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Protecting Children: A Shared Responsibility

GUIDANCE FOR HEALTH PROFESSIONALS IN SCOTLAND: SEPTEMBER 1999

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Protecting Children: A Shared Responsibility

PREFACE



Ms Susan Deacon, MSP
Minister for Health and Community Care

Children are our future. It is the responsibility of all of us to give them the best possible start in life and to encourage them to fulfil their full potential as adults.

Providing support services to families and children can offer prevention from child abuse. It is important that good communications and inter-agency working is part of our approach to ensure that children are

protected.

This document is one of two national guidance documents being prepared by the Scottish Executive and child protection agencies to clarify and restate the roles and responsibilities of individual professions working with children. The second national guidance document, being prepared by the Education Department, is about to be commissioned. The report is in line with the primary guidance, 'Protecting Children -A Shared Responsibility: Guidance on Inter-Agency Co-operation' which was published in 1998 and complements the publication 'Scotland's Children -A Brief Guide to The Children (Scotland) Act 1995'.

This document specifically aims to provide user-friendly information for all health professionals in Scotland. It will be valuable to those who may very rarely come into contact with an abused child or children and their families. It is also an important source of advice for staff who have had more experience in this area and highlights the need for child protection training to be made available for all staff. In addressing multi-disciplinary and multi-agency working and communications, this comprehensive guidance sets out Health Board and Trust specifications, as well as the role and responsibilities of individual health care professionals who are, or may become, involved in dealing with child abuse.

This guidance should be regarded as a working document which should be readily available to all health staff in Scotland. I am pleased to commend this publication to you.

A handwritten signature in dark ink, appearing to read 'Susan Deacon'.

SUSAN DEACON

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Protecting Children: A Shared Responsibility

Chapter 1: INTRODUCTION AND REMIT OF GROUP

This introductory chapter

- Outlines the remit and aims of the Working Group Child Protection Guidance.
- Refers the reader to complementary Scottish publications.
- Highlights the need for the sharing and communication of information between agencies, while also balancing the need for confidentiality and openness.
- Reinforces the welfare of the child as being paramount in making decisions about them and their need to be consulted.

This Guidance has been prepared by a Working Party (Annex A) set up by the then Department of Health at The Scottish Office with the following remit:

"To prepare updated guidance for health professionals on their roles and responsibilities in respect of child protection in the light of organisational c) Act 1995. changes within the National Health Service and local authorities and the introduction of the Children (Scotland)"

This is one of a series of new national guidance documents being prepared by The Scottish Executive and child protection agencies to clarify and restate the roles and responsibilities of individual professionals working with children, inter-agency Child Protection Committees and their constituent bodies. The core guidance is Protecting Children - A Shared Responsibility: Guidance on Inter-agency Co-operation (1998), (a summary overview is attached at Annex B), which complements The Scottish Office Scotland Children Regulation and Guidance Volumes 1-4 (1997) issued on the Children (Scotland) Act 1995, and these should be read in conjunction with this document. Guidance for Education Staff produced by The Scottish Executive Education Department (SEED) will be forthcoming.

The core guidance states that the welfare of the child is the paramount consideration when his or her needs are considered by Courts, Children's Hearings, local authorities and others and that the child's views, taking appropriate account of age and understanding, should be taken into account where major decisions are to be made about his or her future.

Health professionals' involvement in child protection, working alongside families and staff from other agencies, highlights the importance of sharing information and communication but also makes the balance between confidentiality and openness a key issue.

This guidance aims to:

- provide accessible information for health professionals in Scotland both for those who may very rarely have contact with an abused child or children and their families, or for staff who have had more experience or where this is a primary area of responsibility.
- provide a framework for Health Boards and Trusts as they develop strategies for assessing the risk of child abuse and neglect in their population as the basis for support and surveillance by health services and multi-agency prevention of child abuse.
- clarify the role of health service organisations and individuals in inter-agency collaboration.
- assist Boards to commission local health services to provide the full range of prevention, investigation, support, treatment and long-term follow-up for the physical and mental health needs of children and their families, when child abuse is suspected or confirmed.
- outline the role of health services in identifying potential abusers as part of pre-employment screening.
- highlight the need for child protection training to be available for all staff.

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Protecting Children: A Shared Responsibility

Chapter 2: BACKGROUND

This background chapter

- Defines the types of abuse against children and identifies modes of presentation in the health care setting.
- Identifies situations of risk.
- States the principles of the UN Rights of the Child and subsequent legislation in Scotland.
- Makes reference to the Children (Scotland) Act 1995.
- Refers to the need for consideration of the social and cultural context of the child and family.

Children's health and development may be harmed, either suddenly or over a longer period of time, by abuse or neglect which may take a number of different forms. These may occur either alone or in a combination of different types of abuse against one child or group of children:

- Physical injury
- Sexual abuse
- Non-organic failure to thrive
- Emotional abuse
- Physical neglect

(See Glossary of Terms Scottish Office 1992)

There is no commonly accepted view of how much child abuse happens and how this has changed over time (National Commission of Inquiry into the Prevention of Child Abuse 1996). Child abuse may present as an emergency in the form of a serious physical injury or after a sexual assault or following the sudden discovery of abuse which has been going on for a long time in secret. However, more subtle signs and symptoms of abuse may be noticed by, or

revealed to health staff, in the course of their contact with the child and/or family for often an unrelated reason. Concerns about possible child abuse may be shared in confidence with health staff by neighbours or members of the extended family, or referrals may come from teachers, social workers or police.

The abusers may be adult members of the family or carers, adult friends, strangers, an organised network, the mother (or other adult) in the case of an unborn child and other children. Risk factors include domestic violence, post-natal depression or other mental illness in a parent or the circulation of pornography by organised networks, resulting in the systematic abuse of groups of children. When a parent or carer repeatedly presents a child as ill by fabricating history, signs or symptoms, the condition of Munchausen by proxy should be considered.

The UK Government is committed to the principles set out under the UN Convention on the Rights of the Child and the European Convention on Human Rights. The Children (Scotland) Act 1995 is founded on the following principles and themes which are directly relevant to health care staff involved in child protection. These are:

- each child has the right to be treated as an individual.
- each child who can form his or her own views on matters affecting him or her has the right to express those views if he or she wishes.
- the child's views should be taken into account where decisions are made about his or her future.
- each child has the right to protection from all forms of abuse, neglect or exploitation.
- parents should normally be responsible for the upbringing of children and should share that responsibility.
- in decisions relating to protection of children every effort should be made to keep the child in the family home, providing that this is consistent with the child's welfare.
- any intervention by a public authority in the life of a child should be properly justified and should be supported by services from all relevant agencies working in collaboration.

The Children (Scotland) Act 1995 alters the traditional concept of parents having rights over their children to one where both parents have responsibilities towards their children. The Act ensures that children must be consulted and their wishes and views taken into account whenever major decisions are being taken which may affect them. Social work services and police have statutory responsibilities in relation to the welfare and protection of children ([see Chapter 10](#)).

For the purposes of Chapters 2 and 3 of Part II of the Children (Scotland) Act 1995, the definition of a child is someone who has not reached the age of 16 years, although a child can include those up to 18 if there is a supervision order made by a Children's Hearing in force in

respect of them. For the purposes of supporting children and families Chapter 1 of Part II defines a child as a person under the age of 18 years. While therefore child protection procedures may not be appropriate for those over 16 years, authorities still have responsibilities towards children in need over that age. In the Health sector there are differing age criteria applied for children treated in the hospital and community sector and within different specialties.

The implications of the Children Act for health professionals mean that the child who may have been abused must be the focus of all child protection activity, using a child-centred and sensitive approach. This focus has then to be widened to include key family members within the social/cultural setting in which they live.

Whenever there is concern about the possibility of any type of child abuse, it should be considered in the social and cultural context of the child and the family. Particular care should be taken to involve appropriate people as interpreters where English is not the first language. Similarly in situations where the people involved may have visual, hearing or other impairment e.g. speech disorders or illiteracy, or have other disabilities, then appropriate methods of communication must be clearly established.

Health care staff looking after patients and families may need to consider the possibility that adult patients, and health care staff, may have been the victims of child abuse at some time or may be abusers of children in their care.

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Protecting Children: A Shared Responsibility

Chapter 3: NHS LINKS WITH OTHER CHILD PROTECTION AGENCIES

This chapter

- Stresses the need for key child protection inter-agency contact points for health care staff.
- Promotes local co-operation between agencies.
- Outlines the present and future role of the

Key Inter-agency Contact Points

Public inquiries in Scotland and elsewhere in the UK (London Borough of Greenwich and Greenwich Health Authority 1987, Cleveland Report 1988, Fife Report 1992 and Clyde Report 1992), and research studies (DoH 1995) into the operation and effectiveness of child protection systems have found that agencies need to share information and co-operate with each other in planning and delivering help and services to vulnerable children to be effective. Circular SWSG 14/97 (Annex C) assigns to inter-agency Child Protection Committees (CPCs) a role in the production of local procedures to assist agencies in working together.

Many different professionals in statutory agencies and other organisations have contact with children at risk of harm - these include social workers, medical, dental and nursing staff and other health professionals, teachers, educational and clinical psychologists, community education workers, the Children's Reporter, Procurators Fiscal, the police, staff of voluntary organisations and the Armed Services. (Annex D describes the special arrangements for child protection in relation to service families.) Local authorities have a legal duty to safeguard and promote the welfare of children in need in their area and this responsibility is carried out by the department with responsibility for social work services. Education, health services, the police and other departments and agencies also have

significant responsibilities for the protection of children. Some children will need protection through action under local child protection procedures, Children's Hearings or Courts. Many others will need other forms of help and support on a voluntary basis from a range of agencies, and in particular education, social work and health services.

The Child Protection Committee should ensure that advice across agencies is available locally. All agencies should have ready access to advice from social work services about child protection, local procedures and family support services. Social work services in turn may need advice from medical, nursing and child and adolescent mental health services.

Promoting Local Co-operation - The Role of Child Protection Committees

Co-operation in child protection is underpinned by joint agency procedures prepared by local inter-agency Child Protection Committees (CPCs), who monitor and regularly review local inter-agency child protection procedures, and help different agencies improve understanding of each other's roles and functions in child protection. Representatives of CPCs regularly meet with The Scottish Executive to discuss child protection policy and implementation issues.

Circular No SWSG 14/97 (reproduced at Annex C) provides guidance on the following matters in relation to CPCs:

- purpose and functions
- budgetary arrangements
- accountability and authority
- agency representation
- appointment of office bearers
- conduct of meetings
- sub-committees
- reports from and to CPCs.

In response to the Kent Children's Safeguard Review (SO 1997) the Government accepted the recommendation that the role of CPCs should be reviewed. This is being taken forward in 1999. Re-organisation of local government in 1997 increased the number of local CPCs and Authority Reporters with whom Health Boards must liaise. When the Health Board relates to several CPCs it may be appropriate for the designated nurse/doctor formally to delegate responsibility for some CPCs to named professionals from local Trusts.

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Protecting Children: A Shared Responsibility

Chapter 4: HEALTH INPUT INTO PREVENTION OF CHILD ABUSE

This chapter

- Promotes inter-agency working by health care staff.
- Outlines ways of working to protect children.
- Alerts health professionals to ways of supporting children and their families in good parenting.
- States the need for all health staff to have basic knowledge of child abuse and neglect.
- Discusses Children's Service Plans and their development framework.
- Suggests the inclusion of prevention of abuse is included in the school curriculum.
- Identifies the potential role of the School Nurse as an example of health promotion in the prevention and early detection of child abuse.

Working Together to Protect Children

Everyone who works with children and families should be alert to signs that a family is under stress or in need of help with bringing up their children. Early support may help the child or family to tackle problems, improve coping and prevent the risk of significant harm. Guidance on supporting vulnerable children and families is contained in Scotland's Children: Children (Scotland) Act 1995 Regulations and Guidance, Volume 1 - Support and Protection for Children and their Families. Where professionals suspect child abuse or neglect they should consult with senior staff or designated child protection officers, or contact the social work service, the police or the Children's Reporter directly for advice. Any person who believes or suspects that a child is being abused or is at risk should tell the social work service, the police or the Children's Reporter about their concerns. A National Commission of Inquiry into the Prevention of Child Abuse (1996) identified components of child health services required to prevent child abuse or neglect. The aims included specified health checks to take account of child protection concerns, health promotion and prevention and family support and to follow up all children who miss appointments. The strategy suggested to achieve these were:

- core health surveillance programme
- multi-disciplinary collaboration
- interviews with parents and children in supportive settings, for example, family centres and nurseries.

Child health services need to be accessible and supportive with greater emphasis on prevention (pages 89, 92-94).

Promoting Children's Welfare

Health professionals are responsible for the physical and psychological well-being of their patients. They may be the first to see symptoms of abuse or neglect, and should share information about concerns arising from suspicions with other agencies. The future emotional well-being of children is based on the early quality of their relationship with their carers. All professionals working with children and their families need basic information to develop awareness of child abuse and neglect and, where necessary, training to enhance their skills in recognising and identifying signs of physical injury or neglect, or sexual or emotional abuse. For example, midwives and health visitors should be alert to risk factors concerning abuse of drugs and alcohol, and/or mental health in pregnant women including a risk of post-natal depression. Domestic violence can be an important indicator for the risk of child abuse (Scottish Office 1998). The report on Confidential Enquiries into Maternal Deaths in the United Kingdom 1994-1996 *Why Mothers Die* (1998), estimate about 30% of domestic violence starts in pregnancy. Recommendations from the report include the use of simple screening in pregnancy, by sensitive questioning. Nurses and midwives caring for babies in neonatal units need to be aware that infants separated from their mothers may be at risk of developing problems with bonding and attachment which give rise to a higher incidence of child abuse. They should encourage bonding by promoting parent and child contact that forms the foundation of a parent/child relationship, for example through encouraging breastfeeding and assisting the development of good parenting skills. Early recognition and referral of families in difficulty will help promote children's welfare, the provision of support and ensure a prompt response to cases of suspected abuse or neglect. For example, health visitors, school nurses and other professionals can offer considerable advice and support to families under stress. Because of their daily contact with children and families and their specialist training and expertise in preventive health care, health visitors have a key role in supporting vulnerable families and children, helping parents care adequately for their child and ensuring that everything possible is done to avert situations where a child might come to harm. Joint training for professionals from different agencies is one important way to help them understand differing agency responsibilities and perspectives in order to work together more effectively.

So far as is consistent with safeguarding and promoting a child's welfare, public authorities

should promote the upbringing of children by their families. Where parents care of their children is 'good enough' to facilitate their safe development, health and other professionals should provide support and help in order to promote families staying together in the best interests of children.

The Children (Scotland) Act 1995 (Section 19) requires local authorities to prepare and publish Children's Services Plans in consultation with all relevant local interests including social work, health, housing, education, the Reporter, voluntary agencies and service users. Plans should set out the range and level of services available for children in the local authority's area, including local services for children and families in which there are concerns about child abuse and neglect. Child Protection Committees also produce annual reports outlining local inter-agency activity and developments in child protection.

Schools are taking steps within the curriculum to enable children to protect themselves through programmes of education in health and personal safety. Such programmes should deal with the risk to children of abuse or exploitation, not only by strangers but also by people they may know. The school health team should be actively involved with child protection initiatives within their schools and with staff training in the implementation of local child protection procedures.

The Scottish Office Social Work Inspectorate issued a report, A Commitment to Protect (1997); one of its seven recommendations was that all Education Authorities should have in place a Personal Safety Programme for pupils. A useful guide, Promoting Personal Safety and Child Protection in the Curriculum, was published in 1998, with funding from The Scottish Office.

The school nurse activities should contribute to prevention and early detection of child abuse by:

- health promotion, e.g.:
 - involvement with teachers in curricular health and social skills education
 - enabling assertiveness and pupil confidence through group work on specific issues.
- being approachable and available to school children for informal discussions where necessary.
- monitoring the health of the school population in collaboration with the school doctor.
- being involved in school liaison groups.
- supporting and enabling parents with problems to get the kind of help they need.
- liaising effectively with teachers and other professionals.
- developing health profiles of the school populations so that nursing services are targeted where they are most needed.

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Protecting Children: A Shared Responsibility

Chapter 5: PROVISION OF HEALTH SERVICES

This chapter

- Outlines the roles and responsibilities of Health Boards and NHS Trusts in Child Protection.
- Presents a Health Boardspecification for a child protection service.
- Suggests ways of implementing the specification at Trust level.
- Identifies the core responsibilities of clinical managers in the community and those of managers in Accident and Emergency Departments.
- Highlights policy and legislation in areas of staff selection, supervision and support, education and training of staff.
- Addresses research and audit.

When preparing plans for the management and delivery of local health care services, the Priorities and Planning Guidance is the framework to enable the NHSiS to focus on the most important national priorities. The context for this Guidance has been set by the Government White Papers Designed to Care : Renewing the NHS in Scotland (1997) and Towards a Healthier Scotland (1999) and the Comprehensive Spending Review. Against a backdrop of significant constitutional, organisational and service change, the agenda for the coming years emphasises the need to implement existing strategic plans which will deliver improved services to the patient and put in place measures which will ensure the performance of the NHSiS continues to improve in terms of quality, effectiveness and efficiency.

The Government has placed an important focus on improving the health and tackling inequalities of children and young people and this child protection guidance should be part of that attention given to developing services for the young. Health Boards, NHS Trusts and other agencies are required to work together in an open and collaborative manner to produce a Health Improvement Programme (HIP) for the population of each Health Board area. The process should be developed to ensure that the HIPs are collectively owned and seen as the

authoritative reference point for local health care systems. Children's Services Plans are the framework by which health and local authorities plan and deliver child health services, of which child protection is an integral part.

The HIP should build on existing strategies, produce a clear plan, demonstrate the multi-professional and multi-agency approach, recognise service developments and recognise the role of patients and local health councils. Each programme should identify measures, which include protection and safeguarding of the public health, the development of health promotion, and therefore child protection will be included. In addition the HIP will make clear reference to, and be supported by, strategies for human resources, estates, information management and technology and finance.

The principal agenda for the Trusts will be the implementation of the relevant Health Improvement Programmes and this will be supported by the production of a Trust Implementation Plan (TIP), which should involve clinicians, primary care practitioners and the Trust team. The plans must be agreed by the host Health Board to ensure they support the delivery of the Health Improvement Programme and that resource and finance assumptions are consistent. NHS Trusts have an explicit responsibility for the quality of care provided to their patients, and this accountability will be discharged utilising the clinical governance framework: clinical governance being defined as ***the corporate accountability for clinical performance***. Child protection will be included within this framework.

Responsibilities of Health Boards and NHS Trusts

Each Health Board should have a Commissioner with a responsibility for planning and commissioning child health related services, which should include a comprehensive, cohesive and effective child protection service.

Each Trust should identify a doctor and a nurse with responsibilities for liaison between health services including hospital and community services and establish links with Local Medical Committees and other appropriate committees involving individual practitioners, in accordance with the local Child Protection Guidelines.

The responsibilities of the Health Board include:

- commissioning an effective and comprehensive child protection service.
- ensuring that sufficient resources are available and that expert medical and nursing advice on child protection cases is made available to colleagues and other agencies when required.
- ensuring that there is a strategic workforce plan to provide therapists to support and treat children, in line with the Acute Services Review recommendations.
- taking a strategic lead for health and inter-agency child protection matters and co-operating with other agencies in planning, commissioning and monitoring services and undertaking the timeous review of inter-agency guidelines.
- ensuring appropriate managerial and clinical representation on the local Child Protection Committee(s).
- ensuring that the child protection service is consistent with the Health Improvement Programme for Children, Trust Implementation Plans and Local Authority Children's Services Plans.
- ensuring that the Health Board Commissioner responsible for Children's Services works with other Health Boards to ensure that the Health Board meets the obligations under the Children (Scotland) Act 1995 and works towards a consistent approach to good practice across Scotland.

The Health Board Specification for a Child Protection Service should include:

- a policy and framework to develop a comprehensive approach to the prevention of child abuse.
- the identification in all Trusts of a Senior Nurse or Doctor with responsibility for ensuring that there are appropriate guidelines and procedures in place and that the Trust and its staff comply with local child protection/child protection committee procedures.
- the identification of a Senior Nurse and Lead Clinician within Trusts with paediatric services with experience and training in child protection to ensure that there are appropriate guidelines and procedures in place and to ensure that the Trust and its staff comply with local child protection committee procedures.
- the introduction of a formal programme of training in child protection for all staff whose work brings them specifically into contact with children.
- the availability of programmes of training on child protection issues for all staff and these should be included in their general induction programmes.
- the identification of resources to ensure that inter-agency training programmes are in place.
- the establishment of a system of clinical supervision and support for all staff dealing with child abuse cases and a system of peer review.

- establishing a system for ensuring that all newly appointed staff with considerable access to children are checked against policerecords.
- ensuring the validation of professional qualifications with the appropriate professional body.
- the establishment of clear lines of responsibility and communication between other agencies, Trusts and the Health Boards.
- the promulgation of detailed guidance for the organisation of the health service to deal with suspected child abuse including modes of access to health professionals on call 24 hours a day, facilities available, inter-agency working arrangements and access to appropriately trained police surgeons.
- the introduction of a specific mechanism by which health carers may gain access to appropriate legal advice on child protection issues through the Central Legal Office.
- the establishment of an explicit mechanism to access advice from the appropriate lead commissioner at the Health Board.
- the establishment of a mechanism to cascade information to professions supplementary to medicine, as well as doctors and nurses.
- the implementation of a policy on record-keeping which states the purpose and format staff should use when recording information about patients, parents or carers.
- the establishment of guidelines and use of standard proformas to ensure the speedy transfer of the relevant records when the child and/or the family move in or out of the agency area, or information about missing families.
- the establishment of a mechanism by which a current list of Keepers of the Child Protection Register in Scotland is regularly disseminated to clinical managers and mechanisms are in place to identify at risk children as they utilise child health services.
- the promulgation of policies and guidelines for consent and confidentiality issues concerned with child protection.
- the promulgation of detailed guidance for the examination of children suspected of being abused including advice on the nature of the examination, the method of recording, appropriate facilities and equipment and arrangements for joint forensic examination where appropriate.
- the establishment of a comprehensive system for the follow-up of children suspected and proven to have been abused, including the identification and the provision of appropriate treatment as required by the appropriate clinician.
- the commissioning of services for the provision of therapy, counselling and support for children and families where abuse has occurred or where continuing support is needed, ensuring that adequate resources have been allocated.
- the implementation of a system to monitor a child protection element of child health service provision to include:
 - a Trust annual review of all staff whose work involves child protection cases
 - an audit of inter-agency services
 - a mechanism for professional practice accountability for all staff.

Trust Responsibilities and Roles of their Staff in Child Protection

The Trust is responsible for the implementation of the specification.

In line with the Health Improvement Programmes and Trust Implementation Plans, the Trust needs to ensure that a framework exists within which practitioners have the skills and appropriate knowledge to fulfil their responsibilities to protect children. Trusts should ensure that:

- in areas where children are cared for, a pro-active approach to protecting children and responding appropriately to instances of suspected or actual child abuse and neglect is the norm. Child protection may be only a small part of a practitioner's work, but it requires an informed awareness of known indicators as well as detailed knowledge of the local policies and guidelines/procedures of the Child Protection Committee and those of the Trust.
- there is effective leadership and clinical supervision in place which is underpinned with current knowledge and practice in the prevention, identification, assessment and management of child protection. All staff should recognise personal limits of experience and knowledge and not feel inhibited in seeking advice from the Senior Nurse/Lead Clinician Child Protection.
- staff are informed about changes affecting practice and of any additional resources required to fulfil the Trust's responsibilities towards protecting children.
- staff who are likely to come in contact with children or with families with children during their work have access to, and receive, appropriate child protection training, updating and clinical supervision.
- after completing the induction programme all staff understand the Trust's child protection policies, procedures and guidelines.
- the continuing training needs of practitioners are assessed and the workforce remains informed, knowledgeable, competent and performs to a high standard.
- effective communication systems between operational managers and practitioners and between the Senior Nurse/Lead Clinician Child Protection, other disciplines and units are in place. This is to ensure that a regular update about workload and staffing, emergencies, individual cases and changes in procedures is provided for the various units. The operation of the system should be evaluated and reviewed at regular intervals with the Senior Nurse and/or Lead Clinician Child Protection.
- where a case conference is called, relevant information from health services is collated, the Trust is appropriately represented and a system for continuing care and review is in place.
- systems are set up for formal notification of case conferences and formal notice of non-attendance when staff do not attend, together with a copy of any report sent in due to

absence, while ensuring prompt receipt of minutes from the case conference.

- where parent held child health records are in use, consideration should be given to the method of keeping parallel records in situations where there are concerns about abuse and/or neglect.
- to avoid loss of early information from notes, cases are regularly reviewed with staff to ensure that all information about the child or family is considered where children are suspected of having been abused or neglected.
- there is an agreed system for the timely transfer of health records about a child where there are child protection concerns.
- assistance is given in the preparation of inter-agency case review reports whenever a case involves an incident leading to a death of a child where abuse is confirmed or suspected, or a child protection issue is likely to be of major public or professional concern.
- ***the Trust should ensure that all policies are monitored and clinical practice audited.***

The Responsibilities of the Clinical Manager* in the Community

The core responsibilities of the Clinical Manager based in the community are outlined below and these also relate to the specialist clinical managers identified later.

Clinical Managers based in the community should:

- set up a communication system with appropriate health personnel, social work and education departments, Children's Reporter and voluntary organisations about current concerns as well as particular cases. Effective liaison between staff and those of other agencies should be demonstrated.
- regularly review caseloads and monitor those records where children are suspected of having been abused or neglected and, with the practitioner ensure that all the information about the family and child is reviewed.
- be informed about missing families or 'no access' visits, where there is a concern about a family or a child whose name is on the Child Protection Register. On receipt of the information, the manager is responsible for instituting the procedures of the NHS Trust without delay and ensuring that the Keeper of the Child Protection Register is informed if the child is not found in their Health Board area.
- ensure that the system for hand-over from the midwife to health visitor and health visitor to school nurse is effective.
- ensure staff have adequate legal advice when required to appear as witnesses in court

or to submit statements or other medical reports for the court.

- assist in determining the priorities of individual workers, recognising the time necessary for undertaking intensive work with families.
- ensure that appropriate systems of record keeping and reporting are established.
- give professional advice and information to other health professionals and agencies about the specific role of the health visitor in child abuse cases, and emphasise the importance of prevention, detection and ongoing support.
- ensure health visitors have up-to-date knowledge and training in post-natal depression and its early recognition and are aware of the difficulties caused by the condition for bonding between mother and baby, as well as making sure that appropriate referral for treatment mechanisms are in place.

The Clinical Manager for School Nurses

In addition to the core responsibilities, the clinical manager for school nurses should ensure that:

- there is a reliable system of hand-over from the health visitor to the school nurse.
- school nurses are aware of both the child protection procedures of the local authority and the local CPC guidelines.
- there is a system for informing the school nurse about all the children in her schools who are on the Child Protection Register and that nursing records are maintained, with the information contained in these being accessible only to those with the proper authority.
- the manager is informed at the earliest opportunity when a school nurse is aware of, or has become involved in, a case of suspected or known child abuse. The manager will wish to discuss the child and family with her in the light of the information that the school has provided and consider what further action should be taken.
- there is an effective system in place so that the school nurse can monitor and support these children, keep accurate records and offer reports as necessary.
- other professionals and agencies clearly understand the role of the school nurse with school age children.
- liaison takes place, as appropriate, with the local authority education, social work services and police.

The Senior Midwife

The Senior Midwife, who is usually the equivalent to the Clinical Manager, should in addition to the core responsibilities already identified, ensure that:

- there is an effective communication system between midwives and other practitioners.
- there is an agreed arrangement for hand-over between midwives and health visitors, ensuring the name and telephone number are exchanged within the first week after the birth.
- there is an early response to information of a pregnancy in a family where there has been an identified concern for the unborn child and other children, which may require a re-ordering of caseloads or redeployment of midwifery staff.
- parents with special needs, including learning disabilities, have their needs met, are supported and are referred where necessary to the appropriate source of support to enable the child to have appropriate care.

The Responsibilities of The Clinical Manager in Accident and Emergency Departments

The clinical manager should ensure that:

- the agreed procedures and guidelines are easily available and staff are familiar with them.
- there is always a clinical manager available to give advice and support to staff, particularly where there is a difference of opinion with other professionals or conflict with parents/carers.
- the agreed procedures for obtaining advice from the paediatric unit, whenever children who are suspected of child abuse are brought to the department, are followed.
- staff are aware of the potential risk to children, in situations where their mothers present to Accident and Emergency Departments, following injuries from domestic violence.
- there is access to all child protection registers and staff are familiar with the procedure for making enquiries of them. Consideration should be given to 'flagging' notes to highlight cases of risk. Staff should know how to obtain advice from the social work department at all times, and know how to contact the duty social worker.
- arrangements are in place to notify the health visitor or school nurse of all visits made by children up to the age of 16 years to the Accident and Emergency department.
- there are recording and reporting systems of all cases of suspected or actual child abuse admitted to the department and that there is a system for reviewing these records in place.

Staff Selection, Supervision and Support

Employers, and others, who recruit paid or unpaid staff or volunteers who have substantial unsupervised access to children must check applicants' previous employment history and take up references before any appointment. Employers should explore with applicants any gaps in employment history. They should supervise new staff carefully to monitor their relationship with children and so reduce the likelihood of child abuse. Health services must request information from the Scottish Criminal Records Office as to whether prospective recruits who will have access to children have any criminal convictions. This also applies to staff when they move to new posts which give them access to children. The arrangements for disclosure of criminal convictions for statutory bodies are set out in NHS Circular No. 1989(GEN)22. The Government has extended access to information about criminal convictions to voluntary child care organisations and the arrangements will be extended further when the provision of Part V of the Police Act 1997 come into force. This will, in due course, be subject to separate guidance.

Education and Training for Health Staff

All NHS Trust staff, who are likely to come into professional contact with children or with their families, should have access to and receive appropriate training, updating and clinical supervision. Access to training, relevant to the level of responsibility and involvement of the professional, in child protection work should be provided through pre and post-registration education and training and within induction courses. The respective clinician and senior nurse for child protection and the clinical managers are responsible for ensuring that they and their staff have an appropriate knowledge base and skills ([see Annex E](#)). This will be achieved through training, case review and clinical supervision.

All medical staff require training in the identification of children who may have been abused or neglected and in the implementation of the local child protection guidelines. Formal and informal undergraduate and postgraduate training should be available and include some components of inter-agency collaboration.

Paediatricians and police surgeons who are likely to be involved in specialist examinations of children suspected of abuse or neglect require further training in clinical skills, including video-colposcopy, report writing and court processes. Access to regular Continuing Medical Education to update and maintain these skills is essential. National agreement on core skills and experience leading to a process of accreditation is recommended.

All specialist paediatricians and police surgeons undertaking joint paediatric/forensic examinations require regular peer review, both locally and nationally. Informal opportunities to seek advice and support from peers in the management of complex and difficult cases should also be available. (See Section under [Chapter 8](#))

The Child Protection Committee has responsibilities for identifying inter-agency training needs and taking a lead role in developing and promoting inter-disciplinary training programmes.

Education and training enables policy makers and practitioners to evaluate the developing body of knowledge from research and implement relevant changes to practice. The content of education and training programmes on child protection for all health staff is contained in Annex E.

Research and Audit

Local and national research studies and audit projects are required to evaluate and monitor practice to inform both future service development and the maintenance of good clinical practice.

The diagrams overleaf offer flowcharts to highlight the processes involved when there are suspicions that a child has been abused or neglected.

*The term "Clinical Manager" is used in this document, but it is recognised that Trusts are changing their structures and this term may be obsolete. It is however necessary for each Trust to identify a person of equivalent status who will be responsible for fulfilling the identified tasks.

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Protecting Children: A Shared Responsibility

Chapter 6: SUSPECTED CHILD ABUSE AND THE ROLE OF HEALTH STAFF IN THE PROCESSES OF PROTECTION

This chapter

- Offers an overview of the referral process for all health staff involved in child protection.
- Takes a step-by-step approach through the referral process.
- Gives important general information on:
 - Referral
 - Planning Meeting or Discussion
 - Immediate Management
 - Health Involvement in the Child Protection Case Conference
 - The Parent's and Child's Involvement in the Child Protection Case Conference
 - The Child Protection Register
 - The Child Protection Plan
 - Missing Families on the Child Protection Register
 - The Legal System for the Protection of Children at Risk

The Referral Process

Referral

All allegations of child abuse or neglect, including anonymous referrals, should be taken seriously. Professionals should consider all cases with an open mind without assuming that abuse has, or has not, occurred. All referrals involving allegations of abuse warrant a carefully considered and measured response. Health professionals must be alert to the possibility of abuse of children in families they already know, whether or not they have been alerted to a specific concern through the referral process as, for example, cases of emotional abuse or physical neglect, may not be easy to recognise at the point of referral.

When a concern relating to the welfare of a child is raised, whether this is a clear allegation of physical or sexual abuse or a more general concern about the possibility of neglect or emotional abuse, professionals must share information with other agencies involved with the child (police, social work and education) before deciding what further action to take. This will ensure that an early assessment of any potential harm to the child can be made leading to a decision whether or not further child protection inquiries are needed. No one agency can make this assessment without full information and consultation with others. Health professionals or other agencies may separately record information about the child and family over time which may retrospectively suggest a degree of concern which had not prompted referral to social work services or the police. Bringing all this information together may indicate a much more serious level of concern about the child's situation requiring further investigation and intervention. The local authority social work service has the statutory duty to protect children, in partnership with other agencies.

Planning Meeting or Discussion (PMD)

Where significant concerns are apparent these early inter-agency discussions should lead into a planning discussion between senior experienced colleagues in the health, social work and police sectors. This Planning Meeting or Discussion will decide what form the child protection inquiries will take, including the medical component of any investigation. In urgent cases this discussion may take place by telephone where there is insufficient time to enable professionals to meet. Planning child protection inquiries should include discussion relating to:

- the nature of the alleged incident and significant background information.
- the timing, venue and type of any medical examination required e.g. a comprehensive or specialist (as detailed later), the need for a forensic component, the need for specialist photographic facilities, colposcopy and possibly video-colposcopy.
- how the child should be prepared and briefed for the whole process, taking into account emotional and health care needs.
- who will accompany the child to the medical examination, which should take into account the wishes of the child and the need, if possible, that this person should not be a potential witness.
- the timing of any joint police and social work interviews.
- who will give consent for medical examination or interview.

Close co-operation between professionals at the beginning of the investigation is crucial to the success of any subsequent intervention, ensuring that all available information and evidence is gathered timeously and its significance interpreted carefully by appropriately trained and experienced staff. Failure to work together in this way may lead to the loss of forensic evidence particularly in cases of sexual abuse and to the potential risk of delaying medical treatment in a

physically injured child with unsuspected internal abdominal injuries or intracranial bleeding.

The role of health care professionals in the process is detailed on Chapter 8.

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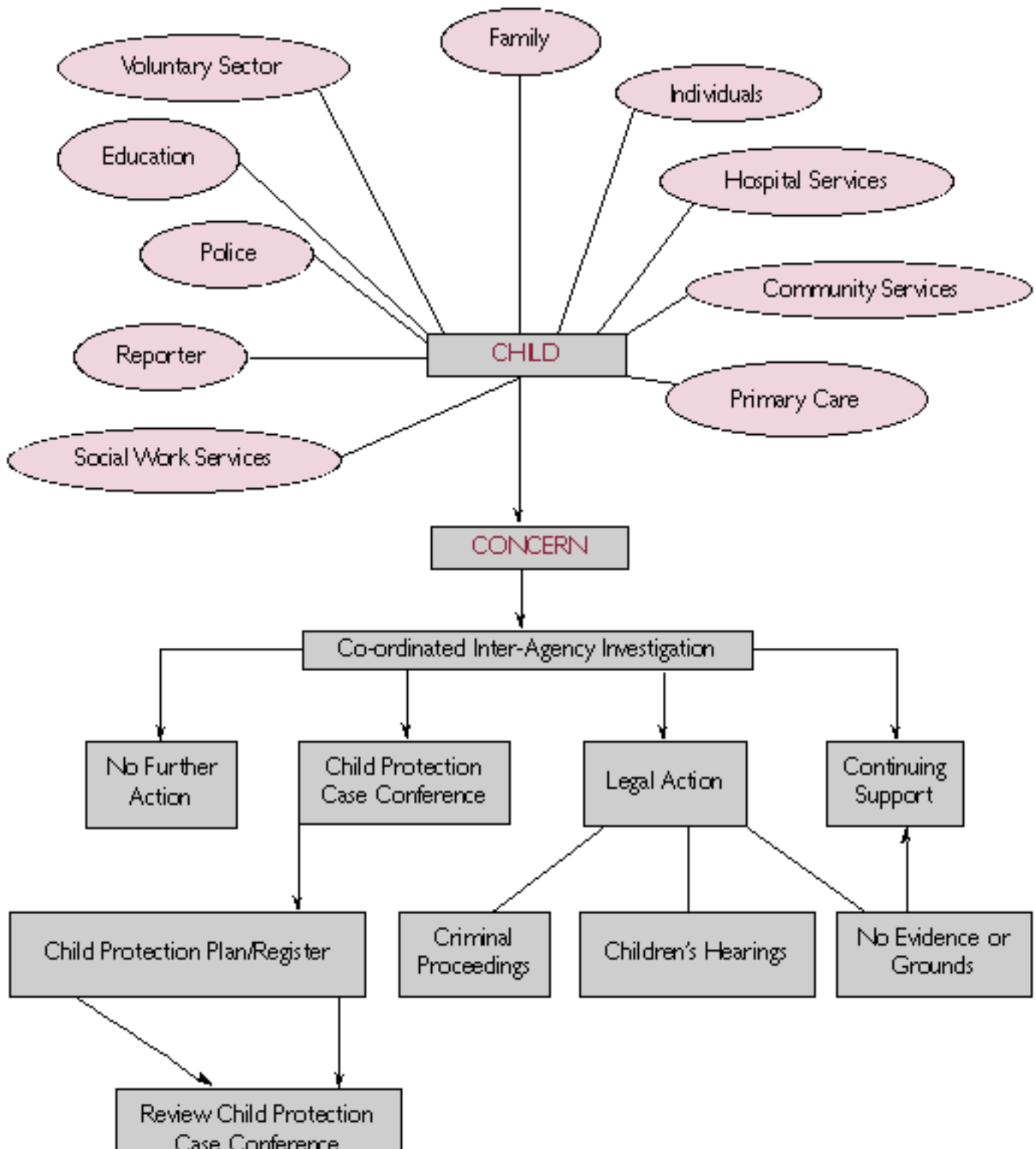
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Fig 1: AN OVERVIEW OF THE CHILD PROTECTION PROCESS



Review Child Protection
Case Conference

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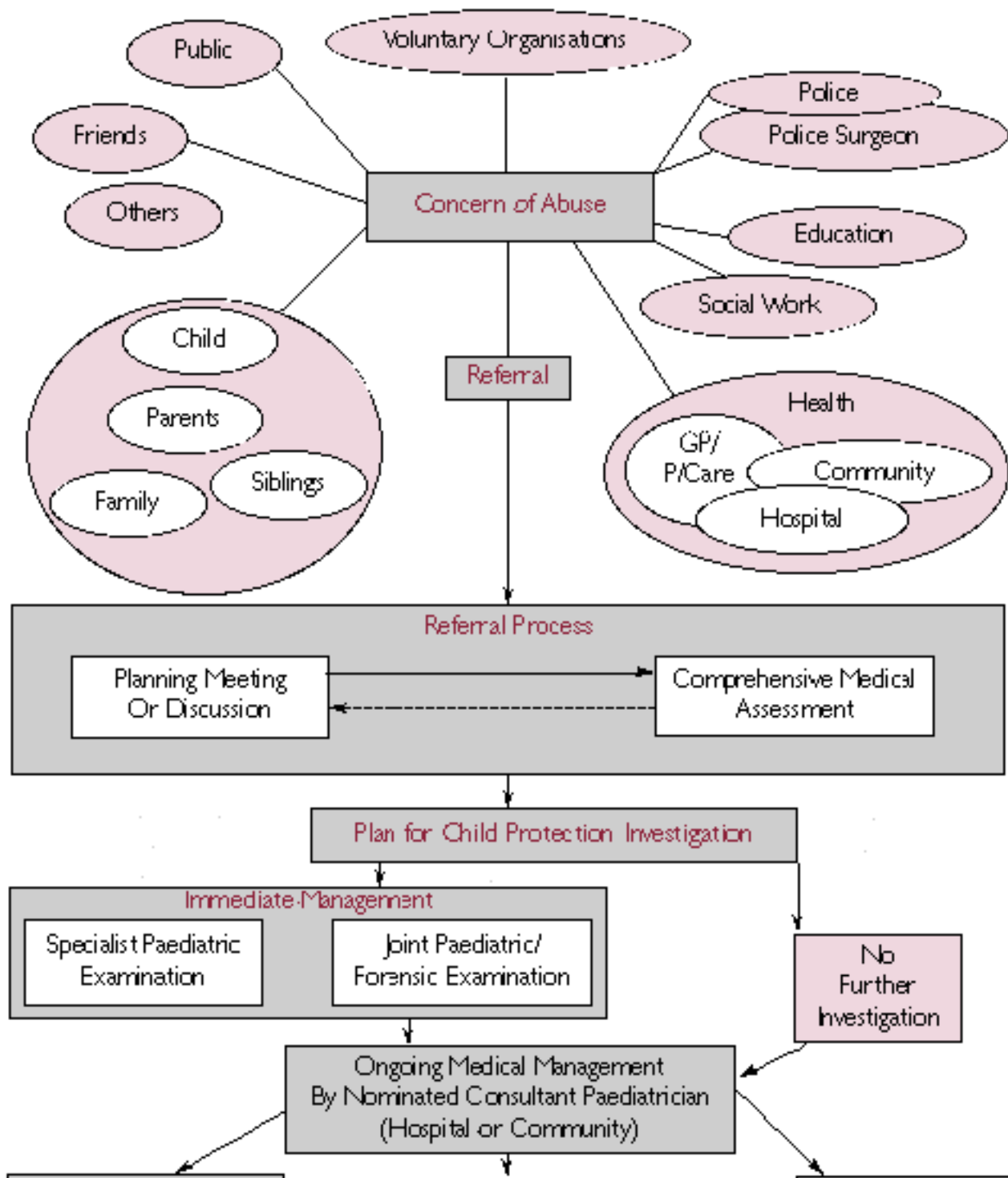
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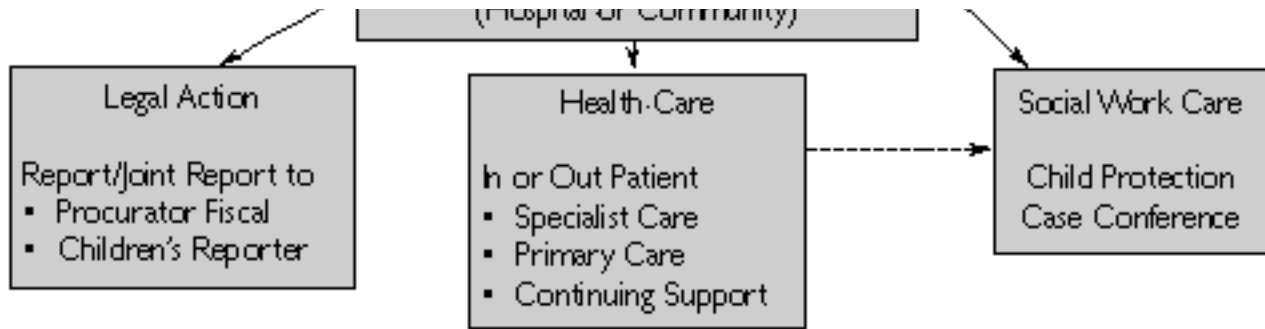
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Fig 2: MEDICAL ASSESSMENT AND CARE OF CHILDREN WITH SUSPECTED ABUSE/NEGLECT





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Comprehensive Medical Assessment (CMA)

It is important to note that the planning meeting or discussions may lead to a joint decision that no further investigation is required or that a "Comprehensive Medical Assessment" (or other form of medical intervention) is required before that decision can be made. In some situations presenting to health professionals the child may have already had a medical evaluation through direct presentation to the Accident and Emergency department, or to the general practitioner's surgery.

The role of doctors in this comprehensive medical assessment is detailed in Chapter 8.

Immediate Management

In situations where the child's immediate clinical condition is causing serious concern, the child should be referred immediately to the appropriate local hospital for emergency care. Where the primary care team have suspicions that the child has been deliberately injured they should make a clear request to the receiving senior clinicians to initiate child protection procedures and alert the local social work service.

In situations where the general practitioner is unsure whether the clinical presentation is due to abuse or illness, for example in a child with unexplained severe bruising which could be due to a haematological condition, referral to the hospital for a second opinion prior to initiating inter-agency discussions may be indicated. This would not be regarded as the formal planning meeting or discussion but a request for a paediatric second opinion. It is important that the primary care team provide the hospital paediatricians with any available social background and previous medical history, which may suggest that the differential diagnosis of abuse is possible.

It is also important for clinicians to note carefully any explanations given for injuries and be aware of giving away information to possible abusers about the medical causes for injuries, so that these explanations can then be incorporated by possible abusers into later explanations and statements given by them.

The child should be kept appropriately informed of the medical findings and should be supported throughout the process.

Once child protection inquiries are under way, the progress of the health component will take place in parallel to other aspects of the police and social work enquiries. It is therefore fundamental to the success of the process that health professionals ensure that their colleagues in other agencies are kept closely informed of their progress and findings, including their provisional conclusions so that decisions particularly relating to the child's immediate protection from further harm may be made appropriately. Medical staff should keep careful notes of any examinations and findings and provide written reports of these at an early stage to the police and local authority if the child's case is the subject of court proceedings or a Children's Hearing.

Health Staff Involvement in Child Protection Case Conferences

A Child Protection Case Conference (CPCC) may be called by the social work service at the conclusion of inter-agency child protection inquiries to gather all relevant information from the involved professionals and make an assessment of the probability that abuse or neglect has occurred and of the ongoing risk to the child and any siblings. In order to achieve this effectively it is vital that health professionals in the primary care team and any other medical or health staff involved in inquiries attend to describe and interpret medical findings and relevant background information. It may also be relevant for the health professionals involved in the secondary care of the child to attend.

Health professionals must be prepared to be open and honest about their views even in the presence of the parents who may also be their patients. Appropriate training, information and support to professionals in this aspect of their work should be made available. In some situations the practitioners may wish to be accompanied by a more senior member of staff but in general only those actively involved with the child and family should attend. Health professionals should normally provide written reports of their involvement and any assessment and findings to the child protection case conference.

A Child Protection Case Conference may have a number of objectives; it will undertake some or all of the following tasks:

- ensure that all relevant information is shared and collated.
- assess the degree of existing and likely future risk to the child.
- identify the child's needs and any services from any of the agencies that may be needed to help him or her, whether or not the case conference concludes the child is at risk.
- formulate or review a current child protection plan which includes a decision whether to

place a child on the Child Protection Register.

The Child Protection Case Conference is the mechanism for deciding that a child's name be placed on the local authority Child Protection Register. Any agency or professional may ask for such a conference but the social work service is responsible for its organisation.

The removal of a child's name from the register offers agencies more flexibility (see Protecting Children - A Shared Responsibility paragraph 3.10 page 22), but support may still be needed.

Children and Parents' Involvement in Child Protection Case Conferences

Professionals should actively seek to develop partnerships with parents and be honest and sympathetic towards parents, but without losing sight of the child's needs. Parents may need to bring someone to support them when they attend a case conference and written information about child protection case conferences should be made available to children and parents, in the form of local leaflets or national public information.

Case conferences should take account of children's views and feelings, having regard to their age and understanding. Whenever children are able to express their wishes and feelings and are able to contribute to assessment, planning and review, they should be invited to attend the case conference, if this is consistent with their welfare. The child should also be told that he or she can ask for someone to be present for support at the conference. If a child does not wish to attend, or if this is inappropriate, the professionals working with the child should make sure that the conference has information, in writing, about his or her views. The keyworker should make sure that the child knows about the plans for him or her.

The Child Protection Register

The Child Protection Register is maintained by the social work service. It is held separately from agency records or case files, in secure conditions. The social work service appoints a person to maintain and manage the Child Protection Register - generally known as the Keeper of the Child Protection

Register. The Keeper of the Register should make sure that all agencies know how to obtain access to information from the Register at any time. There should be 24-hour access to the Register for all professional staff who need to make an enquiry about a child as it provides a central point of rapid inquiry.

The Scottish Executive Children and Young Persons Group maintains a list of current Keepers of Child Protection Registers in Scotland, and contact points for Child Protection Registers in other parts of the UK. (**Telephone Number: 0131 244 5486**). All professional staff should notify the Keepers of local Registers of any changes in the details about children named on the Register.

When a health professional makes an inquiry of the Register by telephone, the Keeper will confirm the person's identity by calling them back at their place of work, before giving out information. The inquirer should be given the name, office address and contact telephone number of the child's keyworker, so that the inquirer can obtain relevant information directly. If the child about whom an inquiry has been made is not registered, but has the same address as another child named on the Register, the inquirer should be given the same information about the keyworker. In such circumstances the Keeper should also contact the keyworker to find out if there is a need to revise registration information, or for the local authority to make further inquiries. Where the keyworker is unlikely to be available, for example out of office hours, the social work service should make arrangements for minimum information to be disclosed directly to inquirers at the point of inquiry.

A note should be kept of all inquiries. The Keeper is responsible for notifying other local authorities of the need to transfer records when a family/child moves into, or out of, their area. The Keeper will also be responsible for attempting to trace a registered child whose whereabouts becomes unknown (see page 24, Missing Families on the Child Protection Register).

Consideration should be given to the automatic flagging of records pertaining to young children who are on the Register when accessing health services, especially accident and emergency services.

The decision to place a child's name on the Register should be taken by a Child Protection Case Conference, or the chair of the conference, when there are reasonable grounds to believe or suspect that a child has been suffering abuse or neglect, or the child is at risk of suffering abuse or neglect, and an inter-agency agreement is needed to protect the child. A child's name should be placed on the local Child Protection Register when:

- one or more of the criteria for registration are met; and
- when his or her safety and welfare is considered to require an inter-agency child protection plan.

The following minimum information about a registered child should be recorded:

- child's full name, known aliases, known address, gender, date of birth, age at registration;
- religious persuasion, race, cultural and linguistic background;
- date of first registration and date of next review case conference;
- legal status of the child, and any Court Orders or supervision requirements in force;
- full names (including maiden name), known aliases, and addresses of parents and/or others caring for the child, the name and address of any other adult member of the household together with information on their relationship to the child, and the name of any parent or person with parental responsibility living outwith the child's household;
- full name(s), date(s) of birth and gender(s) of any other children in the household;
- note of inquiries to register;
- whether the child has any disability and any special needs as regards communication;
- the name, contact address and telephone number of the keyworker for the child.

Outcome of the Child Protection Case Conference

Where child abuse or neglect is confirmed or strongly suspected and the child's name placed on the register, the CPCC will also put together a Child Protection Plan and appoint a keyworker.

Health professionals should make their views on the proposed plan clearly known and should ensure that appropriate colleagues are aware of the tasks or actions required. If they should subsequently find themselves unable to fulfil the agreed plan they must immediately alert their manager and the social work services.

All attending health professionals should receive the case conference minutes and must check these carefully, alerting social work to any errors and ensuring that, in particular, any dissension is clearly minuted.

Where a decision is made by the CPCC to refer the child on to the Reporter further written reports may be required.

Where it appears that information about the mental health of a family member may be relevant to considering the well-being of the child, a psychiatrist or other member of the mental health service should be invited to attend or give written advice, as appropriate.

Child Protection Plan

When the decision has been made to place a child's name on the Register, the Case Conference will proceed to draw up a Child Protection Plan identifying the services and appropriate support which will be required in order to protect that child and the ways in which that child's well-being will be monitored. Health professionals have a vital part to play in this process. Protection, treatment and other services for the child and family should be based on a comprehensive assessment of the child's and family's needs, including an assessment of the level of risk to the child. All cases in which a child's name is placed on the Child Protection Register require a comprehensive assessment. The keyworker is responsible for ensuring that a comprehensive assessment is undertaken. This is fully explained in *Protecting Children - A Shared Responsibility: Guidance for Inter-agency Co-operation* (1998) (pages 36-38).

These situations often provide an opportunity to complete surveillance and immunisation programmes, follow through hospital referrals such as ophthalmology or ENT appointments or treatment, as well as offering an important supervisory health role. The local authority should inform the child's parents or carers and, if he or she is of sufficient age and understanding, the child orally and in writing about the information held on the Child Protection Register and who has access to it. If a parent is concerned that information held on the Child Protection Register is inaccurate, they should be given an opportunity to discuss this with a manager in the social work service. Child Protection Committees should consider a local mechanism enabling parents to challenge decisions taken by an inter-agency Child Protection Case Conference, if they believe the decision is based on inaccurate or partial information or assessment or other objective grounds. (See 4.48 of *Protecting Children - A Shared Responsibility: Guidance for Inter-agency Co-operation* (1998))

When a registered child moves from one local authority to another, the child's name should be placed on the new authority's Child Protection Register pending a review case conference to discuss the child's new circumstances. The local authority in whose area the child was registered should retain responsibility for the management of the case until a review case conference has been held and arrangements agreed for the transfer of the inter-agency Child Protection Plan to agencies in the receiving local authority's area. However, the child may present to health professionals in the new area before that process is complete and health records should therefore be transferred rapidly to the new area with a clear alert to the primary health care team and community child health service that a registered child has moved to their area. Procedures must be in place to facilitate this.

The transferring local authority should provide the receiving local authority with comprehensive information in writing about the registered child(ren) and their family, and should include a social and family history, minutes of the last Child Protection Case Conference and a copy, or written details, of the Child Protection Plan. If a family in which a child has previously been named on the Child Protection Register moves to another local authority area, the transferring local authority should give the receiving local authority written information about previous

concerns and previous and current inter-agency involvement. Both authorities should consider together whether the family's new circumstances increase the likelihood of any risk to the child recurring, or whether the child and family may be in need of support. Health professionals in the area to which a registered, or previously registered, child has transferred should make early contact with the local social work service to find out whether there is a current Child Protection Plan and a keyworker with whom they should liaise.

Missing Families on the Child Protection Register

There should be a procedure in place which ensures that when a health professional is the first to become aware that a family with a child(ren) on the Child Protection Register disappears the senior medical and nursing personnel with child protection responsibilities are notified immediately and checks are made to ensure that all local contacts have been approached and all other action to trace the family locally has been taken. Contact with other agencies, e.g. the social work services and police should be made promptly. The enquiries made must be recorded in professional records.

If a new local address is obtained in the same Health Board, the named nurse should contact the designated or named nurse in that district, ask for it to be verified, and then make arrangements for the child's records to be forwarded as appropriate. In cases where the child or children have specific health needs or disability, the lead doctor for the child protection service should be informed so that appropriate contact may be made with paediatric services in the new area.

When the family moves to another Health Board there should always be an agreed system for the rapid transfer of all records of children whose names are on the Child Protection Register between Trusts and a Health Board and to Trusts in other Health Boards.

The Local Authority Keeper of the Child Protection Register is responsible for attempting to trace a registered child whose whereabouts become unknown.

In circumstances where health professionals have early concerns, exacerbated by the disappearance of the family, the responsibility would rest with the Health Board or Trust to make a decision on disseminating information to other Health Boards/Trusts, or other agencies about a family who have gone missing.

Section 30(1) and (3) of the Data Protection Act 1998 allows flexibility as to how the Act applies to information gathered for health and social work related functions.

Since 1 April 1999, all Health Boards, Special Health Boards and NHS Trusts have appointed

a Guardian of personal health information, in order to safeguard patient confidentiality within their organisation. These Guardians will be charged with promoting the highest standards for safeguarding patient information and responsibility for developing clear rules about disclosing information to other agencies or organisations.

Personal information disseminated by Health Boards/Trusts about missing families should be clearly justified on the basis of the individual case, and subject to scrutiny by the Guardian; a mechanism should be in place to ensure this.

From the practical point of view, knowing who and how to contact personnel from within and across agencies is crucial to effective working. A contact list should be available to staff. A guide is available in Appendix F.

Decision to Remove a Child's Name from the Child Protection Register

When the professionals who are working with the child and family decide that the risk to the child has been reduced, the local authority should remove the child's name from the Child Protection Register. A decision to remove a child's name should normally be made by a review Child Protection Case Conference with representation or views from all the agencies working with the child. If an agency does not think a child's name should be removed, this should be noted in writing, in the minutes of the Case Conference which considers de-registration. Child Protection Committee procedures should describe how these disagreements may be resolved.

Removal of a child's name from the Register should not necessarily lead to a reduction or withdrawal of services or support to the child or family by any or all of the agencies. The risk of child abuse or neglect may have been reduced but the child may continue to be a child in need, and require a variety of services from any or all of the agencies to safeguard and promote his or her welfare.

Legal Measures for the Protection of Children at Risk

The legal framework for child care in Scotland has the Children's Hearings System at its heart. *Any person* may refer a child to the Children's Reporter. The Children's Reporter examines the case impartially and decides whether or not to refer the case to a Children's Hearing. Children's Hearings comprise volunteer lay members drawn from a local Children's Panel, who will discuss a child's difficulties with the child and his or her family and determine how best to meet his or her needs. The Hearing may make a supervision requirement placing the child under the supervision of the local authority. If the child and/or his parents do not accept the

grounds for the child's referral to the Hearing, a Sheriff will hear evidence and decide whether the grounds exist. The child and the parents may also appeal against a Hearing's decision disposing of the case, or keeping the child in a place of safety on a temporary basis. A further appeal to the Sheriff Principal, or Court of Session is available to the child, the parents or the Children's Reporter. (Children (Scotland) Act 1995, Chapter 2, Sections 39-51).

In some cases local authorities must take urgent action to protect a child from significant harm. In some cases a child's parents may agree to the local authority providing the child with accommodation and looking after him or her, until concerns about the child's safety, or allegations of abuse or neglect, can be clarified. The local authority might also consider whether others in the child's extended family or social network could look after the child whilst agencies carry out further inquiries or assessment. However in some cases the risk of significant harm befalling the child may make it necessary for agencies to take legal action for his or her protection. Any person may apply to a Sheriff for a Child Protection Order (CPO) (Section 57 Children (Scotland) Act 1995), or the local authority may apply for an Exclusion Order (EO) (Section 76 Children (Scotland) Act 1995). The CPO authorises the applicant to remove a child from circumstances in which he or she is at risk, or retain him or her in a place of safety. The EO requires the removal of a person suspected of harming the child from the family home. A Justice of the Peace may also, in certain circumstances, authorise the removal of the child for a short period if a Sheriff is unavailable and, in limited circumstances, a police constable may take the child to a place of safety (Section 61 Children (Scotland) Act 1995).

The responsibility to take any urgent action to protect a child rests with the local authority within whose boundaries the child is located when such action is deemed necessary, even if the child does not normally live within that local authority's area. Other agencies or professionals may need to apply to a Sheriff for a CPO or to a Justice of the Peace, where a Sheriff is not available, for authority to remove a child where emergency protection is necessary. Any health professional contemplating such action should contact the local authority social work service for advice. If a local authority or any other person is considering emergency action to protect a particular child, the need for similar action to ensure the safety of any other children in the household should be considered at the same time.

The Children (Scotland) Act 1995 also makes provision for the local authority to apply for a Child Assessment Order (CAO) if it has reasonable cause to suspect that a child may be suffering or is likely to suffer significant harm and the parents or carers are refusing to allow the local authority to see the child (Section 55 Children (Scotland) Act 1995). The CAO requires the parents or carers to produce the child and to allow any assessment needed to take place to help professionals to decide whether they should act to safeguard the child's welfare. The authority may ask, or the Sheriff may direct, someone else such as a GP, paediatrician or psychiatrist to carry out all or any part of the assessment. Professionals must assist in carrying out these assessments when asked to do so and local procedures should make provision for this.

More detailed guidance on the provisions in the 1995 Act is contained in Scotland's Children: Children (Scotland) Act 1995 Regulations and Guidance - Volume 1 Support and Protection for Children and their Families.

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Protecting Children: A Shared Responsibility

Chapter 7: LISTENING, COMMUNICATION, CONFIDENTIALITY, CONSENT AND RECORD KEEPING

This chapter

- Outlines the required skills to ensure professional competency and effective working.
- Addresses confidentiality and professional accountability.
- Highlights consent issues.

Listening

When a child or a young person with a problem approaches a health care worker (or an adult reports abuse during childhood) the professional should listen carefully with sympathy and understanding. While a person's response to a revelation about abuse is coloured by their own life experience, they should avoid expressing shock or disbelief or to start questioning the abused person. The child may be frightened of revealing something which they have been told is a secret, whether in the context of a threat or a "special relationship". They may also be afraid that they will not be believed. It is possible to listen carefully and seriously to a child's report of abuse whilst keeping an open mind as to what may have occurred. A similar approach should be adopted if the source of information is someone other than the abused child.

Where information is offered, those receiving the information should listen carefully to what is being said, be attentive and responsive taking into account the child's age and stage of maturity and development, and allow the child to say what he or she wants to without being drawn into detailed questioning. Care must be taken to avoid undermining future inquiries or police investigation, for example by asking leading or multiple questions. The listener should record as accurately as possible anything a child has said, noting exact words, time, place and context, as far as possible, and should avoid summarising the child's account using the listener's words.

Children or young people who report abuse may be anxious about the information being shared with others. If necessary the listener should reassure them that he or she is right to talk to an adult about being hurt or harmed, and that the adult must take what the child has said very seriously. Any professional should make clear that other people may have to be informed to make sure that the child or young person can be kept safe and protected. They should not make promises to children or young people about confidentiality of information.

In most cases the listener should be able to explain to the child or young person who else will need to be told and why, giving a commitment to keep to a minimum the number of people who need to be informed. The professional should, as far as he or she is able, state what is likely to happen, and should find out the child's or young person's views and wishes to inform the next steps.

When a parent or adult refers concerns about a child, the person receiving the referral should ensure, as far as practically possible, that suspicions or allegations of abuse or neglect are not discussed in the child's hearing. This could prejudice the reliability of any information the child may provide later.

Communication

Participation in child protection covers a wide range of activities from prevention and raising of awareness, to examination and treatment of abused children, attendance at Child Protection Case Conferences and ongoing care of the child and their family. The Child Protection Case Conference is a multi-disciplinary meeting which brings together health, local authority staff, police, professionals and other relevant people concerned with the care and protection of the child. Responsibilities to work in partnership with families increasingly mean that the parents and children may participate in these meetings. In some cases of child abuse problems have arisen when professionals fail to communicate effectively and share information both vertically within a professional structure and between professional agencies involved with the child and their family. It is crucial for the benefit of the child that key people communicate effectively across professional boundaries in an atmosphere of trust.

Sharing Information

Personal information about children and families given to professional agencies is confidential and should be disclosed only for the purposes of protecting children. Nevertheless the need to ensure proper protection for children requires that agencies share information promptly and effectively when necessary. Ethical and statutory codes for each agency identify those

circumstances in which information held by one professional group may be shared with others to protect a child. Agencies should not disclose information given in confidence for any other purpose without consulting the person who provided it.

Confidentiality (The Scottish Office Department of Health, Professional Guidance issued by the GMC and UKCC, and the Caldicott Report on the Review of Patient-Identifiable Information)

Confidentiality of personal health information is the cornerstone of the patient/doctor/health professional relationship. In Scotland, guidance on handling personal health information rests on the Code of Practice on Confidentiality of Personal Health Information, issued to the NHS in 1990. The Code sets out the main principles which have to be followed by all NHS staff. The overriding principle of the Code is that information about the health and welfare of a patient is confidential in respect of that patient and such information should not be disclosed to other persons without the consent of the patient, except in certain well defined circumstances.

These are:

- where disclosure is in the wider public interest;
- where disclosure is necessary to prevent serious injury or damage to the health of a third party;
- where disclosure is in the best interests of the patient.

It is a matter for the health professional with overall responsibility for clinical care to determine whether the wider public interest outweighs the rights of a patient to confidentiality and warrants the disclosure of information. In reaching a decision, all relevant circumstances should be taken into account including the need to protect the public and any rights of the patient to have confidentiality of personal information about him or her protected.

Doctors Professional Accountability

Disclosure without consent is a complex issue. The General Medical Council's advice to doctors is that where they believe a patient to be a victim of neglect or physical or sexual abuse, and that patient cannot give or withhold consent to disclosure, information should be disclosed to the appropriate responsible person or agency where it is felt to be in the patient's best interests. Where such circumstances arise in relation to children, concerns about abuse need to be shared with other agencies such as social work services. It will usually, but not necessarily, be appropriate for those with parental responsibility to be informed.

Each Health Board and NHS Trust has appointed a 'Caldicott Guardian' who is responsible for the way that the organisation handles and protects patient-identifiable information. The Caldicott Guardian is a senior health professional, most usually the Director of Public Health at Health Board level and the Medical or Nursing Director within NHS Trusts. Any queries about the disclosure of personal health information should be referred to the Guardian. (More detailed information on the Caldicott Committee and the role of the 'Guardian' can be found on page 31).

Nurses and Midwives Professional Accountability

All nurses should be familiar with the United Kingdom Central Council's (UKCC) 'Guidelines for Professional Practice (1996)'. The booklet provides a guide for reflection on the statements within the 'Code of Professional Conduct'. It replaces three existing documents: 'Exercising Accountability'; 'Confidentiality'; and 'Advertising by Registered Nurses, Midwives and Health Visitors'. The designated, named or senior nurse should encourage staff to refer to the document, be available to advise them and ensure that the guidelines are covered in in-service training.

The first four clauses of the Code of Professional Conduct makes sure that nurses, health visitors and midwives put the interests of their patients, clients and the public before their own interests and those of their professional colleagues. They are as follows:

"As a registered nurse, midwife or health visitor you are personally accountable for your practice and, in the exercise of your professional accountability, must:

- a) act always in such a manner as to promote and safeguard the interests and well-being of patients and clients;
- b) ensure that no action or omission on your part, or within your sphere of responsibility, is detrimental to the interests, condition or safety of patients and clients;
- c) maintain and improve your professional knowledge and competence; and
- d) acknowledge any limitations in your knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner."

Clause 10 of the UKCC Code of Professional Conduct states that:

"As a registered nurse, midwife or health visitor you are personally accountable for your practice and, in the exercise of your professional accountability, must protect

all confidential information concerning patients and clients obtained in the course of professional practice and make disclosures only with consent, where required by an order of a court or where you can justify disclosure in the wider public interest. Confidentiality should only be broken in exceptional circumstances and should only occur after careful consideration that can justify your action."

The following principles concerning confidentiality apply:

- a patient or client has the right to expect that information given in confidence will be used only for the purpose for which it was given and will not be released to others without their permission;
- you should recognise each patient's or client's rights to have information about themselves kept secure and private;
- if it is appropriate to share information gained in the course of your work with other health or social work practitioners, you must make sure that as far as is reasonable, the information will be kept in strict professional confidence and be used only for the purpose for which the information was given;
- you are responsible for any decision which you make to release confidential information because you think that this is in the public's best interest;
- if you choose to break confidentiality because you believe that this is in the public's best interest, you must have considered the situation carefully enough to justify that decision; and
- you should not deliberately break confidentiality other than in exceptional circumstances (Guidelines for Professional Practice - UKCC (1996)).

Where health information is provided by a child who, in the opinion of the health professional with overall responsibility for their clinical care, does not possess sufficient understanding to give or withhold consent to disclosure, a decision requires to be taken about whether to divulge that information to parents or guardians. Disclosure should only occur where it is felt to be in the patient's best interests.

Consent

All health professionals should ensure that young people are aware of their rights to confidentiality and consent and must assess the individual's maturity and ability to reason when giving consent.

The Age of Legal Capacity (Scotland) Act 1991 provides that a person under the age of 16 years shall have legal capacity to consent on his or her own behalf to any surgical, medical or dental procedure or treatment, including psychological or psychiatric examination, where, in

the opinion of an attending qualified medical practitioner, he or she is capable of understanding the nature and possible consequences of the procedure or treatment. This means that a person of any age has the right to determine their own health care treatment without recourse to the views and wishes of their parents. Even if ordered by a Children's Hearing, medical examinations are governed by the provisions of the Age of Legal Capacity (Scotland) Act 1991. *Children who consent to a medical examination may withhold their consent to any part of the examination including, for example, the taking of photographs.* In order to ensure that children and their families give properly informed consent to medical examinations in child protection inquiries, the examining doctor, if necessary assisted by the social worker or police officer, should provide information about any aspect of the procedure and the uses to which these may be put. Where, in the opinion of the medical practitioner, the child is not capable of understanding the nature and possible consequences of the procedure or treatment, the medical practitioner should seek the consent of the child's parent or guardian. Where children give their consent, parents or carers should also be consulted as a matter of practice. Where a medical examination is thought to be necessary for purposes of obtaining evidence in criminal proceedings but consent to the examination is refused by the parent(s) or guardian, the Procurator Fiscal may consider obtaining a warrant for this purpose. *Where, however, a child who has legal capacity to consent declines to do so, the Procurator Fiscal will not seek a warrant.* If the local authority believes that a medical examination is required to find out whether concerns about a child's safety or welfare are justified, and parents refuse consent, the local authority may apply to a Sheriff for a Child Assessment Order (see Scotland's Children: Children (Scotland) Act 1995 Regulations and Guidance, Volume 1: Support and Protection for Children and their Families).

A child subject to a Child Assessment Order may still withhold his or her consent to examination or assessment if he or she is deemed to have legal capacity.

A series of questions and answers prepared by Kathleen Marshall, in conjunction with the Yorkhill NHS Trust Rights of the Child Group offers a user friendly approach to the law and is to be found in Annex J.

Record Keeping

All professionals involved in inquiries need to record their findings and opinions carefully and legibly. Health professionals may also be required to produce records as evidence in later criminal or civil proceedings. Medical and other health care professionals should provide written reports of their findings when asked to do so by the local authority or the Reporter, as these agencies may need to take action on the basis of medical findings.

Staff should keep up-to-date case records of their involvement in any child protection case.

Records should include:

- details of any concerns about the child and family.
- details of any contact or involvement with the family and any other agencies.
- the findings of any assessment.
- any decisions made about the case within each agency or in discussions with other agencies.
- a note of information shared with other agencies, with whom and when.

The information received in referral must therefore always be written down accurately and in detail, either at the time or immediately afterwards. Child Protection Committees may develop standard referral forms for use by all local agencies. Records should note the date and time that any incident occurred and the date when the record was made. When recording their intervention and activity in child protection cases staff should take contemporaneous notes wherever possible, and should complete records as soon as possible after an event or interview. Original notes and case records, drawings or other written material should be retained even if information is condensed into summary reports, as these original notes are regarded as 'best evidence' by the courts.

Recording systems should meet the requirements of legislation on access to files and data protection. Storage arrangements should be adequately secure and protect client confidentiality. Professional records may need to be made available to the police or the Reporter when required.

Guidance for the retention and destruction of Health Records is set out in NHS MEL (1993) 152, Appendix A, paragraph 6 and Appendix B, 1b.

"Children's and Young Adult's Records (persons aged less than 16 on date of admission) shall be retained for a minimum until the person reaches 25 or 3years after death if this is earlier. At the conclusion of the period, the records may be destroyed, but there is no obligation to do so".

Caldicott Report on Review of Patient-Identifiable Information

The Caldicott Committee, set up to review all patient-identifiable information passing from NHS organisations in England to other NHS or non-NHS bodies for purposes other than direct patient care, medical research or where there is statutory requirement for information, published its report in December 1997. Whilst the Committee's remit did not extend to Scotland the principles considered apply equally here and The Scottish Executive Health Department has been considering how best to take forward a number of the Committee's recommendations.

One of the key recommendations of the Caldicott Report was that 'Guardians' of patient information should be nominated throughout the NHS. Each Health Board, Special Health Board and NHS Trust was asked to nominate a 'Guardian' by no later than 1 April 1999. This role is largely being performed at Health Board level by Directors of Public Health, and within Trusts by Medical or Nursing Directors. Within each GP practice it is proposed that there is a nominated lead for confidentiality issues.

Guardians will be charged with promoting the highest standards for safeguarding the confidentiality of patient information in their organisation. They will also be responsible for developing clear rules about disclosing patient information to other organisations. This work should improve the management of confidential information and will support action to prevent any unnecessary identification of individual patients. Detailed guidance entitled Protecting and Using Patient Information - A manual for Caldicott Guardians issued under cover of NHS MEL (1999)⁴⁸ provides guidance on the key tasks that need to be addressed by the NHS in Scotland and Guardians. It also serves as a resource for Guardians identifying and summarising key guidance and flagging up sources of advice. Much of the guidance builds on existing practice.

Further guidance on implications of the Data Protection Act 1998 for the NHS in Scotland will be issued by The Scottish Executive Health Department before the Act is fully implemented on 1 March 2000.

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Protecting Children: A Shared Responsibility

Chapter 8: GUIDANCE FOR HEALTH STAFF

This chapter

- Builds on the general information presented in Chapters 6 and 7.
- Details the processes for health professionals involved in a child abuse case.
- Details the role of the doctor, community based nurses and midwives.
- Highlights the importance of the Accident and Emergency Department in recognising and responding to the risks of child abuse.
- Addresses the role of all staff employed within the NHS when faced with child abuse in a number of settings.
- Addresses clinical supervision.
- Deals with allegations of abuse against health staff.

Medical Staff Involved in Medical Investigation and Management

This section seeks to provide guidance on the medical assessment and evaluation of children who may have been abused or neglected, whether they present to community or hospital based staff, the school health service, the Community Dental Service, primary health care or mental health teams. It supports a framework for the medical process from referral to case conference and legal procedures and describes the facilities, equipment and personnel that need to be available.

Figure 2

Every Health Board must ensure that arrangements are in place to allow this guidance to be followed. This will involve the availability of appropriately trained and experienced staff who can give prompt advice to colleagues involved in the referral process and facilitate access to specialist staff and facilities. Medical staff with specialist skills in paediatrics and forensic medicine are required and in many areas these are specially trained consultant community

paediatricians and police surgeons. In some Health Board areas the numbers and geographical location of cases will present particular difficulties in setting up local services. Taking into account the exacting level of medical evidence and opinion required by courts, consideration may be given to commissioning some or all of the services from another Trust or Health Board in line with the concept of managed clinical networks as identified in NHS MEL (1999)¹⁰. Models of commissioning may include:

- onward referral of selected cases to the identified unit in another area.
- the development of an outreach service in the host Health Board area from a specialist unit in another area.
- a collaboration between police surgeons in another area with specialist training and local paediatricians.

Whichever model is commissioned it will result in an explicit and agreed framework for child protection services. This particularly applies to the need to access facilities for video-colposcopy of children, who may have been sexually abused. In determining the way forward careful consideration needs to be given both to meeting the needs of children and their families in the least disruptive way, and ensuring that staff have adequate training, experience and peer support.

In planning services for the clinical investigation of children consideration must be given to the range of other support services that may be required for their full assessment and treatment e. g. orthopaedics, ENT, ophthalmology, radiology, haematology, bacteriology and virology, including in-patient care, and access to mental health services (psychology and child and family psychiatry) in the short or long term. It is important to emphasise that the medical examination in any case of possible abuse or neglect must be a Comprehensive Medical Assessment(CMA) of the child's physical state including a full general examination, measurement of growth, and assessment of developmental status and emotional wellbeing. The examination must not be restricted to the documentation and interpretation of the alleged injuries. A Comprehensive Medical Assessment is not only crucial to ensuring the child receives any treatment he/she requires, but also to the assessment of significant harm that the child may have suffered and the degree of ongoing risk.

Consideration must also be given to the child's emotional and physical needs during what may be a protracted investigation; children may be frightened and bewildered as to what is happening to them and this should be fully explained and support may be offered by paediatric nurses and those working in special child protection units, as well as parents, if appropriate.

Careful and appropriate documentation is required to cover all aspects of the case, especially in the joint paediatric/forensicmedical examination and the subsequent reports for the courts. The use of locally or nationally agreed protocols and proformas is highly recommended to facilitate a standardisation of approach and continuity of care and some examples of case

record proformas are given in Annexes H and I.

Clinical Presentation and Identification

Concern that a child may be being abused or neglected can arise from any clinical contact with a child, for example:

- acute injuries which are not adequately explained by the history, or where presentation for treatment has been delayed.
- recurrent acute or chronic symptoms, which are unexplained e.g. abdominal pain, enuresis, encopresis, recurrent urinary symptoms or vaginal discharge.
- unexplained failure to thrive.
- unexplained emotional or behavioural difficulties.
- disclosure by the child or family member during any medical consultation.
- known history of abuse in parents/carers.

Other risk factors that are present in the child or family situation should be taken into consideration, such as domestic violence, substance abuse, mental health problems, disability in the child, post-natal depression and the possibility of Munchausen by proxy.

Where possible, it is good practice for the referring doctor to share his or her concerns with the parent(s) or guardians, when the doctor has decided to refer the child on to the statutory agencies (police or social work) or to a consultant paediatric colleague. Likewise, the consultant may wish to discuss progress with the family doctor. It is important to bear in mind that in some situations this action may place the child or the professional at risk. As the safety of the child is paramount, due consideration should be given to this aspect and in some circumstances it may be more appropriate to refer the child to a paediatric setting, prior to initiating a formal child protection referral.

Doctors should make sure that young people are made aware of their rights with respect to confidentiality and consent and are appropriately informed and involved during any assessments, decisions or treatments.

The issue of confidentiality of the child or parent is often a concern for the referring doctor. ([See Chapter 7](#))

The Planning Meeting or Discussion

When any doctor considers that a child may be the subject of abuse or neglect he or she should make contact with the local social work services. If the doctor is uncertain whether abuse or neglect may be the cause of presenting injuries or symptoms he or she may wish to discuss the case with other specialist advisers, such as the local paediatrician with responsibility for child protection. This discussion may lead to an agreement that the child should be seen either for a second opinion by the receiving general paediatrician or specialist colleague to investigate and exclude an organic cause, or that referral on to the child protection processes through the Planning Meeting or Discussion (PMD) is appropriate. Responsibility for taking the timely referral forward must be agreed within this preliminary discussion, and may be made by the referring doctor where appropriate. However, depending on local arrangements and procedures, it may be appropriate for a general practitioner or community child health doctor (including school health doctors) to refer directly to the statutory organisations in cases of apparent or repeated child abuse, taking full health responsibility within the Planning Meeting or Discussion. Particular attention must be paid to the detailed forensic aspects of each case.

Appropriate advice must be available on a 24-hour basis from suitably trained and experienced hospital or community paediatricians, who have undertaken further training in child protection. These paediatricians will have the appropriate medical experience required to accept this responsibility and will be experienced in inter-agency working and therefore will participate in planning meetings or discussions with colleagues in social work and police.

The referring health professional should contact the duty senior social worker responsible for children and families services. Social workers are also available in all major hospitals during working hours. Out of office hours, local authorities provide a social work emergency service and all GP practices and hospital specialty and A&E departments should have access to the local emergency contact telephone number.

Upon receiving a child protection referral social work services will normally consult with the police. Responsibility for the investigation of the suspected criminal acts rests with the Divisional Detective Chief Inspector or his/her Deputy, who will decide which officer is allocated to the enquiry. Contact can be made directly with the appropriate Divisional Detective Chief Inspector or his/her Deputy or the local specialist police unit which deals with child abuse or sexual assault.

This Planning Meeting or Discussion (PMD) will produce a specific plan for the child protection inquiries.

Account should be taken of the maturity of the child, as well as the chronological age when planning the medical investigation.

A suitably trained police surgeon must be available at all times to discuss the plans for a joint

investigation and to co-operate and take part in a joint paediatric/forensic examination where appropriate. There may be occasions where a child is presented directly to the police and is seen by the police surgeon for a medical assessment. Subsequently, if there is a single isolated injury, a fuller examination (i.e. CMA), may not be indicated. The police surgeon may also be available to give advice to paediatric colleagues on the findings at any preliminary medical assessment or examination, especially where the presentation of the case has unusual features which may or may not be the result of child abuse.

In every case of suspected child abuse or neglect a consultant paediatrician or a community paediatrician should be identified as the Co-ordinator of the ongoing medical investigation and management of the child's and family's health needs.

The Need for a Medical Assessment

A Comprehensive Medical Assessment is an essential component in the multidisciplinary assessment of child abuse and should be considered even when information from other agencies showed little or no cause for concern. Children frequently disclose a little information at a time, even over many years. Accurate and comprehensive records made in the medical case records are essential. In cases of sexual abuse, the forensic evidence may be missed or lost and it is essential that the initial joint police/social work interview has a full description of the suspected abuse, supplemented by any previous appropriate health information. In some cases of child abuse there will be no obvious signs or symptoms and some children will require diagnostic procedures only available in a well equipped hospital or clinic.

The Comprehensive Medical Assessment has five purposes:

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

In order to make the most effective contribution, it is important that the examining doctor has clear information about the cause for concern and the known social background of the family, including previous instances of abuse, or suspected abuse.

The findings of the Comprehensive Medical Assessment must be recorded. The use of a standardised proforma to record the medical findings is an invaluable tool in the documentation of evidence. ([See proforma at Annex H](#)). This facilitates the sharing of information between the examining doctor, the specialists carrying out any subsequent examination and with social work colleagues taking forward the investigation.

When a child presents directly to an Accident and Emergency Department and there is concern that a child's injuries may be the result of abuse, the casualty officer should regard this medical examination as equivalent to a Comprehensive Medical Assessment. It should be consistent with a formal CMA carried out by non invasive techniques and should not include internal vaginal or rectal examination. The locally agreed proforma should be used (Annex H). Urgent medical treatment will be carried out as appropriate, and the Child Protection Register checked in every case. Subsequent action will be taken depending on the degree of concern existing after the Comprehensive Medical Assessment. Where there is little doubt that abuse has occurred, or it seems likely that it may have occurred, the casualty officer should consult with their consultant and/or the senior paediatrician, social workstaff and the police regarding the process to be followed. When less definite concerns arise discussion with a senior paediatric colleague should be undertaken before the child leaves the Accident and Emergency Department. Procedures should be in place to alert the general practitioner and health visitor to any relevant concerns and gather appropriate background information from the primary care team.

Where records are available, it should be standard practice to compare height and weight (and infant's head circumference) information against these records including the use of centile charts, wherever possible.

Discussion between medical, nursing, social work, and police colleagues should be encouraged at all stages, to facilitate good liaison and the communication of concerns.

Understanding the expertise and roles of each group will ensure that health, police and social workstaff respect the contribution provided by each service.

In planning the medical investigation, it is worth noting that it is the duty of the police to provide best evidence, including medical evidence, to the Procurator Fiscal and the Children's Reporter in appropriate cases. Details of the role of the police are referred to in Chapter 10 and also contained in the inter-agency guidelines Protecting Children - A Shared

Responsibility: Guidance on Inter-agency Co-operation (1998).

Once the Children's Reporter is proceeding with an investigation, information may be requested by, or directly passed to, the Children's Reporter. It should be noted that, because Children's Hearings can proceed on a lower standard of evidence compared to criminal proceedings, i.e. the balance of probability rather than beyond reasonable doubt, there are many situations in which the Children's Reporter is able to act, even although it is clear that criminal proceedings cannot be contemplated.

The number of examinations to which a child is subjected must be kept to a minimum and careful planning of the medical component of the examination by experienced medical staff facilitates this. The examining doctor should ensure that the child is kept fully informed of the outcome of all that happens to her or him.

Where the plan is for the child to be 'Looked After', the requirements of the Comprehensive Medical Assessment for Looked After Children should also be fulfilled and the examining doctor should ensure that relevant medical information is recorded and shared with the carers and the child.

Arranging a Medical Examination

The paediatrician, or exceptionally the general practitioner, involved in the Planning Meeting or Discussion should take responsibility for taking the medical assessment forward, agreeing with police and social work colleagues the nature, timing and venue for the examination.

In situations where the referral indicates suspicion that abuse has occurred, the GP or paediatrician should contact the social work service or the police before carrying out a Comprehensive 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 from the referral that a forensic opinion will be required e.g. an allegation or observation of serious physical assault or injury or a disclosure of sexual abuse, the *Comprehensive Medical Assessment should be bypassed*.

In arranging medical assessments the co-operation and involvement of the parent(s) at all times should be sought even if this may seem difficult or parents are hostile. When a parent or guardian is a suspect, or for some reason not supportive of their child's needs, then their attendance during the examination may not be appropriate. Any exclusion of a parent or guardian should be fully discussed by all the agencies in advance of the examination. The

child's views should be taken into account (See [Chapter 7](#) and [Annex J](#)).

The Comprehensive Medical Assessment should normally be carried out locally by the family General Practitioner, school doctor or the on-call Community Child Health Doctor for Child Protection at a Child Health Clinic or in the child's school or nursery.

Where the Comprehensive Medical Assessment is bypassed it is important to ensure that appropriate background health information is sought from the Health Visitor, School Nurse, General Practitioner and Community Child Health staff (including school doctor) so that vital information (e.g. a history of previous concerns) is not overlooked.

The child will require to be accompanied by a parent or other trusted adult during this process. A decision about who should accompany the child should be determined by the circumstances of each individual case.

Informed consent must be obtained from the parent or child, as appropriate. [See Chapter 7](#).

The possibility of arranging an admission to a paediatric ward for observation and further assessment should always be remembered in doubtful cases such as non-organic failure to thrive, or where there are other possible medical differential diagnoses, such as thrombocytopenia.

Specialist Paediatric or Joint Paediatric/Forensic Examination

The following circumstances will indicate the need for a specialist paediatric or joint paediatric/forensic examination to be carried out:

- the child urgently requires follow-up assessment or treatment at a Paediatric Department e.g. head injury, possible fractures.
- the account of the injuries provided by the care giver does not provide an acceptable explanation of the child's condition.
- the result of the preliminary assessment is inconclusive and a specialist's opinion is required to establish the diagnosis.
- lack of corroboration of the allegation such as a clear statement from another child or adult witness indicates that forensic examination, including the taking of photographs, may be necessary as part of the process to support criminal proceedings against the perpetrator and legal remedies to protect the child.
- the child's condition (e.g. failure to thrive; repeated episodes of unexplained bruising) requires further investigation.

In some cases the information gathered from an earlier Comprehensive Medical Assessment may be sufficient together with other supportive evidence (e.g. corroboration of the incident from an eye witness) to enable a conclusion to be reached as to 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.

The decision whether or not to refer the child for more specialist paediatric or joint paediatric/forensic assessment should be a *joint decision* taken by involved professionals from social work, police and health. Where there is a lack of consensus, this should be resolved by the examining doctor referring the child for a second opinion to a senior paediatric colleague.

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

The decision whether a joint paediatric/forensic examination or an examination by a single paediatric examiner is appropriate, should be made during the Planning Meeting or Discussion with social work services and the police. This should take place at the time of the referral. The decision on the type of examination depends partly on the need for corroboration of forensic findings and the taking of appropriate specimens for trace evidence including semen, blood, transferred fibres, etc. This decision is ultimately the responsibility of the Procurator Fiscal and in some circumstances it would be appropriate for the examining doctor to contact the police for discussion before proceeding with the examination.

The paediatrician plays the lead role in assessing the child's health and development, while the forensic colleague assists with the interpretation of any injuries in terms of accidental or non-accidental causation, likely timescales, etc. The forensic colleague also oversees the gathering of any samples for forensic analysis (such as swabs of semen and saliva) while the paediatrician takes responsibility for arranging any other investigations (e.g. for sexually transmitted disease, x-rays, clotting studies, etc). Video and photographic recordings are taken in the presence of both doctors. The consultant paediatrician takes responsibility for the medical component and for ensuring that appropriate arrangements are made for further medical investigation, treatment and follow-up. The Police Surgeon is responsible for the forensic element of the examination, and fulfils the legal requirements in terms of e.g. preserving the chain of evidence.

The presence of two doctors in the joint paediatric/forensic examination, each of whom can speak to the physical findings, is not only important for the corroboration of medical evidence in any subsequent criminal proceeding, but is regarded as good medical practice. The co-

operation of two doctors from the complementary backgrounds of paediatrics and forensic medicine should achieve a high and consistent standard of medical evidence by ensuring appropriate checks and balances are in place. This is important not only in cases of sexual abuse, but in serious cases of physical assault, for example non-accidental injury or where a baby has been injured by shaking. A single doctor examination by a specialist paediatrician may be appropriate in situations of physical abuse, where the findings at the Comprehensive Medical Assessment appear clear and there is already corroborating evidence available.

The Joint Paediatric/Forensic Examination should normally take place in an appropriately equipped paediatric health facility such as a children's hospital or unit, or perhaps a genito-urinary medicine department, in which appropriately qualified staff are available and where there is access to other services which may be needed for further investigation or treatment. A high standard of consulting accommodation with adequate lighting and video-colposcopy facilities for examination of sexually abused female and male children and young people, must be available. Whatever location is used, the facilities should be child friendly, with access to play materials, food and drink and experienced paediatric nursing staff should be available. The same guidelines for history taking and examination should be followed for all children. A standard proforma should be drawn up ensuring that no important information is overlooked including, for example, gathering a full history of relevant signs and symptoms including bowel habit, menstrual history and use of tampons in the case of girls, including line drawings for the recording of injuries and a section for the documentation of consent and examination technique.

The gender of the examiner should be discussed with the child and a choice made available, wherever possible.

These special examinations should be arranged without undue delay. Suitably trained and experienced police surgeons should be available through a duty rota. The doctor carrying out the Comprehensive Medical Assessment will contact the appropriate paediatrician on call (as determined by local arrangements) to advise about the request for a Joint Paediatric/Forensic Examination and the process will be by local arrangement. The venue and the timing of the Joint Paediatric/Forensic Examination should be fully discussed with police and social workers. Social work services should ensure that the child and parent(s) (and/or any other trusted adult accompanying the child) are fully informed of the plan and likely timescale of the investigation as soon as possible, and are taken to the examination.

Following examination, the doctors should confer immediately, review the video if required and give an immediate statement to the police officers who are in attendance.

Certain children may require early referral for specialist medical services such as neurosurgery, gynaecology, genitourinary medicine, general surgery and orthopaedics and psychiatric and psychological services.

The Timing of Medical Examinations

The timing of the examination should be agreed jointly by the medical examiners and the other agencies involved.

It is important to note that it may not be in the child's best interest to rush to an immediate examination whatever the time of day the disclosure has been made. In a number of cases it may be much more appropriate to wait until the child can be rested and prepared adequately. More information may also become available.

It is expected that in the great majority of cases arising in working hours, a Comprehensive Medical Assessment will be carried out locally and quickly by a doctor who knows the child and/or the family. If difficulty is experienced in arranging a Comprehensive Medical Assessment through normal local contacts, the paediatrician responsible for Child Protection should be contacted.

After normal working hours a Comprehensive Medical Assessment may be arranged by agreement with the family's general practitioner or by discussion with the consultant paediatrician on call, (who may delegate to a member of the junior staff) who can be contacted via the appropriate hospital switchboard. This should be discussed during the inter-agency Planning Meeting or Discussion.

In cases of alleged physical or sexual abuse where the incident(s) has taken place some time previously, the examination should be carefully planned to take place during working hours when the skilled personnel and specialist staff are available. Hasty intervention may prove inconclusive and allow an abused child to remain in continued danger. The decision how best to proceed should always be made in discussion with the other agencies involved. Care must be taken to ensure that in appropriate cases, forensic trace evidence is not lost. Particular care should be taken to retain clothing and avoid bathing.

Consent

A full discussion on this is to be found in Chapter 7 and Appendix J. Medical staff should note that it is the examining doctor's responsibility to obtain informed consent including specific consent to the recording of findings by photograph or video, and the provision of a report to the police. With young children consent must always be obtained from the parent or legal guardian.

With older children who are mature enough to understand fully the nature and type of examination to which they will be subjected and who are prepared to consent to it, additional parental consent is not a requirement. The examining doctors however need to confirm that the child is mature enough to comprehend fully the nature of the clinical examination and investigations. If the doctors cannot confirm this, then parental consent is essential. Where children give their consent parents or carers should also be consulted as a matter of good practice.

It is important to note that children who consent to examination may withhold their consent to certain parts of that examination e.g. 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.

When competent consent cannot be obtained, the medical practitioner should obtain legal advice from the social work services and police. In civil Court cases or Children's Hearings, the Children's Reporter will be able to give the necessary advice.

The Report

It is imperative that all medical examinations result in a clear report of the findings and of the doctor's considered opinion speedily submitted within the locally agreed timescale. These reports should be submitted to the Children's Reporter and/or the Procurator Fiscal. If the local authority is seeking a Child Protection or related Order these reports should also be made available to the Court normally through the local authority. Medical samples, if part of the evidence, are the responsibility of the police officer in attendance. In cases where a Child Protection Order has been taken, and is being considered at the second working day hearing, it is important that a sufficiently detailed report is available to meet the Children's Reporter's requirements. Similarly, if the alleged perpetrator has been detained by the police for a court appearance on the first lawful day, the information must be available for the Procurator Fiscal. Written reports may have to serve more than one purpose (e.g. Children's Reporter, Procurator Fiscal or the local authority) and sufficient copies should be made available.

In situations where further information affecting the opinion may become available from investigations requested at the time of examination e.g. x-ray, blood tests, a preliminary report should be provided and care should be taken that a full supplementary report is provided to the Procurator Fiscal and/or Children's Reporter once all the appropriate reports are available.

Where the decision is reached for the child to be Looked After by the local authority, the Comprehensive Medical Assessment should provide the necessary information about health and medical care for the local authority to share with the child's carers. The use of multi-part forms in the Comprehensive Medical Assessment within the child protection procedures which

can fulfil both functions facilitates this. The Specialist Paediatric or Joint Paediatric/Forensic Examination should be documented on an agreed standardised proforma, (an example of which is included at Annex I). This facilitates the accurate documentation of the history and clinical findings (including drawings with measurements) and should be completed contemporaneously during the examination by the doctors. This should also include any verbatim statements made by the child during examination (e.g. clarifying terminology for private parts and explanations for specific injuries). These notes will form the basis for the subsequently typed report. The doctors may be asked to produce these or refer to them in the witness box at a later date.

Where an acute sexual assault has occurred, the police will provide sampling equipment in the form of a standard "Physical Evidence Recovery Kit". Both doctors should co-operate in the gathering, labelling and countersigning of all samples. Similarly, the video in such cases should be sealed and signed by the police and the medical examiners and securely stored by the Trust, as it is considered to be part of the health record.

When the examination is complete, a brief verbal report should be made to the attending police and social workers. Care must be taken to include the content of this verbal report in the final written report.

A "soul and conscience" report which may be sworn as evidence and subject to cross-examination in court must contain details of the examination findings and an opinion must be produced for the Procurator Fiscal and/or the police. This should normally be a joint report by the two examining doctors and signed by both. If, however, separate reports are produced, the opinion they contain must be agreed in advance by the two examining doctors. Where difficulty arises reaching an agreed opinion within the reports, the difference of findings and opinions must be stated. Further medical advice must be obtained by either seeking a further expert opinion or through peer review.

A copy of this "soul and conscience" report should be retained by the examining paediatrician and filed alongside the original hand written Joint Paediatric/Forensic Examination proforma either within the health record or a separate file for reference during any subsequent investigation or legal proceedings. Similar arrangements should be in place for the storage of video evidence. This report is the property of the Procurator Fiscal and *may not be copied to other agencies* without his or her prior permission.

The paediatrician should take responsibility for producing a medical report for the General Practitioner including all relevant background information, a summary of the procedure and findings and the follow up plan. This will be copied to the hospital and the Community Child Health files.

Follow-Up

Once the investigation is complete, the paediatrician(s) involved have a clear responsibility to monitor the physical and emotional health of the child, and ensure appropriate treatment and management of any identified morbidity is carried out. It is imperative that ongoing care and management includes full discussion with the child, referral to the General Practitioner and the Primary Health Care Team.

These situations often provide an opportunity to ensure the child's attendance at previously defaulted hospital, dental or optician appointments, or for missed routine surveillance and immunisation procedures are addressed.

In cases of sexual abuse or under-age sexual activity, arrangements to follow-up the possibility of pregnancy or sexually transmitted disease and the provision of contraceptive services (including postcoital contraception) may be required. Appropriate services may be accessed through the Primary Health Care Team, young person's advisory services (e.g. family planning clinics) or the local genitourinary medicine or gynaecology clinics, depending on local configuration of services.

Where significant concerns about the child's growth and development have been identified and the child has been placed in a substitute family setting, very careful charting of growth and serial assessments of development may show clear reversal of the worrying trends and be of great value in any subsequent legal proceedings.

Psychological or psychiatric sequelae must not be overlooked and arrangements must be in place to allow ready access to mental health services, which are frequently required at a later stage.

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Protecting Children: A Shared Responsibility

Community Based Nurses and Midwives

The deployment of nurses, health visitors and midwives working in the community differs significantly from that of their colleagues working in hospital. In the community setting the relationship between numerous agencies, general medical practice, social services, education, police and voluntary agencies, and the professional relationship of the nurse with her clients and their families have to be considered. Child protection work is an essential part of their duties. The senior nurse in child protection is an expert resource available to all practitioners.

Health visitors and school nurses working with the "well" population monitoring child health, growth and development have a unique role to play in the promotion of children's health and the protection of children from harm. Where opinions of teaching staff and school nurses conflict, the school nurse is accountable for making a referral. Practice nurses who see children should be aware of child protection issues and be alert to signs or symptoms which might give rise for concern. Community children's nurses caring for sick children in their own homes are also well placed to identify the child at risk of significant harm. All nurses working with children in the community should be aware of children who are "in need" and of children on the child protection register. All nurses should receive training, clinical supervision and updating in child protection to equip them with the additional knowledge and skills to protect children, to meet the needs of children and their families, to prevent abuse occurring and to be aware that the interests of the child are paramount.

The nurse, health visitor or midwife involved with a family where there are child protection concerns should ensure as a priority that she attends Child Protection Case Conferences, case reviews and planning meetings. Should she be unable to attend, she should submit a written report, arrange for a colleague to attend and ensure receipt of the minutes. The time taken for these activities should be recognised.

There should be reliable systems for hand-over from midwife to health visitor, and health visitors to school nurse.

District nurses, community psychiatric nurses, learning disability nurses, nursery nurses, therapists, nurses working in child development centres and other clinical settings in the community all meet with children in the course of their duties. The practitioner may become

concerned about the well being of the child, or receive information of concern about the care of the child. For these reasons there must be clear NHS Trust guidelines about the action to be taken if there is a suspicion that the child is at risk of significant harm. These guidelines must include advice about contact with statutory agencies especially during unsocial hours.

Nurses, health visitors and midwives are responsible for ensuring that the key activities are carried out to enable the individual to practice in accordance with the UKCC guidance and to be accountable for their practice.

A review of the Nurses' Contribution to Public Health in Scotland is being undertaken in 1999, to better understand the contribution that nurses, midwives and health visitors can and should make to improving public health in Scotland. It will focus initially on the role of the health visitor, the school nurse and the practice nurse. This work is being commissioned by the Chief Nursing Officer and funded by the Chief Scientist Office of The Scottish Executive.

Health Visitors

The health visitor's role is unique because she offers a universal service to all young children and their families. Parents recognise the public health and health education role of health visitors and respond to her input into family life. Her work is largely with the "well" population with visits to families in their homes being made over a period of time. She is concerned with the family as a whole as well as the individual within it. She is trained to recognise deviation from normal in both health and relationship terms, and is ideally placed to recognise the need for and initiate action at an early stage.

The health visitor is also well placed to recognise early signs of parenting difficulties or poor attachment that will require support to enhance parenting skills. Her unique role offers her the opportunity to monitor the health of children and through regular contact, to assess growth and physical and emotional and social development. Her role in detecting post-natal depression and referring for treatment, may be crucial to the bonding and development of the baby. (National Commission of Inquiry into the Prevention of Child Abuse 1996).

Health visitors play an important role in Child Protection specifically in the identification and referral to the statutory agencies of children at risk or suffering abuse. Because of their frequent contact with children and families and their specialist training and expertise in preventive health care, they have a key role in supporting vulnerable families and children, helping parents care adequately for their child, and ensuring that everything possible is done to avert situations where a child might come to harm.

The role of the health visitor in protecting children in the community is to observe, assess,

record, refer and support. It is not his or her responsibility to investigate child abuse. S/he should be vigilant to the possibility of abuse, and familiar with the procedures for making referrals to the appropriate statutory authorities. This will mean assisting in the prevention of abuse and neglect, the identification and assessment of children causing concern, and the referral for investigation of children who are at risk of or are subject to abuse or neglect.

The health visitor often continues this work when other statutory agencies have formally withdrawn, and he or she provides ongoing support for these families. His or her approach to the family should be one of partnership and long-term support.

School Nurses

Identification

School nurses may identify child abuse and child protection issues in several ways:

- opportunistically when undertaking school health screening activities.
- by monitoring and surveillance of health when a health related problem has been identified and keeping accurate records.
- by listening to and observing children in school.
- by being available to children to approach informally.
- by liaising with teachers, health visitors, clinical medical officers and other professionals involved with children to identify children "at risk" of abuse. *Liaison* School nurses liaise with others involved with children and their liaison role in relation to child protection involves:
 - contact with health visitors, particularly in relation to primary one children and where there are pre-school children in the household.
 - contact with hospital wards and liaison nurses following hospital admission/discharge.
 - discussion with clinical medical officers about health and family issues affecting the school child.
 - discussion with teachers and guidancestaff about concerns affecting the child at school.
 - contact with parents and children who identify problems.
 - contact with social workers.
 - providing summary information through nursing/medical records when a child moves to another area or school.
 - notifying the new nurse if a child causing concern moves to a new address or school. A copy of the summary is sent to the clinical manager concerned.

The Scottish Council for Independent Schools in Scotland have produced a very useful guide

on child protection, written by Kathleen Marshall which will be of use to school nurses.

District Nurses and Clinic/Treatment Room Nurses

In the course of work with patients, the district nurse and clinic/treatment room nurses may be in a position to notice that relationships within a family are dysfunctional. Concerns may be expressed about the well-being of the child or the parent may confide in the nurse about the care of a child. Because of the nature of her work, the district nurse may not normally have experience of child abuse, and it is important that she understands that the protection of the child is paramount. The district nurse and clinic/treatment room nurse must have clear guidelines about the action to be taken if there is suspicion that a child is at risk of potential or actual abuse or neglect. These guidelines must include advice and updated information about contact points and, especially out of office hours, how, in liaison with her clinical manager, to contact the social work duty officer.

District nurses are likely to be the first to be aware of the contribution of young people to the care of sick or disabled parents or other siblings within the home setting. They should ensure that the contribution given by children is appropriate, willingly given and not onerous to them. They should refer children to the local authority for assessment of their needs as children 'affected adversely by the disability of another family member' under the Children (Scotland) Act 1995 and ensure that they have adequate support and respite consistent with their needs and rights.

Practice Nurses

Practice nurses are employed by the GP, but are accountable for their own professional practice. Working in a GP practice they have opportunities to interact with families and should be alert to signs and symptoms which might give rise to concerns about abuse. The General Practitioner has responsibilities that need to be met, especially for training of practice nurses on child protection, liaising and supervision.

Midwives

Midwives have a significant role in identifying risk factors to the child during the mother's pregnancy, birth of the child and in the post-natal period both in the hospital and community. During this period the midwife has the opportunity to participate in preparing the couple or

single mother for parenthood and, using their knowledge of community resources, can assist in the early resolution of problems or provide support (RCM 1998). These can range from issues of poverty and poor diet, to social security benefits and problems with drug-taking, support for those with disabilities including learning disabilities and others with HIV. When a teenager is pregnant the midwife should consider whether they may need more intensive support and the possibility that the very young mother will have particular difficulties in coping with the demands of a new baby. They are in an ideal position to observe unusual attitudes and behaviour in pregnancy and early parenthood which may be the first indication of future difficulties.

Midwives involved in child protection cases, will need to liaise with their clinical manager and have access to advice from the senior nurse for child protection matters, to know what the policies are to which midwives can refer and have access to adequate training, support and clinical supervision in order to carry out this role. Time will be needed to participate and prepare for inter-agency decision making, planning meetings and follow-up action.

Pre-birth Case Conferences

Agencies should consider asking the social work services to convene a child protection case conference concerning an unborn child if there appears to be a risk of significant harm to the child when he or she is born. This case conference will have the same status and form as any other. Parents or carers should be invited to a pre-birth conference, and should be fully informed and involved in planning for the child's future, unless this would increase the risk of harm to the unborn child, for example by prompting the family to avoid contact with ante-natal services, or move out of the area to avoid detection. The case conference may decide that the child's name should be placed on the Child Protection Register when he or she is born, and agree an Inter-agency Child Protection Plan. The conference may recommend that the local authority seek a Child Protection Order at birth. The plan may include the tasks to be undertaken by agencies to support and prepare parents before the child's birth. The social work service should identify a keyworker to co-ordinate the plan.

Adult Mental Health Services

Health professionals working with adults with mental health problems or more severe mental illness should always be aware of how the parents' mental state impacts on any children in the family. They need to be aware that adult mental illness has been a factor in some cases of child abuse and neglect. They should liaise with colleagues in children's services if they have concerns that their patient is unable to provide adequate emotional support or physical care for the children.

Mental illness in parents may affect their children in diverse ways. People who are depressed may be unable to provide adequate levels of care particularly to younger children. Post-natal depression may have an immediate impact on the child's welfare or safety or a longer term impact through emotional unavailability to the child. Adults with personality disorders may themselves have experienced abuse or deprivation and have poorly developed parenting skills. This may lead to emotional abuse. Children may also become caught up in the process of other mental disorders in their parents - for example in the delusional systems of patients with psychotic illness or be drawn into the process of obsessive compulsive disorders.

The children of parents with chronic illness may become the parent's main carer. The nature of the parent's illness may lead to social isolation and lack of "warmth", and children of such parents may well experience emotional abuse or neglect. Some parents may display aggressive behaviour and may be either verbally or physically abusive to their children.

Failure to address the needs of such children who are affected by mental illness in their parents can result in inappropriate and even dangerous situations arising for the children. When a parent's behaviour or mental state poses a risk of abuse or neglect of the child, professionals need to take action to protect the child by referring them to a statutory agency.

In the course of their work with adults, disclosures of abusive behaviour may be made to mental health professionals. They will therefore need to be aware of their role in protecting children, familiar with local CPC procedures and able to receive appropriate child protection training. Clear lines of communication should be established with other agencies. Those mental health professionals who work in community settings, particularly people's homes, should ensure that the welfare of any children in those settings is paramount. Liaison with other health service professionals who may be involved in the care of the children and families is essential. Adult mental health services may be involved in assessing and treating actual or suspected adult abusers and it is therefore vital that appropriate liaison takes place with other health services and relevant agencies. Although the Adult Mental Health Service may be involved primarily in treating the adult, the child's welfare must remain in focus. Mental health professionals assessing or treating actual or suspected abusers should ensure that reports written for another agency or Child Protection Case Conference make a clear statement of risk to any child with whom the abuser has contact regardless of diagnosis or treatability.

Where patients, who are parents or carers of children, are misusing drugs or alcohol the nurse should establish contact with other professionals known to the family.

Awareness of the possible reluctance of those working in the field of mental health to break their confidentiality with their clients should be recognised. However, they must be reminded that the protection of the child is of paramount importance and nurses are referred to the United Kingdom Central Council paper on confidentiality in Guidelines for Professional Practice (1996).

Adult mental health staff should monitor the appropriateness of either children visiting adults in their care or those adults visiting children in hospital or care. A vetting procedure including risk assessment and management may be appropriate.

Child and Adolescent Mental Health Services

Children and young people with emotional and behavioural problems may be particularly vulnerable by virtue of both their past experiences and the circumstances under which they are being looked after. Child and Adolescent Mental Health Teams have a clear role in the follow-up of abused children. It should be recognised that all forms of abuse includes an element of emotional abuse and this applies particularly to all cases of intra familial abuse where there has been a significant failure to maintain basic trust between the child and their primary care givers. This failure is likely to give rise to significant psychological sequelae and to affect the child's emotional and psychological development. These problems may emerge in later years in the form of mood disorder, acts of self harm, eating disorder, or disturbed personality development. Those who work in child and adolescent mental health services may recognise, or come to suspect, that a child has suffered or is at risk of suffering significant harm. They will need to be fully conversant with local child protection procedures and receive regular training and updating concerning these procedures.

Should a child make an unsolicited disclosure this should be reported to social work services, who will determine if there are sufficient grounds to undertake child protection inquiries or a joint investigation with the police. These should be carried out in accordance with the local child protection procedures.

Child and Adolescent Mental Health Services will need to focus on the needs of the child and on those of the parents. However, it is the welfare of that child and of any other children in the family which should be paramount at all times. The Child and Adolescent Mental Health Service may also have a role in the assessment of the alleged abuser if that abuser is a child or adolescent. Liaison should be established with other services providing treatment for abusers. Those working in Mental Health Services assessing actual or suspected abusers should ensure that any report produced, particularly for another agency or child protection conference makes a clear statement of assessment of risk to any child with whom the abuser has contact regardless of diagnosis or treatment.

Substance Misuse

The emphasis for those working in this field is on the early detection of parents who are misusing drugs or alcohol, so that they can establish contact with other professionals involved in working with pregnant women and parents of young children.

While clinical reports have indicated a strong connection between parental substance dependence and child maltreatment, the empirical data gives a more inconsistent picture. It is an open question whether there is a causal link or whether maltreatment of the child arises from common variables in the family such as socio-economic status or reporting bias.

Children who are misusing substances may be at risk and in need, so consideration should be given to involving social work personnel.

Working with People with a Learning Disability

Families, where cases of potential or actual child abuse involves people with a learning difficulty, may be divided into two categories: those where the child has a learning disability; and those where one or other parent may have a learning disability.

Children with a Learning Disability

Research indicates that these children are especially vulnerable to all forms of abuse. The presence of suspected or actual child abuse may be difficult to identify due, for example, to low intellect with super-imposed behavioural or communication problems and other associated physically handicapping conditions. It is important that professionals who know the child are involved in the inquiries.

The health care professionals should ensure that:

- cases of suspected or actual abuse are referred to the appropriate statutory agency. Advice from appropriate specialists is sought to ascertain the child's view.
- when a child who has a learning difficulty is at risk, or has suffered significant harm, specialist advice should be obtained and a co-ordinated care plan should be drawn up by a named individual e.g. community nurse, health visitor including teachers, carers in homes and social workers.

Parents with a Learning Disability

The social work services, following a multi-agency assessment, will be the lead agency for the planning and provision of a care programme to enable the child to remain with his/her parents. The social work service will also make arrangements for placement with foster parents or for adoption when a baby has one or both parents whose degree of disability inhibits adequate parenting. Parents who need help to provide adequate parenting should be supported in the community by the learning disability nurse, health visitor, social worker and other agencies as indicated.

Parents with a learning disability may need access to independent advocacy to help them participate in child protection interviews, conferences and planning.

Children Remaining in Hospital, Nursing Homes and Hospices

Children when admitted to respite care, hospital or nursing homes may show signs of abuse or disclose a history of abuse, and these should be referred to the social work services or the police under local child protection procedures.

Dental Staff in Primary Care, Community or Hospital Services

Approximately 70% of children attend a dentist annually in Scotland. Dentists are particularly well placed to identify physical injury, especially to facial and oral tissues. In addition, they may identify other forms of abuse during their contact with children and they should be aware of the signs and symptoms of such abuse through their education and training. While dentists would not normally be involved in case conferences they should be aware of the contact points within the various agencies to initiate a referral when appropriate. Dental services should be included in the circulation of material concerning these issues.

Hospital Based Professionals

Child protection in the hospital setting should occur within a framework which ensures that the rights of the child are upheld, child-centred health care is offered, the child is not harmed by the experience of hospitalisation, any significant harm is identified and the child is kept fully informed.

The Trust should ensure the safety and security of children in their hospitals, addressing physical security issues and ensuring that appropriate visiting takes place.

Professional health carers and supportstaff in many hospital departments see children in the course of their normal duties and therefore need to be aware of vulnerable children and be alert to the signs of child abuse and neglect. In wards and departments outside the children's unit where children are found there should be a children's nurse available 24 hours a day to advise and support. All these areas should have a child protection policy. The identity of the Trust's Senior Nurse/Lead Clinician Child Protection should be well publicised and staff encouraged to seek his/her advice.

In circumstances where staff believe that a child is at immediate risk of significant harm (e.g. where parents are threatening to remove the child from the ward, A&E department or out-patient clinic) they must be prepared to contact a statutory agency directly without delay. In extreme situations the police service is the agency most able to protect the child, but the relevant social work service must also be notified and a list of the relevant contacts should be available and updated on a 6-monthly basis.

Accident and Emergency Departments

Accident and Emergency staff and emergency dental surgeons may frequently be the first contact in cases of suspected or actual child abuse and neglect. Case evidence suggests staff must be alert to carers who seek medical care from a number of sources in order to conceal the repeated nature of their child's injuries. If a child presents repeatedly, even with slight injuries, in a way that staff find worrying, further consultation and investigation should take place according to local procedures. It is essential for all children attending the department that there are arrangements for obtaining medical and nursing advice from the paediatric department and that these are covered in the guidelines.

Professionals Working in Paediatric Departments, Work Based Creches and all Areas Where Children are Cared For

Protection of the child is of paramount importance. It is the responsibility of hospitals to ensure the safety of children in their care. Open visiting and parents participating in the care of their child necessitates professionals being aware of the legal status of the child and who has parental responsibility. Attention needs to be paid to security to prevent access of strangers to children, to prevent the abduction of children and to minimise the possibilities of children leaving the ward.

In addition to the key activities staff should ensure that:

- i. There is an agreed procedure for obtaining and recording information about the child and his/her family from other agencies, including full details about decisions on the future care of the child, who may have contact, any legal order in force, as well as the names of the social worker and health visitor.
- ii. Information concerning a child admitted to the ward who is thought to have been or has been abused or neglected is given to appropriate managers.
- iii. The level of knowledge or experience is continually updated and that appropriate training, support, guidance and clinical supervision is given.

Clinical Supervision

Clinical supervision is a term used to describe a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance patient/client protection and safety of care in complex clinical situations. It is central to the process of learning and to the expansion of the scope of practice and should be seen as a means of encouraging self-assessment and analytical and reflective skills.

Clinical supervision in child protection may be undertaken by the Senior Nurse/Lead Clinician Child Protection and the clinical manager or other peer supporters. It includes discussing cases of actual or suspected child abuse and monitoring records to ensure that all the information about the child and family is reviewed. A child protection clinical supervision policy should be in place. The main types of supervision are one to one supervision, group supervision with a specified supervisor and peer group supervision. The option chosen should be appropriate to the clinical setting with particular reference to child protection issues.

Allegations of Abuse by Staff

Where staff have any concerns about other staff, they should know where and how to obtain help. Systems should be in place to protect children from abuse by staff. All staff must be clear that they have a duty to raise concerns about behaviour by staff, managers, volunteers or others which may be harmful to children in their care, without prejudice to their own position.

In order for the abuse of children by staff to be prevented, or readily discovered, it is essential that children and staff are encouraged to report their concerns. Children will require reassurance about the importance of their making such reports, and junior staff in particular will need support to access senior management to whom they can refer their concerns.

It is therefore important to have procedures in place in order that concerns can be raised outside the normal line management when they consider the manager has been unresponsive or is the subject of concern.

Children and staff making allegations should be listened to and reminded that their allegation will have to be reported and that this may mean breaking confidentiality. Action should be taken to ensure that children are protected and allegations recorded in writing without delay.

When an allegation of abuse has been made against a member of staff, whether involving children they have contact with in the course of their work, or leisure time, or their own children, the matter should be reported immediately to the Lead Clinician/Clinical Manager or, if not available, other senior members of staff.

There are obvious sensitivities to an allegation or suspicions involving a member of staff. Cases must be dealt with by following local procedures.

The Lead Clinician/Clinical Manager will initiate inquiries and, if there is a child protection issue, involve one of the statutory agencies, usually social work.

There are four possible outcomes of the inquiry:

- a child protection concern requiring the activation of local CPC child protection procedures;
- criminal investigation;
- identification of inappropriate behaviour which, while not significantly harmful, needs to be considered under Trust disciplinary procedures;
- the allegation is unfounded.

Consideration must be given to the need for precautionary suspension of the member of staff and whether to begin disciplinary procedures. Any disciplinary action that is considered should be clearly separated from child protection inquiries or any criminal investigation, and these must take precedence over internal disciplinary procedures (see Protecting Children -A Shared Responsibility (1998) page 47 paras 6.2-6.5). Whilst the disciplinary process may be informed by the child protection inquiries, the child protection process has different objectives from the disciplinary procedure and the two should not be confused. The member of staff accused or suspected of abuse should be advised of his or her right to have union representation during disciplinary procedures and seek legal advice.

All agencies have a duty of care towards their employees who are alleged to have abused children in their care, and should treat them with consideration pending the outcome of any inquiries.

In the case of staff found guilty of offences it may be necessary to report misconduct of a nurse to the UKCC (UKCC 1996), and medical staff to the General Medical Council, in order to serve and protect the public.

Currently the Council for Professions Supplementary to Medicine (CPSM) is a federation of independent, self-regulatory statutory bodies, set up by statute in 1960 to regulate Chiropody, Dietetics, Occupational Therapy, Orthoptics, Physiotherapy, Radiotherapy, Prosthetists and Orthotists, Art Therapists as well as Medical Laboratory Scientific Officers. For professions not covered by CPSM, such as Speech Therapists and Language Therapists the professional body itself deals with cases of complaint. However, reforms are expected in Section 60 of the Health Act 1999, but this may take time before changes are in place in Scotland.

The police are required to notify the professional organisation of any member who has been convicted of a criminal offence.

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Protecting Children: A Shared Responsibility

Chapter 9: HEALTH STAFF INVOLVEMENT IN CRIMINAL PROCEEDINGS

The legal measures for the protection of children at risk are fully explained in sections 4.17-4.20 of Protecting Children - A Shared Responsibility: Guidance on Inter-agency Co-operation (1998).

It is the responsibility of the Trust to ensure Lead Clinicians and the Senior Nurse Child Protection oversee, give support and time to staff to prepare statements and have appropriate legal advice.

Other key activities are to ensure:

- familiarity with local court procedures.
- opportunities to discuss statements or evidence with a lawyer.
- attendance at court to support staff giving evidence.
- following court proceedings, staff have the opportunity to discuss the case and are offered further clinical supervision.

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Protecting Children: A Shared Responsibility

Chapter 10: ROLES OF OTHER AGENCIES

This chapter

- Offers staff a brief outline of the roles of other agencies
- Private Sector Childcare/Healthcare/Education
- Social Workers
- Police
- Children's Reporter
- Procurator Fiscal

Private Sector: Childcare/Health Care/Education

All health professionals who work in private health care, or deliver health care in a private setting, must be aware of their duties to protect children and should know about the CPC child protection procedures of the Health Board in whose district they are based.

Professionals who see children and their families on a private basis must follow the appropriate child protection procedure if they know or suspect that a child is suffering or is at risk of significant harm. The lead commissioner at the Health Board should make themselves known to the nurse in charge of local private health care facilities where children may be cared for.

Health commissioners have a public health responsibility to consider the protection of children in private residential homes and boarding schools.

Statutory Responsibilities of Social Workers

The local authority social work services have statutory duties to protect children. When the local authority receives information which suggests that a child may be in need of compulsory measures of supervision, the social work service will make inquiries and give the Reporter any information which they have been able to discover about the child. Local authorities have a duty to safeguard and promote the welfare of children in need in their area and, so far as is consistent with that duty, promote the upbringing of children by their families, by providing a range and level of services appropriate to the children's needs. Some children who have experienced abuse or neglect will need continuing support from the local authority, including specialist services and counselling. Some may need to be looked after by the local authority. Local authorities' criminal justice services also have responsibilities for the supervision and management of risk from adults who have committed offences against children.

Statutory Responsibilities of the Police

The police have a general duty to protect the public and to investigate 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 assist him or her to decide whether a criminal prosecution should take place. The police shall refer a child to the Children's Reporter if they believe that a child may be in need of compulsory measures of supervision.

Statutory Responsibilities of the Children's Reporter

The Children's Hearings system is Scotland's distinctive way of administering care and justice for children and young people up to the age of 16 (or in some cases 18). The legal framework is sections 52 and 53 of the Children (Scotland) Act 1995, under which any child in respect of whom specified grounds exist may be referred to the Children's Reporter by any agency or individual to whom it appears that the child may be in need of compulsory measures of supervision.

On receipt of information from any source about a case which may require a Children's Hearing to be arranged, the Children's Reporter makes an initial investigation. The Children's Reporter may ask for information from other agencies, or arrange for the local authority social work service to undertake an assessment or prepare a social background report. In order to identify ways of reducing delays in Hearings cases, a blueprint was developed by the Time Intervals Working Group which recommended the introduction of national standards covering timescales and other aspects of the service being delivered to children and families (Scottish Office 1999). Following this investigation and where it appears to the Children's Reporter that a child may be in need of compulsory measures of supervision he or she will arrange a Hearing.

The Children's Reporter prepares the grounds for referral and the formal statement of the reason for bringing the child to a Children's Hearing. If the grounds for referral are disputed by the child or parents, the Children's Reporter will refer the case to a Sheriff in Chambers to determine whether or not the grounds are established.

If the Children's Reporter decides that a Hearing to decide what should happen does not require to be arranged, he or she will inform the child and any other relevant person, including the person who provided the original information. When a Hearing is not arranged, the Children's Reporter may also, if appropriate, refer the case to the local authority so that the child and his or her family can be offered advice and guidance on a voluntary basis.

Statutory Role of Procurator Fiscal

The Procurator Fiscal, as the Lord Advocate's local representative, has a duty to investigate the circumstances of any crime or suspected crime brought to his or her attention. He or she acts in the public interest and decides whether to bring criminal proceedings. Where proceedings have started, the Procurator Fiscal may precognosce (interview) witnesses. Child protection encompasses effective investigation and prosecution of offences against children. Decisions regarding criminal proceedings against adults or children are taken by the Procurator Fiscal in the public interest, which includes, but is not restricted to, the interests of the child as witness or accused. The gravity of the alleged offences and protection of the public are matters which require to be weighed, but in all actions concerning children the Procurator Fiscal will have regard to Article 3 of the United Nations Convention on the Rights of the Child which provides that the best interest of the child shall be a primary consideration.

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Protecting Children: A Shared Responsibility

GLOSSARY OF TERMS AND DEFINITIONS

Care Plan

The local authority has a statutory duty to prepare a written care plan for any child looked after by the local authority, in consultation with the child and his or her family, and other professionals involved. The contents of a care plan are specified in the Arrangements to Look After Children (Scotland) Regulations 1996 and include the arrangements made for the child's care, education and health needs.

Child Protection Plan

An inter-agency Child Protection Plan is made following the child's name being placed on the Child Protection Register. It is agreed jointly by the agencies concerned with a child's welfare and co-ordinates the services they provide. Its aim is to ensure that the child's needs for protection and support to promote his or her welfare and development are met by all agencies working together. The plan should specify goals to be achieved, resources and services to be provided, the allocation of responsibilities, and arrangements for monitoring and review.

Categories of Abuse

Many definitions of abuse are used. The National Commission of Inquiry into the Prevention of Child Abuse (1996) discussed these. A broad definition was adopted by the Commission, "Child abuse consists of anything which individuals, institutions or processes do or fail to do which directly or indirectly harms children or damages their prospects of safe and healthy development into adulthood".

General definition of abuse - children may be in need of protection where their basic needs are not being met, in a manner appropriate to their stage of development, and they will be at risk from avoidable acts of commission or omission on the part of their parent(s), sibling(s), other relative(s), a carer (i.e. the person(s), while not a parent, who has actual custody of a child), other responsible professionals or complete strangers.

To define an act or omission as abusive and/or presenting future risk for the purpose of registration a number of elements must be taken into account. These include demonstrable or predictable harm to the child which must have been avoidable because of action or inaction by the parent or other carer.

Categories of abuse- for recording all cases the following are the standard categories of abuse

(Scottish Office 1992). Although these are presented as discrete definitions, in practice there may be overlap between categories. In such cases local authorities should enter the child's name on the Child Protection Register under one main category of abuse although for the purpose of individual case management, the case conference may identify combinations of abuse categories which the child protection plan will need to address. It may also become necessary to change the category of abuse under which a child is registered as a case progresses.

Physical Injury

Actual or attempted physical injury to a child, including the administration of toxic substances, where there is knowledge, or reasonable suspicion, that the injury was inflicted or knowingly not prevented.

Sexual Abuse

Any child may be deemed to have been sexually abused when any person(s), by design or neglect, exploits the child, directly or indirectly, in any activity intended to lead to the sexual arousal or other forms of gratification of that person or any other person(s) including organised networks. This definition holds whether or not there has been genital contact and whether or not the child is said to have initiated, or consented to, the behaviour.

Non-Organic Failure to Thrive

Children who significantly fail to reach normal growth and developmental milestones (i.e. physical growth, weight, motor, social and intellectual development) where physical and genetic reasons have been medically eliminated and a diagnosis of non-organic failure to thrive has been established.

Emotional Abuse

Failure to provide for the child's basic emotional needs such as to have a severe effect on the behaviour and development of the child.

Physical Neglect

This occurs when a child's essential needs are not met and this is likely to cause impairment to physical health and development. Such needs include food, clothing, cleanliness, shelter and warmth. A lack of appropriate care, including deprivation of access to health care, may result in persistent or severe exposure, through negligence, to circumstances which endanger the child.

Joint Visit

A visit which is carried out by two practitioners from different professions/agencies.

'No Access' Visit

The professional should determine the circumstances which constitute a 'no access' visit and an agreed procedure should be established. Every 'no access' visit should be recorded. Typical examples of 'no access' visits are listed below:

1. *The unseen child*

A visit where the particular child is not seen even though access is gained and other members of the household interviewed, or when access to the dwelling is denied. Where there is cause for concern prompt action must be taken.

2. *'No contact' visit*

A visit where there is no response and no contact is made with any member of the household.

Record

The record is to provide succinct and objective written evidence of action taken, advice given, observations made and future intentions of the practitioner and the patient/client. It should be completed as near as possible to the time of the contact and be signed and dated by the recorder of the information. Further guidance for nurses is available in Standards for Records and Record Keeping (UKCC 1993).

REGISTERS

Child Protection Registers

In each area covered by social work services a central register must be maintained by that department which lists all the children in the area who are considered to be suffering from, or likely to suffer, significant harm and for whom there is a child protection plan. This is not a register of children who have been abused but of children for whom there is an inter-agency child protection plan. The registers should include children who are recognised to be at risk and who are placed in the local authority's area by another local authority or agency. Registration does not of itself provide any protection and it must lead to an inter-agency protection plan. Registration should not be used to obtain resources which might otherwise not be available to the family.

Requirements for Registration

Before a child is registered the conference must decide that there is, or is a likelihood of, significant harm leading to the need for a child protection plan. One of the following requirements needs to be satisfied:

- i. there must be one or more identifiable incidents which can be described as having adversely affected the child. They may be acts of commission or omission. They can be either physical, sexual, emotional or neglect. It is important to identify a specific occasion or occasions where the incident has occurred. Professional judgement is that further incidents are likely; or
- ii. significant harm is expected on the basis of professional judgement of findings of the investigation in this individual case or on research evidence.

The conference will need to establish so far as they can a cause of the harm or likelihood of harm. This cause could also be applied to siblings or other children living in the same household so as to justify registration of them. Such children should be categorised according to the area of concern.

Lead Clinician/Nurse/Doctor for Child Protection

Each Health Board (HB) should identify a senior doctor and a senior nurse, normally with a health visiting qualification, but with responsibilities across the HB to be designated as the senior professional to sit on the CPCs to which the HB relates.

Reorganisation of local government in 1997 increased the number of local CPCs with whom HBs must liaise. When the HB relates to several CPCs it may be appropriate for the designated nurse/doctor formally to delegate responsibility for some CPCs to named professionals from local Trusts.

Clinical Supervision

A term used to describe a formal process of professional support and learning which enables the individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations. It is central to the process of learning and to the expansion of the scope of practice and should be seen as a means of encouraging self-assessment and analytical and reflective skills.

Significant Harm

The term 'significant harm' has not been defined in the Children (Scotland) Act 1995.

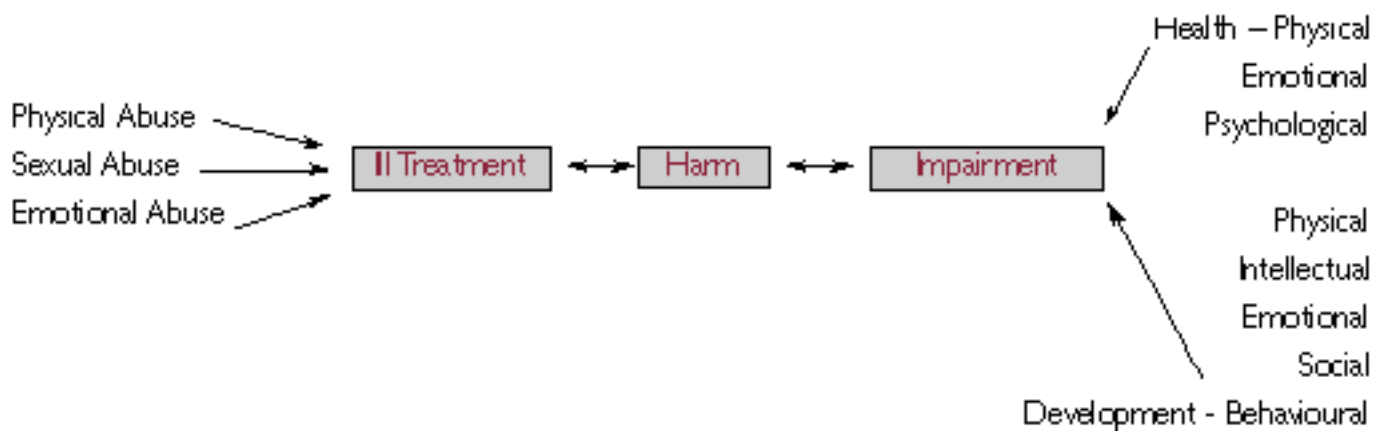
In medical usage, the term is used to encompass the extent of immediate and long-term damage resulting from any form(s) of abuse and neglect. It highlights the need to consider not only the degree of impairment/injury at presentation, physical (including growth), sexual, emotional, but also the degree of long-term impairment/disability, physical, intellectual, emotional, social and behavioural, which is likely to result. For example:

1. Considering the degree of significant harm in a shaken baby would include the

severity of the presenting illness, indicated to some degree by the level of medical intervention required and the long-term sequelae such as cerebral palsy, seizures and visual impairment.

2. Evaluating significant harm in sexual abuse would include not only genital injury but any accompanying physical injury, the possibility of sexually transmitted disease or pregnancy and short/long-term psychological or psychiatric sequelae.

3. In considering the degree of significant harm, both ill treatment and impairment, and impact on long-term functioning require consideration.



Munchausen Syndrome by Proxy (MSBP)

Munchausen Syndrome by Proxy, or induced illness syndrome, may be defined as significant harm which is caused to a child by the actions of a parent or other carer who deliberately fabricates symptoms and/or signs of illness or induces actual illness in a child which would not otherwise be present.

The actions may be as a result of omission or commission and include such behaviour as:

- deliberate poisoning;
- deliberate burning or other damage to the skin to induce symptoms;
- deliberate suffocation to induce symptoms;
- removal of/or tampering with necessary equipment;
- introducing foreign material to tests or other behaviour which causes damaging and unnecessary tests to be performed on the child;
- deliberately inducing fits in the child;
- active withholding of food and/or fluids.

On the extremely rare occasions when MSBP is strongly suspected, it may be considered necessary and justified for the future health and safety of the child to consider the use of covert video surveillance (CVS). However, the use of CVS is contentious, inter-agency protocols must be in place, agreed by the CPC and the Trust Ethical Committee, before it is contemplated.

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Protecting Children: A Shared Responsibility

annex A

CHILD PROTECTION: HEALTH GUIDANCE WORKING PARTY

Chairperson

Professor Christine Hallett, Department of Applied Social Science, University of Stirling

Members

Ms Krysia Binnie, School Nursing Service, Edinburgh

Mrs Anne Burgham, Health Visitor (Child Protection), Dundee

Dr Sandra Davies, Borders Primary Care NHS Trust

Dr Linda de Caestecker, Dept of Public Health Medicine, Greater Glasgow Health Board

Dr C G M Fernie, Principal Police Surgeon, Strathclyde

Mr Bob Ganson, Divisional Education Officer, Perth & Kinross Council

Dr Helen Hammond, Consultant Paediatrician, St John's Hospital at Howden

Mr Mike Johnston, A&E Department, Dundee Royal Infirmary

Mr John McBride, Practice Team Manager, Royal Hospital for Sick Children, Edinburgh

Dr A W F Miller, Medical Director, Yorkhill NHS Trust

Miss Pat Moir, Casualty Sister, Royal Hospital for Sick Children, Aberdeen

Dr G Savage, General Practitioner, Crieff Health Centre

Scottish Executive

Secretary

Mr Willie Farquhar (until 30.9.98)

Miss Jan Nicolson (from 1.10.98)

Medical Advisers

Dr Liz Sowler (until 16.11.97)

Dr Ian Bashford (from 17.11.97)

Nursing Adviser

Mrs Jean Swaffield

Social Work Observer

Miss Jackie McRae

Crown Office

Mrs Alison di Rollo

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Protecting Children: A Shared Responsibility

annex B

PROTECTING CHILDREN: 'A SHARED RESPONSIBILITY':

GUIDANCE ON INTER-AGENCY CO-OPERATION (1998)

SUMMARY OVERVIEW

Paragraphs

Purpose and scope of the guidance

1.7 - 1.9

This guidance is addressed to all agencies working with children and families in the statutory, voluntary or independent sectors, who may have to respond to information or allegations that a child is at risk of significant harm or abuse. It should help agencies and professionals to understand each other's role and functions, and make the best use of their experience and expertise in safeguarding children. The guidance complements The Scottish Office guidance issued on the Children (Scotland) Act 1995 and other guidance to specific agencies, such as education or health services. It should inform local agency guidelines and procedures.

Context

1.1 - 1.13

The UN Convention on the Rights of the Child, and the Children (Scotland) Act 1995, set out the principles and themes which underpin good practice in work to protect children. At the heart of these is listening to children and their families and taking account of their views. Agencies should provide sufficient help at an early stage to reduce the need for compulsory intervention in families' lives. But where a family is not able to care for their child safely, agencies must act promptly, and with skill, to ensure the child's protection. In doing so they should avoid causing the child undue distress or adding unnecessarily to any harm already suffered by the child. The welfare of the child is the paramount consideration when his or her needs are considered by Courts, Children's Hearings and local authorities.

Research indicates that many children at risk of harm live in families in which social exclusion, domestic violence, mental illness or misuse of drugs or alcohol are significant factors. We also know that for many of these families child protection inquiries do not substantiate abuse or harm, and the family receives no help or services. Good health care, education and family support are essential services, to safeguard and promote children's welfare and strengthen the capacity of families under stress to meet the needs of their children before problems progress to abuse or neglect. Child protection is one aspect of services geared towards meeting children's wider developmental needs, and should not be seen as a separate activity. No one agency should be seen as solely responsible for the protection of vulnerable children.

1.15 - 1.16

Some groups of children are particularly vulnerable, or have additional needs, and agencies should consider their circumstances with special care. These include children affected by disability, children from minority ethnic groups or who do not have English as a first language, and children living away from home in residential or other settings.

6.1 - 6.12

ROLES AND RESPONSIBILITIES

Part 2

Each agency makes a distinctive contribution to safeguarding children's welfare within a context of collaboration and shared understanding. Child abuse and neglect has implications for both child welfare and criminal justice agencies. Co-operation in child protection is underpinned by joint procedures prepared by inter-agency Child Protection Committees (CPC) to which all relevant agencies contribute, and appropriate inter-agency training. Local procedures set out arrangements for responding to and sharing information about allegations of child abuse, which should include access to specialist advice or expertise. All agencies should have arrangements in place for the recruitment of suitable staff, and their supervision, training and support to carry out their tasks.

2.11 - 2.15

2.21 - 2.23

THE CHILD PROTECTION REGISTER

Registration is an administrative system for alerting workers to the fact that there is sufficient professional concern about a child to warrant an inter-agency child protection plan, and ensures that the plans for these children are reviewed at least every six months. Local authorities are responsible for maintaining a Register of all children who are the subject of an inter-agency child protection plan, which provides a central point of rapid enquiry for professionals who are concerned about a child's development, welfare or safety. The decision to place a child's name on the Child Protection Register is taken by a multi-disciplinary case conference.

WORKING TOGETHER TO PROTECT CHILDREN

Part 4 sets out guidance to agencies on responding effectively to allegations of abuse or neglect in individual cases.

4.1, 4.7 - 4.9

- Agencies need to understand the causes, and be alert to signs of, child abuse and neglect, and be willing to provide help and support at an early stage.

4.4 - 4.6
- Informed responses to reports of abuse from a child or any other person should not pre-empt, or prejudice, child protection inquiries or criminal investigation.

4.10
- Local authorities should plan child protection inquiries in close consultation with the police, and other agencies, in particular health and education.

4.21 - 4.22
- Evidence should be gathered in ways which ensure the effective prosecution of crimes against children.

4.17 - 4.20
- Legal measures to protect children through the Courts are available in emergencies or when families are unwilling to assist.

4.30 - 4.42;
- All agencies should contribute to assessment and decisions about how to protect children from abuse, and give priority to helping children recover from the trauma of child abuse or neglect.

4.49 - 4.55

- Agencies should work in partnership with families, by informing and involving them in decisions and enabling them to participate actively in plans.

4.43 - 4.48

JOINT INVESTIGATION

Joint investigation describes the process whereby social work, police and health professionals plan and carry out their respective tasks together when responding to complex or substantial child protection referrals. All referrals of child sexual abuse should be considered for joint investigation.

5.1 - 5.3

The police and social work service should share and evaluate jointly all relevant information at an initial planning meeting or discussion, involving health services wherever possible. Planning should consider the child's needs and risk, as well as the conduct of child protection inquiries and any criminal investigation. Medical information and assessment may assist the planning and management of any inquiries.

5.4 - 5.13

When dealing with allegations of organised abuse by adults agencies should adopt a measured approach to investigation which takes care not to prejudice efforts to collect evidence for criminal prosecution of an abuser or group of abusers, but which has the welfare of any child or children at risk as the paramount consideration. The senior investigating police officer may decide to make use of the Home Office Large Major Enquiry System (HOLMES) to enable effective investigation of suspected multi-abuse cases.

5.14 - 5.24

Note: This summary overview has been prepared to provide readers with a brief indication of what the guidance contains. Those who will need to use the guidance in their day-to-day work are advised to study the whole document.

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annex C

CIRCULAR NO: SWSG 14/97

(Previously numbered SWSG 4/96)

Previous Circular Cancelled: SW 18/1991

8 March 1996

Chief Executives of Unitary Authorities

Copy to:

- Chief Social Work Officers
- Directors of Social Work Unitary Authorities
- Directors of Education
- Health Board General Managers
- Chief Constables
- Procurators Fiscal
- Principal Reporter
- Those on attached list (for information)
- Holders of SWSG Guidance Package

Dear Chief Executive

CHILD PROTECTION: LOCAL LIAISON MACHINERY - CHILD PROTECTION COMMITTEES

Summary

1. This Circular provides guidance on child protection committees taking account of the reorganisation of local government on 1 April 1996. It reflects the advice of a working group comprising representatives of existing child protection committees, The Scottish Office and the Crown Office. It asks Chief Executives and chief officers of statutory agencies which have varying public responsibilities for the protection of children from abuse to take action in the light of the guidance. These statutory agencies are

Local authorities (for social work and education functions)

Health boards

Police

Procurator Fiscal service

Scottish Children's Reporter Administration

Circular SW18/1991 is replaced.

Action

2. In recognition of the strategic importance of child protection committees, Chief Executives are asked to initiate discussions with chief officers in those agencies in their areas, in order to agree revised arrangements for such committees from 1 April 1996. Chief officers should accord a high priority to the task of agreeing any necessary changes in the arrangements in their areas.

Background

3. Local child protection committees have been established in all regional and island areas of Scotland. They provide an invaluable forum for facilitating inter-agency working and understanding in child protection. They have helped develop local strategies and joint procedures and they have created a culture in which multi-agency training has come to be recognised as a necessary prerequisite to effective collaboration. Through their contacts with central government, they have been well placed to influence national child protection strategies and policies.

4. With the setting up of the new unitary councils, the existing child protection committee structure and organisation may need to be reviewed and adapted. Where it is decided that new committees are necessary they should build on the legacy of their predecessors.

Transition

5. The process of setting up new committees will be easier to manage if there is as much continuity as is possible between the old and the new. Chief officers will want to draw as far as possible on the experience of personnel who have served on previous committees.

6. New committees may wish to consider the value and suitability of existing inter-agency guidelines. It may be that these could be adopted initially with a minimum of change and reviewed at a later date. Similarly, existing multi-agency training programmes and arrangements may be of use to new committees during the transitional period (and perhaps also beyond that period). Where this is done the management and cost of the training effort could be shared by the committees benefiting from it.

7. The Annex summarises the results of a short survey into how the existing committees function. This may provide pointers for new committees in the immediate and longer term future after reorganisation.

Purpose of Child Protection Committees

8. The justification for co-ordinating machinery lies in the wide range of agencies involved in work which is concerned with protecting children from abuse. Cooperation and practice on individual cases of child abuse need to be sustained by joint agency procedures which are consistent with the policies and plans which each agency has for related service provision. The task of developing, promoting, monitoring and reviewing local child protection policies needs a joint forum. The Government see child protection committees continuing to have a major strategic role, building upon the achievements already made in inter-agency cooperation and allowing agencies to consider sharing resources to ensure their more effective and efficient use.

Functions

9. To be fully effective CPCs need to have a clearly recognised relationship to the responsible agencies. CPCs bring together the main agencies responsible for the provision of services for children and their families so that they can plan effectively for protection of children and encourage full collaboration to that end. Although they are essentially a confederation of individual agencies their functions allow them to exercise a collective and overarching influence on all the agencies concerned. These functions are to:

- ensure that local inter-agency guidelines on procedures to be followed in individual cases are produced, maintained and regularly reviewed and that the procedures, including referral procedures, are known about by those who may need to know;
- promote good inter-disciplinary practice in preventing and dealing with the causes and effects of child abuse;
- assess issues of significance in collaborative working which arise from the handling of cases and from reports on inquiries;
- review arrangements for providing expert advice and inter-agency liaison;
- monitor and review information about the operation of the Child Protection Register;
- identify inter-agency training needs and take a leading role in developing and promoting inter-disciplinary training programmes;
- publish an annual report.

10. Each CPC should agree and work to written terms of reference. Since CPCs have opportunities to influence and contribute to individual agencies' practice and the development of skills and abilities of practitioners, each agency should have in place arrangements for

receiving reports from committees, either direct or through its own representative(s) so that they can respond to and, if necessary, act upon issues raised by the CPC. Reports which have implications for policy, planning and resources need to be dealt with at the appropriate level within agencies.

Organisation

11. Following local government reorganisation a number of organisational models can be considered for CPCs, for example:

- A. one committee per each new council area working independently;
- B. as in model A but with individual committees formally co-operating with committees in adjoining areas by adopting common arrangements, for example inter-agency guidelines and training;
- C. one committee per new council co-operating with adjoining area committees, as in model B, but also having a co-ordinating committee for certain functions;
- D. one committee per health board area on which each new council within that area would be represented;
- E. one committee per police area on which each new council within that area would be represented.

12. Model A is simple, with each local CPC operating on its own. Models B and C build on that by providing means of co-ordinating local CPCs for certain functions. Models D and E would embody combinations of local authority areas. The last four models could serve to bring about a greater degree of consistency over wider areas than would otherwise be the case. They would also facilitate sharing of experience and expertise. No hard and fast rules can, however, be laid down as to how committees should be organised and how they should co-operate with other committees. It will be up to individual agencies to agree arrangements best suited to their particular circumstances. Different models could exist in different parts of Scotland.

Budgetary Responsibilities

13. The Scottish Office has a significant role in encouraging and promoting an inter-agency approach to the protection of children. It produces and reviews central guidance and organises periodic meetings of CPC representatives to exchange information and views on latest developments. This complements the responsibilities of agencies for providing within their areas services which offer protection for children.

14. To ensure that their respective services are delivered as efficiently and effectively as possible, each agency should co-ordinate them with the services provided by other local agencies. The prime focus for achieving this co-ordination is the CPC. Its emphasis is essentially local, on helping in various ways to mobilise services for the protection of children. Its own expenditure - desirably brought together in a designated budget - is therefore a local matter, reflecting investment of the respective agencies in co-ordination which ultimately benefits each of them.

15. Contributions towards expenditure involved in maintaining and operating the CPC should be made primarily from the main service organisations represented, i.e. social work, police, health service and education. They should take account of contributions when preparing their respective forecast expenditure budgets. The CPC accounts to its constituent agencies for management of resources through accounts and annual reports.

Accountability

16 As essentially co-ordinating and advisory bodies, the committees are accountable for the discharge of their functions to the main organisations which constitute them. This is done routinely through annual reports, and on matters which may have implications for policy planning and allocation of resources, through ad-hoc reports to individual agencies and also by working with constituent agencies, at their request, on one-off tasks or assignments.

Authority

17. CPCs do not have any authority over individual agencies since these agencies have a range of statutory responsibilities and duties which cannot be superseded by others. CPCs can, however, develop an effective and influential role in inter-agency policy, practice procedures and training at both local and national level. This can be achieved through periodic meetings between CPCs, The Scottish Office and the Crown Office and through the circulation of CPCs' annual reports.

Representation

18. Core representation on CPCs is most likely to be drawn from the following:

Local Authorities (social work and education departments)

Police

Health Services

Reporters to the Children's Panel

Procurators Fiscal

The Armed Services (in areas where large service bases are located).

19. Committees may also wish to invite participation or representation by those with particular skills and/or experience which would assist the committee in the discharge of its functions. Such persons may participate on a regular basis or they may be invited ad hoc. Members of children's panels, academics and representatives of relevant voluntary organisations could be considered for such participation or membership. Legal advice may from time to time be required and committees may wish to invite a member of the legal profession to attend meetings where necessary.

20. If CPCs are to work well, those appointed to serve on them should be officials with relevant specialist knowledge and experience in their respective fields and they should be able to commit their agency to implement the recommendations and decisions of the committee. For this latter purpose, constituent agencies should determine the level of decision-making powers which may be delegated to representatives without referral back. Elected members may wish to be associated with the appointments of local authority officials to serve on committees.

21. Health Boards have public responsibility for the health input to CPCs but Boards will wish to discuss with NHS Trust Chief Executives how representation on CPCs within health board areas can best be achieved. The participation or membership of Trust personnel should be secured under the terms of the contract between the Board and the Trust(s).

22. Service on a CPC is a specific responsibility which should be recognised in the member's job description and workload so that he or she can attend CPC meetings on a regular basis and to participate in any sub-committees. The appointment of a substitute member to cover any unavoidable absence of the representative will ensure that all services are always represented at meetings.

23. Members should be appointed to CPCs for a term which is consistent with ensuring continuity of experience. There is no ideal period but frequent changes of membership inevitably inflict some discontinuity. Discontinuity is also likely to occur if the same term of appointment is fixed for all members of committee since they would all "retire" at the same time. CPCs need to bear these points in mind when fixing periods of membership.

Sub-Committees

24. Committees may decide that it is desirable to establish sub-committees to concentrate on particular aspects of the remit of the committee and to achieve continuity of planning and implementation. Sub-committees may be commissioned to carry out specific tasks such as:

- over-seeing the development and implementation of local procedures;
- making proposals for programmes of work, e.g. with abusers;
- developing inter-agency training programmes;
- providing specialist advice on ethnic and cultural issues;

- compiling and maintaining a list of "expert witnesses and advisers" who could act as consultants to constituent agencies.

25. These sub-committees may co-opt persons with relevant experience who are not members of the main committee. All such sub-committees will need a defined membership, aims and objectives and explicit lines of communication and accountability to the CPC. CPCs may also wish to set up sub-committees of specialist groups, e.g. health specialists. The same need to define purpose and lines of accountability of such sub-committees would apply.

Meetings

26. The frequency of meetings of the committee or any of its sub-committees is a matter to be determined by the committee (or sub-committee). Meetings should be arranged at times convenient to the maximum number of members.

Chair and Secretariat

27. Experience has shown that CPCs should be left to appoint their own Chairs. Appointees should possess knowledge and experience of child protection work in addition to chairing skills. The committee may appoint an independent person with the requisite knowledge, experience and chairing skills. There may be advantages in agreeing in advance the period of appointment of the Chair. A period of up to three years seems to be appropriate but local circumstances may determine a more appropriate period. Committees will also want to appoint a Vice-Chair to chair meetings in the absence of the Chair and they may wish to consider whether the person appointed should take over automatically when the Chair demits office.

28. The appointment of an administrative officer will help to maintain coherence and focus in the work of CPCs. Such support may be satisfactorily provided by one or more of the constituent agencies deputing the task to a member of staff, or the committee may wish to appoint some other person using committee resources. For small committees, however, the appointment of a dedicated administrative officer may not be justified. Such committees may wish to consider joint appointments with other committees.

Multi-Agency Training

29. Training is essential if human and other resources are to be used effectively and efficiently for the protection of children. It is a means of improving the knowledge, skills and judgement of staff. Effective child protection depends on well trained staff in all the agencies concerned.

30. The basic training of almost all of the professional groups who work in health, education, social work and the police now includes a focus on the identification of signs of child abuse and the measures necessary to ensure a child's legal protection. In addition there is a growing

range of post-qualifying training opportunities which enable staff in all relevant professional groups - and others who work with children such as playgroup leaders and foster parents - which can enable them improve their knowledge and skills.

31. As well as developing professional skills and knowledge, training programmes run by individual agencies need to reinforce the message that in dealing with child abuse the staff of agencies must come together and work in a collaborative and co-operative way. Individual professionals not only require to have a competence in the discharge of their own responsibilities, they also need to be fully aware of the responsibilities of other agencies and other professionals. In-service training has a vital part to play in fostering that awareness. Agencies may invite staff from other agencies to attend or address their training courses. Reciprocal arrangements of this kind may also help to foster good relations between agencies. Whatever means are adopted, individual agency programmes should include training which will help staff- managers as well as practitioners - to work together with staff of other agencies in dealing with child abuse.

32. Multi-agency training is an essential component in building common understanding and fostering good working relationships which are vital to effective child protection. CPCs are well placed to play a central role in the development and delivery of such training which provides a significant influence on successful inter-disciplinary working on actual cases of abuse and in prevention and post-abuse programmes.

33. Some multi-agency training may involve all agencies represented on a CPC; some may involve particular agencies such as social work and the police. The aim of the CPC will be to develop training programmes which complement and build upon the work already done by individual agencies and which embrace identified multi-agency training needs among the staff of the agencies concerned. Committees may adopt different approaches to achieving that aim. Some may wish to appoint a training co-ordinator. For others, as with administrative support, the appointment of a dedicated training co-ordinator may not be justified but the possibility of a number of CPCs jointly appointing a co-ordinator may be considered. Committees may, alternatively, use a standing training committee to carry forward multi-agency training work. Whatever method or combination of methods is adopted, CPCs will want to ensure that they maintain an awareness of evolving and developing training needs and priorities.

34. Different approaches may also be adopted in relation to funding multi-agency training activities. Training co-ordinators may be "seconded" from one of the constituent agencies or they may be engaged by the CPC and paid out of committee resources. Similar arrangements may apply for training courses where individual agencies pay in accordance with the number of places taken; or alternatively, multi-agency training may be funded from the committee budget; or a mixture of both may be appropriate.

Reports from CPCs

35. Committees are accountable to their constituent agencies through annual reports and reports on specific issues. Each committee's annual report will review key areas of its work during the year by describing action taken to:

- produce, or introduce changes in inter-agency guidelines related to child abuse;
- plan or initiate programmes of inter-agency training;
- promote good inter-disciplinary practice.

36. In addition, reports should include information about the number and types of child abuse cases as indicated by Child Protection Registers, indicating the age and gender of the registered children. Details of committee membership, indicating the specific organisation and job title, should be provided, as should information about the agreed funding arrangements. The reports should also be used to convey a planned programme of work for the coming year.

37. Copies of each annual report should be sent to Social Work Services Group so that the Secretary of State can be informed about current issues in child protection. Copies might also be made available to other CPCs to facilitate a wider exchange of useful ideas throughout Scotland.

Reports to CPCs

38. CPCs require to be informed regularly about the level of activity on child abuse work and about the type of abuse and any identifiable trends. Local authorities can derive information for this purpose from Child Protection Registers and the standard Child Protection Management Information System. Other agencies, for example, the Scottish Children's Reporter Administration, may also have relevant information which will be helpful to CPCs. Those providing information should make their reports using aggregated statistics so as to preserve the anonymity of a particular individual or individuals.

Enquiries about this Circular should be addressed to

Mr John Rafferty,
Social Work Services Group,
Room 43,
James Craig Walk,
Edinburgh,
EH1 3BA (telephone 0131 244 5484).¹

Yours sincerely

J W SINCLAIR

¹To holders of the SWSG Circulars and Guidance: This Circular should be placed in Section E3 of the volume containing "E, Children and Families (Sections 1-5)"circulars.

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Protecting Children: A Shared Responsibility

annex D

ARRANGEMENTS FOR CHILD PROTECTION IN THE ARMED SERVICES

Armed Services

1. Family life in the armed forces is, by its very nature, different to that in civilian life. The forces control the movement of the family in relation to service commitments, and families often endure long periods of separation, without extended family support. Although it is local authorities who have primary responsibility for the care and protection of children, it is essential for local authorities and other agencies to note these differences and share information with the service authority when a service family becomes the subject of child protection inquiries. Each service has their own welfare organisation, which supports service families. In addition the service authorities provide housing for their families, and due to the frequency with which the families move, it is important that the service authorities are fully aware of any child who is deemed to be at risk within their family.

Forces based in Scotland

2. The Service Authorities seek to co-operate with statutory agencies and to support service families where child abuse or neglect occurs. The information they hold on any family can help in the assessment and review of such cases. Procedures exist in all the services overseas to register and monitor the protection of children at risk, and the usual rules of confidentiality are observed. In working together the services, service authorities and the local authority social work service need to keep in mind that legislation places the primary responsibility for the care and protection of children on the local authority.

Army

3. The welfare of army families whose children are considered by a social work service to be at risk is the responsibility of the Army Welfare Service (AWS). The AWS provides a comprehensive and professional confidential welfare support service to all Army personnel and their families through the Soldiers', Sailors' and Airmen's Families Association (SSAFA) Social Workers (SW) and Army Welfare Workers (AWW). Social work services should liaise with one of the three Welfare Support Officers (WSO) who between them provide cover for the whole of Scotland. They respond to the Principal Welfare Support Officer AWS (PWSO AWS) who

works together with the SSAFA Senior Social Work Adviser (SSWA) for Scotland in Army Headquarters Scotland. Contact telephone numbers are as follows:-

Army HQ Scotland (Edinburgh)

PWSO AWS	0131-310 2107/2108
SSAFA SSWA	0131-310 2618

East Scotland (Edinburgh)

WSO AWS	0131-310 2850
AWW AWS	0131-310 2845

West Scotland and Hebrides (Glasgow)

WSO AWS	0141-332 0396
AWW AWS	0131-310 2845

Highlands (Perth northwards), Orkney & Shetland (Inverness)

WSO AWS	01463 233132
AWW AWS	01463 233132

Royal Navy

4. All child protection matters within the Royal Navy are handled by the Naval Personal and Family Service (NPFS), the Royal Navy's own social work service. This provides a confidential and professional social work service to all Naval personnel and their families liaising as appropriate with social work services, particularly as required by statute for child protection cases. Child protection involving a member of the Royal Navy should be referred to one of the three civilian Area Officers, listed below, who are in a position to negotiate service action on behalf of Naval families and NPFS should be involved in any case conferences concerning them. All cases abroad are initially handled by the Eastern Area.

East: Area Officer (NPFS)
HMS NELSON
Queen Street
Portsmouth
Hampshire PO1 3HH
Tel: 01705 820932/826774

West: Area Officer (NPFS)
HMS DRAKE
HM Naval Base
Devonport
Plymouth PL2 2BG
Tel: 01752 568611

North: Area Officer (NPFS)
HMS NEPTUNE
Triton House
1-5 Churchill Square
Helensburgh
Argyll and Bute
G84 9HL
Tel: 01436 672798

Royal Marines

5. All welfare matters within the Royal Marines are dealt with by the Royal Marine Welfare Service. This is a non-statutory agency which provides a confidential and professional service to all Royal Marine personnel and their families. The Royal Marine Welfare Service will liaise with the local social work service and will negotiate service action on behalf of families. The Royal Marine Welfare Service should be informed in all cases of child protection involving a member of the Royal Marines.

Scotland Welfare Officer
RM Condor
Arbroath
Angus
DD11 3SJ
Tel: 01241 872201 Ext.2015/6
Tel: 01705 547542

SO3 WFS
Welfare Office
HQRN
West Battery
Whale Island
Portsmouth
HANTS PO2 8DX

Royal Air Force

6. The Royal Air Force has an independent welfare organisation on each station in an area. Social work is managed as a normal function of command and co-ordinated by each Station's Personnel Officer; the Officer Commanding Personnel Management Squadron (OCPMS) who is supported by a qualified SSAFA Forces Help Social Work Adviser, or, in some cases, a Social Work Assistant. Whenever child protection inquiries concern the family of a serving member of the RAF, the social work service should notify the parent unit, or if this is not known, the nearest RAF unit by contacting the OCPMS or SSAFA Forces Help Adviser. Every RAF unit has an officer appointed to this duty and he or she will be familiar with child protection procedures. If you wish to discuss informally contact the SSAFA Social Work Adviser at RAF Lossiemouth (Tel: 01343 812121 Ext. 7399).

Service families going or returning from overseas

7. Where NPFS are aware of child protection issues within a family who are being considered for overseas service, this will be highlighted during the screening process and action taken to prevent the family's move before any child protection issues have been resolved. It is essential that the local authority social work service exchange information about agencies' involvement with a service family to ensure that no child named on a UK Child Protection Register can be taken abroad, and to make sure that parental support is not removed at a critical time.

8. The Soldiers', Sailors' and Airmen's Families Association (SSAFA) provides, at the request of the Ministry of Defence, a qualified social work and health visiting service for families of all services on overseas stations.

9. Where there is a child protection plan in this country for a child in a service family who are to move overseas, the social work service concerned should notify SSAFA in writing with full documentation, case summary, case conference notes, etc. to:

Assistant Controller (Services Support) SSAFA UK

SSAFA Forces Help
HQ Land Command
Erskine Barracks
Wilton
Salisbury
SP2 0AG
Tel: 01722 438245/438251

10. This information is forwarded to the relevant SSAFA social worker overseas in order that:-

- a. the case may be entered on the overseas British Forces Child Protection Register;
- b. the practitioners at the overseas base can be alerted and a case conference arranged; and
- c. appropriate support and supervision are provided to the family.

11. Where there is a statutory involvement (e.g. a supervision requirement), SSAFA will provide regular reports to the local authority concerned. Similarly, when a service family with a child in need of protection returns to the UK, SSAFA will contact the social work service in the local authority area in which they will reside, and ensure that full documentation is provided to assist in the management of the case.

Emergency Action Regarding Service Families Overseas

12. When it appears that a child is in urgent need of care or control an officer having jurisdiction in relation to the child may order the child to be removed to and detained in a place of safety. If the officer makes an order to transfer the child to the United Kingdom so that care of the child can become the responsibility of the relevant local authority all necessary action will be arranged and agreed beforehand between the responsible agencies concerned.

13. New arrangements for dealing with the emergency protection of children of Service families abroad were introduced in the Armed Forces Act 1991. These provide for the officer having jurisdiction in relation to a child to make an order to remove the child or keep him or her in accommodation provided by or on behalf of the person who applied for the order.

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Protecting Children: A Shared Responsibility

annex E:

CONTENT FOR EDUCATION AND TRAINING PROGRAMMES FOR HEALTH STAFF

- recognition of the importance of health promotion and prevention of abuse and neglect of children;
- knowledge of the indicators and pre-disposing factors in children and parents of child abuse and neglect, including children who abuse other children and children with disabilities;
- knowledge of the physical, emotional and behavioural signs, symptoms and indicators of possible child abuse and neglect, and the assessment of risk;
- psychological impact of all forms of abuse on children both in the acute and chronic stages and the long-term consequences to their psychological welfare and the impact on future relationships;
- the role and responsibilities of health practitioners and their advisers/clinicians/senior nurses in child protection;
- the child protection committee inter-agency procedures and the Trust(s) child protection guidelines;
- knowledge of the professional advice and guidance, case review and child protection clinical supervision available to practitioners;
- inter-disciplinary and inter-agency referral and liaison;
- record keeping including personal health child records and professional records;
- the legislative framework, the Children (Scotland) Act 1995, legal orders, preparation for and attendance at court cases, writing reports and statements for court cases;
- preparation for and attendance at child protection conferences, this will include providing written reports for conferences and other child protection meetings;
- accountability and confidentiality in child protection work;
- UN Convention on the Rights of the Child;
- an understanding of consent and the Age of Legal Capacity (Scotland) Act 1991;
- working openly and in partnership with families.

The outcome of training should be an understanding of the knowledge and skills necessary to work with others in multi-disciplinary and inter-agency collaboration for the protection of children from abuse and neglect.

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Protecting Children: A Shared Responsibility

annex F

EXAMPLE OF A CONTACT LIST

A contact list should be put together to include telephone numbers and addresses of key personnel.

Suggested contacts could be:

- Local Child Protection Committee
- Social Work - main offices and centres
- Social Work hospital teams
- Social Work - Emergency Duty Team
- Scottish Office Social Work Group. List of all Register Holders
- Police - HQ
- Divisions
- Police Surgeon
- Health Board Commissioner
- Hospitals
- Community paediatrician for child protection
- On call community child health doctor for child protection
- Specialist Services
- Department of Genito-Urinary Medicine
- Child and Adolescence Mental Health Service
- Forensic Odontologist
- Child Protection Keeper of Child Protection Register
- Children's Reporters
- Procurator Fiscal
- Interpreting and Translation Service Trust
- Children First
- Other local voluntary organisations
- Other local contacts
- Education Departments
- Caldicott Guardians

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annex G

EQUIPMENT AND FACILITIES APPROPRIATE FOR MEDICAL ASSESSMENT

Appropriate Paediatric Consulting Facilities with the following:

- Light source
- Colposcope
- Video link
- Kit for: Bacteriology/virology samples

Blood samples for clotting studies

HIV/HEP status

- Medical photography
- X-ray
- Standard referral form
- Standard proformas for the CMA, Specialist Paediatric and Joint Paediatric/Forensic Examination
- Secure video storage facilities
- Laboratory support including out of hours services
- Out of hours specialist services e.g. haematology
- Radiology support which will include the access to expert opinion on films and specialist investigation such as MRI
- Information leaflet especially regarding medical services and post abuse support service
- Physical evidence recovery kit: For use following acute sexual assault provided by police/forensic samples going to police laboratory
- Police photographs.

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annex H

COMPREHENSIVE MEDICAL ASSESSMENT FORM

On completion of form, separate the copies and staple together those of same colour.

White copy to Social Work

Pink copy to Community Child Health Doctor

Yellow copy to General Practitioner

COMPREHENSIVE MEDICAL ASSESSMENT OF CHILD WHO MAY HAVE BEEN ABUSED or NEGLECTED

*(This report fulfills the requirements of part 1 of the comprehensive medical assessment
of a child being looked after by the Local Authority.)*

Child's Surname	Forename(s)		
Known as			
Address		Date of Birth	
		Sex	
		CHI No.	
GP		Date of Examination	
Address		Time of Examination	
School/Nursery Attended			
Person Accompanying Child			
Mother in attendance? YES NO		Father in attendance? YES NO	

BACKGROUND INFORMATION

(e.g. previous concerns re. developmental delay, poor growth, possible episodes of NAI)

BACKGROUND INFORMATION

(e.g. previous concerns re. developmental delay, poor growth, possible episodes of NAI)

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Protecting Children: A Shared Responsibility

ACCOUNT OF CIRCUMSTANCES LEADING TO REFERRAL

(a) From Referrer:

Name:**Position:**

(b) From Accompanying Adult:

Name:**Position:**

(c) From Child:

CONSENT (source, i.e. parent, young person, person holding parental rights):

Date:**Witnessed by:**

Name

Position

CONCERNS RAISED BY CHILD/PARENT/CARER/SOCIAL WORKER/ (Tick box if problem raised and discussed)

Diet/Feeding

☐

Growth/Development

☐

Illness

☐

Diet/Feeding	<input type="checkbox"/>	Growth/Development	<input type="checkbox"/>	Illness	<input type="checkbox"/>
Behaviour	<input type="checkbox"/>	Hearing	<input type="checkbox"/>	Vision	<input type="checkbox"/>
Movement	<input type="checkbox"/>	Energy	<input type="checkbox"/>	Encopresis/Enuresis	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>				
Comments:					



Protecting Children: A Shared Responsibility

CLINICAL EXAMINATION

General physical appearance of child (note especially any evidence of infection, neglect or injury)

Demeanour/behaviour/impression of developmental/maturation status

Measurements

Weight	kg	centile
Height	cm	centile
Head circumference	cm	centile

Findings on external physical examination

(Tick appropriate boxes and where possible record findings on pages 4 & 5 of form.)

Comment

(a) Skin and hair		
(b) Teeth		
(c) Eyes		
(d) Ears, nose and throat		
(e) Cardiovascular system		
(f) Blood pressure (if applicable)		
(g) Respiratory system		
(h) Alimentary system		
(i) Genitalia/testes		
(j) Nervous system		

(j) Nervous system		
(k) Locomotion/posture		
(l) Visual acuity	R	
	L	
(m) Hearing	R	
	L	

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Protecting Children: A Shared Responsibility

Date of Birth	FRONT	BACK
Child's Surname	<p>Please indicate on the charts any areas of bruising or abrasions and describe on page 5.</p>	

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Protecting Children: A Shared Responsibility

DESCRIPTION OF INJURIES/NEGLECT

CONCLUSION

ACTION

Further investigation of possible abuse

Social Work/Police Investigation

☐

Joint Paediatric/Forensic Examination

☐

Need for further assessment (please circle)

Other medical/developmental/
specialist, eg orthopaedic/educational

Signed _____ Date _____		
Name in Block Letters	Designation	Time Completed
Information shared with (please circle) Parents / Social Work / Police / GP / HV / Paediatrician		

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Protecting Children: A Shared Responsibility

annex I

SAMPLE PAEDIATRIC/FORENSIC EXAMINATION FORM

Confidential Medical Information

**An example of a form for the
Joint Paediatric/Forensic Examination/
Specialist Paediatric Examination of
Child who may have been Abused or Neglected**

Place of Examination		Name of Examiner(s)	
Child's Surname		Forename(s)	
Known as			
Address		Date of Birth	
		Sex	
		CHI No.	
GP		Date of Examination	
Address		Time of Examination	
Child accompanied to clinic by (please tick) Mother <input type="checkbox"/> Father <input type="checkbox"/> SW <input type="checkbox"/> Police <input type="checkbox"/> Other <input type="checkbox"/>			

(please tick)	Mother <input type="checkbox"/>	Father <input type="checkbox"/>	SW <input type="checkbox"/>	Police <input type="checkbox"/>	Other <input type="checkbox"/>
School/Nursery Attended					

BACKGROUND INFORMATION

(e.g. previous concerns re. developmental delay, poor growth, possible episodes of NAI)
Family/Social History

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Protecting Children: A Shared Responsibility

ACCOUNT OF CIRCUMSTANCES LEADING TO REFERRAL

(a) From Referrer:

Name:

Position:

(b) From Accompanying Adult:

Name:

Position:

(c) From Child:

In the presence of:

Child's Terminology

Breasts _____

Vagina _____

Anus _____

Urethra _____

Abdomen _____

Semen _____

Penis _____

Penis

Scrotum

CONSENT

(source, i.e. parent, young person, person holding parental rights)

Date:

Witnessed by:

Name

Position

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Protecting Children: A Shared Responsibility

PRESENTING SYMPTOMS

Has the child exhibited any behavioural symptoms:

Masturbation ☐

Secondary wetting ☐

Aggression/Anger ☐

Sexualised Play ☐

Soiling ☐

Conduct disorder ☐

Other ☐

SYSTEMATIC ENQUIRY

(Genito-urinary enquiry)
see over

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Protecting Children: A Shared Responsibility

GASTRO-INTESTINAL/GENITO-URINARY ENQUIRY

			Comment
Bowels	Frequency		_____
	Consistency of stool		_____
	Pain on defaecation	Yes / No	_____
	Bleeding on defaecation/blood on wiping	Yes / No	_____
	Constipation	Yes / No	_____
	Soiling	Yes / No	_____
	Mucous	Yes / No	_____
	Other	Yes / No	_____
Urinary Tract	Previous UTI	(Suspected)	Yes / No _____
		(Confirmed)	Yes / No _____
	Frequency		Yes / No _____
	Dysuria		Yes / No _____
	Urgency		Yes / No _____
	Wetting - day/night		Yes / No _____
	Other		Yes / No _____
	Genital	Bleeding/blood on pants	
Discharge			Yes / No _____
Itch			Yes / No _____
Rash/inflammation			Yes / No _____
Circumcised			Yes / No _____
Menarche age			_____
Menstrual cycle			_____

Menstrual cycle

Date of last period

Routine sanitary protection

Tampon / Towel / Both

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Protecting Children: A Shared Responsibility

CLINICAL EXAMINATION

People in attendance during examination

General physical appearance of child (note especially any evidence of infection, neglect or injury)

Demeanour/behaviour/impression of maturational status

Measurements

Weight	kg	centile
Height	cm	centile
Head circumference	cm	centile

Findings on external physical examination

(Tick appropriate boxes and where possible record findings. Omit if Preliminary Medical Assessment Form has already been completed.)

Comment

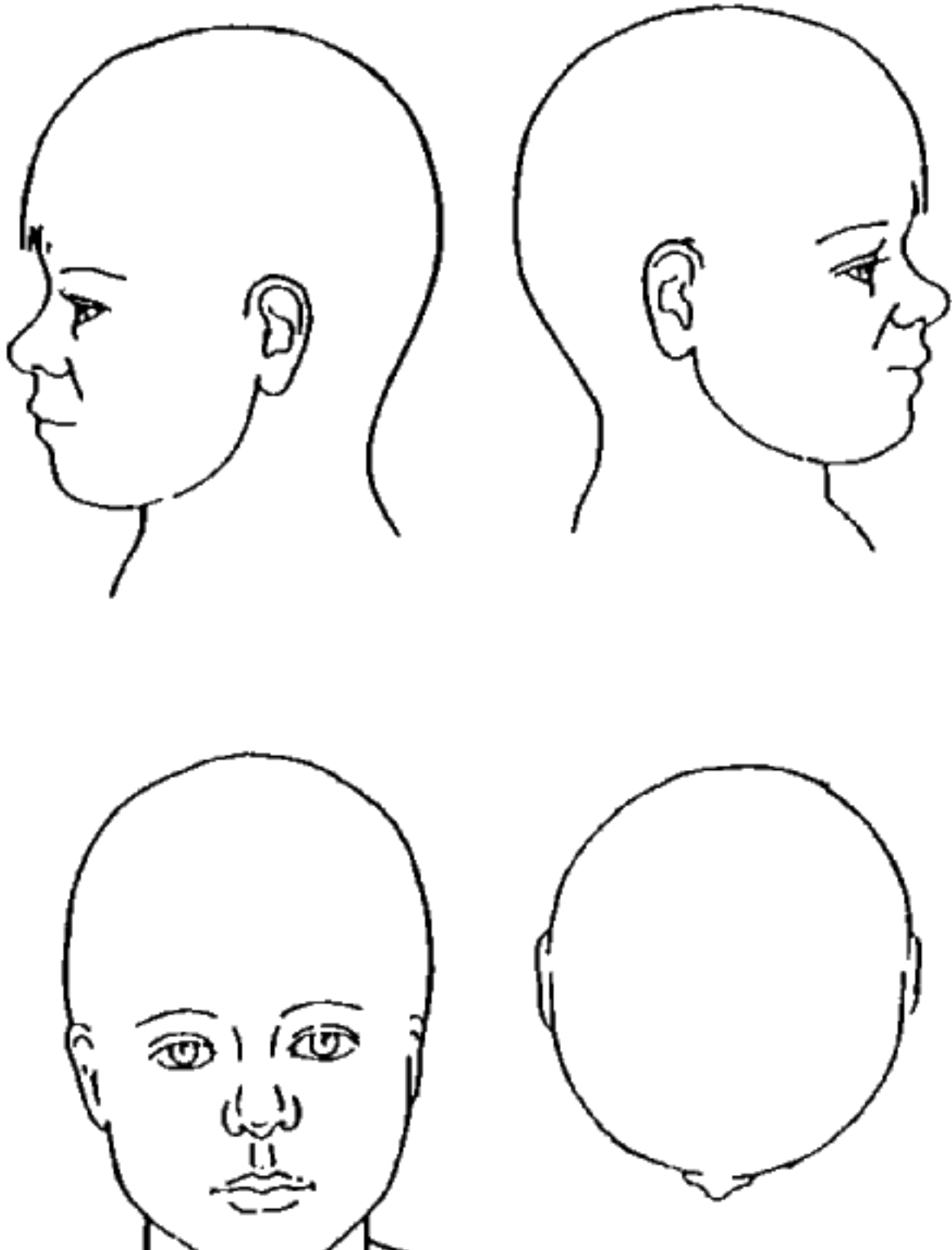
(a) Skin and hair		
(b) Teeth		
(c) Eyes		
(d) Ears, nose and throat		
(e) Cardiovascular system		
(f) Blood pressure (if applicable)		
(g) Respiratory system		

(g)	Respiratory system		
(h)	Alimentary system		
(i)	Genitalia/testes		
(j)	Nervous system		
(k)	Locomotion/posture		
(l)	Other		

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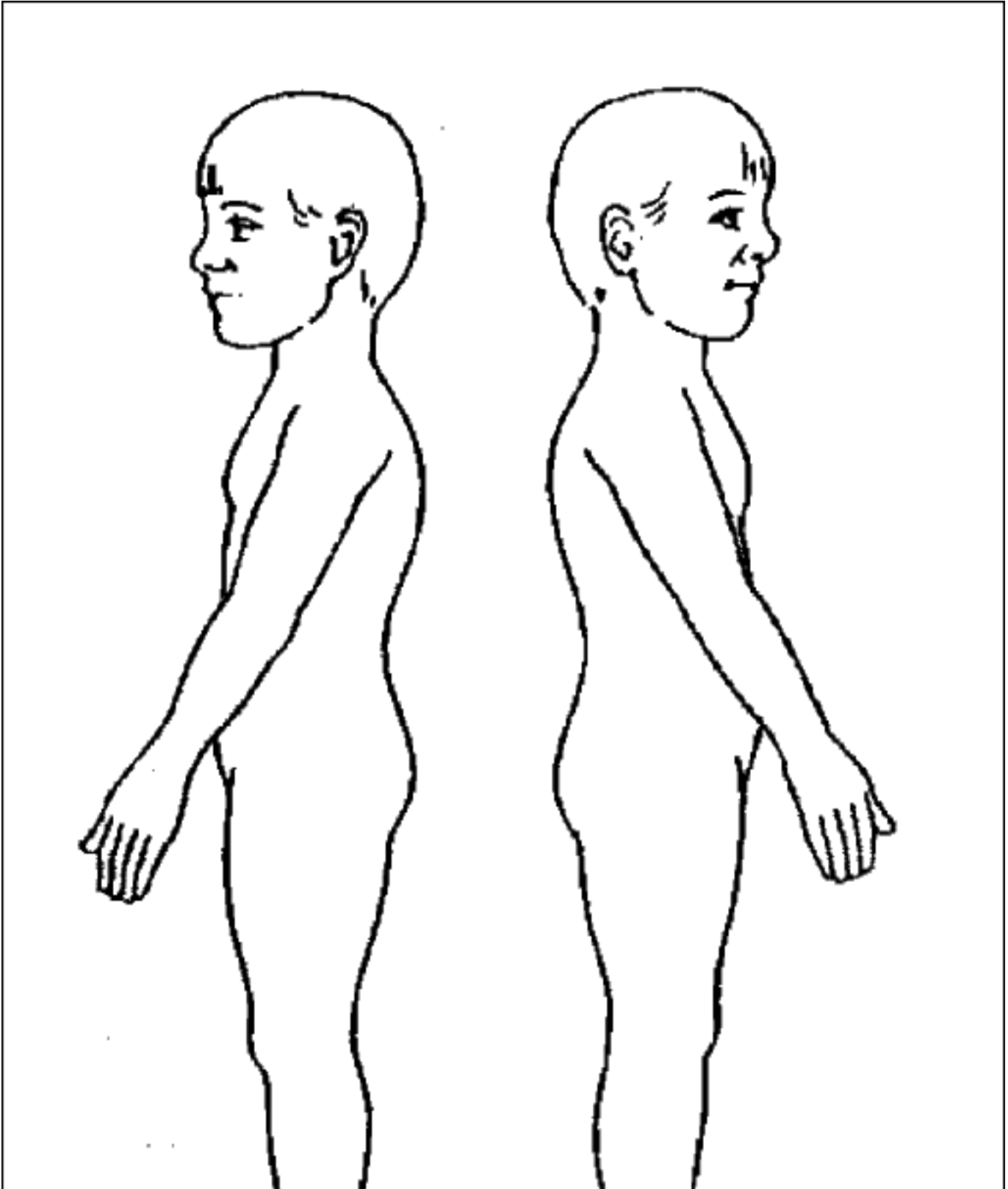
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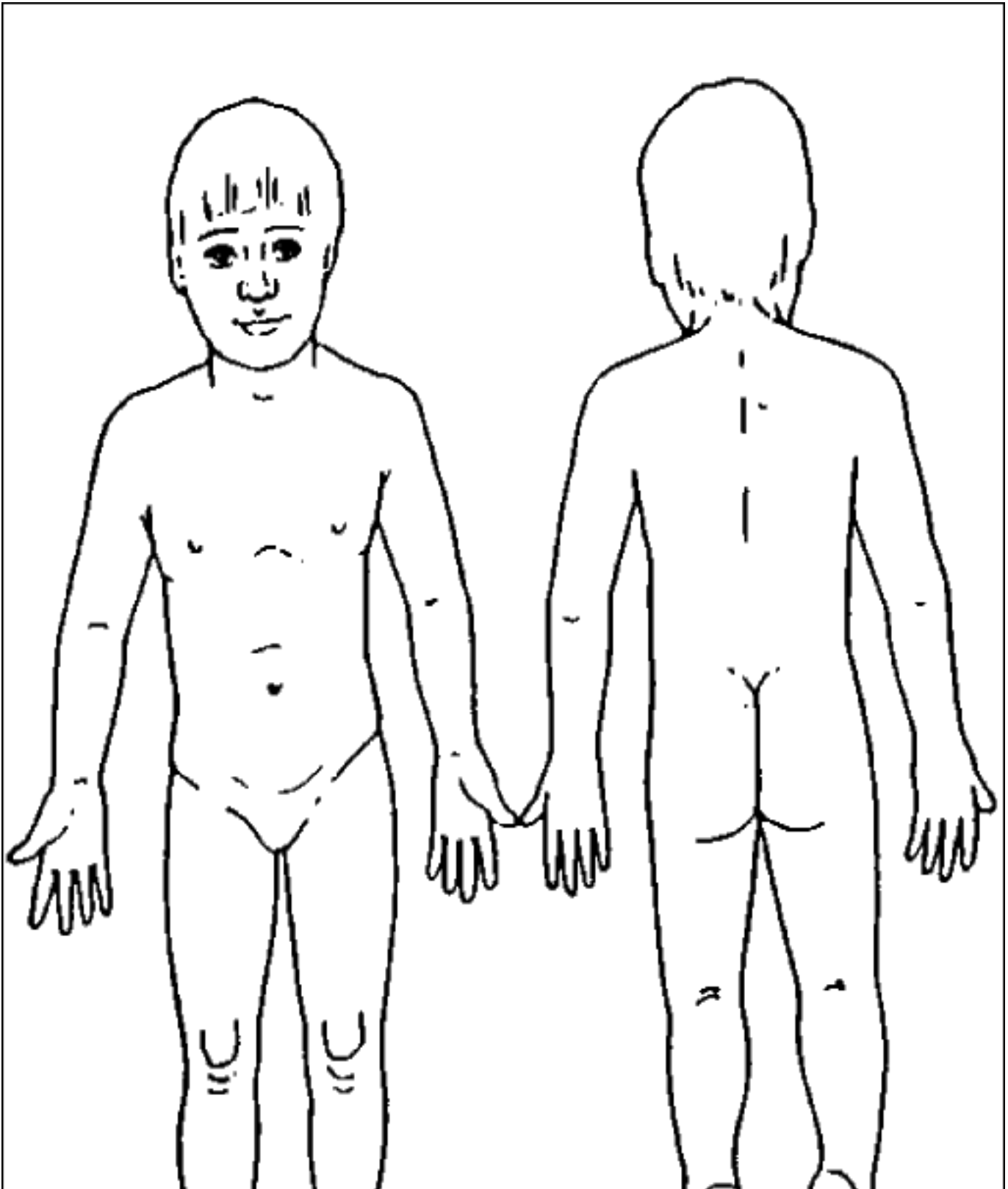
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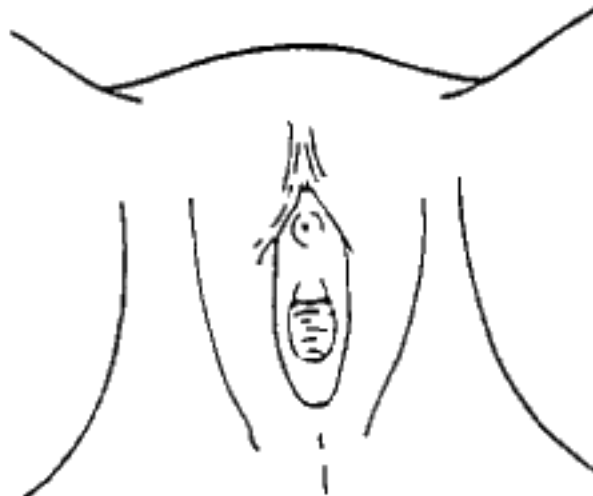
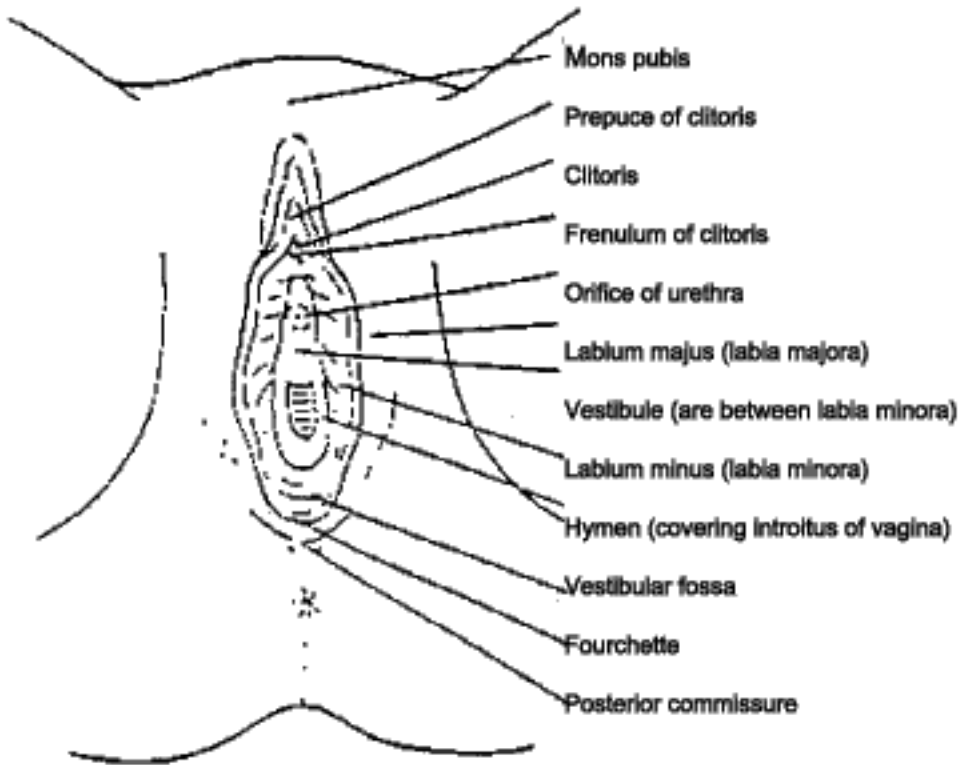
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Genital Examination

Position _____

Method _____

Magnification _____

Video Yes / No

Identification:

Identification:

Video No. _____

Serial No. _____



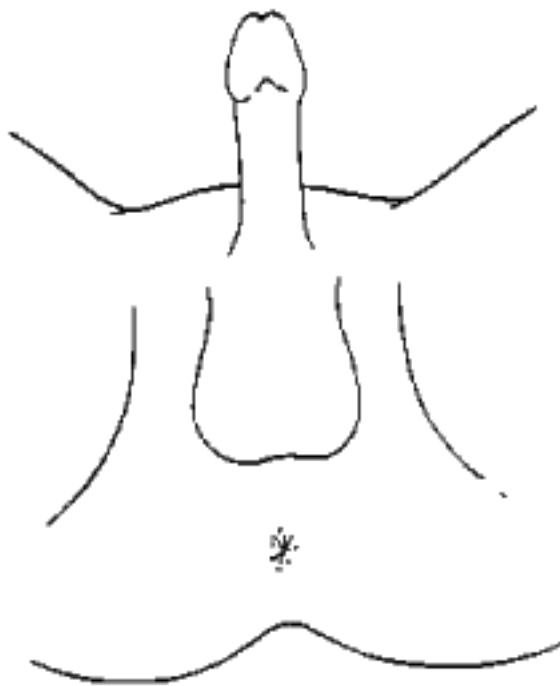
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Genital Examination

Position _____

Method _____

Magnification _____

Video Yes / No

Identification:

Video No. _____

Serial No. _____

Examination of Anus

Position _____

Method _____

Magnification _____



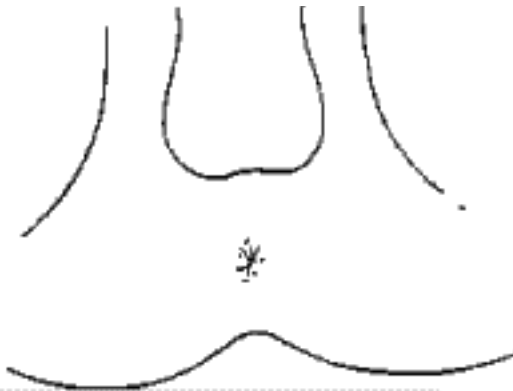
Magnification _____

Video Yes / No

Identification:

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INVESTIGATIONS

☐**Photography**

Taken by:

Police:

Processed at:

Medical Staff:

Identifier:

☐**X-Rays**☐**Coagulation Profile**

Routine Specialist:

☐**Serum HIV/Hepatitis**☐**Swabs**

Site:

☐**Urine**☐**Pregnancy Test**☐**Other**

CONCLUSION/OPINION

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TREATMENT/ACTION REQUIRED

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INFORMATION SHARING


		Time	Name	Present Tel. No.
Parent	Present/Contact/No contact			
Social Worker	Present/Contact/No contact			
Police	Present/Contact/No contact			
General Practitioner	Contact/No contact			
HV/School Nurse	Contact/No contact			

AGREED PLAN

1. Further investigation of possible abuse.
2. Need for further assessment of medical/developmental problems.
(NB: If child is looked after/accommodated, Part 2 of the "Initial Medical Assessment" will be required.)
3. Other action required:



 1. Admit to hospital
 2. Refer for Child Protection Order
 3. Refer for Child Assessment Order
 4. Refer to Reporter
 5. Discuss with Procurator Fiscal
 6. Contact GP
 7. Other (specify)
4. Report sent to:



 1. General Practitioner
 2. Social Worker
 3. Reporter
 4. Procurator Fiscal
 5. Hospital Records

Signed _____ Date _____

Name in Block Letters

Designation

Time Completed

Signed _____ Date _____		
Name in Block Letters	Designation	Time Completed

AUDIT

--



Protecting Children: A Shared Responsibility

annex J

QUESTIONS AND ANSWERS ON CONSENT ISSUES

New Law on Children and Medical Consent - A briefing by Kathleen Marshall, Gulbenkian Fellow in Children's Rights, Centre for the Child and Society, University of Glasgow, prepared in conjunction with the Yorkhill NHS Trust, Rights of the Child Group (1997).

Q. When does a person cease to be a "child" for the purpose of medical consent?

Under Scottish Law, young people aged 16 and over have the same right to consent or refuse as adults.

Q. Who has the right to give consent on behalf of a child?

Children under 16 can give their own consent if the medical practitioner attending the child considers the child capable of understanding the nature and possible consequences of the procedure or treatment. If the child is judged capable, the practitioner must seek the consent of the child rather than of the parent.

Where a child is judged incapable of consenting, consent should normally be obtained from a person with parental responsibilities and rights, or one of the other categories of person listed below.

It should be noted that, if a child is capable of giving his or her own consent, the parents lose any right they may have had to consent on the child's behalf. This does not mean that parents must always be excluded from the discussions. Unless there are issues about the child's confidentiality, it would be reasonable to involve parents in helping the child to reach a

decision. This would also be consistent with the philosophy of partnership with parents which underlies the Children (Scotland) Act. However if the child is judged competent, it is the child's consent alone that is legally effective.

Subject to any court order restricting parental rights, those who can give consent on behalf of an incapable child are:

- *The mother whether married to the father or not.*
- *The child's natural father, if married to the mother.*
- *The child's natural father, even if divorced from the mother.*
- *An unmarried father who has entered and registered a formal Parental Responsibilities and Parental Rights Agreement with the mother. This is a new agreement introduced by the 1995 Act. Those holding rights under such an Agreement will have been issued with an "extract" from the Books of the Council and Session where it is registered.*
- *A legal guardian nominated in writing by a parent before the parent's death. This appointment comes into effect automatically on the death of the parent.*
- *A person holding a Residence Order in relation to the child, or any other court order giving them the right to consent on the child's behalf.*
- *A person aged 16 or over who has care or control of a child, unless it is within their knowledge that a parent would refuse consent. The right to consent under this provision is limited to what is "reasonable in all the circumstances to safeguard the child's health, development and welfare". It is a protective, fallback provision and could not be used to authorise, for example, organ donation, non-therapeutic cosmetic surgery or involvement in research for the benefit of others. This provision could apply to relatives or friends with whom the child is living whether permanently or temporarily. It could also include childminders and baby-sitters. It may be particularly useful with regard to foster carers. Children may be in foster care for a variety of reasons. In most cases, the child's natural parents will retain parental responsibility subject to any orders made by the court or children's hearing. This provision will allow medical practitioners to take the foster carer's consent to the limited kinds of treatment described above, without requiring too much enquiry into the child's legal status. This provision does not apply to teachers or other whose care or control is restricted to the school setting.*
- *A person to whom the parent or other person with parental responsibilities and rights has delegated the right to consent to medical procedures or treatment in relation to the child. There are no formal requirements in relation to this delegation.*

Q. What if a parent requests a procedure or treatment which medical staff consider will not be in the interests of the child?

Parental responsibilities and rights are subject to a qualification that their exercise must be in

the interests of the child. They exist for the benefit of the child, not of the parent. Parents have no right to insist on treatment which is clearly not going to benefit the child.

Other Issues Relating to the Interests of Children

Q. What if parents want to do other things which do not appear to be in the child's interests?

The qualification of parental responsibilities and rights in favour of the interests of the child applies across the board. This means that the parents cannot insist on any action, such as access to a child, if it is clearly not in the child's interests to facilitate it. This provision does not give licence to undermine parental rights nor to substitute one's own judgement for that of the parent. It does mean that, in difficult situations, proposed actions by a parent which would clearly act against a child's interests can be resisted. If the child has views on the matter in dispute and wishes to express them, these should be sensitively ascertained and taken into account in accordance with the child's age and maturity.

Q. What if parents consistently fail to visit a child in hospital?

If there is, or is likely to be, no contact for a period of three months or more, the Health Board or Trust has a legal duty to inform the local authority with a view to their looking into the matter. Even if three months have not elapsed, staff should consider making a referral if they have concerns about the child's welfare.

Court Orders and Warrants Authorising Medical Examination or Treatment

The Children (Scotland) Act 1995 introduces a number of new orders and warrants which may grant authority for the medical examination and/or treatment of a child:

- Child Protection Orders (which replace Place of Safety Orders).
- Child Assessment Orders (for situations in which there are concerns about a child but satisfactory assessment is impossible without an Order because for example, the parents refuse to allow it.)
- Warrants for detention of a child in a place of safety may now include such conditions.
- Supervision requirements from a Children's Hearing may now impose such conditions.

The effect of any authorisations contained in these orders or warrants is to dispense with the need for parental consent. The Act is quite clear that it is still open to a capable child to refuse consent. No such examination, procedure or treatment can be enforced against the wishes of a child judged capable by the attending medical practitioner.

Issues for Practitioners

Medical practitioners may wish to consider the following issues:

- Their approach to assessing whether a child is capable of understanding the nature and possible consequences of the procedure or treatment contemplated.
- How the child's consent should be sought. What information to give the child as a basis for consent.
- What to do if a child refuses to consent to something which is essential or highly desirable. Sometimes sensitive counselling can explore the child's concerns and provide sufficient reassurance to enable the child to proceed. If a competent child refuses consent, this should normally be accepted in the same way as an adult refusal. If there are doubts about the attending medical practitioner's assessment of the child's competence, a second opinion might be sought. It is possible that recourse could be had to the court orders and warrants referred to above, or to other court orders dealing with parental responsibilities, at least to the extent of bringing a child before another medical practitioner for another assessment. The availability of court intervention in these circumstances is yet to be tested. Advice should be sought on individual cases.
- How to speak to parents about the rights of a child.
- How to ascertain who has the right to consent on behalf of a child judged incapable of consenting.

Reports for Children's Hearings

Practitioners should be aware that, as a result of a decision of the European Court of Human Rights, Children's Reporters are now obliged to make available to parents any information which is made available to members of the children's panel considering their child's case. This has implications for the way in which reports are written. For example, it is important to be clear about the distinction between information which is relevant to the child's welfare (which would be sent to panel members and therefore to parents) and information relating to evidential matters which may be used to support establishment of grounds of referral (which will not be sent to panel members or parents). There may be advantages in preparing separate reports in appropriate cases.

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