ensuring concerns are raised immediately with social work services. It is good practice to ensure Consultant on call, line manager and Protection Nurse Advisor (when available), are involved in these discussions. A flowchart is available internally for A&E staff to follow in considering concerns about a child.

1.9 Scottish Ambulance Service

The Scottish Ambulance Service covers the whole of Scotland. It recognises its responsibility in the care and protection of children. Ambulance crews attend emergency and urgent calls across the whole country and will often be front line to identify children in ‘at risk’ situations. Ambulance staff have child protection as part of their training and ongoing education. There are defined reporting procedures in place for children identified as possibly being at risk.

1.10 NHS 24

NHS 24 is Scotland’s National Telehealth and Telecare Service. It provides access to clinical assessment, healthcare advice and information. It aims to give service users assistance and advice to meet their health needs, including onward referral as appropriate. 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 the information with partners from other agencies to ensure that services are alerted to the protection needs of the unborn baby, child or young person. NHS 24 must ensure all relevant clinical information is copied to other clinical staff involved in the care of the child or
young person (e.g. Protection Nurse Advisor, GP and Named Person). This is particularly relevant for child protection where parents or carers may seek health advice and treatment from many different health providers to avoid detection of neglect or abuse.

1.1 Community pharmacy services

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 parents with drug problems 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. This may include identification of child protection concerns, referring to appropriate agencies or responding to a social work request for information about a child or their family as part of an investigation or a child protection plan.

1.12 Mental Health Services

1.12.1 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.

1.12.2 Health Practitioners working with adults with mental health problems should always be aware of how those problems may 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 colleague’s in children’s services. 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. Services need to respond in a co-ordinated way with other services to any emerging problems.

1.13 Adult healthcare providers

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.
1.14 **Dental care practitioners**

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.

1.15 **Other health services**

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.

1.16 **Substance Misuse services**

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. In Shetland the Community Drug and Alcohol Support Service and the Substance Misuse Recovery Service provide services to people with substance misuse problems. For further information, see [Shetland CPC Protocol 4 Children Affected by Parental alcohol and drug misuse, in Section 3 of these Procedures](#).
2. **Schools Staff**

2.1 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.

2.2 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.

2.3 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.

2.4 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 (see [Protocol 7 Shetland Procedure re local and national Missing Child/Family Alert Procedure](#)).

2.5 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. In Shetland the Homelink service supports parents who choose to educate at home.
3. Early Years

3.1 As part of local authority education services, Early Learning and Child Care Centres and partner provider centres share the same responsibility as their colleagues on 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.

3.2 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 Inspectorate. 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.

4. Housing

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.
5. **Cultural and Leisure Services**

5.1 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 third sector 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 Protection in the Community Sub Group and have child protection procedures and training in place for staff.

6. **Scottish Children’s Reporter Administration**

6.1 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 co-operation with agencies, which all leads to an assessment of need for compulsory measures of supervision.

6.2 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.

6.3 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.
6.4 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.

6.5 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.

6.6 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.

7. **Procurator Fiscal Services**

7.1 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.
7.2 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.

7.3 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.

8. **Sports Organisations and Clubs**

8.1 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 involved 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.children1st.org.uk/what-we-do/our-services/search-our-services/safeguarding-in-sport/](http://www.children1st.org.uk/what-we-do/our-services/search-our-services/safeguarding-in-sport/).

8.2 In Shetland local sporting groups may be 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 separately. The child may be able to request access when they are older or 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.

Wherever possible share the contents of your report with Parents prior to the conference. If there is already a Child’s Plan in place for the child who is the subject of the Child Protection Case Conference and your role is that of Lead Professional, then rather than write information in the following format, it is more appropriate to share an existing GIRFEC assessment and plan that you have already written – although this may need to be updated with the information that has led to the decision to call a Child Protection case conference.
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 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 with completing the relevant forms for CPO applications to the Sheriff and should be read in conjunction with departmental child protection procedures.

1.6 Form 48 is the application form for a CPO for any person other than an employee of Shetland Islands Council. The paragraph numbers in these guidance notes refer to the paragraphs in Form 48. If you are a local authority employee you need a slightly different form which is available from the Council’s Legal Section or from the Scottish Courts website.

1.7 Form 50 is the notice to the child that a CPO has been obtained.
1.8 **Form 51** is the notice to the named person (parent, carer, etc.) that a CPO has been obtained.

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

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

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

**Para 1.1** N/A

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

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

- any parent enjoying parental responsibilities or rights. This includes the natural father who is not married to the mother but whose name appears on the birth certificate if the child is born after 4 May 2006;

- any person in whom parental responsibilities or rights have been vested; and

- any person who appears to be a person who ordinarily has charge of, or control over, the child (this excludes people caring for a child by reason of employment, but could for example be a step-parent).

N.B. Consideration will need to be given to absent parents; both divorced parents will usually retain parental responsibilities and rights. Before considering an application for a CPO it is likely that the possibility of the absent parent taking charge of the child will have been explored. If it is believed that the child cannot remain safely with either parent, then notice of the application will have to be served on both.
1.4 Insert name, address, telephone and fax numbers of any safeguarder appointed by a children's hearing or court in respect of the child.

1.5 N/A

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

Part 2 Information about the application and orders sought

Para

2.1 N/A

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

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

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

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

Para

3.1 Insert name of child subject to the application.

3.2 Delete those bullet points which do not apply.

3.3 Parents of children who are subject to Child Protection Orders retain all parental rights and responsibilities. This means that any medical examination, treatment or interview can only be carried out with a parent's permission. If such permission is unlikely to be forthcoming, and if it is considered essential that any such interview occur, then the parental rights to do so must be applied for at the time of the CPO application. Insert here details of the direction(s) sought.
Contact between child and parent(s) should normally be encouraged and facilitated. If restricted contact (e.g. supervised only) or no contact is considered necessary to protect the best interests of the child, a direction should be sought here, with reasons and supporting evidence entered at para 2.3

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

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

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

Part 4 Details of first order sought from the Sheriff

Para 4.1 Insert the child's name; if directions are not being sought as per paragraphs 3.3 and 3.4, then all after * should be deleted. However, it is likely that most applications will seek some directions at this stage.

4.2 The applicant is responsible for serving on both the child and the relevant person, a copy of the application, the CPO and the notice (form 50 for the child and form 51 for the relevant person). If it is felt that the child should receive only a copy of the notice, then delete at 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)
Appendix 5

CP Case Conference Appeals Process

Appeal against the Decision of a Child Protection Case Conference

Complaint about individual agency or staff member

Any complaints about individual agencies or staff members cannot be dealt with through this appeals process, but would be addressed by the relevant agencies’ complaints procedures.

Appeal against CP Case Conference decision

Grounds of appeal:
- The decision to place a child’s name on the Child Protection Register
- The decision to remove a child’s name from the Child Protection Register
- The provisions of the Child Protection Plan approved by the Child Protection Case Conference

Offer of Dispute Resolution meeting

Accepted

Appellant meets Chair of CP conference

Appeal resolved

Appeal upheld

Recommendation to hold CP case conference

Recommendations to agencies

Not Accepted

Appeal Unresolved

Re-run case conference or hold early review

Panel make final decision

Appeal not upheld

Recommendations to agencies

Referred to CPC Chair who appoints independent Appeal Panel
Process

1. Any Parent, Carer, Child or Young person who has either attended or been excluded from attending an Initial, Pre-Birth, Review or Transfer Child Protection Case Conference can use this process to challenge the decision of the child protection case conference.

2. The appeal process is in relation to decisions of the Child Protection Case conference. The decisions which can be appealed are therefore as follows:
   - The decision to place a child’s name on the Child Protection Register
   - The decision to remove a child’s name from the Child Protection Register
   - The provisions of the Child Protection Plan approved by the Child Protection Case Conference.

3. It is always important to address any concerns and seek to resolve them. They often provide good opportunities for agencies involved in child protection work to learn and improve. However this process must not detract from the need to focus on the safety of a child and any protection plans put in place to reduce risk will be adhered to whilst the appeal process is ongoing and until a Review Child Protection Case Conference makes a decision which changes the protection plan.

4. Child Protection Case Conferences are interagency meetings. If a parent, carer, child or young person has a concern about the information shared at the case conference by a particular person representing their agency or the professional conduct of a staff member then the agencies individual complaints procedure should be used to raise this. The Chair of the Child Protection Case Conference can provide advice on who to contact and how to go about making a complaint.

5. Child Protection Case Conferences can be stressful and upsetting for families and support and help to assist them to participate fully and understand why a case conference has been called and has reached a particular decision is the shared responsibility of the Team Leader in Children and Families Social Work, The Lead Professional and the Chair of the case conference. If following informal discussions the parent, carer, child or young person remains dissatisfied and wants to pursue an appeal, they should be referred to the Chair of the Case Conference for advice on this appeal process.

6. There are two grounds for appealing a decision to either place a child’s name on the child protection register or remove a child’s name:
   - The criteria for registration or de-registration have not been met. The criteria for registration are that the child is assessed as being or likely to be at risk of significant harm. The criteria for de-registration are that the child is no longer at risk of significant harm.
   - That the process was sufficiently unfair to invalidate the outcome. This may refer to, but is not limited to, the way in which the meeting was chaired, not following proper procedure as laid down in the Shetland Interagency Child Protection Procedures, the opportunities for parents, carers, children and young people to participate, the way in which the decision about registration was reached or the information shared at the conference that influenced the decision.
7. The grounds for appealing the Child Protection Plan are that the terms of the plan do not protect and promote the best interests of the child.

8. If possible the person making the appeal should write or e mail the Chair of the conference stating the decision they wish to appeal and the grounds for their appeal. If this is difficult then the Chair can have a preliminary meeting with the person making the appeal to clarify and record their reasons.

9. On the receipt of an appeal the Chair will offer to arrange a formal Dispute Resolution meeting. The appellant can refuse a Dispute Resolution meeting and proceed with an appeal to the Appeal Panel. People making an appeal can bring a supporter or an advocate to the Dispute Resolution meeting to assist them. The Chair will arrange for the minutes and reports considered at the case conference to be available at the Dispute Resolution meeting. The Dispute Resolution meeting should be minuted and copies of the minutes provided to everyone who attends, unless to do so may place the child or any other person at risk. This process should take place within 20 days of the Chair of the case conference being notified that an appeal has been made.

10. The outcome of the Dispute will be one of the following:
   - The matter is resolved and the appeal closed
   - There are grounds to uphold the appeal and a review Child Protection Case Conference should take place or some other agreement is reached with the appellant.
   - The appellant remains dissatisfied and seeks a formal appeal.

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

11. Following the meeting the Chair should write to the person making the appeal outlining the outcome of the Dispute Resolution meeting and any next steps.

12. In the event that there is to be a Review Child Protection Case Conference, in most cases it will be appropriate that the same person should chair the Review conference, but in some situations it may be helpful to have a different chair, particularly if the fairness of the original conference is in question. The Chief Social Work Officer will decide who should chair the Review Child Protection Case Conference and will have due regard to the view of the person who appealed when making this decision.

13. If there has been a change of circumstances identified at the time of the Dispute Resolution meeting, so that there is new or emerging information that indicates the level of risk to the child is changing and either a new initial case conference to consider increased risk or an early review to consider reducing risk is appropriate a case conference will be arranged in accordance with usual child protection procedures.
14. The Chair of Shetland Child Protection Committee will convene a three member Appeal Panel from members of CPC. The Panel will be chaired by the CPC Chair or their nominee. The Panel members should represent as far as possible the membership of CPC.

15. The Lead Officer for Adult and Child Protection will act as Clerk to the Appeal Panel unless they have already acted as the Chair at the disputed Child Protection Case Conference in which case another officer of the Council will take the Clerk’s role.

16. The appellant shall be invited to the Appeal Panel Hearing and shall be entitled to submit a short written statement in support of his or her appeal in advance of the meeting. The appellant shall be entitled to be heard by the Appeal Panel and may be accompanied by a friend or supporter at the discretion of the Appeal Panel.

17. The Chair of the disputed case conference shall be invited to the Appeal Panel Hearing and shall provide the minutes of the case conference and any Dispute Resolution meeting to the Appeal Panel. The Chair of the disputed case conference shall be entitled to submit a short written statement in explanation of his or her views in advance of the meeting and shall be entitled to be heard by the Appeal Panel.

18. The Chair of the Appeal Panel shall regulate the hearing as he or she thinks fit. The Appeal Panel may deal with the matter in the absence of the appellant or any other person.

19. The Appeal Panel can decide that either:
   - The decision of the disputed Case Conference is not upheld and further action is recommended to one of the partner agencies. The Appeal Panel can recommend that a Child Protection Case Conference is held to reconsider the decision made by the disputed case conference. The Appeal Panel cannot register or de-register a child.
   - The decision of the disputed Case Conference is upheld and no further action is required or recommendations for improvement are made to one of the partner agencies or the CPC.

20. The Clerk to the Appeal Panel shall arrange for the decision of the Panel and the reasons for that decision to be sent to the appellant in writing within 7 days of the date of the hearing.

SECTION THREE – PROTOCOLS:

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

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

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

1. Introduction

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

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

2. Circumstances when a Child Protection Referral MUST be made

2.1 A child protection 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 check-list 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 coerced/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 Chapter 11 on Legal Action).

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 patients’ personal information may be disclosed if it is in the public interest; and this would be if it is likely to protect individuals or society from risks of serious harm, such as serious communicable diseases or serious crime, to reduce the risk of death or serious harm to the patient or a third party. Consensual sexual activity between two teenagers is unlikely to be considered as a serious crime in this context.

10. Further guidance

Practitioners should also bear in mind that there may be opportunities to discuss concerns relating to under-age sexual activity on an informal, 'hypothetical' basis - whether for general advice on procedures and processes, or to ascertain whether information they hold should be shared on a wider basis. These types of discussion can help increase knowledge and skills base, and help promote the development of inter-agency relations and understanding. Such discussions may be within the practitioners own organisation; with local child protection advisors or with professional bodies such as the General Medical Council, Royal College of Nursing and medical defence organisations. The duty social worker may also be of assistance.
Protocol 2

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

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

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

The Executive Manager, Children 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’s Hearing (Scotland) Act 2011 http://www.legislation.gov.uk/asp/2011/1/contents
Children’s Hearing (Scotland) Act 2011

GROUNDS FOR REFERRAL

Meaning of “section 67 ground”

67. (1) In this Act “section 67 ground”, in relation to a child, means any of the grounds mentioned in subsection (2)

(2) The grounds are that –

(a) the child is likely to suffer unnecessarily, or the health or development of the child is likely to be seriously impaired, due to a lack of parental care,

(b) a schedule 1 offence has been committed in respect of the child

(c) the child has, or is likely to have, a close connection with a person who has committed a schedule 1 offence

(d) the child is, or is likely to become, a member of the same household as a child in respect of whom a schedule 1 offence has been committed

(e) the child is being, or is likely to be, exposed to persons whose conduct is (or has been) such that it is likely that –

(i) the child will be abused or harmed, or

(ii) the child’s health, safety or development will be seriously adversely affected

(f) the child has, or is likely to have, a close connection with a person who has carried out domestic abuse

(g) the child has, or is likely to have, a close connection with a person who has committed an offence under Part 1, 4 or 5 of the Sexual Offences (Scotland) Act 2009 (asp9)

(h) the child is being provided with accommodation by a local authority under section 25 of the 1995 Act and special measures are needed to support the child

(i) a permanence order is in force in respect of the child and special measures are needed to support the child

(j) the child has committed an offence

(k) the child has misused alcohol

(l) the child has misused a drug (whether or not a controlled drug)

(m) the child’s conduct has had, or is likely to have, a serious adverse effect on the health, safety or development of the child or another person

(n) the child is beyond the control of the relevant person

(o) the child has failed without reasonable excuse to attend regularly at school

(p) the child –

(i) is being, or is likely to be, subject to physical, emotional or other pressure to enter into a marriage or civil partnership, or

(ii) is, or is likely to become, a member of the same household as such a child

(3) For the purposes of paragraphs (c), (f) and (g) of subsection (2), a child is to be taken to have a close connection with a person if –

(a) the child is a member of the same household as the person, or

(b) the child is not a member of the same household as the person but the child has significant contact with the person.
Protocol 3

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

1. General Introduction

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

2. Purpose

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

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

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

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

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

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

Information to be Shared by the Council

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

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

Information to be Shared by NHS Shetland

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

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

Notification should also include any of the following relevant information:

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

4. How and When is the Information Shared?

Information to be Shared by the Council

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

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

The web access procedure will be configured such that the file passes directly between the Council network and the NHS network by means of a private fibre-
optic cable linking the two networks. The folder within each site will be maintained by their respective IT departments such that only the Keeper of the Register, the Keeper’s delegates, the Designated Officer and the Designated Officer’s delegates have access rights.

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

**Information to be Shared by NHS Shetland**

A&E Staff will advise Duty 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) .......................... 8.6.2010 (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
Protecting Children and Young people affected by adults with problem substance misuse

SECTION ONE
Introduction
All agencies in Shetland - those working with children and families and those providing services to adults - have a responsibility to care for and protect children and young people as laid out in the National Guidance for Child Protection in Scotland 2010

“All agencies, professional bodies and services that deliver adult and/or child services and work with children and their families have a responsibility to recognise and actively consider potential risks to a child, irrespective of whether the child is the main focus of their involvement. They are expected to identify and consider the child’s needs, share information and concerns with other agencies and work collaboratively with other services (as well as the child and their family) to improve outcomes for the child” (paragraph 119 national Guidance p 37).

Additionally the Scottish Government has provided guidance specifically focussed on the needs of children affected by adult substance misuse, “Getting our Priorities Right” (GOPR) was revised and reissued in 2013 (http://www.scotland.gov.uk/Publications/2013/04/23055). “Adults can recover from problematic alcohol or drug use while being effective parents and carers for children. However, where parental alcohol and/or drug use becomes a problem this can have significant and damaging consequences for any dependent children. This can result in risks to their wellbeing and impair an adult’s capacity to parent well. Where children are affected as a result, they are entitled to effective help, support and protection, within their own families wherever possible. Parents too will often need strong support from services to tackle and overcome their problems and help them to promote their child’s full potential.” (paragraph 2 GOPR p13 2013)

“Getting Our Priorities Right” makes it clear that early intervention through Getting It Right For Every Child (GIRFEC) should be used wherever possible to identify and support children and families with the aim of improving outcomes for children and managing risk so as to reduce the likelihood of child protection measures being required. GIRFEC is based on the wellbeing of children and the importance of every child being safe, healthy, active nurtured, achieving, respected, responsible and included (SHANARRI). The Scottish Government have recently passed the Children and Young People (Scotland) Act 2014 which places into legislation the framework for GIRFEC. It is expected that through 2015 and 2016 this Act will come into force. All staff, whether working with adults or children in Shetland, should be familiar with the
Shetland GIRFEC policy and procedures
http://www.shetland.gov.uk/children_and_families/GIRFEC.asp as this provides the foundation and framework for supporting children who are affected by parental substance misuse and who do not need a response under child protection procedures. Early intervention is about seeking consent to work cooperatively with families

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

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

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

Agencies must adhere to the following guiding principle:

**The welfare of the child is paramount and will always override the needs of the parents.**
SECTION TWO
Background Information

2.1 What is problematic substance misuse?
Problematic substance misuse is defined in different ways, but refers to situations where the physical, psychological, emotional, social and practical aspects of life and work are being interfered with due to the regular use of alcohol, legal or illegal drugs. This affects relationships and the ability to nurture and meet the needs of children. Adults may or may not recognise that their use of substances is affecting them and those close to them.

2.1.1 Drugs

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

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

Problem drug use can also include the misuse of over the counter drugs or prescribed medicines and increasingly the use of novel psychoactive substances also need to be considered. Drug use in pregnancy can lead to babies being born with neonatal abstinence syndrome.

2.1.2 Alcohol

Alcohol is by far the most popular substance in Shetland and Scotland. Sensible drinking guidelines for men and women are far lower than most people think. The recommended guideline is that women should not regularly drink more than 2-3 units per day and men should not regularly drink more than 3-4 units per day. Guidelines also recommend that everyone should have at least 2 alcohol free days per week, and should not binge drink (HM Government 2007, Scottish Government 2009).

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

- Hazardous/risky drinking refers to the consumption above a level that may cause harm in the future, but does not currently appear to be causing harm. This is typically taken to mean between 21 and 50 units a week for men and 14 and 35 units for women. Hazardous/risky drinking may also include ‘binge drinking’, commonly defined as excessive consumption of alcohol on any one occasion involving 8 units or more for men, and 6 units or more for women, even though they may not exceed weekly limits.
Harmful drinking is defined as a pattern of drinking that is currently causing evidence of damage to physical or mental health. Harmful drinking is usually taken to mean consumption at above 50 units per week for men and over 35 units for women.

A diagnosis of alcohol/drug dependence is made when three or more of the following criteria have been experienced or exhibited in the previous year. Relapse (or reinstatement of problem drinking or drug-taking after a period of abstinence) is also a common feature. The criteria included a strong desire to take the substance, difficulties in controlling its use, persisting in its use despite harmful consequences and a higher priority given to substance use than to other activities and obligations, increased tolerance to the substance and a physical withdrawal state.

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

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

2.2 What is the scale of the problem in Shetland?

In 2012/13 parental substance misuse was recorded as a concern contributing to the decision to place a child’s name on Shetland’s child protection register in 58% of conferences. In 2013/14 it was 65%. National figures for Scotland were 34% and 37% respectively. Agencies in Shetland do not have information about how many children and young people are affected by parental substance misuse who do not reach the child protection threshold. Certainly some children who have additional support needs are likely to have been affected pre-birth by maternal alcohol misuse (see section 2.3.1 below).

2.3 The Impact of parental substance misuse on children of different ages

(the following is adapted from “Getting our Priorities Right”)

2.3.1 Pre-conception and pregnancy

Guidance at these stages tends to highlight lower thresholds of adult problematic alcohol and/or drug use before services should consider interventions to protect children.
• Pre-conception and pregnancy are the earliest, and most critical, of these stages at which services can put in place effective interventions that will prevent long-term harm to children and families. For example, 'Improving Maternal and Infant Nutrition: A Framework for Action' states that “in addition to advice before pregnancy, during pregnancy women are advised to avoid alcohol completely.” Drug use, at these critical stages, would be considered problematic, for example, where any woman reported regular use (i.e. more than once a week).

• Women and their partners are often incentivised to improve their problematic drug and alcohol use when either trying to conceive or are about to become parents. Maternal alcohol and/or drug use can harm unborn babies in different ways at different times during pregnancy, increasing the risk of complications such as low birth weight, miscarriage, prematurity and stillbirth.

• Some babies are born dependent on alcohol and drugs and can develop withdrawal symptoms – known as Neonatal Abstinence Syndrome (NAS). Neonatal withdrawal symptoms vary in onset, duration and severity. Some babies can be very unwell for days or weeks and can require close observation and special medical and nursing care.

• NAS can also have an impact on attachment, parent-infant interactions, and the infant’s longer-term growth and development.

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

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

• Neglect can occur while the parent/carer is under the influence of substances, unaware of what is going on around him/her. Children may have their physical needs neglected; for example, they may be unfed or unwashed.
• Unhappiness, tension and irritability of parents under the influence of substances—coupled with a lack of commitment to parenting when preoccupied with substance use—may lead to poor parenting.

• Poor or inconsistent parenting may damage the attachment process between parent and child.

• Poor childcare, little stimulation or inconsistent and unpredictable parental behaviour may hinder the child’s cognitive and emotional development.

• Lack of contact with other children, when attendance at nursery is irregular or erratic, may compound other problems in social and emotional development. Emotional difficulties should be addressed early to avoid more serious mental health issues from developing.

• Children can become withdrawn and isolated and develop an inability to form relationships.

• The financial demands of problematic alcohol and/or drug use may mean that the child’s material environment is poor.

• They may be subjected to direct physical violence by parents, and learn inappropriate behaviour through witnessing domestic abuse.

• They may be exposed to other substance misusing adults who associate with their parents and this can include adults who are a risk to children— for example who may be seeking to sexually abuse children

2.3.4 Children of primary school age

At primary school age, children:

• may be at increased risk of injury, and show symptoms of extreme anxiety and fear of hostility;

• may develop poor self-esteem and blame themselves for their parents’ problems;

• may be harmed by parental neglect or disinterest, especially with regards to how well they do at school;

• may feel embarrassment and shame; and

• may take on too much responsibility for themselves, their parents and younger siblings.
2.3.5 Older children

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

- greater risk of injury by parents as a result of becoming out of their parents control;

- there is an increase of emotional disturbance and conduct disorders, including bullying.

- young people in families – where other family members misuse drugs and/or alcohol may develop early problems with drugs and alcohol themselves.

- If there are concerns about young people aged 16-18 then please see Protocol 11 below in these Procedures, regarding Vulnerable Young People.
SECTION THREE

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

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

Significant case reviews and child protection research indicates that parental substance misuse is linked to high risks for children – especially very young children. Children can be at risk of serious neglect, physical harm and emotional and psychological harm. The “toxic trio” of substance misuse, domestic abuse and mental health issues would raise concerns of high risk for children and young people. Risk of significant harm is not just linked to individual incidents, but an accumulation of incidents, a history of neglect and emotional abuse, a parent unwilling or unable to change can mean that the threshold of risk of significant harm is reached over a period of time. Good chronologies are essential in being able to record such incidents and concerns and allowing damaging patterns to be recognised.

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

Every child from birth to 18 has a named person who has specific role in being a point of contact for parents and children and any professional who may have a concern about a child. They will trigger additional help for a child or their family if required. Children, young people and families will have clear information about who is the child/young person’s named person. The named person will be accessible to the child, young person and parent/carer and will work to develop a trusting relationship with them, as someone they can talk to about any area affecting their child. The named person will remain associated with the child, even if additional help is offered.

The named person holds basic information about the child and family and has a basic chronology. If information is shared with the named person by any agency or professional that indicates a child’s wellbeing is being affected in some way then the named person can begin an assessment of the situation. A Lead Professional (who may or may not be the named person) will be indentified and they will then take a more active role in working closely with parents and children and any agencies or services who are assisting the family or who could assist the family to draw up a child’s plan. This plan is based on assessed need and is outcome focussed, for example, for a primary school aged child, the named person will be the Head Teacher/Depute Head Teacher in the school. If, acting on concerns shared about the child, the Head Teacher/Depute Head Teacher decides that the child requires additional support they will start an assessment and identify a Lead Professional. This – for example – could be the child’s class teacher who knows the child very well and has an existing relationship with the child’s parents. Further information is available at the following web link:

http://www.shetland.gov.uk/children_and_families/GIRFEC.asp

Who is the Named Person?

<table>
<thead>
<tr>
<th>Age of child or young person</th>
<th>Named Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre birth - 10 days</td>
<td>Midwife</td>
</tr>
<tr>
<td>10 days - Primary School entry to P1</td>
<td>Health Visitor</td>
</tr>
<tr>
<td>Primary School P1 - P7</td>
<td>Head teacher or designated other; this is likely to be a Depute Head teacher or Principal Teacher</td>
</tr>
<tr>
<td>Secondary School up to the age of 18</td>
<td>Head teacher or designated; Depute Head teacher, Pupil Support or Principle ASN Teacher</td>
</tr>
<tr>
<td>Young people aged 16-18 who are not in school</td>
<td>Duty Social worker can advise how to contact the named Person</td>
</tr>
</tbody>
</table>

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

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

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

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

If the process of assessment identifies that the adult has child care responsibilities then a routine check with the named person with the adult's consent to check on the welfare of the child is necessary. Additionally the Children and Families Duty Social Worker can inform a member of staff working with the adult if there is already a child's plan in place and who the lead professional is. Staff providing services to adults who have child care responsibilities should contact the named person for each child.

If the adult refuses consent for a member of staff to contact their child's named person, careful consideration will need to be given about what to do next. Adults may be fearful of being judged or that the named person may not respect confidentiality and this needs to be approached with care and sensitivity. If a refusal of consent means a possible risk for the child, then it may be necessary to proceed without consent. Further information about consent and confidentiality is contained in 3.6 below and Appendix 1.

Contact between the adult service worker and the named person may provide reassurance that the child is doing well and nothing further is required other than a watching brief by the named person, or sharing some information (with consent) about the parent’s problems may assist the named person in understanding why the child is behaving in certain ways or why their development is being affected, and allow information from other agencies to be linked. This may indicate that a GIRFEC assessment and plan may be required to assist the child and the adult services worker may find themselves supporting the adult they are working with to be part of that process.
If the process of assessment identifies child protection concerns then the inter-agency child protection procedures should be followed and a child protection referral made to the Children and Families Duty Social worker without delay. Please see paragraph 3.4 below (re Child Protection Referrals).

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

Living with a parent who has a substance misuse problem is unlikely not to pose psychological and emotional consequences for a child of any age and so this guidance would encourage staff working with adults to factor into their work a discussion about contacting the child’s named person and wherever possible this should happen.

3.3 Guidance for Staff working in Children’s Services

Staff working in universal services – police, dental services, primary care, midwifery, nursery, schools and youth work and also more specialist services such as physiotherapy, occupational therapy, additional support needs schools staff, short breaks, etc., may identify a concern about a child. Using the GIRFEC guidance this information should be shared with the Named Person (see above and web link to GIRFEC http://www.shetland.gov.uk/children_and_families/GIRFEC.asp). The information in section 3 above should also be used and the GIRFEC Flowchart (see link http://www.dumgal.gov.uk/CHttpHandler.ashx?id=14093&p=0).

3.4 Child Protection Referrals

A child protection referral should always be made if assessments of both a child and family situation or of an adult seeking help for a substance misuse problem indicates that there is a risk of significant harm to a child.

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

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

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

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

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

Preventative and protective factors
Some of the impacts on children and families described above can be counterbalanced by other factors. Children and young people need support in dealing with what are often confused feelings and emotions towards their parents and families. They need strategies to help them cope with the various consequences of their parent’s problematic alcohol and/or drug use. Resilience has been viewed as “normal development under difficult conditions”. Focusing on the positives and the strengths in a child’s life is likely to help improve outcomes by building the protective network around the child and the self-protective potentials within the child. At the same time, it is important to be alert to factors of adversity or vulnerability, which may potentially impact upon the child’s wellbeing and the interaction of these factors with any identified resilience and protective aspects. The second core component of the National Risk Framework to Support the Assessment of Children and Young People (http://www.gov.scot/Publications/2012/11/7143/0) builds upon the Resilience/Vulnerability Matrix within the GIRFEC Practice Model. A set of Matrix Related Indicators have been developed here to support practitioners explore the key concepts of adversity/protective factors and vulnerability/resilience.
3.6 Confidentiality, Consent and Data Sharing

All staff, whether working primarily with adults or children, have a duty to respect confidentiality, share information when necessary and in proportionate and appropriate ways and record and store data securely. There are already in place data sharing agreements that underpin the Shetland GIRFEC procedures and these also underpin this protocol. The GIRFEC information sharing document is available at

http://www.shetland.gov.uk/children_and_families/GIRFEC.asp

Consent is not required for child protection referrals where there are concerns about the risk of significant harm to child. Shetland Interagency Child Protection Procedures should be followed. The following link will take you to the current procedures.

http://www.safershetland.com/child-protection

References


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

Audit and Analysis of Significant Case Reviews Scottish Government 2012

Hidden Harm Advisory Council on the Misuse of Drugs 2003

Fetal Alcohol Spectrum Disorder Awareness Toolkit Scottish Government 2013
Appendix 1 GIRFEC Information Sharing policy

Please follow the web link to the information sharing policy


http://www.shetland.gov.uk/children_and_families/GIRFEC.asp
1. Introduction


1.2 When a child dies or is significantly harmed (please see the criteria listed below at 2.1 and 2.2), 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.

1.3 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.

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

2. Criteria for SCR

2.1 Criteria

*When a child dies and* the incident or accumulation of incidents (a case) gives rise to significant/serious concerns about professional and/or service involvement or lack of involvement, and *one or more of the following apply*:  
- Abuse or neglect is known or suspected to be a factor in the child’s death;  
- The child is on, or has been on, the Child Protection Register (CPR) or a sibling is or was on the CPR. This is regardless of whether or not abuse or neglect is known or suspected to be a factor in the child’s death unless it is absolutely clear to the Child Protection Committee that the child having been on the CPR has no bearing on the case;  
- The death is by suicide or accidental death;  
- The death is by alleged murder, culpable homicide, reckless conduct, or act of violence;  
- At the time of their death the child was looked after by, or was receiving aftercare or continuing care from, the local authority;
2.2 **Criteria**

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

2.3 Anyone requiring further information about significant case reviews please contact the Lead Officer for Child Protection (01595 744435) or follow the weblink below:

Protocol 6

Working with Children and Young People who display sexually harmful behaviour

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 (third sector 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 paragraph 7 below 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 it 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. Please also see Annex 2 regarding management of risk in schools.
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? (Chapter 6 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

Risk management plan + team (consider GIRFEC if appropriate)

Monthly meetings to review risk management plan

Child Protection process

Initial strategy discussion + plan for child protection investigation

Initial Child Protection Conference

Not Registered

Registered

Core group includes risk management group

Monthly meetings of protection plan + risk management plan and review CPCCfs (if de-reg’d, still possible risks to others, set up risk manag’t team

Protocol approved by CPC 10.12.08
Protocol 7

Shetland Multi Agency Procedure For National and Local Missing Children/Family Alerts

1. Introduction

The Shetland Multi Agency Working Group for Missing Children and Families was created at the request of the Shetland Child Protection Committee (item 11 CPC Business Plan 2008-09). The remit of the Working Group was to create a multi agency procedure with clear roles and responsibilities for handling national and local requests for information regarding children or families who are regarded as missing from a known address (referred to as ‘alerts’ in this document).

There are currently two national processes established in Scotland:

1) Children Missing in Education, ScotXed and
2) Missing Family Alert Protocol, Health Department

These processes appear to be robust and effective for information within the Schools service and NHS, for Scottish alerts.

There was however an outstanding requirement to clarify the process for requesting information when single agency searches fail, having clear roles, responsibilities and methods for passing on information to all partner public agencies in Shetland.

2. Purpose

To provide a clear process for public agencies in Shetland:

- to request searches from other Shetland agencies,
- inform agencies of outcomes, and,
- where necessary, initiate national searches,

on missing children and families alerts.

3. National alerts

Each agency in Shetland receives national alerts in different ways. National alerts are usually sent via agencies, e.g. NHS, Education, 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.
http://www.shetland.gov.uk/children_and_families/GIRFEC.asp
The sharing of some key personal identifiers, as laid out in Appendix 1, will fall under the ‘overriding justification’ as described in Section 5.4 of the Policy. The person responsible for taking the decision to proceed with this process will record the information required in the Policy as part of their Risk Assessment leading up to the initiation of this process:

7.2.1. Personal information must not be disclosed without the consent of the person concerned, unless there are statutory grounds or an overriding justification for so doing.

7.2.2. Each organisation will therefore appoint or identify a person or persons who has the authority and knowledge to take responsibility for such a decision. This authority will be available at all times, to enable emergency situations to be dealt with.
7.2.3. If information is disclosed without consent, then full details will be recorded about the information disclosed, the reasons why the decision to disclose was taken, the person who authorised the disclosure and the person(s) to whom it was disclosed. Individual procedures will specify the person(s) responsible for ensuring this happens.

7.2.4. Recipients of the information will be made aware that it has been disclosed without consent and will put agreed security procedures in place.

7.3. If a decision is made to share further information between separate agencies as part of this process, existing procedures should be used. The appropriate procedure will be determined by the outcome of the risk assessment and the circumstances of engagement.

Shetland has the following inter agency procedures in place:


Getting it Right for Every Child (GIRFEC) – http://www.shetland.gov.uk/children_and_families/GIRFEC.asp

With You For You (for over 16’s where GIRFEC is not appropriate) – http://www.shetland.gov.uk/community_care/with_you_for_you.asp

8. Records Management – Retention and Storage

8.1. Each party to this procedure is responsible for ensuring all personal information they hold in relation to missing children and linked persons is stored and destroyed in accordance with their own Data Protection and/or Retention and Destruction policy.

8.2. Shetland Islands Council is responsible for removing all information relating to this procedure held on the Social Care SWIFT system in accordance with their corporate Retention and Destruction policy.
9. Complaints and Breaches

9.1 All parties to this procedure are responsible for ensuring that their staff follow the procedure and adhere to it.

9.2 All parties to this procedure are individually responsible for ensuring that all supporting policies and procedures necessary to comply with this procedure are implemented within their own organisation.

9.3 Any breaches of this procedure must be brought with immediate attention to the Data Controller and missing children/families co-ordinator within the agency where the breach occurred.

9.4 Any person wishing to make a complaint regarding how their personal information has been handled in the carrying out of this procedure should do so through the complaints procedure of the agency that has caused concern.

10. Review of this procedure

10.1 This procedure was reviewed in 2015
Case Details
Please give the following details for the originator of this request.

Name: 
Designation: 
School: 
Telephone number: 
Email: 

Details of local investigations for all children in this case to be included in the search

<table>
<thead>
<tr>
<th>Local searches completed</th>
<th>Date carried out and by whom</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enquiries made with other children in the class</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enquiries made with other school staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enquiries made with other establishments where siblings are known to be or where siblings were enrolled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home contact attempted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– by phone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– by letter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– by visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact made with relatives/emergency contact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact made with parent’s last known employer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact made with other agencies:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Social Work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Housing Dept/Housing Agency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Voluntary Agencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Police</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Local Authority Details**

<table>
<thead>
<tr>
<th>Local Authority:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Shetland search co-ordinator:</td>
<td></td>
</tr>
<tr>
<td>Designation:</td>
<td></td>
</tr>
<tr>
<td>Telephone number:</td>
<td></td>
</tr>
<tr>
<td>Email address:</td>
<td></td>
</tr>
<tr>
<td>How many sets of child details are being sent with this referral?</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
</tbody>
</table>

**Please ensure you complete**
- a case details sheet
- a family sheet
- one or more child sheets

**Family Details**

<table>
<thead>
<tr>
<th>Family surname:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Last known address:</td>
<td></td>
</tr>
<tr>
<td>Other names the family has been known by:</td>
<td></td>
</tr>
<tr>
<td>Mother’s first and maiden name (if known)</td>
<td></td>
</tr>
<tr>
<td>Father’s name:</td>
<td></td>
</tr>
<tr>
<td>Is either parent in the military?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Is anyone in this family an asylum seeker?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Is anyone in this family a refugee?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Other known family whereabouts and telephone numbers:</td>
<td></td>
</tr>
<tr>
<td>Emergency contact and telephone number:</td>
<td></td>
</tr>
</tbody>
</table>

**Any other background information**

Please include in this section any other background information about why this case has been referred and/or any other relevant details e.g. medical issues, confidentiality etc.

|  |  |
Appendix 3

Missing Children/Family Co-ordinators
Named Agency Contacts

NHS Shetland:
Public Health Administration –
   Email  kimgovier@nhs.net
   Telephone  01595 743340

SIC Schools Service:
Management Information Systems Assistants –
   Email  Gail.Burgess@shetland.gov.uk
           Anna.Hutcheon@shetland.gov.uk
   Telephone  01595 744000

SIC Social Care Children and Families Team:
Fieldwork Assistants –
   Email  childrens.services@shetland.gsx.gov.uk
   Telephone  01595 744470/744421

SIC Housing Service:–
   Email  Shirley.Mills@shetland.gov.uk
           Ian.Bray@shetland.gov.uk
   Telephone  01595 744360
1. **Introduction**

1.1 **Definitions**

1.1.1 Unseen children and non-engaging families can be issues that come together – the family that does not want to engage with professional staff and so prevents access to the child. However there are situations where parents or carers will allow a child to be seen, but refuse to engage in any meaningful work. A child may be compromised in being able to build helping relationships with practitioners if they know that they do not have parental support and approval. A parent may allow access to the child, but refuse to engage in work that will assist them – so, for example, not keeping appointments with the mental health worker who is trying to assist the adult.

1.1.2 Following initial information gathering in respect of an unseen child or non-engaging family, it may be established that the family are actually missing. In this case [Shetland Multi Agency Procedure](#) for National and Local Missing Children/Family Alerts (Protocol 7) should be followed.

1.1.3 Pregnant women who disengage with maternity services – particularly if there are concerns for their welfare or the welfare or safety of their unborn baby – will require rapid follow up to re-establish contact wherever possible. NHS Scotland “Guidance for Health Professionals Responding to Missing Families and Unborn Babies for whom there are concerns” should be followed and if necessary child protection referrals made.

1.2 **Unseen Children**

1.2.1 **What do we mean by an Unseen child?**

A child who is not seen by one of the practitioners (from universal, specialist, third sector etc. agencies) involved with the child's family, even when an appointment has been made to see the child either at home, school or in a medical centre. Sometimes access to the family home may be gained and other members of the household are seen. More concerning would be a situation where the parents refuse to say where the child is.

1.2.2 A child does not have to be named on the Child Protection Register in order for this procedure to apply. This procedure applies in the case of any child who should be seen by one practitioner or another, but who it seems is, effectively, being kept hidden from view.
1.2.3 Not all agencies with responsibilities for child welfare will visit a child at home, but for those who do it is good practice to include both planned and unplanned home visits in their contact with families; observe the child and his/her interaction with the parents, and gather information about daily routines and sleeping arrangements for the child.

1.2.4 For children who repeatedly fail to attend medical and dental appointments, NHS Shetland have a local Protocol for the Management of Non-responders and Non-attendees for Health Service Appointments which should be used by Health staff in Shetland.

1.3 **Purpose of this Protocol**

1.3.1 The purpose of this multi-agency protocol is to ensure that all practitioners know what to do in situations where a child is “unseen” or in situations where families are not engaging with services. Whenever a pattern begins to emerge in which a child is not being seen, concern should be heightened and action taken to ensure that the child is seen.

1.3.2 This protocol applies equally in cases where a practitioner’s focus of work is with an adult in the household and when it is known, or believed, that there are children also in the home. Practitioners working with adults may not be required to assess the child's circumstances for the purposes of their work, but if they form a view that any child in the house is deliberately being kept out of their view, they need to act on this concern.

1.3.3 This protocol applies to any situation where practitioners are offering services to children and families.

For the absence of any doubt this protocol applies to
- children accessing universal services – Health visiting, Dental Services, Schools, etc., who start to be missed
- Children for whom there is a Child’s Plan (in Shetland commonly referred to as a GIRFEC plan) with a Lead Professional coordinating the Child’s Plan. This also covers children whose names are on the Child Protection Register and whose Child’s Plan is also a protection plan and children who are Looked After.

1.3.4 In general the process for gaining access to children is one of movement from negotiation to increased use of authority. Practitioners working together must be mindful that a pattern may be created if, over a period, a number of them have failed to see the child on one or two occasions. Good communication and information-sharing between practitioners is vital to establish if a pattern of not engaging is emerging.

1.3.5 Every child's circumstances are unique and what constitutes a concerning pattern of not being seen is a matter for professional decision-making, led by good management and supervision. The important point is that every professional remains alert to such a pattern emerging and acts whenever that happens. It will be the case that, for some children, the Child's Plan will specify
the regularity and frequency with which the child must be seen. For other children the Child’s Plan may not specify the regularity of contact, but may specify the need to meet with medical professionals or specialists as part of assessing need or progressing a Child’s Plan.

1.3.6 This protocol:
- informs staff about what to do if they are worried that a child is not being seen;
- facilitates decision-making when concerns are raised about a non-engaging family or that access to child is being denied or frustrated. The process is summarised in a flow chart at Appendix 1.

2 Non-Engaging Families
(The following is adapted from the National Guidance for Child Protection in Scotland 2014):

2.1 Evidence shows that some adults will deliberately evade practitioner interventions aimed at supporting or protecting a child. In many cases of child abuse and neglect, this is a clear and deliberate strategy adopted by one or more of the adults with responsibility for the care of a child. It is also the case that the nature of child protection work can result in parents/carers behaving in a negative and hostile way towards practitioners.

2.2 The terms ‘non-engagement’ and ‘non-compliance’ are used to describe a range of deliberate behaviour and attitudes, such as:
- failure to enable necessary contact (for example missing appointments) or refusing to allow access to the child or to the home;
- active non-compliance with the actions set out in the Child’s Plan (or Child Protection Plan contained therein);
- disguised non-compliance, where the parent/carer appears to co-operate without actually carrying out actions or enabling them to be effective; and
- threats of violence or other intimidation towards practitioners.

2.3 Consideration needs to be given to determining which family member(s) is or are stopping engagement from taking place and why. For example, it may be the case that one partner is ‘silencing’ the other and that domestic abuse is a factor. Service users may find it easier to work with some practitioners than others. For example, young parents may agree to work with a health visitor, but not a social worker.

2.4 If there are risk factors associated with the care of children, risk is likely to be increased where any of the responsible adults with caring responsibilities fail to engage or comply with the child’s plan or child protection services. Non-engagement and non-compliance, including disguised compliance, should be taken account of in information collection and assessment. Non-engagement and non-compliance may point to a need for compulsory or emergency measures under the Children’s Hearing Act (Scotland) Act 2011 or Children’s (Scotland) Act 1995.
3. **Planned and Unplanned Visits**

3.1 Making appointments – by letter, text, e-mail, and card – or making the next appointment, having seen the family, are all routine ways of working with children and families. It is important to be clear with families from the beginning, when establishing a working relationship (either as part of a Child’s Plan or as part of single agency support to child or family), what is expected and why professionals want to work with parents and see and assess children. Discussing what may be the best times and places to see the child and family are important. If English is not the family’s first language, then using the language line or any other means to ensure good communication is important.

3.2 So that the genuinely forgotten or missed appointment does not escalate responses, it is helpful to ask parent and carers for a second contact number – a relative, friend or neighbour. There will be times when unplanned visits are appropriate in response to the need to check on wellbeing or safety.

3.3 Good record keeping of visits – both successful and unsuccessful – will help establish any significant patterns.

4. **Acting in response to concerns about a child being unseen or a family not engaging**

4.1 Responses to a child being unseen, or a family being unable or unwilling to engage with services, will need to be appropriate to the circumstances and reason for the involvement with the family. Interagency communication is key to establishing if there is a need for urgent action or if a more measured response can be made. For example, if the Health Visitor acting as Lead Professional has not been able to see a child to undertake work outlined as part of a Child’s Plan, it would be sensible to check with the nursery or playgroup to find out if they have seen the child. If the child has been attending and seen by staff that could be reassuring and the best way forward may be to convene a review of the Child’s Plan.

4.2 Attempting to understand why the parent or family has not supported access to the child and what can be done to improve that or reassure parents is helpful. Using the GIRFEC notification process to alert the Named Person to missed appointments and concerns about non-engagement would be important. Writing to parents to encourage cooperation and being clear what the consequence could be if contact is not re-established is appropriate.

4.3 When considering non-compliance or lack of cooperation by a parent or carer, it is important to consider if concerns have been explained clearly taking account of language, culture, disability and literacy. Practitioners will need to assess if all possible strategies have been tried to establish partnership working with the parent or carer: i.e. a change of worker, use of another agency – for example a young parent may accept help from a health visitor, but not be willing to work with a social worker.
4.4 If contact with a child is not re-established or the family continues to be disengaged and if this indicates that there could be a risk of significant harm, then a child protection referral should be made to the Duty Social Worker. **This is particularly important if there has been a history of or concerns about parental substance misuse, mental illness or domestic abuse.**

4.5 If the child’s name is already on the Child Protection Register or the child is Looked After, then Children and Families Social Work Services would need to consider immediate action. Visiting with the police is one option. Applications for a Child Protection Order or Assessment Order will also need to be considered. Any agency can refer the child to the Reporter for consideration of the need for compulsory measures and this is appropriate in situations where working on a voluntary basis has broken down.

4.6 If contact is not re-established and the concern is about the child’s wellbeing, rather than a risk of significant harm, practitioners should notify the Named Person using the GIRFEC Notification Form. The Named Person for the child can request that the situation is discussed at the Weekly Inter-Agency Screening Meeting. Children and Families Social Work, NHS Shetland, Schools Service and Police Scotland meet to discuss any child for whom there is a concern. Practitioners and Named Persons can ask the representative from their agency to share information about an unseen child or non-engaging family and seek information from others. This meeting can also make a plan of how to address this issue.

4.7 Practitioners working in the Third Sector can refer back to the professional who referred the child or family to their service, or notify the Named Person.

4.8 It is difficult to give any professional exact guidance for every situation, but advice can always be sought from the Duty Social Worker. Striking a balance between overreacting to missed appointments that may have an explanation and not taking action to protect a child is not always easy, but the main principle of this guidance is to ensure effective interagency information sharing and response. Being persistent and supportive is important, but, equally, not allowing situations to drift on for weeks without a child being seen, or being able to work effectively with parents and carers, is not safe.

5. **Safety of Staff**

5.1 Non-engagement and refusal to allow a professional to see a child may be accompanied by threats and aggressive behaviour. Some parents can be very intimidating towards staff. Staff safety is important and, if any agency is aware of aggressive or violent behaviour, then sharing that information urgently with other agencies is important. A professional planning meeting to discuss how to take matters forward without placing staff at risk would need to be convened, either by the Named Person or through Duty Social Work.

5.2 Staff safety is important. It is also vital to remember that if staff are frightened and intimidated, then children may not be safe.
NOT ENGAGING
(Strategies Tried)

Risk of significant harm?
Existing Child Protection concerns?

Child Protection Referral to Duty Social Worker

Wellbeing concerns

Discussion with Named Person

Named Person to check if Child has been seen by others – at school, nursery, etc.

Yes

- Review existing Child’s Plan
- Or
- Assess and consider need for Child’s Plan

Contact re-established – No Further Action

Contact not re-established – Wellbeing concerns remain

Request made by Named Person or Lead Professional that situation discussed at *Screening Meeting (see box on left)

No

Child not seen – Child Protection Referral

*Weekly Screening Meeting*
- Attended by Police, Social Work, Schools, NHS Shetland
- Named Person or Lead Professional who has the concern about the non-engaging family can ask the representative from their own agency to ensure that the situation is discussed and feedback provided
- The Screening Meeting should collate information and assist in planning a way forward – this could include Referral to the Children’s Reporter and Child Protection processes.

*To: Main Contents Page*
INTERNET SAFETY PROTOCOL

1. INTRODUCTION

This protocol is aimed at all practitioners in Shetland who are working with and providing services to children and young people

- to promote and encourage the safe use of the internet,
- to prevent children and young people being affected by online abuse,
- to recognise when children and young people may be at risk of significant harm and child protection processes need to be put in place,
- to share information both to protect children and disrupt online offending.

This protocol relates primarily to the risk of sexual abuse or exploitation of children and young people through the use of internet and mobile technology. It is also important to recognise that children and young people can be groomed or subject to influences which seek to radicalise them (for more information please see Section 1, Chapter 7, Child Protection in Special Circumstances) However the principles of using the internet safely should help prevent other situations that may cause distress to a child.

The protocol gives some background information including definitions of the terms used and gives guidance on how to promote safe internet usage in order to prevent children and young people being harmed or distressed. It also gives guidance about those situations where child protection referrals would be appropriate.

This protocol is broadly designed to protect children and young people up to the age of 18 and is consistent with the Children and Young Persons (Scotland) Act 2014. Shetland Inter-agency Child Protection Procedures relate to children and young people up to the age of 16 and Adult Protection Procedures may need to be considered for those aged over 16. Please see Protocol 11, Shetland Inter-agency Child Protection Procedures for further information about vulnerable 16-18 year olds. Young people who are Looked After or entitled to a Through Care and Aftercare service would also be covered by this protocol.

Working with children and young people who are vulnerable to this type of exploitation is complex and no single policy or procedure can be expected to cover all eventualities. For this reason it is very important that in every case there is discussion between professionals regarding children and young people who are considered to be at risk.
2. BACKGROUND INFORMATION

2.1 Definitions

2.1.1 Online Abuse

(Adapted from NSPCC Inform Briefing Online Abuse)

Online abuse is any type of abuse that happens on the web, whether through social networks, playing online games or using mobile phones. Children and young people may experience cyber bullying, grooming, sexual abuse, sexual exploitation or emotional abuse.

Children can be at risk of online abuse from people they know as well as from strangers. Abuse may begin online and move into the real world - for example grooming that then moves on to contact sexual abuse. Online abuse may be a continuation of abuse that is already taking place in the real world - for example bullying. In some situations the abuse only happens online - for example persuading children to take part in sexual activity online.

Children and young people can feel like there is no escape from online abuse - abusers can contact them at any time of the day or night, the abuse can come into safe places like the bedroom and images and videos can be stored and shared with other people.

2.1.2 Online Child Sexual Abuse

This has been described as:

- The production, distribution, downloading and viewing of child abuse material (both still and video images).
- The online solicitation of children and young people to produce self-generated child abuse material, to engage them in sexual chat or other online sexual activity, or to arrange an offline meeting for the purposes of sexual activity, also known as grooming or luring.
- The facilitation of any of the above.

These activities will often constitute a criminal offence. However, even if an offence is not committed, or there is insufficient evidence to prosecute, a child or young person may be considered to be at risk of significant harm due to the activity and a child protection referral should be made.

‘Child abuse images’ are often referred to as ‘child pornography’. Nevertheless, the term ‘child abuse image’ is preferred. ‘Child pornography’ can suggest legitimacy, with the child or young person being a willing participant. It can also suggest images of children or young people posing in ‘provocative’ positions rather than being subject to sexual abuse.

2.2 How Children and Young People Use the Internet

Children and young people may use the internet in a range of ways, including:
Social Networking
Social Networking websites help connect friends using a number of tools such as blogs, profiles, internal email systems and photos. The popularity of certain sites change over time and the easiest way to stay up to date is to use a Google search for the most popular networking sites. In 2014 NSPCC Inform research found that 28% of children aged 11-16 who have a profile on a social networking site had experienced something upsetting on it in the last year. The most common upsetting experience was “trolling” – unkind comments or rumours circulated online. However a significant minority had received a sexual message, been encouraged to self-harm or subjected to language that was violent or aggressive.

Chat and Instant Messaging
Instant messaging (IM) is a form of real-time text-based communication conveyed over a network, such as the internet. IM technologies often include features that make them even more popular such as having the ability to talk directly for free; to share files; or to view the other party through a webcam.

Gaming
Video games are amongst the most popular leisure pursuits for young people. These include Massively Multiplayer Online Role-playing Games (MMORPGs) which involve a large number of players interacting with one another in a virtual online world. These games often have a science fiction or fantasy theme. Other sites, such as Moshi Monsters or Club Penguin are aimed at younger children and have a social networking element.

Downloading and Uploading
Children and young people increasingly access music through sites such as iTunes, and listen to the radio or watch TV online. Sites such as YouTube allow contributors to create video content and upload it. Blogs are a sort of online diary or reflections on a subject. They are usually maintained by an individual or a small group, and readers can comment on entries.

Education/Research
Increasingly, schools are using websites to manage homework, and support study. Children and young people can also use other public sites such as Wikipedia for research.

Children and young people access the internet at home, in public places such as schools and libraries, and on smart phones. The setting itself can add to either risk or protective factors.

2.2.1 Risks of Sexual Abuse/Exploitation

2.2.2 Who is at Risk?

Action and interaction online may have an impact on children’s sense of self and be particular risk to those who are already vulnerable in the offline world.

All children and young people may engage in risky behaviour when using the internet, whether due to lack of confidence and experience in the online world, or high exposure due to increased accessibility. NSPCC research in 2014 identified that of the 1,024 children and young people involved in the research 1 in 4 of them had created a sexual image or video of themselves and sent it to someone else.
CEOPS estimated in 2012 that there were 50,000 individuals in the UK involved in downloading and sharing indecent images of children and young people.

Parents and carers and others supervising children’s online activity should take appropriate measures to create a safe environment, and inform children about safe practices online. There is a lot of information available for children, young people, parents and carers, which can be found in Appendix 2 – Key Safety Messages.

There are specific risks for the most vulnerable children and young people. For example, children or young people with poor parental relationships and lower satisfaction in life may seek out sensation experiences and greater online communication from friends or strangers.

There are other factors that contribute to individual children or young people’s abilities to benefit and manage risks from the online world:

- Biological predisposition (neuro-developmental profiles, temperament) including additional developmental support needs and disabilities.
- Psychological factors (attitudes, thoughts, emotions) i.e. existing issues of self harm behaviours, emotional distress and body image.
- Socio cultural context (models of behaviour going on around the child or young person – beliefs, attitudes, ideology) i.e. issues of violence or abuse in the child or young person’s world may be validated or normalised by access to inappropriate violent or sexual content or contact.

Whittle et al (2013) identify the following risk factors:

<table>
<thead>
<tr>
<th>Individual risk factors</th>
<th>Family factors</th>
<th>Community factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Offline and online</strong></td>
<td>Conflict with parents</td>
<td>Social isolation</td>
</tr>
<tr>
<td>Adolescents</td>
<td>Single parent or reconstituted family</td>
<td>Possibly problems with school</td>
</tr>
<tr>
<td>Being female</td>
<td>Low satisfaction with family</td>
<td>Possibly dissatisfaction</td>
</tr>
<tr>
<td>Confusion around sexual orientation</td>
<td>Parental substance abuse</td>
<td>with school</td>
</tr>
<tr>
<td>Low self esteem</td>
<td>Lack of family cohesion</td>
<td>Possibly additional support needs</td>
</tr>
<tr>
<td>Mental health problems</td>
<td>Poor family relationships</td>
<td>Weak or limited peer support</td>
</tr>
<tr>
<td>Social isolation / loneliness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk taking behaviours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personality traits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous victimisation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Online only</strong></td>
<td>Parental failure to monitor online activity</td>
<td>Possibly rural location - but largely unknown</td>
</tr>
<tr>
<td>Adolescents</td>
<td>Lack of parental involvement with the Internet</td>
<td></td>
</tr>
<tr>
<td>Frequent internet access</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

However, the online world can also provide significant opportunities for other vulnerable groups of children and young people. For example children with disabilities or those who can be socially isolated may benefit from increased opportunities to build and sustain relationships.

It is important then that we weigh up the risks with the benefits that the online world can bring to children and young people.
2.3.2 Where does the risk come from?

The risks to children and young people in relation to sexual abuse / exploitation have been categorised as:

- Content – i.e. accessing pornographic or unwelcome sexual content
- Contact – i.e. being targeted by a stranger who develops a relationship with the intent of sexual exploitation
- Conduct – i.e. creating, uploading or seeking out sexually inappropriate material

Content Risk

In a survey of children and young people:
- 38% exposed to pornographic pop-up advert
- 36% stumbled on pornographic website
- 25% receiving unsolicited pornographic material by email or instant messaging
- 10% purposely sought out pornographic websites

Over half of 9-19 year olds report coming into contact with online pornography or indecent images. A minority of children, particularly boys and older children, seek out sexually explicit material. For a quarter of those surveyed, this is the issue they are most concerned about on the internet. Many children and young people report that they are distressed, disgusted and offended by sexually explicit material, although few report it to parents.

Contact Risk

In surveys with children and young people:
- 31% of 9-19 year olds with weekly online use report having received unwanted sexual comments via email, chat, instant or text messaging
- 12-14 year olds tend to talk to strangers online more than older teenagers
- 25% of UK children have met someone offline, who they first met online

Children and young people often form relationships online. An abuser will create a persona, often posing as another child or young person, in order to develop a friendship. The abuse may take place online, or the abuser may persuade the child or young person to meet up, and abuse them.

The abuser will take time to build trust and invest in the child or young person. In some cases, when they reveal their true identity the child or young person is so invested in the relationship they will accept this. Alternatively the abuser may have obtained information from the child or young person that they use as a means of coercion. This may include indecent images that the child or young person has given them.

Children or young people in foster or residential care may make contact with birth families through social networking, which can be problematic. If this occurs, the matter should be referred to the child or young person’s social worker or carer’s link worker.
Conduct Risk

In surveys of children:
- Only 40% of children set their social networking profiles to private – leaving 60% with personal information exposed
- 27% of children have posted others information or photographs online without consent

Children and young people themselves may take photographs or create videos that they share with other friends. Once this content is online it can be taken by other people and used out of context. Children and young people need to be aware that indecent images they produce or distribute may be illegal. Such images may also be used by others to bully or exploit them.

Combinations of Risk

Content, Contact and Conduct risks are intrinsically linked, and children can behave in different roles at different times. This needs to be considered when undertaking any assessment. In particular the questions should be considered: what risks are posed to the child or young person and what risks (if any) the child or young person poses to others.

Hasebrink et al identify the following ways that content, contact and conduct risks may occur:

<table>
<thead>
<tr>
<th>Aggressive</th>
<th>Contact Child as participant</th>
<th>Conduct Child as actor</th>
<th>Conduct Child as actor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violent/gory content</td>
<td>Being bullied or stalked</td>
<td>Bullying or harassing</td>
<td></td>
</tr>
<tr>
<td>Sexual</td>
<td>Pornography, unwelcome sexual content</td>
<td>Grooming, unwanted sexual comments</td>
<td>Sexual harassment</td>
</tr>
<tr>
<td>Values</td>
<td>Racist/hate</td>
<td>Ideological persuasion</td>
<td>Self harm</td>
</tr>
<tr>
<td>Commercial</td>
<td>Embedded marketing</td>
<td>Privacy/data abuse</td>
<td>Illegal downloads, gambling, hacking</td>
</tr>
</tbody>
</table>

2.3.4. Risk perception of adults

A significant factor in identifying and assessing risk is the different understanding of the use of the internet between children and young people, and adults. Adults have become familiar with using the internet for information gathering and lifestyle support; for example shopping, keeping contact with friends and other recreational interests that supplement their “real life”.

Parents and carers are often more concerned about risks to their children in the real world and do not always appreciate that there can be risks online. A child sitting in their bedroom using the internet may be considered by a parent to be in a safe place as opposed to child who is out playing in the street.

Children and young people generally do not see a distinction between the online world and real life; the two are more fully integrated. For example, they may form relationships with people they have met through social networking or gaming sites,
who they consider to be friends, although they have never met one another. This means they can be very open in sharing personal information, and not consider the need to take precautionary measures when meeting up. In addition, they are more likely to create content and upload it, rather than simply downloading. This distinction in internet use has been described as Web 1.0 and 2.0.

This difference in experience and knowledge can create barriers to understanding, reducing confidence of practitioners in supporting children and young people to benefit from the Web whilst keeping them safe.

3. PROMOTING SAFE USE OF THE INTERNET AND PREVENTING ABUSE

Curriculum for Excellence (CfE) recognises that being skilled in using information and communications technology (ICT) is essential if children and young people are to be effective contributors able to communicate and interact on a global scale. They need to be equipped with the learning and employability skills required for the 21st century. It also acknowledges that there is a need for children and young people to develop the skills and knowledge to keep themselves safe in what is a potentially unsafe environment, with the expectation that all children will achieve the following CfE outcome: ‘I am developing my knowledge and use of safe and acceptable conduct as I use different technologies to interact and share experiences, ideas and information with others’ (TCH1-08a/ TCH 2-08a).

Education of children, young people, parents and carers and practitioners is important. The following resources are currently in place and Shetland Child Protection Committee would urge everyone to make use of these resources:

- Network of Child Exploitation and Online Protection Service (CEOP) trained trainers to deliver sessions to groups of children or adults about keeping safe online
- PSE session delivered by School Staff and Peer Educators
- Online resources are included in Appendix 2

4. RECOGNISE AND RESPOND TO CONCERNS THAT A CHILD OR YOUNG PERSON MAY BE AT RISK OF SIGNIFICANT HARM AND CHILD PROTECTION PROCESSES NEED TO BE PUT IN PLACE

Whenever there is any suspicion that a child or young person may be at risk of abuse through the internet, this should be treated as a child protection concern, and progressed under local child protection procedures.

If there is a concern that the child or young person may themselves be posing a risk, or have engaged in illegal activity, this should be considered alongside the question of what protection they may need themselves. Shetland Inter-agency Child Protection Procedures make it clear that any child or young person who poses a risk to other children should also have their own needs considered and a child protection conference arranged to discuss their situation as well as any child they may have harmed. (Please see Section 1, Chapter 7, Child Protection in Special Circumstances – Shetland Inter-Agency Child Protection Procedures) Where appropriate, they should be supported to access legal advice.
In particular, in order to preserve evidence:

- Do not delete any information found on computers/mobile phones.
- Take a note of any websites, email addresses or telephone numbers.
- Note any names, addresses or other contact details.
- Print out/take a screen shot of any concerning materials.

It should be remembered that children will often not consider themselves to be a victim of abuse or exploitation, and may well consider their abuser to be someone who loves or cares for them. Adults working with children therefore need to be particularly sensitive in engaging with children or young people where there is a suspicion they are being abused or groomed online.
References


http://www.educationscotland.gov.uk/Images/all_experiences_outcomes_tcm4-539562.pdf, p.303

http://www.educationscotland.gov.uk/Images/all_experiences_outcomes_tcm4-539562.pdf, p.310

Get Safe Online (2007) *Social networkers and wireless networks users provide “rich pickings” for criminals.* (Press release). Available at:

http://www.getsafeonline.org/nqcontent.cfm?a_id=1469


http://sfcs.cals.arizona.edu/azsearch/sites/sfcs.cals.arizona.edu.azsearch/files/Hinduja,%202008.pdf

Ibid, p47


Appendix 1 – Legislation

The following pieces of legislation are particularly relevant in relation to internet child sexual abuse and exploitation.

PROTECTION OF CHILDREN AND PREVENTION OF SEXUAL OFFENCES (SCOTLAND) ACT 2005


Grooming
Section 1 make it an offence for a person (A) to meet, travel to, or make arrangements to meet another person (B) if:

- A has previously met or been in contact with B;
- A intends to engage in unlawful sexual activity with, or in the presence of B; and
- B is under 16 or B is a police officer.

The course of conduct prior to the meeting that triggers the offence may have an explicitly sexual content, though this need not be the case. The evidence of A’s intention to engage in unlawful sexual activity may be drawn from the communications between A and B prior to the meeting, or may be drawn from other circumstances, for example if A travels to the meeting with condoms and lubricants. However, the intended sexual contact does not have to take place for the offence of grooming to take place. It is a defence if A reasonably believed B to be over 16

Risk of Sexual Harm Orders
Section 2 introduces the Risk of Sexual Harm Order (RSHO). The police can apply to a sheriff court in respect of a person who has, on at least two occasions, engaged in sexually explicit conduct or communication with a child/children (under 16) and there is reasonable cause to believe that the order is necessary to protect a child/children in the future.

The application may be made in the sheriffdom where the person lives, is believed to be in, is intending to come to; or where the alleged acts are said to have taken place. The application must generally be made within three months of the second incident, though the sheriff may accept an application outwith this timescale.

The sexual conduct may be:

- engaging in sexual activity involving, or in the presence of a child;
- causing or inciting a child to watch a person engaging in sexual activity or to look at a moving or still image that is sexual;
- giving a child anything that relates to, or contains a reference to sexual activity;
- communicating with a child, where any part of the communication is sexual.

The sexual conduct may amount to a criminal offence, but this need not be the case.

CIVIC GOVERNMENT (SCOTLAND) ACT 1982


Indecent Child Images
Section 52 makes it an offence to take, allow, or make any indecent photograph, film or other digital image of a child. It is also an offence to distribute or publish such an image, or to possess one with a view to distributing it. The image may be a copy, or a file stored on a computer or other storage device. It is a defence if there is a legitimate reason to have the image, or the person in possession had not seen the image and had no reason to suspect it was indecent.

SEXUAL OFFENCES (SCOTLAND) ACT 2009


Coercing a person into looking at a sexual image
There are three relevant sections for this offence. Section 6 makes it an offence to cause another person, without their consent, to look at a sexual image, if it is done for the sexual gratification of the alleged offender, or to humiliate, distress or alarm the other person. A sexual image is either an image of the sender or someone else engaging in a sexual activity, or an image of the genitalia of the sender or someone else.

Section 23 makes it an offence for anyone to show such an image to a child under 13 years, whether they consent or not.
APPENDIX 2 - KEY SAFETY MESSAGES

Byron recommended that:

“Children and young people need to be empowered to keep themselves safe – this isn’t just about a top-down approach. Children will be children – pushing boundaries and taking risks.”

Children and young people need to be able to

- Explore and use the internet and play video games for fun, creativity and development.
- Achieve this in an environment where there is a reduced risk of coming across harmful or inappropriate material.
- Manage or be able to find the support to manage risks that are age-appropriate should they encounter them.
- Take ownership of their own online safety and gaming and be supported to do so in environments that encourage and promote safe behaviour and provide user-friendly safety information and tools.

Ultimately it is the responsibility of the adults in a child or young person’s life to protect them. This will involve both setting boundaries and overseeing the child or young person’s internet use; and empowering the child or young person to manage themselves safely and to access help if they need it.

Key safety messages for children are available in age appropriate language on the ThinkUKnow website – www.thinkuknow.co.uk. These include:

- How to have fun
  - Information about the range of applications and programmes

- How to stay in control
  - Managing your privacy settings
  - Choosing what information to share e.g. personal info, pictures
  - Making contact with people online

- What can go wrong
  - Putting up stuff you wish you hadn’t
  - Seeing things you wish you hadn’t
  - Talking to people who make you feel uncomfortable
  - Feeling pressured to do things you don’t want to

- How to report
  - Talking to a trusted adult
  - Using CEOP Report Abuse Button
  - What will happen next

There are many other useful websites available with information for children, carers and professionals. These include:

Get Safe Online provides computer users with advice on using the internet confidently, safely and securely. It covers a wide range of issues, including internet safety for children and young people. http://www.getsafeonline.org/

Childnet has information for children and young people on how to use the internet constructively and develop “net literacy” skills, as well as information for those working to protect children online.

http://www.childnet-int.org/default.aspx

CEOP is a national police agency, which is engaged in operational police work and intelligence gathering to combat online child abuse and exploitation, as well as training and awareness raising for children, carers and professionals.

http://ceop.police.uk/
APPENDIX 3 – IMPACT OF AGE AND BRAIN DEVELOPMENT ON ABILITY TO MANAGE RISK ONLINE

The following table identifies the benefits and vulnerabilities in relation to Internet use at different ages, and highlights particular support needs.

<table>
<thead>
<tr>
<th>Age</th>
<th>Brain Development – Key Stages</th>
<th>Benefits</th>
<th>Vulnerabilities</th>
<th>Support needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-school</td>
<td>Family focused</td>
<td>Fun – imaginative and role play</td>
<td>Difficulty defining fantasy from reality</td>
<td>Significant online supervision and restriction to minimise inappropriate exposure.</td>
</tr>
<tr>
<td></td>
<td>Forming appropriate adult relationships and developing attachment</td>
<td>Development of responsibility and routine</td>
<td>Vulnerable to violent, sexual, emotional content and contact</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mirroring of negative behaviours observed online</td>
<td></td>
</tr>
<tr>
<td>5-11yrs</td>
<td>Beginning to develop peer friendships</td>
<td>Opportunity to develop critical evaluation</td>
<td>Impulse controls still inhibited</td>
<td>Management and regulation alongside discussion that creates opportunities for development of evaluation and self regulation</td>
</tr>
<tr>
<td></td>
<td>Learning right from wrong</td>
<td>and self management</td>
<td>Immature self regulation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Beginning to understand social rules and norms</td>
<td></td>
<td>Increasingly pushing boundaries of parental or commercial control</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Defining reality from fantasy</td>
<td></td>
<td>Confusion and emotional harm from poor social judgements</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Experiences inform development of frontal cortex</td>
<td></td>
<td>Peak usage age</td>
<td></td>
</tr>
<tr>
<td>11-14yrs</td>
<td>Significant hormonal, physical and mental changes</td>
<td>Opportunity to test behaviours and identity</td>
<td>Increase vulnerability of mental health and esteem issues</td>
<td>Support to take ‘safe’ risks and development through collaborative management involving discussion and mediation.</td>
</tr>
<tr>
<td></td>
<td>Drive for external social interaction</td>
<td>development</td>
<td>Susceptible to social acceptance demands</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social identity development</td>
<td>Development of peer communication and</td>
<td>Increasing restricted access to outdoor socialisation plus drive for social experiences increases likelihood of creating online experiences.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Changes in ‘reward’ network resulting in increased risk taking behaviours</td>
<td>relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Learning opportunities for exploration and</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>experimentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-18yrs</td>
<td>Near adult brain functioning</td>
<td>Opportunity for autonomous decision making</td>
<td>Changes in the structure and function of the brain from reduced development of key skills caused by extensive online and lack of offline activities and skills development.</td>
<td>Providing opportunity for independent decision making and testing whilst ensuring a supportive and trusting relationship remains available to assist if necessary.</td>
</tr>
<tr>
<td></td>
<td>Value and belief system development</td>
<td>and independence, and for identity construction</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Protocol 10

Supporting Children and Young People who Self Harm

Protocol for staff who working with children and young people who self-harm

Introduction
This protocol is designed to link with both the Shetland Getting it Right for every Child Guidance and the Shetland Interagency Child Protection Procedures. The purpose of this protocol is to ensure that all agencies working in Shetland provide a consistent, caring and appropriate response to children and young people who are at risk of self-harm and suicide.

It is influenced by the views of young people and what they find helpful. It is also designed to give guidance about assessing levels of risk and what help can be given.

It is divided into 4 sections- Information about Self –harm and suicide, Guidance for Staff, Confidentiality and Information sharing and useful websites and further information. Additionally Appendix 1 contains a table that identifies protective factors versus risk factors Appendix 2 has further information for staff working with children who self-harm and Appendix 3 has a link to the the GIRFEC information sharing policy.

The aims of this guidance are to:

- ensure the child or young person is seen as central to the whole process and accorded appropriate priority by the agencies involved;
- ensure a consistent response to and understanding of self-harm across all agencies concerned with children and young people;
- provide an agreed set of procedures for dealing with disclosure of self harm or abusive experiences that are leading to self-harm;
- minimise harm and support the emotional health and wellbeing of the child and young person through collaborative working;
- provide children and young people with opportunities and strategies for hope and recovery from the effects of self-harming or attempting suicide;
- minimise the risk of future harm;
- support staff to carry out a risk assessment to ensure that if a child or young person is at risk of abuse or suicide then child protection referrals or appropriate requests for medical help can be made.
Section 1 Information about Self-harm and Suicide

1.1 Introduction

Self-harm is defined by the National Institute of Clinical Excellence (NICE) as

“Self-harm is an expression of personal distress, usually made in private, by an individual who hurts him or herself. The nature and meaning of self-harm, however, vary greatly from person to person. In addition, the reason a person harms him or herself may be different on each occasion, and should not be presumed to be the same.”

Self-harm is generally a way of coping with overwhelming emotional distress. Most young people who self-harm have no intention of committing suicide. However research shows that some young people who self harm can be at higher risk of suicide.

1.2 Misconceptions about Self –harm

The following is taken from the National Self-Harm Networks website www.nshn.co.uk

Misconception 1 Self-harm is attempted suicide

This is rarely the case. A survey of 758 people who self-harmed carried out by the National Self-Harm network in 2009 showed that 4% of those had suicidal feelings.

Misconception 2 Self-harm is all about attention seeking

More often than not self-harm is a very private and hidden behaviour that does not involve anyone else. Some individuals who do let people know about their self-harm may do this as they have no other way to communicate how they are feeling.

Misconception 3 The more serious the injury the more serious the problem

It is important to take all injuries seriously as the nature of the wound does not represent the extent of the anguish being experienced.

Misconception 4 They must like the pain

Self harm is not about liking pain. It is a way to cope with thoughts and feelings that are depressing or distressing and to regain some control over how you feel. A lot of the time, individuals who self harm do not actually feel any pain due to adrenaline instead they feel a release.

Self harm can also be a mechanism that allows individuals to ‘feel' something as the feeling of being emotionally numb and empty are common symptoms of depression. Such feelings of pain can also be used to ‘ground’ oneself in reality when feeling disassociated such as during flashbacks common with Post Traumatic Stress Disorder or manic episodes such as those experienced by individuals with Bi-polar Disorder.
In some cases individuals self harm to punish themselves. This may be due to feelings of guilt or shame. This is common in cases of sexual abuse and sexual assault. Individuals who self harm for these reasons are seeking pain but not for gratification

**Misconception 5 Self-harm is a young person’s issue**

It is not only the young that self harm, triggers for self harm are experienced by people of all ages.

Results from an NSHN survey (390 respondents)
What age are you?

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 16</td>
<td>9.5%</td>
</tr>
<tr>
<td>17 - 25</td>
<td>50.3%</td>
</tr>
<tr>
<td>26 - 34</td>
<td>21.7%</td>
</tr>
<tr>
<td>35 - 44</td>
<td>12.1%</td>
</tr>
<tr>
<td>45 - 54</td>
<td>5.9%</td>
</tr>
<tr>
<td>55 - 64</td>
<td>0.5%</td>
</tr>
<tr>
<td>65 plus</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Misconception 6 People who self harm can stop easily if they want to**

Self harm is very often a coping mechanism; therefore it is very difficult for someone to stop without learning new ways of coping. Triggers for self harm such as abuse, bullying etc. are unlikely to be resolved over night. Recovery can be a slow process. It is possible that self harm can also turn into an addiction. Therefore it can be a great struggle to stop even if you want to, the same way as it would be for somebody trying to give up smoking or drinking to excess. Individuals may need a great deal of support to move away from using self harm as a method of coping

**Misconception 7 Self harm is the problem, if we stop this then the person will be fine**

Self harm is rarely the problem, but a solution until other issues are resolved. It is the reasons that lay behind individuals self harm that need to be addressed in order to aid a recovery from self harm.

**Misconception 8 Only Girls do it**

Society holds this image of self-harm just affecting vulnerable young teenage girls, but that is not true. Self-harm can affect everyone and anyone. And that means boys and men too.

Statistics vary - some think that for every 2 girls self-harming there is only 1 boy, but actually the figures could be about the same. Boys have emotions and difficulties every bit the same as every girl their own age. Teenage years are no easier for boys than they are for girls, girls are no more likely to have a rough time at home or school than boys, and girls are no more likely to be unhappy than boys. Boys have feelings, boys hurt, and boys self-harm.
1.3 Who self-harms?

It is estimated that nationally that in every secondary school classroom there will be **two young people** who have self-harmed. No specific statistics are gathered for Shetland, but there is nothing to suggest that the numbers in Shetland would be any different to national estimates.

Any young person may self-harm -sometimes as an isolated incident and sometimes as a result of bullying, abuse or other traumatic event. Self-harm does not discriminate and can affect anyone. Self harm in young children - lower primary age or pre-school - would always be a warning sign of high risk requiring an immediate child protection response and medical help as it is more unusual to find self-harming behaviour in young or very young children. Some groups of young people who may be experiencing emotional distress due to their circumstances can be at increased risk of using self-harm as a way of coping. Young people who have experienced abuse, Looked After Children particularly those placed in residential settings, young Asian women coping with societal and cultural pressures and racism, LGBT young people may all be at greater risk. There is some evidence that children living in more rural and isolated areas and teenage girls can be at increased risk also.

Self-harm often takes place very privately and may not be obvious. It is important to remember that self-harm may be a response to a difficult situation and there may be times when it is appropriate to ask about this in a sensitive and appropriate way.

Children and young people can be influenced by a friend who self-harms or membership of a sub-culture that advocates self-harm. It is is important not to just label this as copy-cat behaviour, but to see that the young person is reacting to peer pressure and still needs some understanding and support.

1.4 How do young people self-harm?

Examples of self-harming behaviour

- Cutting
- Taking an overdose of tablets
- Swallowing hazardous materials or substances
- Burning either physically or chemically
- Over/under-medicating, e.g. misuse of insulin
- Punching/hitting/bruising
- Hair-pulling/skin-picking/head-banging
- Episodes of alcohol/drug abuse
- Over or under-eating at times may be deliberate acts of self-harm
- Risky sexual behaviour
1.5 Why do young people self harm?

In trying to understand why some young people may self-harm it is important to understand the physiological and psychological aspects. The physical manifestation of emotional pain can help people cope.

Self-harm is a coping mechanism which enables a person to express difficult emotions. Young people who hurt themselves often feel that physical pain is easier to deal with than the emotional pain they are experiencing, because it is tangible. But the behaviour only provides temporary relief and fails to deal with the underlying issues that a young person is facing.

For some people, self-harm may last for a short time. For others, it can become a long-term problem. Some people self-harm, stop for a while, and then return to it months, even years, later, in times of distress.

The reasons people gave for self-harming are varied and include:

- self-harm temporarily relieves intense feelings, pressure or anxiety;
- self-harm provides a sense of being real, being alive - of feeling something other than emotional numbness;
- harming oneself is a way to externalise emotional internal pain - to feel pain on the outside instead of the inside;
- self-harm is a way to control and manage pain – unlike the pain experienced through physical or sexual abuse;
- self-harm is self-soothing behaviour for someone who does not have other means to calm intense emotions;
- self-loathing - some people who self-harm are punishing themselves for having strong feelings (which they were usually not allowed to express as children), or for a sense that somehow they are bad and undeserving (for example, an outgrowth of abuse and a belief that it was deserved);
- self-harm followed by tending to wounds is a way to be self-nurturing, for someone who never was shown by an adult to express self-care;
- harming oneself can be a way to draw attention to the need for help, to ask for assistance in an indirect way;
- on rare occasions self-harm is used to manipulate others: make other people feel guilty or bad, make them care, or make them go away;
- self-harm can be influenced by alcohol and drug misuse.
- Self harm can sometimes be seen as part of a ‘trend’. This can be related to trends in the local area or may be influenced by trends in the media such as the behaviour of pop stars or celebrities.

1.6 Biological effects of self harm:

- Self-harm can bring its own physical release
- Impact of neurochemicals – endogenous opioids and serotonin
- May generate feelings of calm and well-being
- These neurochemicals are released particularly when the body is injured in any way
- Produce insensitivity to pain
- Body grows to expect a higher level of these chemicals
Section 2  Guidance for staff

2.1 Introduction

This guidance is primarily aimed at supporting staff that are providing services to children and young people up to the age of 16. However it provides a good practice guideline for young people aged 16 – 18 and can be helpful for young adults aged up to 25.

Anyone can make a child protection referral if they are concerned that a child or young person aged under 16 may be at risk of significant harm. For young people aged 16-18 Protocol 11 Vulnerable Young people may be helpful. Once a young person is over 16 they are also covered by Adult Protection Procedures and the Adult Support and Protection (Scotland) Act 2007

The legal situation for 16 – 18 year olds can be complex. If they are over 16, but Looked After Children by reason of being accommodated or subject to a supervision requirement then child protection procedures and legislation will still cover them. If you are not sure about the legal situation, particularly for 16-18 year olds, then Shetland Island Council Staff can seek advice from legal services and anyone can ask the duty social worker for some advice. Additionally Protocol 11 Vulnerable Young People Aged 16-18 can be used.

2.2 How to Respond

If a young person tells you they have been self-harming or you see an injury or receive information from others then the most important response is not to panic, but to deal with it calmly. If you see an injury or receive information that young person has been self-harming then speak to them quietly and privately and show that you are concerned for their welfare. If they have a current injury and it is serious or has been done with suicidal intent (the young person may tell you this or have left a message to this effect) then seek medical help quickly by calling an ambulance or going to A+E.

You can also seek medical advice about a less serious injury. This could include contacting NHS 24 on 08454 24 24 24 (open 24 hours) or through a nurse or doctor locally.

Staff can find contact details for their local health centre here: http://www.shb.scot.nhs.uk/community/index.asp

Listen carefully to what a young person is telling you. If you feel that speaking to them about self-harming behavior is beyond your skills or abilities speak immediately to a line manger or someone who can discuss the situation with the child or young person. It is important that any response is helpful and places the child at the centre so if you do need to speak to someone else let the young person know what you are doing and why.

Your core skills and values of empathy, understanding, non-judgmental listening and respect for individuals are all vital in this area.
Good practice in minimising self-harm and providing empathetic listening includes:

- refraining from telling young person to stop, as this can make things worse;
- explaining your role and the limits of your confidentiality;
- giving information/education about self-harm and causes in a straightforward and matter of fact manner;
- advising the child or young person about the range of available support;
- involving young person actively in seeking help;
- following procedures when responding to any injury;
- addressing safety issues such as the risk of infection, nerve damage, illness such as HIV, AIDs, Hepatitis C or even risk of accidental death;
- being aware that the child or young person may be feeling guilty and ashamed;
- being aware of the stigma associated with self-harm;
- being non-judgmental;
- treating young person with respect;
- listening empathetically with a view to joint problem solving;
- providing reassurance that problems can be solved;
- checking for associated problems such as bullying, bereavement, relationship difficulties, abuse, and sexuality;
- involving the child or young person in the assessment around risk of self-harm;
- assessing if/how and when parents will be involved;
- discussing if, how and when parents should be informed and would the risk around self-harm with the child or young person be increased by telling them;
- making appropriate referrals if required;

Take all suicide gestures and thoughts seriously and seek help immediately.

It is vital that the young person retains some control of their situation - is fully aware of who needs to be informed and why, is consulted on their views, is allowed wherever possible to set the pace and make choices. To do otherwise could result in a worsening of the self-harm.

Remember that self-harm is often a way of coping, so stopping the self-harm is not always the best thing to aim for immediately. Safety and understanding are more important in the short term. There is no quick fix.

Some further dos and don’ts are included in the table at Appendix 2.
2.3 Assessing Risk

Risk assessment needs to consider both the risk that the young person is placing themselves at by the method and frequency of self-harming that they are using and also if the reasons they are self-harming indicate that they may be being abused or at risk of harm from others. For example we know that young people can be at risk of domestic abuse within relationships. If a young person was self-harming to cope with the emotional effects of being in an abusive relationship then there may be two elements of risk that would need to be considered. It is important to assess the risk, but this needs to be done with care and in a way that does not further distress the child or young person or bombard them with too many questions. Finding a safe and private place to speak is important. Use the following sections of this protocol to think through likely risks.

2.4 Suicide and Self-Harm

Self harming behaviours can increase the risk of attempting suicide; most people who self harm have no intention of suicide and for many, self harm will be a way of coping and staying alive. However if you are supporting a young person who has self harmed, it is worth checking out whether they have any suicidal thoughts or feelings. Sometimes staff may feel anxious about asking a young person if they feel suicidal. At the root of this anxiety is often the mistaken belief that asking someone about suicide may give them the idea to try it. This is not true. Asking someone if they are feeling suicidal has the potential to save their life. If you do need to ask a young person if they feel suicidal do so gently and with compassion. Consider your choice of language to ensure that the young person will be able to understand you and that there will be no ambiguity that suicide is what you are talking about.

For example: “do you feel like you want to die?” or “do you want to end your life?”

If they say “yes”, you should refer them to their GP, and make a plan to help keep the young person safe until they can get further support.

Asking about suicide can feel uncomfortable and emotional so it is important that you also seek support for yourself from colleagues or your supervisor.

2.5 Child Protection

If the episode of self-harm is associated with sexual abuse, physical abuse, psychological or emotional abuse and the child or young person (or other children or young people) are at risk then follow the Shetland Interagency Child Protection Procedures and contact your line manager and duty social worker. If you are not sure whether this may be child protection or not then you can seek advice from the duty social worker.
2.6 Gathering Information

In speaking to a young person about their self-harm the following may be helpful in assessing why they are self-harming and what may be causing them distress

- Health
  - Ask about other health issues – eating, sleeping, physical and emotional feelings.
  - Mental wellbeing.

- Other risk taking behaviours
  - Use of alcohol and drugs.
  - Placing themselves at risk sexually.

- General Distress
  - Current level of distress.
  - Ascertain what needs to happen to help the child feel better.
  - What can you do to help them feel better?
  - What support is the child already receiving?

- Future Support
  - Ask them “What would you like me to do to help you?”
  - Can harm reduction help keep the young person safer?
  - Elicit current strategies that have been used to resist the urge to self-harm.
  - Who knows about this situation and who can help?
  - Discuss contacting parents if that would be helpful. – Approach with caution as parents may be a contributing factor
  - Discuss around referral to other services.
  - Discuss who you will contact and what you will say.

Section 3 below has more information about consent and confidentiality and may help when considering with the young person who to tell about their self harming behaviour.

2.7 What to do if you suspect self-harm or have third party information

Staff may have observed a young person behaving in a way that indicates they may be self-harming. Staff may receive third party information from other young people or the young person’s parents that the person is self-harming. Staff may be aware of something on a Facebook page or other electronic way of communicating that indicates self-harm. If observations or third party information indicates high risk- child protection or suicidal intent then staff should always follow procedures and refer on quickly.

If there is no evidence of immediate high risk then speaking to the child’s Named Person and agreeing a way forward is appropriate. (see below for more information on Named Persons) Someone who knows the child or young person well – and that may or may not be the person who had the original concern – should find a quiet and calm time and place to speak to the young person. By indicating that you are not shocked and there are safe places to go to seek help, you may be able to assist the young person. Websites and other information in Section 4 may also be helpful to share.
2.8 The role of the Named Person, Lead Professional and the Child’s Plan.

Every child from birth to 18 has a Named Person who has specific role in being a point of contact for parents and children and any practitioner who may have a concern about a child. They will trigger additional help for a child or their family if required. Children, young people and families will have clear information about who is the child/young person’s named person. The Named Person will be accessible to the child, young person and parent/carer as someone they can talk to about any area affecting their child. The Named Person will remain associated with the child, even if additional help is offered.

The Named Person holds basic information about the child and family. If information is shared with the Named Person by any agency or professional that indicates a child’s wellbeing is being affected in some way then the Named Person can begin an assessment of the situation. If required a Lead Professional (who may or may not be the Named Person) will be indentified and they will then take a more active role in working closely with parents and children and any agencies or services who are assisting the family or who could assist the family to draw up a child’s plan. This plan is based on assessed need and is outcome focussed.

To illustrate how this may work in practice for a primary school aged child the named person will be the Head Teacher/Depute Head Teacher in the school. If, acting on concerns shared about the child, the Head Teacher/Depute Head Teacher decides that the child requires additional support they will start an assessment and identify a Lead Professional. This – for example – could be the child’s class teacher who knows the child very well and has an existing relationship with the child’s parents. Further information is available at the following web link: [http://www.shetland.gov.uk/children_and_families/GIRFEC.asp](http://www.shetland.gov.uk/children_and_families/GIRFEC.asp)

Who is the Named Person?

<table>
<thead>
<tr>
<th>Age of child or young person</th>
<th>Named Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre birth - 10 days</td>
<td>Midwife</td>
</tr>
<tr>
<td>10 days - Primary School entry to P1</td>
<td>Health Visitor</td>
</tr>
<tr>
<td>Primary School P1 - P7</td>
<td>Head teacher or designated other; this is likely to be a Depute Head teacher or Principal Teacher</td>
</tr>
<tr>
<td>Secondary School up to the age of 18</td>
<td>Head teacher or designated; Depute Head teacher, Pupil Support or Principle ASN Teacher</td>
</tr>
<tr>
<td>Young people aged 16-18 who are not in school</td>
<td>The Duty Social Worker can advise about Named People</td>
</tr>
</tbody>
</table>

The presenting problems that may trigger a Named Person to begin an assessment and Child’s Plan may not initially be about self-harming behaviour and this issue may come to light as a result of work with the family. For example the child who is always late to school, struggling in school and who appears unhappy may, on further assessment, be self-harming due to experiences of bullying or low self-esteem.
2.9 Help and Support

If staff are concerned about the mental health of the child or young person then seeking help through a GP is appropriate. The Child and Adolescent Mental Health Team are available to staff who need some advice about children and young people who self-harm. Most young people who self-harm do not have a mental illness, but some may need more specialised help.

Positive Staff Attitudes

Children and Young people’s experiences of services are much more positive when they encounter staff with non-judgmental attitudes who try to understand self-harm behavior. For example respondents to recent research reported that their experiences were greatly improved when healthcare professionals showed them respect and were calm, reassuring and considerate.

‘My doctor shows me respect … the way he talks about me to this other professionals …he is saying this person’s ok … but I’m just so lucky to have a real good GP who can do that.’ (F)

Service users appreciate tolerance and understanding, for example:

‘He actually spoke to me, rather than talking down to me. He spoke to me like a person, instead of just a silly little girl, who cuts up and all this. He was different. Because a lot of GPs' attitudes are “Oh, it's nothing. You'll get over it.” But he wasn't. He was genuinely concerned, for a change, so it was nice’. (Respondent talking about her GP, BYWATERS2002)

‘My GP, who has admitted that he does not fully understand what self-harm is about, has however made himself available to me at any time and has been extremely supportive (i.e. I always get the last appointment so that he doesn’t have to rush the consultation and we have more time to discuss things)’. (Respondent about GP, DUROSE2000)

Substitutes for self-harm

If staff are working with young people on a continuing basis then speaking about alternatives to self-harm may be appropriate. Young people have shared their most successful ones with us, and these are:

- Using a red felt tip pen to mark where you might usually cut
- Hitting a punch bag to vent anger and frustration
- Hitting pillows or cushions, or having a good scream into a pillow or cushion
- Rubbing ice across your skin where you might usually cut, or holding an ice-cube in the crook of your arm or leg
- Getting outdoors and having a fast walk
- All other forms of exercise – these are really good at changing your mood and releasing adrenaline
- Making lots of noise, either with a musical instrument or just banging on pots and pans
- Writing negative feelings on a piece of paper and then ripping it up
- Keeping a journal
- Scribbling on a large piece of paper with a red crayon or pen
- Putting elastic bands on wrists, arms or legs and flicking them instead of cutting or hitting
- Calling and talking to a friend (not necessarily about self-harm)
- Collage or artwork – doing something creative
- Getting online and looking at self-help websites

“I’ve tried so many distraction techniques – from holding an ice-cube, elastic band flicking on the wrist, writing down my thoughts, hitting a pillow, listening to music, writing down pros and cons. But the most helpful to my recovery was the five minutes rule, where if you feel like you want to self-harm you wait for five minutes before you do, then see if you can go another five minutes, and so on till eventually the urge is over.”
Section 3 Consent and Confidentiality

3.1 Child Protection and Risk of Suicide

Consent is not required for child protection referrals where there are concerns about the risk of significant harm to child. Shetland Interagency Child Protection Procedures should be followed. The following link will take you to the current procedures.

http://www.safershetland.com/child-protection - then click on the GREEN button

If a child or young person is at risk of suicide then consent is not required to seek immediate medical help from a GP or from Accident and Emergency.

If the young person is over 16 and it is safe to do so then discussing a referral with them would be good practice. However consent is not needed to make an adult at risk referral. Medical help can be requested if the young person is at risk of suicide. Consent from any parent/carer/guardian would not be needed.

3.2 Confidentiality, Consent and Data Sharing

All staff, whether working primarily with adults or children, have a duty to respect confidentiality, share relevant, appropriate and proportionate information when necessary and record and store data securely. Consent to share information in accordance with GIRFEC in Shetland guidance should be informed consent given freely. There are already in place data sharing agreements that support the GIRFEC in Shetland procedures and this protocol.

For Information Sharing Procedure for Practitioners, please see latest version on: http://www.shetland.gov.uk/children_and_families/GIRFEC.asp - under heading ‘Information Sharing’, sub-heading ‘For Practitioners’

The above web link also gives information about GIRFEC that can be shared with parents and children and young people
Section 4 Useful Information

NHS Shetland Health Improvement Team

The team offers training in respect of supporting young people with self-harm. Further information is available from jillian.hood@nhs.net

National Self-Harm Network  www.nshn.co.uk
NSHN aims to:
Support
- Support individuals who self harm to reduce emotional distress and to improve their quality of life
- Support and provide information for family and carers of individuals who self harm

Empower
- Empower and enable individuals that self harm to seek further support and alternatives to self harm

Educate
- Educate service providers and carers on matters relating to self harm, raise awareness, dispel myths and challenge misconceptions through providing information and training
- Influence health and social care policies at local and national levels

Young Minds  www.youngminds.org.uk
YoungMinds is the UK’s leading charity committed to improving the emotional wellbeing and mental health of children and young people. Driven by their experiences, they campaign, research and influence policy and practice.

Mental Health Foundation  www.mentalhealth.org.uk
Mental Health Foundation provides information about a range of mental health issues and mental wellbeing

Life Signs  www.lifesigns.org.uk
Life SIGNS is an online user led voluntary organisation. They aim to provide understanding, information and support to anyone affected by self harm.

Mind Your Head  http://www.mindyourhead.org.uk/info/problems/self-harm
Mind Your Head are a local mental health charity. They provide information about various mental health issues and do ongoing work to reduce the stigma associated with mental health.

Self Harm: www.selfharm.co.uk/home
www.selfharm.co.uk is a project dedicated to supporting young people impacted by self-harm, providing a safe space to talk, ask any questions and be honest about what's going on in your life.
## Appendix 1

### Protective Factors Verses Risk Factors

#### Protective Factors

<table>
<thead>
<tr>
<th>Child</th>
<th>Parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ High self-esteem</td>
<td>➢ High self-esteem</td>
</tr>
<tr>
<td>➢ Good problem solving skills</td>
<td>➢ Warm relationship between adults</td>
</tr>
<tr>
<td>➢ Easy temperament</td>
<td>➢ High marital satisfaction</td>
</tr>
<tr>
<td>➢ Able to love and feel loved</td>
<td>➢ Good communication skills</td>
</tr>
<tr>
<td>➢ Secure early attachments</td>
<td>➢ Good sense of humour</td>
</tr>
<tr>
<td>➢ Good sense of humour</td>
<td>➢ Capable of demonstrating unconditional love</td>
</tr>
<tr>
<td>➢ A love of learning</td>
<td>➢ Set developmentally appropriate goals for child</td>
</tr>
<tr>
<td>➢ Being female</td>
<td>➢ Provide accurate feedback to the child</td>
</tr>
<tr>
<td>➢ Good Communication Skills</td>
<td>➢ Uses firm but loving boundaries</td>
</tr>
<tr>
<td>➢ Belief in something bigger than the self</td>
<td>➢ Believes in and practice a ‘higher purpose’</td>
</tr>
<tr>
<td>➢ Having close friends</td>
<td></td>
</tr>
</tbody>
</table>

#### Risk Factors

<table>
<thead>
<tr>
<th>Child</th>
<th>Parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Low self-esteem</td>
<td>➢ Low self-esteem</td>
</tr>
<tr>
<td>➢ Few problem solving skills</td>
<td>➢ Violence or unresolved conflict between adults</td>
</tr>
<tr>
<td>➢ Difficult temperament</td>
<td>➢ Low marital satisfaction</td>
</tr>
<tr>
<td>➢ Unloving and reject love from others</td>
<td>➢ High criticism/low warmth interactions</td>
</tr>
<tr>
<td>➢ Difficult early attachments</td>
<td>➢ Condition love</td>
</tr>
<tr>
<td>➢ Tendency to see things literally</td>
<td>➢ Excessively high or low goals set for the child</td>
</tr>
<tr>
<td>➢ Fear of failure</td>
<td>➢ Neglect of child’s basic needs</td>
</tr>
<tr>
<td>➢ Genetic vulnerability</td>
<td>➢ Inconsistent or inaccurate feedback for the child</td>
</tr>
<tr>
<td>➢ Being male</td>
<td>➢ Parents with drug or alcohol problems</td>
</tr>
<tr>
<td>➢ Poor communication skills</td>
<td>➢ Parental mental health problems</td>
</tr>
<tr>
<td>➢ Self-centred thinking</td>
<td></td>
</tr>
<tr>
<td>➢ Rejected/isolated from peer group</td>
<td></td>
</tr>
<tr>
<td>Protective Factors</td>
<td>Environmental Factors</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>School</strong></td>
<td><strong>Housing and Community</strong></td>
</tr>
<tr>
<td>➢ Caring Ethos</td>
<td>➢ Permanent home base</td>
</tr>
<tr>
<td>➢ Students treated as individuals</td>
<td>➢ Adequate levels of food and basic needs</td>
</tr>
<tr>
<td>➢ Warm relationships between staff and children</td>
<td>➢ Access to leisure and other social amenities</td>
</tr>
<tr>
<td>➢ Close relationships between parents and social</td>
<td>➢ Low fear of crime</td>
</tr>
<tr>
<td>➢ Good PSE in schools (I don’t know what this is?)</td>
<td>➢ Low level of drug use in the community</td>
</tr>
<tr>
<td>➢ Effectively written and implemented behaviour, anti-bullying, pastoral policies</td>
<td>➢ Strong links between members of the community</td>
</tr>
<tr>
<td>➢ Accurate assessment of special needs with appropriate provision</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Risk Factors</strong></th>
<th><strong>Environmental Factors</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>School</strong></td>
<td><strong>Housing and Community</strong></td>
</tr>
<tr>
<td>➢ Excessively low or high demands placed on child</td>
<td>➢ Homelessness</td>
</tr>
<tr>
<td>➢ Student body treated as a single unit</td>
<td>➢ Inadequate provision of basic needs</td>
</tr>
<tr>
<td>➢ Distance maintained between staff and children</td>
<td>➢ Little or no access to leisure and other social amenities</td>
</tr>
<tr>
<td>➢ Absent or conflictual relationships between staff and school</td>
<td>➢ High fear of crime</td>
</tr>
<tr>
<td>➢ Low emphasis on PHSEE</td>
<td>➢ High levels of drug use</td>
</tr>
<tr>
<td>➢ Unclear or inconsistent policies and practice for behaviour, bullying and pastoral care</td>
<td>➢ Social isolated communities</td>
</tr>
<tr>
<td>➢ Ignoring or rejecting special needs</td>
<td></td>
</tr>
<tr>
<td>➢ Fear of failure</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2

The following table gives some simple and clear thought about what to say and do and what not to say or do when working with young people who are self-harming

<table>
<thead>
<tr>
<th>Don’t</th>
<th>Do</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Panic</strong> – Unfortunately many young people self-harm – It is a complex issue and each young person will have a different reason or story behind their behaviour – panicking will not help the young person feel safe and contained.</td>
<td><strong>Stay Calm</strong> – Do not show anxiety, disapproval or disgust. Be prepared to be shocked then......</td>
</tr>
<tr>
<td><strong>Don’t send the young person away</strong> – Make some time for them – either help them find other ways of coping or support them in getting the right kind of support.</td>
<td><strong>Listen</strong> – Just being listened to can be a brilliant support and bring great relief to someone particularly if they have never spoken to anyone about their self-harming before.</td>
</tr>
<tr>
<td><strong>Don’t be judgemental</strong> – Keep an open mind about the behaviour and don’t refer to it as “attention seeking”.</td>
<td><strong>Listen Intently</strong> – Does not just require ears – Observe the young person’s non verbal clues – look at their body language – does what they say and what you see match up? What is the underlying mood state – Is it anger? Sadness? Frustration?</td>
</tr>
<tr>
<td><strong>Work Alone</strong> – You may still see a young person alone, but you will need to offload with an appropriate staff member or colleague from another agency. Seek advice and support for yourself- helping young people who self harm is difficult.</td>
<td><strong>Think carefully before you act</strong> – What is in the best interest of the young person.</td>
</tr>
<tr>
<td>Don’t offer to take the young person to your home environment. Don’t give them your mobile number or your house number – or get into texting the young person. It is more appropriate and professional for you to help the young person identify their supportive network, than for you to take this upon yourself.</td>
<td>Remember most episodes of self-harm have nothing to do with suicide. However the easiest way to differentiate between suicide and self-harm is by asking the young person what was their intent behind the self-harm behaviours.</td>
</tr>
<tr>
<td>Self-harming behaviours can be extremely concerning, but remaining calm and supportive and as objective as possible are the best ways to help</td>
<td>Treat a suicide intention as an emergency, do not leave the young person alone or in a vulnerable environment – get help and support as soon as possible and remain calm.</td>
</tr>
</tbody>
</table>
Appendix 3 GIRFEC Information Sharing policy

This policy is updated regularly so using this web link will ensure that the most recent version is used

http://www.shetland.gov.uk/children_and_families/GIRFEC.asp
1.0 INTRODUCTION

This protocol is designed to work with the Shetland Inter-agency Child Protection Procedures and Shetland Inter-agency Adult Procedures. It is also consistent with Getting It Right for Every Child.

2.0 BACKGROUND

2.1 It is recognised that within Shetland there is a small number of young people at risk of causing significant harm to themselves or others. This risk may be as a consequence of their own behaviour or a consequence of others behaviour towards them. The protocol is intended to give guidance for the assessment, decision making and co-ordination of a multi-agency response to the needs of this group of young people.

2.2 Work with young people involved in high risk activity/behaviours should be co-ordinated as part of a multiagency protection system. The protocol is necessary to ensure:

2.3 This protocol will assist agencies and professionals to plan and work together to help reduce risk to the young person or others affected by their behaviour.

2.4 Concerns about confidentiality must not obstruct the exchange of information between agencies/organisations which may be essential to the protection of young person’s at risk of significant harm to themselves or others.

2.5 This protocol is intended to complement the existing Child Protection, Adult Support and Protection and MAPPA Procedures. If there is any debate whether a case falls within this protocol or within the Child Protection, Adult Support and Protection or MAPPA procedures the Child Protection, Adult Support and Protection and MAPPA Procedures will always take precedence.

2.6 The examples given are not an exhaustive list of what can be considered under VYP protocol, professional judgement is required to be used to decide whether it will assist the young person.
3.0 **AIMS AND OBJECTIVES**

3.1 To identify young people who are placing themselves or others at risk of significant harm

3.2 To reduce the risk of harm to young persons and others

3.3 To undertake a multi-agency integrated risk assessment

3.4 To produce and review an outcome based VYP plan

4.0 **SCOPE OF PROTOCOL**

4.1 This inter-agency protocol is for all staff (including voluntary workers) working with young people aged 16-18 years in the Shetland Islands area.

4.2 These procedures should be implemented when agencies consider a young person's behaviour to be of a level of concern which could lead to serious physical and/or emotional difficulties to themselves or others. In some instances the level of risk may be life threatening.

5.0 **CRITERIA FOR REFERRAL**

5.1 Two conditions need to be met when someone is considering making a vulnerable young person referral:

5.11 There is no existing multi-agency plan and support in place for the Vulnerable Young Person or the referrer considers that the current multi agency support and plan is insufficient to manage the risk that the vulnerable young person poses to themselves or others

and

5.12 The situation meets one or more of the following criteria:

a) He / she regularly goes missing from home or their care placement and where concern has been expressed about their safety and well being (Consider regularity of absconding, pattern, possible destinations, absconding with others/alone, level of risk)

b) He / she is involved in chaotic and/or dependent drug, alcohol or volatile substance misuse. (*A clear deterioration in the overall situation characterised by an increase in substance misuse, evidence of dependency, evidence of beginning to inject, mixing different drugs and alcohol ie polydrug use, poor level of self-awareness, loss of control, health related problems.*)

c) He / she is sexually exploitative or exploited. Exploitative sexual behaviours are when individual(s) have power over a young person by virtue of one or more of the following – age, emotional maturity, gender, physical strength or intellect. This could be through an emerging pattern of concerning behaviours examples of which could include:
 The exchange of money or other forms of coercion (a young person may become involved in prostitution and may find themselves having sex in order that they have a bed for the night, food, cigarettes etc. Some young people become involved in abusive relationships which can result in serious emotional difficulties or violence )

 A young person is groomed or targeted through technology (social networking sites, mobile phones, web sites, message boards etc).

d) He / she is involved in serious incidents of self-harm. (Consideration needs to be given to the nature of the incident, pattern of behaviour/seriousness of incident/level of self-awareness/ likelihood of repeated action.)

e) His / her offending behaviour places themselves or others at risk of significant harm. (Any young person who is likely to meet the grounds for being placed in prison / secure accommodation / intensive support and monitoring may have their needs considered by this protocol.)

f) His / her violent or abusive behaviour places themselves or others at risk of significant harm. (Consideration to be given to level of verbal, emotional, physical and sexual aggression, their risk to themselves and others in their homes or in the community)

g) He / she has a mental health, additional support needs or learning disability which places themselves or others at significant risk

h) He / she is involved in an abusive relationship which places themselves or others in danger (Consideration to be given to level of verbal, emotional, physical and sexual aggression)

Undue Pressure/ Consent/ Capacity

The law in Scotland relating to people with mental disorder is (as defined in Mental Health Care & Treatment Act 2003) designed to strike a balance in protecting those people who do not have the capacity to consent or are vulnerable to the risk of harm, whilst upholding and preserving the rights of those people who do have the necessary capacity to consent.

The Adult Support and Protection (Scotland) Act 2007 permits council officers to investigate circumstances where individuals may have capacity to choose but not the ability to exercise that choice because of Undue Pressure.

➢ Undue Pressure occurs in situations where it appears that harm is being, or is likely to be, inflicted by a person whom the adult has confidence and trust in;
➢ Undue pressure may also occur in circumstances where the adult at risk is afraid of or being threatened by another person.
Capacity

The law starts from the assumption that all individuals have capacity. Capacity is a legal test which is decision specific. If someone has a mental disorder this does not mean that they necessarily lack the capacity to consent. Sect 6 Adults with Incapacity Act states “incapable” means Incapable of –Acting on decisions; making decisions; communicating decisions; retaining the memory of decisions and understanding decisions. For example, With regards to sexual relations, the person needs to understand that a sexual relationship is distinctly different from other forms of relationships. They need to understand the nature of the sexual act and the possible consequences of it as well as being able to communicate their consent or dissent and be able to act on this decision. A decision about whether a person has capacity must be made by a medical practitioner this should involve consultation with those who are involved with the person professionally or in a caring role.

In the case of a child, consent within the context of child abuse is irrelevant. Any concerns that reach the threshold for child protection intervention should be considered under Shetland Interagency Child Protection Procedures.

Information Sharing

There is nothing in Scottish, United Kingdom or European Law that prevents practitioners from sharing personal information, and in some cases sensitive personal information, where they are worried or concerned about a child or young person’s wellbeing or safety. This is strengthened through legislation via the Children and Young People’s Act 2014.

6.0 REFERRAL PROCESS

6.1 Any worker from an agency or organisation who is concerned about the high risk behaviours of a young person up to the age of 18 should contact the Duty Social Worker in the Children and Families Social Work Team.

There may be occasions when the Duty Social Worker may direct the referral to the Through Care and Aftercare Team if the young person is or was a looked after child or to the Criminal Justice Team if the young person is involved in offending.

6.2 The situation of some young people aged 16-18 may met the three point test for Adult Support and Protection and in this case the Duty Social Worker in the Children and Families Team should liaise with the Duty Senior Social worker in the Community Care Team. The result of this discussion should be an agreement about which Team is going to respond to the referral.

6.3 It is good practice to inform the young person unless it is impossible to do so or to do so would increase the risk to the young person or others.

6.4 Decisions regarding involvement of parents / carers should take account of the views of the young person.
6.5 If, following discussion, the referrer and the Duty Social Worker agree the criteria for a Vulnerable Young Person has not been met the matter will be managed through existing processes e.g. a multi agency meeting (for children).

6.6 If the young person’s situation meets the criteria then consultation with other agencies as detailed below should happen. Young people aged 16-18 will have a Named Person who should be notified and involved in interagency discussions. In some cases it will be the Named Person who has made the referral to children and families social work. For young people who are in education their School will provide a Named Person. For those not in schools the Duty Social Worker will know what arrangements have been put in place.

7.0 INTER-AGENCY DISCUSSION

7.1 If the situation of the child or young person suggests that there is immediate high risk then a strategy meeting should be convened and child protection processes – even if the young person is over 16 – should be followed. A strategy meeting should put into place an interim safety plan.

7.2 If the situation is not of immediate risk then the young person’s situation should be discussed at the Children’s Services weekly screening meeting and a plan put in place.

7.3 A decision should be made about the need for a vulnerable young person’s conference.

7.4 A VYP meeting should be held within 10 days of the decision to hold the meeting.

7.5 The Named Person for the Young person should be notified of this referral and meeting.

8.0 VULNERABLE YOUNG PERSON’S MEETING

8.1 The meeting will be chaired by a Team Leader or Senior from the Children and Families Social work. This will be convened under GIRFEC processes with the expectation is that the allocated social worker acting as Lead Professional will complete an assessment and draft child’s plan.

8.2 The young person will be encouraged to attend. If they choose not to attend their views must be sought.

8.3 The initial VYP meeting will:
- Share all relevant information.
- Consider the information in respect of risk and need.
- Agree what further assessment is required for the review meeting considering any relevant risk assessment tool available, any specialist who can contribute etc.
- Agree an interim Childs Plan with clear action allocated to professionals.
- Give the young person’s rights full consideration.
8.4 The minutes of the meeting will be approved and distributed by the Chair within ten working days.

8.5 For young people and/or parents/carers who are difficult to engage professionals need to assess all available information and assess the implications for the failure to receive appropriate support/services. Professionals should take steps to ensure that young people and/or parents are able to make informed choices and be flexible in negotiating alternative means of offering support/services.

8.6 If a young person has come under the VYP protocol before the age of 21 years they will remain under the protocol until the group working with the young person agrees they should come off.

9.0 VULNERABLE YOUNG PERSON’S (VYP) PLAN

9.1 The Interim Child’s Plan with risks and management included will be circulated within three working days of the initial VYP Meeting.

9.2 A Lead Professional will be identified and core/review group membership established. Depending on the level of risk identified the Lead Professional is likely to be an allocated social worker, but it may be appropriate in some cases for the Lead Professional to come from another agency if that professional has a good working relationship with the young person.

9.3 The Interim Child’s Plan will identify who is responsible for providing feedback and getting the views of the young person if they did not attend.

9.4 The identified lead professional must further develop the Interim Child’s Plan to a full outcome based plan for the first core/review group meeting.

9.5 The Named Person should be given a copy of the finalised Child Plan by the Lead Professional.

10.0 CORE GROUP

10.1 The initial core/review group will be held within 21 days of the initial VYP meeting and will be chaired by the Senior or Team Leader from the Children and Families Social work Team.

10.2 Core/Review groups thereafter will be held 4-6 weekly and will be chaired by the Lead Professional.

10.3 All core/review groups must review the current level of risk to the young person.

10.4 The core/review group will oversee the implementation of the Child’s Plan. They can make amendments to the Child’s Plan as agreed. Any significant change must be discussed with the Senior or Team leader from the Children and Families Team.
10.5 The core/review group can at any time request a review VYP meeting.

10.6 All core/review group meetings must be minuted and the minute distributed within ten working days.

11.0 REVIEW

11.1 The first VYP Review Meeting will take place within three months and subsequent reviews will be held at six monthly intervals thereafter.

11.2 It will be chaired by the same Chair as the Initial meeting, wherever possible.

11.3 If required, a comprehensive risk assessment will be completed for the first review VYP meeting.

11.4 If all are in agreement that the risks have significantly reduced and the child/young person is no longer considered to meet the risk criteria a decision should be made that the child/young person should no longer be subject to a VYP plan. If this is the decision a minimum of one final core/review group must take place following the Review VYP meeting. No agency will end their involvement prior to this core group without full discussion with the other agencies involved.

12 WORKING WITH YOUNG PEOPLE

12.1 Young people need to be empowered to participate as fully as possible in this process. They may need assistance from an advocate or the Children’s Rights’ Service in order for their views to be heard.

12.2 Some vulnerable young people may be very difficult to engage with and whilst every effort should be made to try and work with them there may be times when this is just not possible. A decision to close a case or withdraw support should only ever be a last resort when all attempts have failed and should be taken by a review VYP meeting.

Shetland Child Protection Committee
August 2015
Young Person at risk is identified

Do you believe the Young Person meets the Vulnerable Young Person criteria (see guidance)

Yes

Contact the Duty Social Worker Children and Families Social Work Team to discuss:

No

Notification/Discussion with Named person
Offers of single agency support

Referrer and Duty Social Worker agree Vulnerable Young Person criteria met

Referrer and Duty Social Worker agree the Young Person does not meet the Vulnerable Young Person criteria

Manage situation through existing services or signpost to alternative support

No further action or manage through existing services or signpost to alternative support

Duty Social Worker contacts Team Leader

IRD to be convened

Agreement about lead agency who will in turn convene a Vulnerable Young Person’s Meeting within 10 working days

Do you believe the Young Person meets the Vulnerable Young Person criteria (see guidance)

Notification/Discussion with Named person
Offers of single agency support

Referrer and Duty Social Worker agree the Young Person does not meet the Vulnerable Young Person criteria

Manage situation through existing services or signpost to alternative support

No further action or manage through existing services or signpost to alternative support

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Contact Details for Shetland Islands VYP Protocol

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<thead>
<tr>
<th><strong>Children and Families Team</strong></th>
<th><strong>Adult Services</strong></th>
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<tbody>
<tr>
<td>Duty Social Worker</td>
<td>Duty Social Worker</td>
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<tr>
<td>01595 744421</td>
<td>01595 744400</td>
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</tbody>
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<tr>
<th><strong>Out of Hours Duty Social Worker</strong> (Adults and Children)</th>
<th><strong>Shetland Adult and Child Protection Committee</strong></th>
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**Police Scotland**
Lerwick Police Station
Lerwick
Shetland
Tel: 101

In an emergency call 999

The Child and Adult Support and Protection procedures are available via the above website.