CHILD PROTECTION GUIDANCE
for Health Professionals

The Scottish Government, Edinburgh 2013
CONTENTS

MINISTERIAL FOREWORD

Introduction and Purpose of Guidance

PART 1    IDENTIFYING AND RESPONDING TO CONCERNS ABOUT CHILDREN AND YOUNG PEOPLE

Chapter 1  Supporting Vulnerable Children and Young People and Families
Chapter 2  Roles and Responsibilities of Healthcare Staff in the Process of Protecting Children
Chapter 3  Sharing a Child Protection Concern
Chapter 4  Medical Assessments in Child Abuse

PART 2    HEALTH SERVICES RESPONSIBILITIES IN CHILD PROTECTION

Chapter 5  NHS Links with Other Agencies
Chapter 6  Health Boards Structure for Delivering Child Protection Services

PART 3    HEALTH BOARD PROCESSES TO SUPPORT PRACTITIONERS DELIVER HIGH QUALITY CHILD PROTECTION

Chapter 7  Caldicott Guardians, Information Sharing and Record Keeping
Chapter 8  Education, Learning and Development for Healthcare Staff
Chapter 9  Advice on Court Proceedings

Appendices

Appendix 1 Key Definitions and Concepts
Appendix 2 GIRFEC Tools/Diagram
Appendix 3 Process for Responding to Concerns
Appendix 4 Proformas for Medical Assessment
Appendix 5 Indicators of Risk in Specific Circumstances
  ● Supporting the Unseen Child or Young Person
  ● High Risk Families
  ● Children and Young People with Disabilities
Appendix 6 References
MINISTERIAL FOREWORD

Keeping Scotland’s children and young people safe is at the heart of the Scottish Government’s vision for the future. Ensuring children and young people are safe is the first step to enabling them to become the responsible citizens, successful learners, confident individuals and effective contributors that they deserve to be.

To achieve this we need to provide you, the healthcare professional, with the right resources to support your local practice. Your role is vital and we are committed to making sure that you have the necessary tools to enable you to undertake that role with confidence and vigour.

As part of that commitment, in 2010 we published National Guidance on Child Protection in Scotland which set out common standards for child protection services in Scotland. At that time we recognised the need to update the specific guidance available for health professionals to reflect the National Guidance. I am pleased that the commitment we made has resulted in this guidance to help with your role in child protection.

While child protection is clearly a collective responsibility, it is often a health professional who will have the first, and sometimes only, contact with a child or young person or their family. It is crucial that these early opportunities to protect the child or young person and support the family are not missed. Protecting children and young people, keeping them safe from harm is one of the most important responsibilities anyone can have but it is also one of the most demanding. I recognise this and this guidance is intended to help all staff who work in health services, regardless of whether their main contact is with a child, a young person or an adult.

Putting the needs of the child or young person at the centre of your practice is essential. The Getting it Right for Every Child programme provides a framework for professionals to do this and we are bringing forward legislation during this Parliament to put the planning and delivery of services provided to children and young people onto a statutory foundation.

We want Scotland to be best place in the world for children to grow up. I know that there is excellent work going on across Scotland to help realise this goal and I hope you find this guidance useful in helping you give children and young people one of the most important things they can have while growing up – the feeling of being safe.

Aileen Campbell
Minister for Children and Young People
Introduction and Purpose of Guidance

Professionalism, Commitment, Courage

This guidance is supplementary to, and should be read in conjunction with, the Scottish Government National Guidance for Child Protection in Scotland 2010 “the National Guidance”.¹ The National Guidance outlines key definitions and concepts, specifically a definition of what constitutes child abuse and neglect and harm/significant harm (Appendix 1). In addition, there is a series of appendices which are important and explore in more detail specific child protection scenarios.

This guidance:

- Is intended to act as a practical reference point for all healthcare staff working within an adult and child service context.
- Includes children and young people up to the age of 18. Further information on the relevant legislation relating to the definition of a child, particularly for those aged between 16-18 is outlined in Appendix 1.
- Highlights the specific roles and responsibilities of specialist staff working in particular settings wherever children and young people will usually be seen.
- Sets out the framework to aid practitioners in their role in dealing with child protection concerns.

Articles of the UN Convention on the Rights of the Child are ratified by the UK Government and endorsed by the Scottish Government. They should underpin all code and practice in child protection. In addition to the Convention, the Children’s Charter was drawn up following consultation with children and young people as part of the Scottish Government’s child protection reform programme. The Framework for Standards² is the detailed means for translating the commitments made in the Children’s Charter into practice. Further information is available at the “Principles and Standards for Child Protection” section contained in Part 1 of the National Guidance.

All children and young people have a right to be protected. As health is a universal provider for children and young people and their families’ and many will only ever access universal services’ it is important for all healthcare staff to understand their responsibilities when treating and managing children and young people or their parents and carers.

Young people aged between 16 and 18 are potentially vulnerable to falling “between the gaps” and local services must ensure that processes are in place to enable staff to offer ongoing support and protection as needed, via continuous single planning for the young person.

Getting it right for every child³ is a consistent way for people to work with all children and young people to improve their wellbeing. The GIRFEC approach helps practitioners focus on what makes a positive difference for children and young people – and how they can act to deliver these improvements. GIRFEC is being threaded through all existing policy, practice, strategy and legislation.
affecting children, young people and their families. Its primary components include:

- A common approach to gaining consent and sharing information where appropriate.
- An integral role for children, young people and families in assessment, planning and intervention.
- A co-ordinated and unified approach to identifying concerns, assessing needs, agreeing actions and outcomes, based on the Wellbeing Indicators.
- A Named Person in universal services.
- A Lead Professional to co-ordinate and monitor a Child's Plan for children with more complex needs that cannot be addresses by the Named Person alone.
- A skilled workforce within universal services that can address needs and risks at the earliest possible point.

The Getting it Right Practice Model and “My World” triangle are detailed at Appendix 2.

3 http://www.scotland.gov.uk/Topics/People/Young-People/gettingright - Getting it Right for Every Child
PART 1 – IDENTIFYING AND RESPONDING TO CONCERNS ABOUT CHILDREN AND YOUNG PEOPLE

Chapter 1 Supporting Vulnerable Children and Young People and Families

This section:
- Provides information on identifying risks and needs.
- Gives detail on applying the principles of Getting it Right for Every Child (GIRFEC).
- Describes the key NHS professionals involved in the care of children, young people and families.

The NHS is the provider of universal health services for the people of Scotland. Staff working within the NHS may be the first to become aware that families are experiencing difficulties in looking after their children therefore, healthcare staff have a role in identifying risk factors for child abuse and neglect and must participate in single and multi-agency responses to concerns regarding a child or young person’s welfare. The GIRFEC approach stresses the importance of understanding needs and risks within a framework of the child or young person’s whole world and wellbeing. When assessing a child or young person, all staff should be alert to the potential risk factors in their life.

Intervention should be proportionate and timely and a holistic approach should be taken to identifying and responding to a child’s needs as well as any risks they may face. Practitioners, if they are concerned about a child, should seek all the information they need to inform their assessment, including direct questions to the child to obtain the child’s view.

Getting it right for every child (GIRFEC)

Using the principles and practice outlined in Getting it right for every child (GIRFEC) (Appendix 2) health practitioners can fully assess their contribution to the child or young person and plan what type of support or intervention they might require to maximise their wellbeing. In dealing with children and young people and their families, healthcare staff should consider the following questions when they have concerns, or if children and young people or families ask for help:

- What is getting in the way of this child or young person’s wellbeing?
- Do I have all the information I need to help this child or young person?
- What can I do now to help this child or young person?
- What can my agency do to help this child or young person?
- What additional help, if any, may be needed from others?

These questions, along with the GIRFEC practice model, will help health professionals consider all aspects of a child or young person’s life. When it is recognised that a child or young person’s care and protection is compromised, healthcare staff must comply with local child protection policies and protocols.
and must be familiar with local procedures when they have a child protection concern and take the appropriate action.

National Risk Framework for Assessment of Children and Young People

Based on the GIRFEC approach to wellbeing, and using the National Practice Model as its basis, the Framework sets out a process for assessing risks of children and young people from harm and abuse, and a set of practical tools to consider key factors in their lives.

Named Persons

Under the GIRFEC approach, where a child or young person only requires support from a single agency or service (and consequently not requiring Lead Professional support), the Named Person is designated to be the contact for the child or young person and involved in supporting those who are in regular contact with the child or young person.

The Named Person - who can be the midwife, public health nurse-health visitor (PHN-HV), family nurse (at pre-school stage) and education staff (at school age) - will have an overview of the wellbeing of the child and will carry out a single agency assessment or participate in an interagency assessment framework in line with GIRFEC. This will inform the process of assessing and identifying the needs of the child and will be used during child support or protection processes.

If a health professional has concerns about a child or young person and/or is involved in child protection processes they must ensure the Named Person is informed. The Named Person must ensure that all relevant healthcare staff involved in providing a service to the child, young person and/or family are informed of the concerns. It is the Named Person’s responsibility to liaise with the Lead Professional who, in cases where there are child protection concerns, is often the social worker.

Lead Professionals

During the assessment of the child’s needs, using the GIRFEC approach, there may be cases where it is identified that a child or young person’s safety is the primary issue, or there is a statutory requirement such as where a child or young person becomes Looked After. In such cases a worker from a specialist part of health or education or another agency may take the lead for co-ordinating help. This person will become the “Lead Professional”. In child protection cases the Lead Professional is often a social worker, however, in cases where concerns are not part of formal child protection procedures the Lead Professional could be any practitioner involved with the family. The Lead Professional will sometimes commence the role through a formal meeting, including the key practitioners involved with a particular child. It is important that if child protection concerns emerge at any stage, the Lead Professional needs to follow local child protection procedures.
KEY PROFESSIONALS INVOLVED IN SUPPORTING VULNERABLE CHILDREN

Midwives

Midwives have a significant role in identifying risk factors to the unborn child during pregnancy, birth and the post-natal period both in hospital and the community. Midwives should be alert to risk factors for the mother and infant including, but not limited to, alcohol and/or drug misuse, domestic abuse and mental health problems such as post-natal depression. HPI can be allocated during the antenatal period and the midwife and PHN services will work collaboratively in addressing the needs of the pregnant woman, unborn child and family as appropriate.

Unborn Babies and the Role of Healthcare staff

Healthcare staff must consider the needs of the unborn baby including whether there could be child protection risks after birth. Health Boards must have robust processes to consider the needs of vulnerable unborn babies/babies. This includes pre-birth planning with other agencies to address these needs in line with National Guidance. A Pathway of Care for Vulnerable Families (0-3)¹ provides guidance to ensure that vulnerable children (from conception to age 3) and families in all parts of Scotland receive support that is equitable, proportionate, effective and timely.

This process should ensure that all vulnerable pregnant women, including those with drug-related problems, learning disabilities or mental health issues, receive appropriate ante-natal care² and support to maximise both their own and their baby’s health and wellbeing. Good practice indicates that regular information sharing between all agencies is vital. Healthcare staff often take a leading role in this process. If concerns continue, or are considered high, the need for a child protection referral must be considered.

After the birth of the baby where possible, the obstetric and midwifery teams should consider the need for a pre-discharge discussion/meeting to ensure that the correct support services and monitoring processes are in place to protect the child following discharge. Good inter-agency liaison, as appropriate, with social care and social work services is crucial, including the importance of clear communication on key issues and roles and responsibilities of different staff.

Public Health Nurses – Health Visitors

PHN-HV play a pivotal role in the prevention and early identification of concerns regarding the wellbeing of a child that may include more serious protection and care concerns. After the midwife’s post-natal care ends, a PHN/HV will become a child’s Named Person (or in some cases, their Lead Professional), normally until the child starts full-time primary education. PHN-HV nurses provide a consistent, knowledgeable and skilled point of contact for families, assessing children’s development and planning with parents and carers to ensure their needs are met. As a universal service, they are often the first to be aware that families are
experiencing difficulties in looking after their children and can play a crucial role in providing support.

Family Nurse

The Family Nurse Partnership programme (FNP) is being delivered across many areas in Scotland. The family nurse works with first-time teenage mothers and their families from pregnancy until their child is 2 years old. The PHN-HV then supports the family after the child reaches 2 years of age. The family nurse works with parents to develop confidence in their parenting and focus on their strengths to do this.

Public Health Nurse - School Nurses

The PHN - school nurse has an important role in promoting the wellbeing of children and young people and can contribute to prevention and early detection of child abuse through a range of health promotion activities. These include: working with teachers on personal, social and health education; monitoring the health of the school population; liaising effectively with teachers and other practitioners; and profiling the health of the school population so that nursing services can be targeted where they are needed most. School nurses continue to monitor the development and health and wellbeing of all children and young people who have additional health plan indicators from Primary 1 onwards for as long as necessary. Where child protection concerns arise, the school nurse should always be alerted and, where appropriate, involved to ensure the health needs are fully identified and met.

General Practitioners

The role of the General Practitioner (GP) and the practice team in child protection will be critical in detecting potential concerns, since they will often regularly engage with children and families. Their role includes prevention, early recognition and detection of concerns, assessments and ongoing care and treatment. Surgery consultations, home visits, treatment room sessions, child health clinic attendance, drop-in centre and information for staff such as PHN-HVs, midwives, school nurses, family nurse and practice nurses will all help to build up a picture of the child or young person’s situation and highlight any areas of concern. Following the GMC guidance³ GPs must promptly tell an appropriate agency if they are concerned that a child or young person is at risk of, or is experiencing abuse or neglect unless it is not in the child or young person’s best interest to do so. The possible consequences of not sharing relevant information will, in the overwhelming majority of cases, outweigh any harm that sharing concerns with an appropriate agency might cause. GPs can provide direct support to children, young people and their families and contribute to the child’s plan, specifically, the child protection case conference and/or the child protection plan. GPs and practices must have protocols in place for engaging with other services where child protection concerns arise.

GPs are also key in the identification and support to adults with significant risk factors such as addictions and mental health difficulties which may impact on their ability to care. GPs should be familiar with national and local policy outlining
key issues and recommendations for working with families where there are risks. Local guidance should be developed in line with the national change programmes and frameworks relevant to children affected by parental alcohol and or drug misuse. “Getting our Priorities Right” specifically highlights important themes for all staff working with parents affected by substance misuse. GPs must also consider risks for children and young people registered with another practice where adult patients present with potential difficulties.

Paediatricians

All paediatricians have a duty to identify child abuse and neglect and must therefore maintain their skills in this area and make sure they are familiar with the procedures to be followed where abuse of neglect is suspected.

Other Health Practitioners

Many other disciplines of health practitioners work directly and indirectly with children and young people and/or parents and carers. These not only include those working in children and family services but also those working with a wide range of adult orientated services. All practitioners should adopt a GIRFEC approach and therefore should be mindful of the wellbeing of any child or young person that they come into contact with or who may be in contact with their patients/clients. In particular, practitioners should be aware of local child protection policies, guidance and protocols and their responsibility to share information regarding concerns for a child or young person’s wellbeing. Local protocols should be in place to manage any concerns or relevant information and to direct these to the Named Person for the child or young person.

Further specific advice on the role of GPs, emergency medicine specialists and paediatricians is detailed on pages 16-18.

2 http://www.scotland.gov.uk/Publications/2012/07/9484 Getting our Priorities Right updated good practice framework for all child and adult service practitioners working with children and families affected by problem parental alcohol and/or drug use.  
4 http://www.scotland.gov.uk/Publications/2012/07/9484 Getting Our Priorities Right updated good practice framework for all child and adult service practitioners working with children and families affected by problem parental alcohol and/or drug use.
Chapter 2 Roles and Responsibilities of Healthcare Staff in the Process of Protecting Children

This section:
- Describes particular circumstances which may increase the chance of harm.
- Sets out actions that should be taken when concerns appear.
- Provides advice on how to recognise and understand when there are concerns about a child or young person.

The National on Child Protection Guidance states that: “All agencies that work with children and their families have a shared responsibility for protecting children and safeguarding their welfare. Each has a different contribution to make to this common task.”

Where concerns are raised about the potential significant harm to a child or young person they should be considered **child protection** concerns.

All healthcare staff have a responsibility to act to make sure that all children and young people are protected from harm. **This responsibility includes acting on concerns about a child or young person even if the child or young person is not your patient.** All healthcare staff should be aware of the significance of the following situations as these may be an indication of stress within a family creating increased risk to the child/ren or young person. Local guidance should be available in relation to these issues and indicators of risk are discussed in more detail in Part 4 of the National Guidance. Further indicators of risk in specific circumstances are explored in more detail at Appendix 5.

<table>
<thead>
<tr>
<th>INDICATORS OF RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes in family dynamics (e.g. bereavement, new partner, separation, relapse in addiction/ mental health, etc).</td>
</tr>
<tr>
<td>‘Closure’ of a family (e.g. no access, non-engagement/non-compliance with professionals).</td>
</tr>
<tr>
<td>Longstanding educational difficulties.</td>
</tr>
<tr>
<td>Experiencing discrimination, perhaps because of their race, nationality, sexuality or religion.</td>
</tr>
<tr>
<td>Third party information shared with healthcare staff.</td>
</tr>
<tr>
<td>Refusal or withdrawal from health services – parents have the responsibility to act on behalf of their child/ren to ensure that they are in receipt of health services.</td>
</tr>
<tr>
<td>Refusal of treatment where a child or young person experiences or is likely to experience significant harm or neglect can never be considered in the child’s best interest.</td>
</tr>
<tr>
<td>Not registered with GP – healthcare staff have a responsibility to support the process of facilitating registration.</td>
</tr>
<tr>
<td>Overuse/frequent attendees of health services.</td>
</tr>
<tr>
<td>The unseen child or young person</td>
</tr>
</tbody>
</table>
Disguised compliance and failure to improve outcomes for the child or young person.
Families who frequently move area.

Identifying and communicating concerns about a child or young person’s wellbeing

All concerns regarding the wellbeing of a child or young person should be communicated to the Named Person. However, where there are child protection concerns there is an immediate need to fully consider concerns along with local policies, procedures and protocols. The following four questions will help understand those concerns:

1. Why do I think this child or young person is not safe?
2. What is getting in the way of this child or young person being safe?
3. What have I observed, heard, or identified from the child or young person’s history that causes concern?
4. Are there factors that indicate risk of significant harm present and, in my view, is the severity of factors enough to warrant immediate action?

After the answers to the above questions have been considered, staff may continue to be concerned about the welfare or safety of the child or young person (their care and protection). In these circumstances staff need to act. Concerns must be raised with social work.

If this is the case and the practitioner considers abuse and/or neglect, the following actions are required:

- Record your concerns and document actions.
- Look for other features of maltreatment in the child or young person’s history, presentation or parent/child interactions now or in the past.
- Discuss concerns with a more experienced colleague or child protection adviser (as per local protocol).
- Share information with other agencies and health disciplines as appropriate and record in the child or young persons clinical record details of the concern.
- Ensure review of the child or young person at a date appropriate to the concern.
- Be aware of repeated presentation of this or other features.
- Ensure the concern has been brought to the attention of the Named Person.
- Share concerns with social work department if appropriate.

If the child or young person is in immediate danger staff must speak directly to the police.
Chapter 3 Sharing a Child Protection Concern

This section:
- Provides information on sharing concerns about a child or young person.
- Gives detail on joint investigation/assessment.
- Describes the role of healthcare staff in a Child Protection Case Conference (CPCC).

When it is recognised that a child or young person’s safety is compromised and/or that they are likely to experience significant harm (Appendix 1), healthcare staff have a responsibility to follow local procedures for reporting and sharing these concerns.

Healthcare staff must telephone the local social work department as per local guidelines, clearly stating that their call is a child protection matter. This communication between social work and health must then be followed up in writing confirming the conversation using a locally agreed form. This must provide sufficient information to enable social work to make an informed decision. A copy will be placed in the child or young person’s records.

Clearly state:

Who you are and your role

You have concerns about the safety of a child or young person

Once speaking to a social worker state:

What your concerns are

All relevant information

Where the child is now

What you have observed, heard and what sense you have made of the information. Be clear about what is fact and what is opinion

Clarify what action the social worker will take as a result of your concerns and when you can expect to know of the outcome

Record the discussion

If staff experience any difficulty accessing the duty social worker/police or in sharing child protection concerns, ask to speak to a more senior social worker/police officer. It is important that staff feel supported through this process. Advice and support is available from line managers or the child protection Nurse Adviser.
At each stage consideration must be given to whether emergency action is required to protect the child or young person and to involving the child or young person and their family.

It is good practice during this period to continue to work with the family. It is only in exceptional circumstances that the family would not be informed, for example, if the healthcare staff felt at personal risk or it may place the child at additional risk or result in evidence being destroyed. Advice on this is available from the child protection advisory team or social worker if staff are unsure what to do. The next stage would be a joint investigation/assessment.

**Joint Investigation/Assessment**

Social work services and police have a clear statutory role in deciding whether an investigation should take place. The purpose of joint investigations is to establish the facts regarding a potential crime or offence against a child or young person and to gather and share information to inform the assessment of risk and need for that child or young person, and the need for any protective action.

It enables relevant information from key agencies to be considered. Healthcare staff have a duty to share relevant background information regarding a child, young person or family to inform whether an investigation is required or immediate action is needed to protect the child, young person and any others in the community. Healthcare staff need to be involved in planning all child protection investigations to ensure appropriate decisions about the wider health needs of the child or young person and whether or not a full medical examination is required are fully considered. Decisions about whether or not a medical examination is required should not be taken by police and social work staff without consulting a suitably qualified health professional as identified and agreed locally. In planning a medical assessment or forensic medical examination, discussion with healthcare staff is essential in order that the welfare needs of the child or young person are considered together with the need to collect forensic evidence. Decisions about the nature and timing of medical examinations should be made by appropriately trained paediatricians.

The process of responding to child protection concerns in diagrammatic form is represented in Appendix 3. However, it should be noted that at any stage, the process may be stopped if it is felt emergency measures are required to protect the child or no further response under child protection is necessary.

**Child Protection Case Conference**

A core component of GIRFEC is the child’s plan. Within the context of child protection activity, where the plan includes action to address the risk of significant harm, it is known as a Child Protection Plan (CPP) and any meetings to consider such a plan is known as a CPCC. Further detail on CPCCs is contained in Part 3 of the National Guidance.

Healthcare staff may be invited to attend a CPCC where services and agencies can share information, assessment and chronologies where there are suspicions or allegations of child neglect.
Healthcare staff have a duty to co-operate with the Local Authority in line with national and local child protection procedures.

Healthcare staff must submit a report in advance, attend the CPCC and be responsible for checking minutes for accuracy following the meeting. It is expected that the health professional will discuss with the family the content of their report. If the health professional is unable to attend the meeting they should discuss with their line manager and child protection team.

When a specialist service is working with the family it will be appropriate for that specialist to attend the CPCC contributing to the process; providing relevant health information; interpreting the significance and the potential impact on the health issues on the child (e.g. a member of the mental health service, adult addiction services, and speech and language therapist).

All attending healthcare staff should receive the CPCC minutes and must check these carefully alerting the CPCC chair to any errors and ensuring that in particular any inaccurate information or dissention is clearly minuted.

Healthcare staff should seek advice and support from their child protection team if required to ensure they are supported, confident and competent to fulfil their responsibilities.

Healthcare staff must be prepared to be open and honest about their views even in the presence of parents/carer who may also be their patients. In some situations it may be appropriate for the staff to be accompanied by a more senior member of staff, but in general only those actively involved with the child and family should be involved in the CPCC.

Healthcare staff will be involved in the CPP and demonstrate active commitment to this interagency plan. Healthcare staff must feel confident to influence and shape the CPP. Healthcare staff have a responsibility to ensure that CPPs are outcome focused avoiding task allocation and time constraints. Healthcare staff will remain focused on the improvements required to achieve positive outcome for the child. It is important that healthcare staff regularly review and re-evaluate the CPP and the desired outcomes for the child have been achieved. Healthcare staff should be involved and attend the Core Group which meets regularly to review decisions and the plan. This can be particularly challenging in case of neglect. If healthcare staff have difficulty in fulfilling their role within the CPP they must inform the Chair of the CPCC and seek advice from their line manager or child protection team.
Chapter 4 Medical Assessments in Child Abuse

This section:
- Outlines which medical specialities examine children and young people.
- Sets out the role of:
  - GP services
  - emergency and urgent care medical services
  - emergency medicine services.
- Outlines when to request a medical assessment.
- Describes the types of medical examination in child protection.

Some medical specialities will regularly see vulnerable children in their practice (child and adolescent psychiatry, paediatric specialties). Other medical specialities see adults where risk factors may exist which increase the potential risk to the wellbeing or actual harm to children and young people (e.g. mental health, addictions, or learning disability). Some services will see both children and adults; these include primary care and emergency medicine. In addition, Obstetrics will deal with pregnant women who may be vulnerable.

The medical, nursing and AHPs who work in these specialities will require to have high levels of competency and skill in managing vulnerable families and children, and should complete additional training to ensure they are able to recognise concerns to wellbeing, the signs and symptoms of child abuse and risk factors which make child abuse more likely.

All staff should know who to seek further advice and support from if they are concerned about a child’s care and protection. Medical practitioners will have specific responsibilities regarding decision making, interpretation of injury and giving an opinion about the probability of abuse.

All doctors who provide care for children and young people must be aware of the signs and symptoms of abuse and neglect. They must also be aware of any other factors which increase the risk of abuse especially parental factors such as mental health problems, domestic abuse, drug and alcohol addiction, and learning disabilities.

Doctors must listen carefully to the history from the carer and the child or young person if it is appropriate and observe the child or young person to take into account the whole picture of the child or young person. If appropriate, the views of the child or young person themselves should be taken. They must seek an explanation for any presentation in an open and non-judgemental manner. The doctor must record all concerns as well as, exactly what is observed and heard from whom and when. Doctors must be direct, honest and empathetic with the parents but focus on the needs of the child or young person especially the care and protection of the child or young person. After examination, the doctor should explain any concerns about their observations and indicate their role in the protection of the child or young person to the parents, and seek senior opinion or follow local child protection health guidelines to access further advice.

Doctors must speak directly to social work services if they have a serious concern of abuse about any child or young person.
Specific advice is provided below regarding the role of GPs, Emergency Medicine Specialists and Paediatricians

Medical Staff

The General Medical Council (GMC) has issued new guidance to every doctor in the UK to help them protect children from abuse or neglect. Protecting children and young people: the responsibilities of all doctors underlines the duty on doctors to act if they are concerned that a child or young person is at risk. It provides detailed advice for doctors on information sharing, working in partnership with other agencies, consent for child protection examinations, acting as a witness in court, and where to turn for support. The guidance can be found on the GMC website www.gmc-uk.org/childprotection. The website also contains:

- Short guides for GPs – highlighting the sections of the new guidance which are likely to be most useful for those working in primary care.
- Short guides for doctors who treat adult patients – highlighting the sections in the guidance that are most likely to be relevant for doctors whose adult patients may pose a risk to children or young people.
- Learning materials – including case studies and a flowchart to help doctors decide whether to share information about child protection concerns.

Doctors will often be asked to examine children or young people by parents or carers. If a child or young person has presented specifically because of concerns about their care or protection, the first examining doctor should follow the usual format for clinical assessment noting the following specific aspects:

- The state of dress, cleanliness of child or young person including hair and skin.
- The general demeanour and emotional state, and state of nutrition (including dentition), as well as other appropriate examination according to the symptoms.
- Additional information, including a chronology of events in the child or young person’s life should be sought from the Named Person for that child or young person.

Liaison with the local child protection adviser can be useful.

General Practitioners

GPs are an essential part of the health service as they provide universal contact for all children, young people and families. They are in a unique position to identify the child or young person with concerns based on both the child or young person’s presentation and the GPs’ wider holistic assessment of the family. There should be a system in place in each GP practice that facilitates the early effective sharing of information about vulnerable children, young people and families between GPs and other members of the primary care team.
GPs may identify children or young people where there may be concerns:

- When receiving information or examining an adult with health problems including adults who are the carers of children or young people registered with another GP.
- When a child or young person has general health problems.
- When a child or young person has been brought by parents/carer following an allegation.
- When a child or young person has been seen by another member of the primary care team (e.g. PHN-HV, family nurse).

GPs may identify children or young people where there are clear signs or indications of abuse or neglect and should follow local guidance for raising concerns about such children or young people with social work services. They may also see children or young people where the explanation for presenting concern may include abuse or neglect. In such cases they must also record concerns, share information with relevant professionals and consider raising concerns with social work. This is particularly important when considering neglect or emotional abuse where careful recording and discussion of concerns is important to avoid missing such presentations. NICE clinical guidelines 89, When to Suspect Child Maltreatment¹ gives advice on identifying children and young people who may be being maltreated.

When GPs see adults who present potential risks to children or young people they must assess and consider the impact of this risk on the child or young person.

It is critical that the GP responds appropriately and follows local and national guidance. GPs have a duty to report concerns and share information about children or young people promptly and directly with other agencies. Further advice and guidance is provided in the RCGP Safeguarding Children Toolkit² and the GMC guidance, ‘Protecting Children and Young People - the Responsibilities of all Doctors³

¹ http://www.nice.org.uk/CG89
³ http://www.gmc-uk.org/guidance/ethical_guidance/13257.asp
Emergency and Urgent Care Medical Services

This includes Out of Hours GP Medical Services, NHS 24 and Scottish Ambulance Service. During office hours it is best practice for social work services to direct a request for health or medical assessment through the local NHS child protection services in the first instance. The urgency and type of health assessment can be discussed as part of the joint assessment with appropriate healthcare staff. It should therefore be rarely that a social worker contacts emergency medical services directly. If social work staff contact an emergency medical service/NHS 24 because of concerns regarding a child or young person’s injuries or illness the first contact health professional should:

- Establish whether social work have discussed the case with the local NHS child protection service and held a joint investigation.
- Consult previous medical records (plus IT systems) to check any previous attendance.
- Consider what clinical care is appropriate at the time of presentation.
- Consider deferring the examination until the child protection doctor is available, as it may not be appropriate to examine the child.

It is critical that for **all cases of child sexual abuse**, where a specialist two doctor Joint Paediatric Examination must be conducted or for **chronic neglect** where a Comprehensive Medical Assessment can be planned at a later date when all relevant information has been collated, that the child protection service is involved as soon as possible.

Emergency Medicine Services

Children or young people with suspected abuse or neglect may be taken to the Emergency Department for the provision of immediate medical care or for an opinion about possible mechanisms of injury. Local procedures for raising child protection concerns should be followed as appropriate. Local systems should be in place if the child or young person or their parent/carer leave the Emergency Department prematurely or refuse treatment. The Named Person should be informed and child protection procedures for “immediate concerns” should be followed.

If, after examination, healthcare staff suspect that a child or young person attending the Emergency Department has experienced, or is at risk of abuse or neglect, Emergency Department staff should:

- Provide any immediate medical care required.
- Gather information from the child or young person’s medical records and the local child protection register by contacting social work standby services.
- Examine the child for evidence of injuries, remembering that these may be concealed under clothing.
- Document carefully all clinical findings including skin condition, bruising, scars, weight and height.
- Ensure that senior staff are involved in any decision-making process.
Follow local child protection procedures, including ensuring concerns are raised immediately with social work services.

Paediatric Assessments for Child Abuse and Neglect

If the first examining doctor suspects child abuse or neglect they should discuss this with their senior clinician and consult local child protection procedures. If it is deemed appropriate, their concerns should be shared immediately with social work before referral for paediatric assessment in order to initiate a child protection investigation. All details should be carefully recorded in the child or young person’s medical record. If the doctor is not clear whether injuries or clinical features are suggestive of abuse, but considers abuse in his differential diagnosis, he may refer the child or young person for a general paediatric examination and opinion. It is important that an appropriate professional gives an opinion about the probability of abuse. In most cases this will be a consultant paediatrician. However, it is important to note there are a number of different types of paediatric examinations:

General Paediatric Assessment

This acute medical assessment is appropriate if there is a differential diagnosis which includes abuse (e.g. multiple bruising, seizures, failure to thrive, or fractures). This would only be appropriate if the child has no other concerning features in the history including social history. It is important that any paediatric examination provides the following:

- Clinical care decisions for the child or young person.
- Interpretation of evidence to support a diagnosis of abuse.
- An opinion about the probability of abuse.
- Identification of a child or young person’s health needs and interventions.

Comprehensive Medical Assessment

This planned medical examination is done by a paediatrician usually as an outpatient. This specialist paediatric assessment would be indicated if there are concerns about neglect, or chronic abuse over a period of time. It is usually carried out as part of a social work investigation. It requires a number of additional tasks to be completed usually by the Lead Professional (e.g. collation of all previous medical records from PHN/HV, family nurse, school nurse, GP, hospital and Emergency Department records, community child health and child psychiatry records). A chronology would be expected prior to examination, and any social work reports should be made available. A full typewritten medical report and opinion will be given to social work and copies sent to the Reporter to the Children’s Panel and GP. A proforma should be used to record all details (Appendix 4).
Specialist Child Protection Paediatric Assessment

This will usually be urgently requested after social work involvement (and after a joint investigation), if there are acute signs and symptoms suggestive of physical abuse. It is a single doctor examination and should be carried out by an experienced trained paediatrician, who has additional skills in child protection. There should be a proforma (see Appendix 4) for recording clinical assessment including history, examination (using body maps) and any investigations planned. It is imperative that clear and detailed notes are kept. Photographs will usually be taken, and a medical report completed with an opinion stated, for social work (and police) as part of the investigation. The child or young person may need admission to the paediatric ward for further tests (e.g. X-rays, blood investigations).

Joint Paediatric/Forensic Assessment

The need for a joint paediatric/forensic assessment is indicated if there are serious injuries or illness (e.g. complex fractures, head injuries, burns, or the result of preliminary assessment is inconclusive and a specialist’s opinion is required to establish the diagnosis).

This two doctor examination is the most specialised type of examination and only undertaken after a joint discussion with social work, police and health. It is usually arranged during working hours with the appropriate skilled personnel and facilities available. This specialist examination provides a high standard of forensic evidence to sustain any criminal or care proceedings, provide treatment and ongoing care, and offers reassurance and advice to the child or young person and carer. It is always done for Child Sexual Abuse. It is usually carried out by a paediatrician and forensic physician, but can be carried out by paediatric and any other appropriately trained doctor.

There may be the need for appropriate specimens for trace evidence including semen, blood, fibres etc. The forensic physician takes responsibility for the gathering of any samples for forensic analysis while the paediatrician takes responsibility for arranging other investigations (e.g. X-rays, MRI, blood clotting tests).

The presence of two doctors in the joint paediatric forensic assessment is not only important for the corroboration of medical evidence in any subsequent criminal proceedings but is regarded as good practice. Following assessment the two doctors should confer immediately, and give an immediate statement to the police officers who may be in attendance.

Medical Report

If doctors are asked by social work or police for a report they should provide a typewritten report detailing the referral pathway to them, the time and place of examination, the names of those present, details of history and examination and specific details of any injuries or abnormalities. The report should summarise significant positive and negative findings as this will be considered evidence. Most doctors will be recording their involvement as witnesses “to fact”. Some specialists such as consultant paediatricians will be expected to also give an
opinion (as courts consider them “experts”) based on their findings and will have to clearly state the probability of abuse.

It is imperative that all specialist paediatric medical examinations result in a clear report. This should also contain details of the doctor’s role, experience and status. It should contain statements of fact (evidence found on history and examination), then an opinion about whether abuse may be possible or probable. It must be sufficiently detailed to meet the Reporter’s requirement as well as the Procurator Fiscal, if necessary, in criminal cases. This is called a Stage 1 report.

A Stage 2 report may be completed after further investigations and results are available, and may have additional evidence from research to support the diagnosis of abuse. This is usually written by a specialist consultant in child protection.
PART 2 HEALTH SERVICES RESPONSIBILITIES IN CHILD PROTECTION

Chapter 5 NHS Links with Other Agencies

This section:
- Highlights importance of inter-agency working.
- Outlines role of Chief Officers in promoting joint working.
- Outlines role of Child Protection Committees.
- Sets out the responsibilities of NHS 24 and Scottish Ambulance Service.

All healthcare staff, in accordance with their statutory and professional responsibilities, must work with local authorities, police and other partner agencies, to protect children and young people to reduce risk and protect from abuse, neglect, and to promote their wellbeing. All front-line staff must know how to access local child protection guidelines and child protection advisers.

Strategic Links between Boards and Local Authorities

The Framework for Standards outlines the standards which all services should strive to provide. These include that:
- Agencies and professionals should work together to assess needs and risks and develop effective plans on an interdisciplinary and interagency basis.
- Agencies work in partnership with members of the community to protect children and young people.
- Agencies individually and collectively demonstrate leadership and accountability for their work and its effectiveness.

A Quality Improvement Framework, using quality indicators, helps services evaluate how well they protect children and meet their needs.¹

Chief Constables, Chief Executives of Health Boards and Local Authorities, referred to as Chief Officers, are responsible for ensuring that their agencies, individually and collectively, work to protect children and young people as effectively as possible. In order to achieve effective partnership working, there needs to be positive and constructive working relationships between individuals and agencies, exemplified and promoted by strong leadership and commitment of Chief Executives, Directors, and Lead Members in all agencies.

It is essential that health services have robust and effective joint working with other agencies to promote the wellbeing of children and young people and protect them from abuse and neglect. Within each Health Board area there are a number of strategic groups which plan and deliver systems and processes to improve joint working and communication across and between agencies, in particular Integrated Children Service Planning and the Child Protection Committee.

Chief Officers should demonstrate effective collaborative working to discharge their child protection responsibilities and consistently promote effective joint working within and across services.
Chief Officers will determine their own local membership and business arrangements. They will ensure that they are transparent and accountable to elected members and Scottish Ministers. Their partnership working will focus on providing better outcomes for vulnerable children and families.

They will set up arrangements for gathering and presenting performance management and monitoring information that is relevant to achieving these outcomes in their areas and taking appropriate action in response to unsatisfactory performance. They will ensure that there is an interface with adult protection, offender management/Multi-Agency Public Protection Arrangements (MAPPA), Alcohol and Drug Partnerships and other planning fora.

**Child Protection Committee**

Child Protection Committees are the primary strategic planning fora for developing and implementing multi-agency child protection work and are established in each local authority area.

Chief Officers are responsible for ensuring that their agencies, individually and collectively, work to protect children and young people as effectively as possible. Chief Officers must ensure that their Child Protection Committees are properly constituted, resourced and clearly focussed. The guidance “Protecting Children and Young People: Child Protection Committees 2005” provides further information.

Chief Officers across Scotland are individually and collectively responsible for the leadership, direction and scrutiny of their respective child protection services and their Child Protection Committees.

Chief Officers are responsible for overseeing the commissioning of all child protection services and are accountable for this work and its effectiveness. They are individually responsible for promoting child protection across all areas of their individual services and agencies, thus ensuring a corporate approach.

The specification for a child protection service should include preventative strategies using the GIRFEC approach which supports prevention and early intervention to reduce the number of children within the child protection system (e.g. services to promote the wellbeing of children and provide support to families where health inequalities, parental substance misuse or domestic abuse is an issue). These services are not only involved in providing healthcare but also in the promotion of health, in reducing health inequalities and meeting the wider public health agendas. The implementation of GIRFEC will create a network of support around the child to promote wellbeing. Concerns regarding a child’s wellbeing should be identified early often within universal services that will either result in a single agency plan co-ordinated by the child’s Named Person or where the Named Person requires support from another agency a Lead Professional will be appointed to co-ordinate the child’s plan.
NHS 24

NHS 24 is Scotland’s National Telehealth and Telecare Service. NHS 24 provides access to clinical assessment, healthcare advice and information and aims to give service users the assistance and advice they require to meet their health needs including onward referral as appropriate. Most calls to NHS 24 are made out of hours, when GP surgeries are closed, but the service is available 24 hours a day. When NHS 24 staff identify a child protection issue they will share this information with partners from other agencies to ensure that services are alert to the protection needs of the unborn baby, child or young person. NHS 24 must ensure that all relevant clinical information is copied to other clinical staff involved in the care of the child or young person (e.g. the Named Person, Lead Professional or primary care team). This is particularly relevant for child protection where parents or carers may seek health advice and treatment from many different health providers to avoid detection of neglect or abuse.

Scottish Ambulance Service

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

Chapter 6 Health Boards Structure for Delivering Child Protection Services

This section:

- Outlines the strategic and corporate responsibilities of Health Boards in child protection.
- Sets out specific responsibilities of key personnel for delivering child protection health services.
- Identifies the responsibilities of operational managers in health services.

This guidance applies to all staff who have strategic responsibilities whether as part of their specific role or delegated to them from other strategic leaders.

Collective Responsibilities for Child Protection

The National Guidance for Child Protection sets out the responsibility of all agencies, professional bodies and services that deliver adult and/or child and young person services and work with children and young people and families to recognise and actively consider potential risks to a child or young person, irrespective of whether the child or young person is the main focus of their involvement. They are expected to identify and consider the child or young person’s needs, share information and concerns with other agencies and work collaboratively with other services (as well as the child or young person and their family) to improve outcomes for the child or young person. Further information is contained in Part 2 of the National Guidance – “Roles and Responsibilities for Child Protection”.

Strategic Leadership for Child Protection

Chief Officers are responsible for ensuring that their agencies, individually and collectively work to protect children and young people as effectively as possible. They also have responsibility for maximising the involvement of those agencies not under their direct control, including the Scottish Children’s Reporter Administration, the Crown Office and Procurator Fiscal Service and the third sector.

The following flowchart sets out the Health Board accountability structure which describes the people with strategic and senior management responsibilities at Board level.
Specification for a Child Protection Service

Each Health Board in Scotland must ensure they provide the following services, processes and policies to ensure a high quality, safe and effective child protection service.

Each Health Board should have:

- Services which include preventative strategies using the GIRFEC approach which supports prevention and early intervention to reduce the number of children and young people within the child protection system.
- A governance, accountability and reporting framework that promotes good practice in child protection and a learning culture to ensure gaps in child protection services and systems which may have an adverse impact on the outcomes for children and young people are identified and addressed.
- Robust information sharing systems that support the identification of vulnerable children and young people.
- A child protection education and development strategy and delivery programme for all healthcare staff within their Health Board area including independent contractors (GPs) and their staff.
- Robust systems in place to ensure that NHS staff contribute to the child protection interagency training programmes such as the local authority, police and voluntary services to ensure that all healthcare staff are trained to the level appropriate to their role and responsibility within the organisation.
- Child protection information, guidance, protocols and procedures which are evidence based and are in line with local, interagency and national policy and are accessible to all staff.
- A quality assurance framework which improves outcomes for children and young people. This should include regular self evaluation and audits in relation to child protection and vulnerable families.
- Safe and robust recruitment processes within current legislation and policies.
- Commissioned services for the provision of therapy, counselling and support for children and young people and families where abuse has occurred or where continuing support is required.
- Sufficient prioritisation of resources allocated to ensure the Board meets its responsibilities in the protection of children and young people.
- Services are in place so the health needs of all Looked After Children are assessed and their needs met.
Specialist Responsibilities

The Chief Executive

The Scottish Government requires Chief Executives of Health Boards to have responsibility for the delivery of high quality services to support child protection. This includes the overall strategic direction for child protection and strategic management of all child protection health services delivered by the Health Board. The Chief Executive may delegate some of these responsibilities to an Executive Director/Lead for Child Protection. This Executive Director will report directly to the Chief Executive and will be responsible for the leadership, co-ordination and management of the child protection services in that Board.

The Chief Executive will:

- Ensure that the role and responsibilities of the NHS Board in relation to child protection are met as set out above and provide performance monitoring reports to the NHS Board on progress and reports on areas that require the Board’s support.
- Work in partnership with the Local Authority and Police Chief Officers collectively to identify and commission inter-agency services to protect children and young people.
- Ensure meeting the needs of and protecting vulnerable children and young people is prioritised within Board and Integrated Children’s Services Plans.
- Ensure the “Vision, Value and Aims” of child protection is disseminated and known by all staff and incorporated within all policies and guidelines.
- Ensure operational services are resourced to support/respond to the demands of child protection effectively.
- Ensure that services are delivered in ways that provide equity of service and take account of diversity.
- Ensure an effective child protection service and training and supervision strategies are adequately resourced and delivered.
- Ensure children and young people’s views are sought within the development of services.
- Undertake the duties in respect of the roles and responsibilities of Chief Officer for the NHS Board.
- Ensure the NHS Board adheres to relevant current national guidance and standards for child protection.

Executive Director Lead Child Protection

The Scottish Government requires NHS Boards to have a Director at Board level with responsibility for child protection. The Executive Director Lead for child protection will report directly to the Chief Executive on the performance of delegated responsibilities and is responsible for providing leadership, co-ordinating the management and leading the long term strategic planning processes for all health services for children and young people across the Board.
The Executive Director Lead Child Protection will:

- Report directly to the Chief Executive on delegated child protection matters.
- Ensure the child protection service is aligned with the Community Health Plans and Children’s Service Plans and to the Risk Management Strategy and Health Care Governance Framework.
- Ensure that the appropriate expert medical and nursing advice on child protection cases is made available to staff within the Health Board.
- Ensure that all specialist child protection staff have training on all aspects of child protection, achieved competencies and where appropriate, have a relevant qualification in child protection in line with current intercollegiate guidance.
- Ensure appropriate managerial and clinical representation on all Child Protection Committees.
- Take strategic lead for health and inter-agency child protection matters including co-operating with other agencies in planning, commissioning and monitoring services and undertaking timeous review of inter-agency procedures.
- Be accountable for commissioning of Significant Case Reviews.

The performance and delivery of all dedicated child protection services will be regularly monitored and reported to the Chief Executive or appropriate strategic board. Additional responsibilities of the Health Board include ensuring access to the appropriate child protection expert medical and nursing advice. This advice should be provided to the Board strategically and to all healthcare staff within the Board. This expert advice will be provided by a Lead Paediatrician for child protection and supported by a Nurse Consultant/Lead Nurse child protection/vulnerable children or designated other professional as decided by individual Health Boards.

**Lead Paediatrician for Child Protection**

The Lead Paediatrician for child protection should be a Consultant Paediatrician with child protection expertise, competencies and training. They should advise the Health Board on child protection matters and contribute to the development of child protection strategic planning arrangements, standards and guidelines with the Lead Nurse both on an intra- and interagency basis. They are a member of the Child Protection Committee and are involved in the work of the subgroups.

The Lead Paediatrician should also provide clinical leadership to all medical and non-medical clinical staff, and direct professional leadership to other paediatricians delivering child protection services. They may have operational management responsibilities which include:

- Ensuring accessible expert child protection advice is available to all medical staff both within the acute and community service, including GPs.
- Having a working knowledge of all policies and procedures and legislation which may go beyond that of a generalist paediatrician.
- Working jointly with the Nurse Consultant/Lead Nurse to develop and undertake the evaluation and quality assurance of the child protection services provided by the Health Board.
- Ensuring that there are suitable facilities for the examination of children and young people suspected of being abused including advice on the nature of the examination, method of recording, and access to suitably trained forensic police surgeons.
- Developing, leading and participating in regular peer review, advice and support both locally and nationally with peers in the management of complex and difficult cases.
- Developing the medical workforce and training other doctors as appropriate.

Nurse Consultant/Lead Nurse for Child Protection/Vulnerable Children

The Nurse Consultant for child protection/vulnerable children provides strategic and professional leadership in child protection to all healthcare staff and to services working with vulnerable children and young people within the Health Board area. They should have additional training, competencies, qualifications and masters in a relevant subject. The Lead Nurse should advise the appropriate Health Board Executive staff on child protection services, contribute to the development of strategic planning arrangements, standards and guidelines with the Lead Paediatrician for child protection. The Lead Nurse may represent the Board in local, regional or national strategic groups in child protection.

The Lead Nurse for child protection will:
- Provide expert clinical advice on child protection to all healthcare staff.
- Work jointly with the Lead Paediatrician in order to undertake self evaluation and ensure quality assurance and service development in child protection.
- Ensure the national training strategy for child protection for all healthcare staff is incorporated, implemented and evaluated.
- Provide supervision for those nurses with a role in child protection including any operational responsibility and line management of the dedicated posts within the health child protection service and services for Looked After Children.
- Ensure direct child protection supervision for designated staff is in place.
- Ensure specialist advice and support is accessible to all staff in relation to child protection.
- Provide clinical and professional leadership in child protection and work in collaboration with medical colleagues, Allied Health Professionals (AHPs), managers and front-line staff to deliver high quality child protection services.

Child Protection Nurse Adviser

In some larger Health Boards there will be a Child Protection Nurse Adviser. The Child Protection Nurse Adviser will:
- Support the Nurse Consultant/Lead Nurse in delivering the child protection service across the Board area both in an intra and interagency basis.
• Provide advice and support on child protection to all healthcare staff as well as staff from partner agencies.
• Be involved in the design, planning and implementation of child protection policies and protocols, which includes the work of the Child Protection Committee and relevant subgroups.
• Take a lead role in the planning and delivery of child protection training to all healthcare staff, both single and multi agency.
• Participate in interagency meetings where appropriate (e.g. child protection case conferences).

Other Key Personnel in Health Boards

Health Boards must ensure there is access to child protection advice and support to all healthcare staff, 24 hours a day. This may be provided by child protection Nurse Advisers, Lead Nurses for child protection or paediatricians with specific responsibilities for child protection. In larger Health Boards, child protection Nurse Advisers may have specific areas of child protection responsibility where they can provide local support to specific groups (e.g. PHN-HV, family nurse, AHP’s, mental healthcare staff, emergency medicine staff). Child protection Nurse Advisers may also have operational roles including delivering training in child protection and attending child protection case conferences to support other clinical staff or to provide specific clinical care to vulnerable children and young people (e.g. Looked After Children health assessments or comprehensive health assessments for neglect).

Operational Managers

An operational manager within a Health Board is anyone who directly line manages clinical and non-clinical staff in all services including child and adult services.

All operational managers in Health Board services have a responsibility to manage staff and services, ensure appropriate guidelines and policies are in place and comply with governance procedures. In particular, for child protection they have a responsibility to:
• Ensure that the staff they manage are aware of, and have access to, the national and local child protection procedures and that staff are aware of the contact details specialist advisory staff who offer advice and support.
• Ensure they are aware of their own responsibility and accountability as managers to protect children and young people within professional, local and national guidelines.
• Ensure that staff they manage have achieved the relevant competence to deliver services to manage their caseload.
• Identify the training and supervision needs of their staff in respect of these procedures and guidance.
• Establish a system of clinical supervision and support for all staff dealing with child protection cases and a system of peer review.
• Release their staff to attend child protection training as appropriate and ensuring that this is recorded for audit purposes.
PART 3 HEALTH BOARD PROCESSES TO SUPPORT PRACTITIONERS DELIVER HIGH QUALITY CHILD PROTECTION

Chapter 7 Caldicott Guardian, Information Sharing and Record Keeping

This section:
- Provides general principles for information sharing.
- Gives details of the role of the Caldicott Guardian.
- Provides links to professional codes of conduct and guidance.

Information Sharing

Healthcare staff have a duty to share information when a child or young person may be at risk of significant harm. This will always override a professional or agency requirement to keep information confidential. Information should be disclosed only for the purpose of protecting children and young people and therefore should be relevant and proportionate and shared promptly and effectively when necessary. Healthcare staff should seek their professional bodies guidance if unsure.

Information sharing for child protection – general principles:
- The safety, welfare and wellbeing of a child or young person are of central importance when making decisions to lawfully share information with or about them.
- Children and young people have a right to express their views and have them taken into account when decisions are made about what should happen to them.
- The reasons why information needs to be shared and particular actions taken should be communicated openly and honestly with children or young people, and where appropriate with families.
- In general, information will normally only be shared with the consent of the child or young person (depending on age and maturity). However, where there are concerns that seeking consent would increase the risk to a child or young person or others or prejudice any subsequent investigation; information may need to be shared without consent.
- At all times, information shared should be relevant, necessary and proportionate to the circumstances of the child or young person, and limited to those who need to know.
- When gathering information about possible risks to a child or young person, information should be sought from all relevant sources, including services that may be involved with other family members. Relevant historical information should also be taken into account.
- When information is shared, a record should be made of when it was shared, with whom, for what purpose, in what form and whether it was disclosed with or without informed consent. Similarly, any decision not to share information should be recorded.
- Agencies should provide clear guidance for practitioners on sharing information. This should include advice on sharing information about adults who may pose a risk to children or young people, dealing with disputes over information-sharing and clear policies on whistle-blowing.
Healthcare staff should seek advice if they are not confident about sharing information. This advice can be obtained from line managers, NHS child protection team or Caldicott Guardian.

Health Professionals will be aware of their duty of confidentiality in relation to one-to-one consultations and in relation to written health records or consultations. However, there will be circumstances where information relating to a patient or patients should and can be released without breaching these principles. Responsibility for ensuring that patient-identifiable information remains confidential is both an organisational and individual one. It is the responsibility of the Caldicott Guardian to facilitate understanding and awareness of that responsibility and to ensure that all such activities within an organisation are lawful - [http://www.knowledge.scot.nhs.uk/caldicottguardians.aspx](http://www.knowledge.scot.nhs.uk/caldicottguardians.aspx)

The Caldicott Guardian:

- Can advise on individual cases where there are any concerns about the potential for the disclosure of patient-identifiable information.
- Has a particular responsibility for reflecting patients interests regarding the use of patient identifiable information.
- Is responsible for ensuring patient identifiable information is shared in an appropriate and secure manner.

Each Health Board will have a Caldicott Guardian who may be:

- An existing member of the management board of the organisation.
- A senior health professional.
- An individual with responsibility for promoting clinical governance within the organisation.

It is particularly important that the Caldicott Guardian has the seniority and authority to exercise the necessary influence on policy and strategic planning and carry the confidence of his or her colleagues.

All GP or Dental Practices, Opticians and Pharmacists must meet their information governance obligations. The Medical Director of the aforementioned may take up the role of Caldicott Guardian. All patients have a right to expect that:

- Information relating to them will be properly created and managed.
- It will be handled in confidence.
- Patient-identifiable information will only be shared with those whose justification for receiving such information has been rigorously tested.

**CONFIDENTIALITY**

In practice, all patient information, whether held on paper, computer, video or audio tape, or even when it is simply held in the memory of a health professional, must not normally be disclosed to a third party without the consent of the patient. This duty applies regardless of age, mental health or capacity.
There are however four sets of circumstances in which the disclosure of confidential information to a third party is lawful:

- Where the patient has given consent
- Where disclosure is in the overriding public interest
- Where there is a legal duty to disclose for example by court order
- Where there is a statutory basis which permits disclosure

Records Management

Record Keeping

All health professionals have a responsibility to have accurate contemporaneous records in line with their professional bodies, for example, the Nursing and Midwifery Council and General Medical Council.

NHSScotland Code of Practice on records management

http://www.scotland.gov.uk/Publications/2012/01/10143104/0

All Staff

All NHS staff, whether clinical or administrative, who create, receive and use documents and records have records management responsibilities. All staff must ensure that they keep appropriate records of their work and manage those records in keeping with the records management codes of practice and the relevant policies and guidance within their Board.

NHS organisations need robust records management procedures to meet the requirements set out under the Data Protection Act 1998, the Freedom of Information (Scotland) Act 2002 and the Environmental Information (Scotland) Regulations 2004. In addition they will be required to produce and implement a records management plan under the terms of the Public Records (Scotland) Act 2011.

Records are a valuable resource because of the information they contain. High quality information underpins the delivery of high quality evidence-based healthcare, accountability, clinical and corporate governance and many other key service deliverables. Information has most value when it is accurate, up-to-date and accessible when it is needed. An effective records management service ensures that information is properly managed and is available whenever and wherever there is a justified need for information, and in whatever media it is held or required to:

- Support patient care and continuity of care.
- Support day-to day-business which underpins the delivery of care.
- Support evidence-based clinical practice.
- Support sound administrative and managerial decision making, as part of the knowledge base for NHS services.
- Meet legal requirements, including requests from patients or other

- Assist clinical and other audits.
- Support improvements in clinical effectiveness through research and also support archival functions by taking account of the historical importance of material and the needs of future research.
- Support patient choice and control over treatment and services designed around patients.

The **NHS Board** is responsible for ensuring that it corporately meets its legal responsibilities, and for the adoption of internal and external governance requirements.

The **Chief Executive**: has overall responsibility for records management in the NHS Board. As accountable officer he/she is responsible for the management of the organisation and for ensuring appropriate mechanisms are in place to support service delivery and continuity. Records management is key to this as it will ensure appropriate, accurate information is available whenever required.

**Professional Regulations**
All health professionals should refer to their own professional bodies for advice.

**Doctors**
All doctors should be aware of their professional responsibilities in dealing with child protection. The GMC has produced child protection guidance for all doctors – Protecting Children and Young People: the responsibility of all doctors¹. In addition, doctors must be familiar with their Health Board child protection policies, and know how to access Child Protection Advice from colleagues at any time of the day or night.

**Nurses and Midwives**
All nurses and midwives will be familiar with the Nursing and Midwifery Council Code: standards of conduct, performance and ethics for nurses and midwives 2008.²

---


Chapter 8 Education, Learning and Development for Healthcare staff

This section:
- Highlights roles and responsibilities for education, learning and development.

Child protection education and training is fundamental for all staff employed by NHS Scotland. 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. This will be achieved through training, case review and clinical supervision.

Since the launch of National Guidance on Child Protection in 2010, two key documents have been produced to support education and training in NHSScotland. These are:

**Scottish Government National Framework for Child Protection Learning and Development in Scotland**

This is a multi-agency framework for all those who have role in keeping children safe. It introduces a new way of describing the workforce to ensure consistency in practice and understanding. It is a multi-agency document for those who commission, develop, purchase and deliver education training and learning for those working with children and young people, to help them protect children and young people from risk of harm. This framework does not replace any local multi-agency or single-agency frameworks but aims to enhance and support them as required. Child Protection Committees will have the strategic responsibility for delivering the framework within their local areas.

**NHS Education for Scotland Core Competency Framework for the Protection of Children**

This Core Competency Framework has been developed for all disciplines, professions and staff groups undertaking a clinical role within NHSScotland. The twin aims of the framework are: (1) to describe the key areas of child protection work that are common and core across all disciplines, professions and staff groups with a clinical role, and (2) to describe the recommended core knowledge and understanding necessary to support these areas of work. This framework is closely aligned to the NHS Knowledge and Skills Framework (NHS KSF) (Scottish Executive, 2004).

**These documents set out the standards and competencies that NHS Boards should adopt when designing and developing education and training for their workforce.**
All medical staff require both single-agency and multi-agency training in the identification of children or young people 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 or young people suspected of abuse or neglect require further training in clinical skills, including videocolposcopy, 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.

The Child Protection Committee and managers have the responsibility for identifying multi-agency training needs. CPCs have the lead role in developing and promoting multi-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.

**Staff Training**

All healthcare staff must complete child protection training in line with their local child protection training strategy. Advice will be available from line managers and child protection department. Training should be planned as part of a personal development program (PDP) and should be linked to the Knowledge and Skills Framework. Healthcare staff will have:

- An awareness of child protection guidance and procedures.
- Confidence in raising concerns about a child or young person.
- A clear understanding of their role in the process of protecting children and young people.
- Access to advice and support through child protection team.

**Supervision**

All healthcare staff should have access to clinical supervision on a regular basis. Supervision facilitates discussion and reflection on cases and enables staff to be more objective about their involvements and to seek advice on the approaches that they need to take. Healthcare staff working with complex child protection cases must seek and have access to supervision and be supported by their managers to have protected time if they have specific responsibilities for child protection cases.
Chapter 9 Advice on Court Proceedings

This section:
- Provides information on the Children’s Hearings system.
- Gives advice on citations for court.
- Gives advice on precognition statements.

The Children’s Hearing System

The Children’s Hearing system deals with children who have committed offences or have had offences committed against them or who may be in need of care for other reasons. The Children’s Hearing system considers if these children are in need of compulsory measures of supervision.

At various times healthcare staff may be professionally involved in the Children’s Hearing system. It is important that healthcare staff are able to fully participate in the Children’s Hearing system. They must be confident regarding their responsibilities when such involvement occurs. Healthcare staff should attend hearings, court and all other activities associated with the Children’s Hearing system. If healthcare staff are not clear about their role they should discuss with their line manager or Child Protection team.

The Children’s Hearing panel which sits to consider a child’s case consists of three panel members. The panel members having received reports prior to the Hearing and, having taken account of the information given to them at the Hearing, will decide if the child is in need of compulsory measures of supervision and if so what form these measures should take. Present at the Hearing will usually be the child, relevant persons, the Children’s Reporter and professionals involved with the child and family. The child and/or family’s legal representative may be present also. The Chair of the Hearing has a duty to ensure that the people present have a legitimate right to be there. While keeping to a strict legal framework the Hearing endeavours to make the proceedings informal.

When a member of healthcare staff receives a request from the Children’s Reporter for a report this must be provided and delivered to the Children’s Reporter within the time specified as per local guidance.

Citations for Court

On receipt of a witness citation regarding child protection, healthcare staff should immediately inform their line manager. Failure to attend court when cited is a criminal offence and an arrest warrant can be issued for such a failure. If a member of healthcare staff cannot attend they must immediately inform the person who has cited them, this information will be contained in the citation. There are certain circumstances where non-attendance will be accepted, for example, if the person cited is abroad on annual leave or unable to attend due to ill health. However, the person who issued the citation must be informed. Staff who receive citations should always inform the Lead Clinician or child protection adviser in their area. The Lead Clinician or child protection adviser will offer the member of staff advice, guidance and support as required. Citations could be
from the reporter or from an agent representing the child or relevant person. This could be in relation to a proof or an appeal against a children’s hearing decision.

**Precognition Statement**

A precognition statement is often taken prior to a case being heard in court. Its purpose is to try and establish the evidence in the case. The GMC acknowledges this arrangement that is peculiar to Scots Law where there is limited disclosure of information in advance of a criminal trial, to both the Crown and Defence, without the patient’s express consent. There is also the facility to have a witness cited under oath within the provisions of the Criminal Procedure (Scotland) Act 1995 to appear in front of a Sheriff for this purpose. Staff who have received citations for court may be approached by the Children’s Reporter, the child’s legal representative or the family’s legal representative for a statement. Good practice should be seeking advice from the Lead Clinician or child protection adviser when a request is made.

The legal measures for the protection of children and young people at risk are fully explained earlier in this document.

It is the responsibility of the Board to ensure that designated officers oversee, give support and time to staff to undertake the necessary administrative work, prepare detailed reports and to have access to appropriate legal advice.

Other key activities are to:
- Ensure familiarity with local court procedures including the workings of the Children’s Reporter, the Sheriff Court and the High Court.
- Ensure that there are opportunities to be precognosed in advance of the court process by a solicitor.
- Attend court to provide support to staff through the evidential process.
- Allow staff the opportunity to discuss their involvement in the case and be offered further clinical supervision following court proceedings.
- Facilitate peer review in a supportive environment.

There is a requirement that the staff involved in child protection have the necessary training, skills and experience in this area of practice where there is compliance with any revalidation requirements of their respective regulatory bodies. This will involve knowledge of relevant quality standards such as those from the Faculty of Forensic and Legal Medicine (FFLM), the ability to produce court reports of the necessary quality and to give effective evidence in court if called upon to do so.

To that end, it may also be beneficial to attend a report writing and courtroom skills course where a number of commercial organisations and the Faculty of Advocates can assist in this respect.

The three medical defence organisations in the UK are able to provide generic advice on giving evidence but as the doctor is giving evidence of fact in their professional capacity or expert evidence, it is not possible for them to be separately represented. It may also be useful to discuss the case with a representative of the Central Legal Office but it is important to bear in mind that
an increasing number of doctors have been referred to the GMC in respect to expert evidence and any issues with the regulator will not be covered by NHS indemnity. Consequently, doctors undertaking this work should ensure valid membership of a defence organisation in case they are required to account in this way.
Appendix 1

Key Definitions and Concepts (taken from the National Guidance on Child Protection in Scotland)

A clear and consistent understanding of the different concepts and terminology in child protection is essential. If action to support and protect children is to be informed and effective, all stakeholders must have a clear, consistent understanding of what is meant by terms such as “child”, “child abuse”, “neglect” and “child protection”. This chapter of the guidance therefore provides definitions and explanations of key terms within child protection processes.

Who is a Child?

A child can be defined differently in different legal contexts.

- Section 93(2)(a) and (b) of the Children (Scotland) Act 1995 defines a child in relation to the powers and duties of the local authority. Young people between the age of 16 and 18, who are still subject to a supervision requirement by a Children’s Hearing, can be viewed as a child. Young people over the age of 16 may still require intervention to protect them.

- The United Nations Convention on the Rights of the Child applies to anyone under the age of 18. However, Article 1 states that this is the case unless majority is attained earlier under the law applicable to the child.

Although the differing legal definitions of the age of a child can be confusing, the priority is to ensure that a vulnerable young person who is, or may be, at risk of significant harm is offered support and protection. The individual young person’s circumstances and age will, by default, dictate what legal measures can be applied. For example, the Adult Support and Protection (Scotland) Act 2007 can be applied to over-16s where the criteria are met. This further heightens the need for local areas to establish very clear links between their Child and Adult Protection Committees and to put clear guidelines in place for the transition from child to adult services. Young people aged between 16 and 18 are potentially vulnerable to falling “between the gaps” and local services must ensure that processes are in place to enable staff to offer ongoing support and protection as needed, via continuous single planning for the young person.

Where a young person between the age of 16 and 18 requires protection, services will need to consider which legislation, if any, can be applied. This will depend on the young person’s individual circumstances as well as on the particular legislation or policy framework. Special consideration will need to be given to the issue of consent and whether an intervention can be undertaken where a young person has withheld their consent.

This guidance is designed to include children and young people up to the age of 18. However, as noted above, the protective interventions that can be taken will
depend on the circumstances and legislation relevant to that child or young person.

Who are Parents and Carers?

A “parent” is defined as someone who is the genetic or adoptive mother or father of the child. A “mother” has full parental rights and responsibilities. A “father” has parental rights and responsibilities if he is or was married to the mother at the time of the child’s conception or subsequently, or if the child’s birth has been registered after 4 May 2006 and he has been registered as the father of the child on the child’s birth certificate. A father may also acquire parental responsibilities or rights under the Children (Scotland) Act 1995 by entering into a formal agreement with the mother or by making an application to the courts.

Parental rights are necessary to allow a parent to fulfil their responsibilities, which include looking after their child’s health, development and welfare, providing guidance to their child, maintaining regular contact with their child if they do not live with them and acting as their child’s legal representative. In order to fulfil these responsibilities, parental rights include the right to have their child live with them and to decide how their child is brought up.

A “carer” is someone other than a parent who has rights/responsibilities for looking after a child or young person. “Relevant persons” have extensive rights within the Children’s Hearing system, including the right to attend Children’s Hearings, receive all relevant documentation and challenge decisions taken within those proceedings. A carer may be a ‘relevant person’ within the Children’s Hearing system.

A ‘kinship carer’ can be a person who is related to the child or a person who is known to the child and with whom the child has a pre-existing relationship (‘related’ means related to the child either by blood, marriage or civil partnership). Regulation 10 of the Looked After Children (Scotland) Regulations 2009 provides that a local authority may make a decision to approve a kinship carer as a suitable carer for a child who is looked after by that authority under the terms of section 17(6) of the Children (Scotland) Act 1995. Before making such a decision the authority must, so far as reasonably practicable, obtain and record in writing the information specified in Schedule 3 to the Regulations and, taking into account that information, carry out an assessment of that person’s suitability to care for the child. Local authorities’ duties are designed to ensure that they do not make or sustain placements that are not safe or in the child’s best interests, and that placements are subject to regular review.

Preventative and protective work is necessary to support carers and, in particular, kinship carers who may face added challenges. These include the potential risks posed by parents; where the kinship carer is a grandparent, this may mean making decisions as to how best to protect their grandchild or grandchildren from their own child. Kinship carers may have ambivalent feelings about the circumstances that have resulted in them having to care for a child or young person. Services should be sensitive to these issues and offer support wherever possible.
Informal kinship care refers to care arrangements made by parents or those with parental responsibilities with close relatives or, in the case of orphaned or abandoned children, by those relatives providing care. A child cared for by informal kinship carers is not “looked after”. The carer in such circumstances is not a foster carer, nor is assessment of such a carer by the local authority a legal requirement.

“Private fostering” refers to children placed by private arrangement with persons who are not close relatives. “Close relative” in this context means mother, father, brother, sister, uncle, aunt, grandparent, of full blood or half blood or by marriage. Where the child’s parents have never married, the term will include the birth father and any person who would have been defined as a relative had the parents been married.

**What is Child Abuse and Child Neglect?**

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting, or by failing to act to prevent, significant harm to the child. Children may be abused in a family or in an institutional setting, by those known to them or, more rarely, by a stranger. Assessments will need to consider whether abuse has occurred or is likely to occur.

While it is not necessary to identify a specific category of abuse when adding a child's name to the Child Protection Register, it is still helpful to consider and understand the different ways in which children can be abused. The following definitions show some of the ways in which abuse may be experienced by a child but are not exhaustive, as the individual circumstances of abuse will vary from child to child.

**Physical Abuse**

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

**Emotional Abuse**

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

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

Neglect

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

What is Child Protection?

'Child protection' means protecting a child from child abuse or neglect. Abuse or neglect need not have taken place; it is sufficient for a risk assessment to have identified a likelihood or risk of significant harm from abuse or neglect. Equally, in instances where a child may have been abused or neglected but the risk of future abuse has not been identified, the child and their family may require support and recovery services but not a Child Protection Plan. In such cases, an investigation may still be necessary to determine whether a criminal investigation is needed and to inform an assessment that a Child Protection Plan is not required.

There are also circumstances where, although abuse has taken place, formal child protection procedures are not required. For example, the child's family may take protective action by removing the child from the source of risk. Children who are abused by strangers would not necessarily require a Child Protection Plan unless the abuse occurred in circumstances resulting from a failure in familial responsibility. For example, if a young child is abused by a stranger, a Child Protection Plan may be required only if the family were in some way responsible for the abuse occurring in the first instance or were unable to adequately protect the child in the future without the support of a Child Protection Plan.
What is Harm and Significant Harm in a Child Protection Context?

Child protection is closely linked to the risk of “significant harm”. Significant harm is a complex matter and subject to professional judgement based on a multi-agency assessment of the circumstances of the child and their family. Where there are concerns about harm, abuse or neglect, these must be shared with the relevant agencies so that they can decide together whether the harm is, or is likely to be, significant.

Significant harm can result from a specific incident, a series of incidents or an accumulation of concerns over a period of time. It is essential that when considering the presence or likelihood of significant harm that the impact (or potential impact) on the child takes priority and not simply the alleged abusive behaviour. The following sections illustrate considerations that need to be taken into account when exercising that professional judgement.

In order to understand the concept of significant harm, it is helpful to look first at the relevant definitions.

- “Harm” means the ill treatment or the impairment of the health or development of the child, including, for example, impairment experienced as a result of seeing or hearing the ill treatment of another. In this context, “development” can mean physical, intellectual, emotional, social or behavioural development and 'health' can mean physical or mental health.
- Whether the harm experienced, or likely to be experienced, by a child or young person is ‘significant’ is determined by comparing the child's health and development with what might be reasonably expected of a similar child.

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

To understand and identify significant harm, it is necessary to consider:

- the nature of harm, either through an act of commission or omission;
- the impact on the child’s health and development, taking into account their age and stage of development;
- the child's development within the context of their family and wider environment;
- the context in which a harmful incident or behaviour occurred;
- any particular needs, such as a medical condition, communication impairment or disability, that may affect the child’s development, make
them more vulnerable to harm or influence the level and type of care provided by the family;

- the capacity of parents or carers to meet adequately the child’s needs; and
- the wider and environmental family context.

The reactions, perceptions, wishes and feelings of the child must also be considered, with account taken of their age and level of understanding. This will depend on effective communication, including those children and young people who find communication difficult because of their age, impairment or particular psychological or social situation. It is important to observe what children do as well as what they say, and to bear in mind that children may experience a strong desire to be loyal to their parents/carers (who may also hold some power over the child). Steps should be taken to ensure that any accounts of adverse experiences given by children are accurate and complete, and that they are recorded fully.

**What is Risk in a Child Protection Context?**

Understanding the concept of risk is critical to child protection. In the context of this guidance, risk is the likelihood or probability of a particular outcome given the presence of factors in a child or young person’s life. Risk is part and parcel of everyday life: a toddler learning to walk is likely to be at risk from some stumbles and scrapes, but this does not mean the child should not be encouraged to walk. “Risks” may be deemed acceptable; they may also be reduced by parents/carers or through the early intervention of universal services. At other times, a number of services may need to respond together as part of a co-ordinated intervention. Only where risks cause, or are likely to cause, significant harm to a child would a response under child protection be required. Where a child has already been exposed to actual harm, assessment will mean looking at the extent to which they are at risk of repeated harm and at the potential effects of continued exposure over time.

**What is the Child’s Plan and the Lead Professional?**

This guidance is rooted in the GIRFEC approach. Under this approach, when two or more agencies work together to support a child or young person and their family, a “Lead Professional” should be nominated to co-ordinate that support. Where evidence suggests that a co-ordinated plan involving two or more agencies will be necessary, a “Child’s Plan” should also be drawn up.

The Child’s Plan should comprise a single plan of action and be managed and reviewed through a single meeting structure, even if the child is involved in several processes; for example, being looked after or having a co-ordinated support plan. The Lead Professional should ensure that the expertise of those involved is properly integrated along with evidence gathered through specialist assessments, in order to give the fullest possible picture of the child’s needs and how best they can be met. The Lead Professional is also responsible for co-ordinating any actions taken to improve the outcomes for the child.
Where a child is thought to be at risk of significant harm, the primary concern will be for their safety. The planning process must reflect this. The “Child Protection Case Conference” is the term applied in this guidance to the single meeting in respect of a child about whom there are concerns about significant harm. It will be for the chair of the meeting to ensure that the discussion stays focused on specific concerns about the safety of the child, the actions required to reduce risk and whether the case should be referred to the Children's Reporter.

The Lead Professional will be responsible for ensuring the production of an agreed multi-agency Child's Plan, based on an assessment of needs and with a particular focus on the risks to the child and the interventions needed to reduce these risks. The plan will incorporate and, if necessary, amend any previous plans by individual agencies. The plan will identify when a review is needed and the Lead Professional will arrange for relevant materials to be produced in time for that review. Materials will be circulated to everyone involved, especially the child and family, and should be available in a range of formats to ensure that they are accessible to all including, for example, children or parents/carers with learning disabilities.

In child protection cases, the role of the Lead Professional will typically be taken by the local authority social worker. Where a child is believed to be at risk of significant harm, the Child's Plan will be known as the “Child Protection Plan” for as long as the risk of significant harm is deemed to last. The multi-agency group working with the child and their family will be known as the core group.

The Lead Professional will be expected to:

- act as the main point of contact with the child and family to discuss the plan, how it is working and any changes in circumstances that may affect the plan;
- be a main point of contact for all practitioners who are delivering services to the child;
- make sure that the help provided is consistent with the Child’s Plan and that services are not duplicated;
- work with the child, their family and relevant practitioners to make sure that the child’s and family’s views and wishes are heard and properly taken into account and, when necessary, to link the child and family with specialist advocacy;
- support the child and family to make use of help from practitioners and agencies;
- in conjunction with other services and the child and their family, monitor how well the Child’s Plan is working and whether it is improving the child’s situation;
- co-ordinate the provision of other help or specialist assessments as needed, with advice from other practitioners where necessary, and make arrangements for these to take place;
- arrange for relevant agencies to review together their involvement and amend the Child's Plan when necessary;
- make sure the child is supported through key transition points; and
- ensure a careful and planned transfer of responsibility when another practitioner becomes the Lead Professional, for example if the child's needs change or the family moves away.

A related concept is the "named person". The named person has an important part to play in supporting early intervention via the universal services of health and education. Where a child has a social worker, they will have a multi-agency plan and, therefore, a Lead Professional. Where a child only requires support from a single agency or service, a named person will be responsible for maintaining contact with the child and/or supporting those who do see the child every day such as nursery or playgroup staff. Further guidance on the roles of the Lead Professional and the named person is available on the GIRFEC website.

**What is the Child Protection Register?**

All local authorities are responsible for maintaining a central register of all children – including unborn children – who are the subject of an inter-agency Child Protection Plan. This is called the Child Protection Register. The register has no legal status but provides an administrative system for alerting practitioners that there is sufficient professional concern about a child to warrant an inter-agency Child Protection Plan. Local authority social work services are responsible for maintaining a register of all children in their area who are subject to a Child Protection Plan, though the decision to put a child on the register will be based on a multi-agency assessment. The local authority may have its own register or maintain a joint register with other authorities. The Child Protection Register provides a central resource for practitioners concerned about a child's safety or care.

The decision to place a child's name on the register should be taken, following a Child Protection Case Conference, where there are reasonable grounds to believe or suspect that a child has suffered or will suffer significant harm from abuse or neglect, and that a Child Protection Plan is needed to protect and support the child.

When placing a child on the register, it is no longer necessary to identify a category of registration relating to the primary type of abuse and neglect. Instead, the local authority should ensure the child's name and details are entered on the register, as well as a record of the key areas of risk to the child. The local authority should inform the child's parents or carers and, where the child has sufficient age and understanding, the child, orally and in writing, about the information held on the register and who has access to it.

**Removing a Child from the Child Protection Register**

If and when the practitioners who are working with the child and family decide that the risk of significant harm to the child has been sufficiently reduced and the child or young person is no longer in need of a Child Protection Plan, the local authority should remove the child from the Child Protection Register. The
decision to remove a child’s name will be made by a review CPCC at which all the relevant agencies are represented, as well as the child and their family. When a child's name is removed from the register, the child and their family must be informed.

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 and family by any or all of the agencies. The risk of significant harm to the child may have receded, but the child may continue to require a range of support; this will form part of the single planning process for the child. At the point of de-registration, consideration should be given to whether a different Lead Professional should be appointed and, if so, arrangements made for the transfer to be agreed. The Child Protection Plan will, following de-registration, become a Child's Plan.

Making Use of the Register

The register should be maintained by social work services. It should be held separately from agency records or case files and in secure conditions. Social work services should appoint a person to maintain and manage the register – generally known as the Keeper of the Child Protection Register. The keeper should make sure that all agencies know how to obtain access information from the register at any time. There should be 24-hour access to the register for all practitioners who need to make an enquiry about a child and online access for partner agencies, wherever possible.

Local areas should have in place mechanisms and arrangements for practitioners making an enquiry to the register, including criteria for when this should be done and by whom. Local protocols should be in place to make sure information is shared and every relevant system and organisation is alerted when there is a child protection concern.

The Scottish Government 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. Local authorities should notify the Scottish Government of any changes so that the list can be kept up-to-date. All practitioners should notify the keepers of local registers of any changes to details relating to children named on the register.

The Keeper of the Child Protection Register will be responsible for attempting to trace a registered child whose whereabouts become unknown, including notifications and alerts to other areas and services.

Temporary moves of children who are on the Child Protection Register

When families move between authority areas – whether temporarily or permanently – the original authority will notify the receiving authority immediately, then follow up the notification in writing. The receiving authority should immediately place the child's name on their local register. Where possible, the original authority should advise how long the child is expected to stay in the area. The authorities should make each other aware when the temporary registration is
no longer required and why this is the case, for example because the child has returned to their home address.

If the child is temporarily residing in another local authority, arrangements must be agreed for the monitoring/supervision of the child while they are in the area and for the implementation of the Child Protection Plan. Assigning responsibility for monitoring is likely to depend on a number of practical considerations, for example, distance. Consultation between the two authorities is essential. Where agreement cannot be reached about monitoring arrangements, the matter must be immediately passed to senior managers for resolution. Whatever the difficulties and however these are resolved, the safety of the child is paramount and adequate monitoring arrangements must be in place.
GIRFEC PRACTICE MODEL
The Getting It Right For Every Child "My World Triangle":

**My World Triangle**

- **My Wider World**
  - Support from family, friends & other people
  - School
  - Local resources
  - Enough money
  - Comfortable & safe housing
  - Work opportunities for my family
  - Belonging

- **What I Need From People who Look After Me**
  - Guidance, supporting me to make the right choices
  - Keeping me safe
  - Knowing what is going to happen & when
  - Understanding my family's history, background & beliefs
  - Being there for me
  - Play, encouragement & fun

- **How I Grow & Develop**
  - Learning to be responsible
  - Becoming independent, looking after myself
  - Enjoying family & friends
  - Being able to communicate
  - Confidence in who I am

**The whole child or young person: Physical, Social, Educational, Emotional, Spiritual & Psychological development**
Appendix 3

Process for Responding to Concerns

Concerns raised practitioner/public

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

Police

Use their powers to remove the child

Social work

seeks CP Order

Initial information-gathering

Police

Information gathering and the decision to launch investigation is done jointly, but in consultation with health services and other appropriate agencies

Social work

Decision to launch investigation

Further Action

Social work, police and health services (and any other agencies as required) agree need and arrangements for join investigative

No Further Action

No further action required under CP but may require other support or intervention
# Paediatric Forensic Examination Proforma

This proforma is designed to be completed as appropriate for individual cases

## 1. Examination details

<table>
<thead>
<tr>
<th>Name of kid</th>
<th>Date of examination</th>
<th>Time of examination</th>
<th>Location of examination</th>
</tr>
</thead>
</table>

## 2. Doctor details

<table>
<thead>
<tr>
<th>Name of paediatrician</th>
<th>Name of forensic physician</th>
<th>Other doctors (if present)</th>
</tr>
</thead>
</table>

## 3. Others present

<table>
<thead>
<tr>
<th>Social worker/care worker</th>
<th>Others (relationship to examinee)</th>
</tr>
</thead>
</table>

## 4. Police details

<table>
<thead>
<tr>
<th>Name and number of attending police officer</th>
<th>Name of investigating officer</th>
</tr>
</thead>
</table>

## 5. Other relevant professionals

<table>
<thead>
<tr>
<th>Social worker/care worker</th>
<th>Health visitor</th>
<th>GP</th>
<th>Others</th>
</tr>
</thead>
</table>

## 5. Family composition (draw family tree overleaf if preferred)

<table>
<thead>
<tr>
<th>Adults (names, Date of Birth, relationship)</th>
<th>Children (names, Date of Birth, relationship)</th>
</tr>
</thead>
</table>

## Additional Information

<table>
<thead>
<tr>
<th>Child on Child Protection Register?</th>
<th>Yes ☐ No ☐</th>
<th>Court Orders? (PPO/EPO/ICO/CO)</th>
<th>Yes ☐ No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category</td>
<td>Neglect ☐</td>
<td>Physical injury ☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sexual abuse ☐</td>
<td>Emotional abuse ☐</td>
<td></td>
</tr>
</tbody>
</table>

Has the Court granted leave for this examination? ☐ Yes ☐ No ☐
7. Consent to history, examination and report

Name and address of persons with parental responsibility

1

2

I ______________________ consent to a paediatric forensic examination, as explained to me by Dr ____________________, being conducted on_______

Signed (child if applicable)

Date

Signed (person with parental responsibility)

Date

I understand that the paediatric forensic examination will include (delete if not applicable):

A. Full medical history and complete examination.

B. Collection of forensic and/or medical specimens.

C. Taking of notes, photographs/videos/digital images for record and evidential purposes.

D. Consent for the use of anonymised photographs/videos/digital images for further opinions, peer review and teaching.

E. I understand and agree that the doctor(s) may provide a statement/report for the police, social services, paediatric services and the patient’s GP (delete any not acceptable).

F. I understand and agree that a copy of the medical notes may be given to professionals involved in the case (e.g. police or lawyers) and may be used in a court.

G. I understand and agree that the doctor(s) may share the medical notes and/or photographs with other medical experts involved in the case. I have been told that any sensitive photographs, videos and/or digital images will be stored securely and only be made available to other non-medical professionals on the order of a judge.

I have been advised that I may halt the examination at any time.
8. Reason for referral

Briefing taken from

Contact details

Names of persons present during briefing

Location of assault(s)

History of events (continue overleaf if necessary)

CSA Checklist

Penis to mouth? Yes ☐ No ☐
Mouth to genitalia? Yes ☐ No ☐
Penis to anus? Yes ☐ No ☐
Penis to vulva/vagina? Yes ☐ No ☐
Details
Object to vulva/vagina/anus? Yes ☐ No ☐
Details
Kissing/licking/biting? Yes ☐ No ☐
Injuries? details
Ano-genital bleeding? Yes ☐ No ☐
Weapon used? Yes ☐ No ☐
Damage to clothing? Yes ☐ No ☐
### 9. Drug and alcohol use in relation to assault

<table>
<thead>
<tr>
<th>Was alcohol consumed?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No □ Yes □ Not known □</td>
<td></td>
</tr>
</tbody>
</table>

If **Yes** please specify
- Prior □ During □ After □ offence

- **Start of drinking**
- **End of drinking**

**Quantity and type of beverage consumed**

<table>
<thead>
<tr>
<th>Have any illicit drugs been used/administered to the subject within 4 days of the examination?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No □ Yes □ Not known □</td>
<td></td>
</tr>
</tbody>
</table>

If **Yes** please specify
- Prior □ During □ After □ offence

**Give details**

**If applicable – drugs/alcohol history**

---

### 10. Post assault – ask if relevant

<table>
<thead>
<tr>
<th><strong>Eaten</strong></th>
<th>Yes □ No □</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drank</strong></td>
<td>Yes □ No □</td>
</tr>
<tr>
<td><strong>Passed urine</strong></td>
<td>Yes □ No □</td>
</tr>
<tr>
<td><strong>Note time</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Bowels open</strong></td>
<td>Yes □ No □</td>
</tr>
<tr>
<td><strong>Wiped/washed</strong></td>
<td>Yes □ No □</td>
</tr>
<tr>
<td><strong>specify site and disposal of e.g. cloth/tissue</strong></td>
<td></td>
</tr>
</tbody>
</table>

| **Changed clothes** | Yes □ No □ |
| **Specify** |
| **Self harm** | Yes □ No □ |
| **Sites** |
| **Complaints of pain/soreness/bleeding post assault** | Yes □ No □ |

**Details**

- **Brushed teeth □ gums □ dentures □**
- **Mouth wash □ spray used □**
- **Washed □ bathed □ showered □ douched □**
- **Changed tampon □ pad □ sponge □ diaphragm □**
- **Forensic samples taken before examination started**

**Give details**

**By whom taken**

---
11. Birth/Medical history
Past medical/surgical history/hospital admissions/visits to A&E &/or GP

16. Behaviour
Detail any problems at home or school
e.g. wetting / soiling / aggression / sexualised play

13. Immunisations

14. Development
Motor milestones
- normal
- delayed
Speech
- normal
- delayed
Toilet training

Special needs (please specify)
17. Direct questions

If Yes record frequency and severity

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
<th>DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinary tract infection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal discharge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhoea</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constipation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genital injury</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anal bleeding/itching</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal bleeding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faecal incontinence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary incontinence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin diseases</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nappy rash/redness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soreness in genital area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is your child on prescribed medication?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is your child on any other medication?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child use bubble bath or disinfectants in the bath?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child use medicated soap or creams?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sexual history (note who was present when taken)

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>SI prior to assault in last 14 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, was condom used</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, was lubricant used (note type)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SI post assault</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Types of intercourse in last 14 days only

<table>
<thead>
<tr>
<th>Menstrual History: applicable/not applicable</th>
<th>LMP</th>
<th>Sanitary towels/tampons</th>
<th>Birth control</th>
<th>Pregnancies</th>
<th>Any children?</th>
<th>Abortions?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at onset</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regularity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous consensual sexual activity? (note who was present when asked)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# General examination

Name(s) of persons present

<table>
<thead>
<tr>
<th>Weight</th>
<th>Height</th>
<th>Head circumference</th>
</tr>
</thead>
<tbody>
<tr>
<td>kgs</td>
<td>cm</td>
<td>cm</td>
</tr>
<tr>
<td></td>
<td>centile</td>
<td>centile</td>
</tr>
</tbody>
</table>

General appearance (hygiene)

Skin colour

Hair colour

Demeanour/behaviour

Pre-existing physical problems (note type)

## Head to Toe Survey

<table>
<thead>
<tr>
<th>Scalp/hair</th>
<th>Examined</th>
<th>Injuries</th>
<th>See body chart</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Face</th>
<th>Examined</th>
<th>Injuries</th>
<th>See body chart</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eyes</th>
<th>Examined</th>
<th>Injuries</th>
<th>See body chart</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lips</th>
<th>Examined</th>
<th>Injuries</th>
<th>See body chart</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inside mouth/palate</th>
<th>Examined</th>
<th>Injuries</th>
<th>See body chart</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Teeth</th>
<th>Examined</th>
<th>Injuries</th>
<th>See body chart</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Back</th>
<th>Examined</th>
<th>Injuries</th>
<th>See body chart</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Buttocks</th>
<th>Examined</th>
<th>Injuries</th>
<th>See body chart</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Arms</th>
<th>Right Left</th>
<th>Examined</th>
<th>Injuries</th>
<th>See body chart</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fingers/nails</th>
<th>Right Left</th>
<th>Examined</th>
<th>Injuries</th>
<th>See body chart</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Right</td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Left</td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Front of chest</th>
<th>Examined</th>
<th>Injuries</th>
<th>See body chart</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Breasts (Tanner stage)</th>
<th>Examined</th>
<th>Injuries</th>
<th>See body chart</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Abdomen</th>
<th>Examined</th>
<th>Injuries</th>
<th>See body chart</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Legs</th>
<th>Right Left</th>
<th>Examined</th>
<th>Injuries</th>
<th>See body chart</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feet/ankles/soles</th>
<th>Right Left</th>
<th>Examined</th>
<th>Injuries</th>
<th>See body chart</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Right</td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Left</td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other findings</th>
<th>Examined</th>
<th>Injuries</th>
<th>See body chart</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
</tbody>
</table>
### 19. Systems examination (if relevant)

<table>
<thead>
<tr>
<th>CVS</th>
<th>CNS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulse rate/character</td>
<td>Pupil size and reactions</td>
</tr>
<tr>
<td>BP</td>
<td>Eye movement/nystagmus</td>
</tr>
<tr>
<td>Heart sounds</td>
<td>Conjectiva</td>
</tr>
<tr>
<td>Other findings</td>
<td></td>
</tr>
<tr>
<td><strong>RS</strong></td>
<td></td>
</tr>
<tr>
<td>Trachea/air entry/percussion note etc</td>
<td></td>
</tr>
<tr>
<td>Breath sounds</td>
<td></td>
</tr>
<tr>
<td>PEFR (if indicated)</td>
<td></td>
</tr>
<tr>
<td><strong>Abdomen</strong></td>
<td></td>
</tr>
<tr>
<td>L.K.K.S</td>
<td></td>
</tr>
<tr>
<td>Tenderness/masses</td>
<td></td>
</tr>
<tr>
<td>Bowel sounds</td>
<td></td>
</tr>
<tr>
<td>Diagram (if indicated)</td>
<td></td>
</tr>
</tbody>
</table>

### 20. Genital examination

<table>
<thead>
<tr>
<th></th>
<th>Position used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extra lighting</td>
<td>Yes □ No □</td>
</tr>
<tr>
<td>Colposcope</td>
<td>Yes □ No □</td>
</tr>
<tr>
<td>Additional magnification</td>
<td>Yes □ No □</td>
</tr>
<tr>
<td>Details of female genital findings</td>
<td>Internal findings (if applicable)</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Genital examination position</td>
<td>Vaginal wall</td>
</tr>
<tr>
<td>Thighs</td>
<td></td>
</tr>
<tr>
<td>Pubic area</td>
<td></td>
</tr>
<tr>
<td>Pubic hair (Tanner stage ________ )</td>
<td></td>
</tr>
<tr>
<td>Labia majora</td>
<td></td>
</tr>
<tr>
<td>Labia minora</td>
<td></td>
</tr>
<tr>
<td>Fourchette</td>
<td></td>
</tr>
<tr>
<td>Fossa navicularis</td>
<td></td>
</tr>
<tr>
<td>Vestibule</td>
<td></td>
</tr>
<tr>
<td>Hymen</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Genital examination position</th>
<th>Internal findings (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genital examination position</td>
<td>Vaginal wall</td>
</tr>
<tr>
<td>Thighs</td>
<td></td>
</tr>
<tr>
<td>Pubic area</td>
<td></td>
</tr>
<tr>
<td>Pubic hair (Tanner stage ________ )</td>
<td></td>
</tr>
<tr>
<td>Labia majora</td>
<td></td>
</tr>
<tr>
<td>Labia minora</td>
<td></td>
</tr>
<tr>
<td>Fourchette</td>
<td></td>
</tr>
<tr>
<td>Fossa navicularis</td>
<td></td>
</tr>
<tr>
<td>Vestibule</td>
<td></td>
</tr>
<tr>
<td>Hymen</td>
<td></td>
</tr>
</tbody>
</table>

Size of speculum if used: small ☐ medium ☐ large ☐

Foley catheter used
Yes ☐ No ☐

Sterile water used
Yes ☐ No ☐

Lubricant used type
Yes ☐ No ☐
Mons pubis
Prepuce of clitoris
Clitoris
Frenulum of clitoris
Orifice of urethra
Labium majus (labia majora)
Vestibule (area between labia minora)
Labium minus (labia minora)
Hymen (covering introitus of vagina)
Vestibular fossa
Fourchette
Posterior commissure
<table>
<thead>
<tr>
<th>Details of male genital findings</th>
<th>Scrotum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genital examination position</td>
<td>Testes (Tanner stage _________ )</td>
</tr>
<tr>
<td>Thighs</td>
<td>Penis</td>
</tr>
<tr>
<td>Pubic area</td>
<td>Foreskin</td>
</tr>
<tr>
<td>Pubic hair (Tanner stage _________ )</td>
<td></td>
</tr>
</tbody>
</table>

![Diagram of male genital findings](image-url)
### Details of anal findings

**Natal fold**

**Perianal/anal margin**

---

**Internal findings**

---

**Proctoscope if used: size and type**

<table>
<thead>
<tr>
<th>Sterile water used</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lubricant used</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

---

#### 21. Forensic samples (If Forensic Science form attach instead)

<table>
<thead>
<tr>
<th>Identification number</th>
<th>Description of sample</th>
<th>Moistened Yes/No</th>
<th>Time taken</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**To whom handed**

**Date and time samples handed over**
### 22. Medical samples

List any samples obtained and record where samples are sent

---

### 23. Photographs

List any photographs/videos obtained and where stored

---

### 24. After care

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>STI screening referral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EC given/referral for IUD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotics given</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other medication given</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral for Hep B immunisation/PEP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to GP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to paediatrician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to other support service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post sexual assault leaflet given</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice given to patient/carer</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

### 25. Conclusions/advice given to police/social care services

---

**Name/Title examining doctor(s)**  
**Signature of examining doctor(s)**  

---
Part 4 of the National Guidance sets out child protection in specific circumstances. This appendix give additional information on certain circumstances of which health professionals may become aware. As stated in the National Guidance not all the indicators set out here are common, nor should their presence lead to any immediate assumptions about the level of risk for an individual child or young person. Where identified they should act as a prompt for all staff, where in an adult of child care setting to consider how they may impact on a child or young person.

**Supporting the Unseen Child or Young Person**

Healthcare professionals frequently have patients or carers where there is a pattern of non attendance for health appointments or where they cannot gain access to the home of the client. A patient/carer may make excuses for the professional not to see the child or young person, or refuse the service.

In such circumstances, best practice would suggest that health practitioners will review the child or young person and wider family records to find out whether there is any other information that would suggest increased vulnerability. They must inform the named person and key health professionals working with the family.

This guidance has been developed to assist practitioners in determining the most appropriate course of action to take in situations where the child or young person is "unseen", and incorporates the core components of Getting It Right for Every Child (GIRFEC).

The **unseen child or young person** may result from the following:

- Address unknown
- Mobile or travelling families
- Homelessness
- Failure to attend routine appointments (e.g. immunisations, dental care)
- Failure to attend specialist appointments (e.g. diabetes clinic)
- Refusal of the service
- No access visits
- Denied access visit

**Definitions regarding visits by universal services**

**Child or young person not seen** – when the healthcare professional is granted access but does not see the child or young person (e.g. the child is said to be asleep and not to be disturbed, or is in the care of others, not in the house).

**Denied access visits** – when the door is opened by the carer in charge and the healthcare professional is refused access.
**No access visit** – when a visit has been arranged but there is no response at the door and it appears that no one is at home.

Health Boards should refer to the NHSScotland publication – “Effective Booking for NHSScotland” and develop local protocols to reduce did not attend rates to ensure these vulnerable children, young people and families receive the care and support they need.

**Assessing Risk to a Child or Young Person in Secondary Care**

It is often difficult to quantify the likely risk to the child/young person of a no access visit. In view of this it is preferable to discuss this with the GP referrer, parent/carer and possibly other professionals who have knowledge of the family e.g. nursery and schools. In this way more information can be obtained, allowing for a more holistic assessment of the possible impact on the child/young person resulting from no access.

At any time, where there are concerns regarding the welfare of a child/young person further advice can be sought from the line manager or child protection adviser.

**Refusal or Withdrawal from Healthcare Services**

It is up to those with parental responsibility to act on the behalf of a child, under the age of informed consent, to ensure that the child is a recipient of these services. In circumstances where the child is denied these services by their parents/carers, healthcare professionals including GPs must consider that it is their professional responsibility and duty to act on the child’s behalf.

It is advised that professionals take into account each individual child’s circumstances and the likely implications of failure to receive appropriate services. Professionals should take steps to ensure that parents are able to make informed choice and be flexible in negotiating alternative means of offering services. In non-urgent circumstances this may entail sending a letter to the parents/carers. Where services would normally be accessed in a clinic, a surgery or school, consideration should be given to home visits as an alternative means of offering services. Children who are persistently missing from school or who have been excluded may require home visits to facilitate uptake of services.

If, after all attempts to work in partnership with parents/carers are not achieved and the child’s health and development may be significantly impaired as a result of this, consideration needs to be given to raising your concerns with social work.

**Refusal of Prescribed Treatment**

There are situations where refusal or withdrawal of prescribed medical and therapeutic treatment for children or young people may constitute neglect and it is important for staff to be aware of the following:

- Where parents, the child or young person or others refuse, withdraw or actively withhold commonly available foods or fluids, or fail to co-operate with
prescribed medical or therapeutic treatment such that a child or young person experiences, or is likely to experience significant harm, or neglect, a concern should be raised immediately to the social work department.

- Attempts may be made to justify the above neglect on some basis (e.g. religion). However, this does not change the legal duties of all agencies to protect the child or young person’s best interests.

**Refusal or Withdrawal of a child from Routine Health Services**

In circumstances where children or young people are denied access repeatedly to routine health services designed to promote their health and development, health professionals must ensure when writing to parents/carers that they give sufficient information about the importance of the services to the child or young person, outlining alternative means of provision and enabling them to make informed choices. It is important for professionals to demonstrate that they are seeking opportunities to work in partnership with parents in order to achieve good outcomes for the child or young person.

It is important to have written evidence to prove that you have attempted to gain co-operation with parents/carers in the routine delivery of services. A standard letter should be sent including the following key points:

- The number of home contacts attempted, including the dates and times visited and number of written “no access” communications left.
- What services are on offer at the child health clinic, surgery, health centre, at home or from the school health service.
- Why the services are important emphasising benefits to the child or young person and the implications for the child or young person of not receiving these.
- Inquire from the parent/carer whether there are particular difficulties gaining access to the services which you may be able to help them overcome (e.g. timing of clinics/sessions, transport). Consider if the family would prefer to access the services from an alternative practitioner (e.g. the GP).
- Inform parents/carers how to contact you, should they choose to have the service.
- Continue to send all appointments for routine health surveillance, immunisations and screening tests.
- If at any time you feel the withdrawal from health services is likely to result in harm for the child or young person, consult the child protection adviser or social work to decide on further action.
- Continue to monitor whether this family is registered with a named GP, in the area. If not and the whereabouts of the family are unknown, refer to “Missing Family Alert” guidance below.
Missing Family Alert

The purpose of the Missing Family Alert is to locate children who have disappeared from a known address and for whom there may be concerns of significant harm.

Each Health Board must ensure staff comply with the National Missing Family Alert guidance and process. The Lead Nurse for child protection in each Health Board has designated responsibility for this process.

Definition of Missing Family

This is a family who has disappeared from a known location within a Health Board area for whom there may be concerns of significant harm for the child or young person in respect of unmet need, vulnerability or abuse. This includes risks to unborn children.

There are several stages to the use of alerts:

Stage 1

It is critical to speak to any extended family and neighbours, and other significant community members, of which only the team around the child or young person are likely to be aware. It is important to communicate with the Named Person or Lead Professional.

Should the child or young person be on the Child Protection Register or is Looked After the Keeper of the Register in the authority area should be notified immediately. When this process has been followed and the family have not been located this then needs to progress to Stage 2.

Stage 2

NHS personnel with evidence that a family is missing should contact the child protection nurse with responsibility for their locality/area of work. All reasonable and practical efforts should continue to be undertaken to locate the family. This now needs to include discussion with other health professionals and partner agencies; and interrogation of IT systems such as Community Health Index (CHI), Standard Immunisation Recall (SIRS) and Patient Administrative System (PAS). Partner agencies may be able to assist (e.g. housing, social work, and education).

Police have a specific role to trace missing persons and they have access to numerous databases, which can assist in gathering information or intelligence, which will assist in tracing missing children, young people and families. They should be contacted as soon as there are concerns that a child/young person/family is missing.
Stage 3

Progress to raising a “Missing Family Alert” is reached when a child or young person or family has not been located and there are concerns of significant harm. The speed in reaching this stage is determined by the risk assessment.

This now needs to be discussed with the Lead Nurse for child protection within the Health Board. The Lead Nurse will collaborate with the Caldicott Guardian as required and agree the appropriateness of raising a NHSScotland Missing Family Alert Form.

When a Missing Child or Young Person is Found

The Lead Nurse will contact the appropriate people to ensure that the child/young person/family are in receipt of NHS services and that appropriate and relevant risk assessment and referrals are made in accordance with professional practice, information sharing protocols and child protection guidelines. This will enable appropriate planning and actions can be taken to support the child/young person and family.
High Risk Families

Although child abuse and neglect can occur in any family, it is concentrated in particular sectors of society where families may be vulnerable to a combination of complex risk factors. Many of the risk factors for physical abuse are multiple, for example, domestic abuse; alcohol and drug (mis)use; and mental health issues. What is important to remember is that ‘multiples matter’ (Spratt, 2011) and that it is usually the accumulation of risk rather than the presence of any single risk factor that affects outcomes. Certainly the ‘toxic trio’ of domestic abuse, substance misuse and parental mental ill health provide a milieu of most risk, but we do not know enough about the relative weightings of each and there is a need to separate alcohol and substance dependencies. Beginning to identify risk factors, though, is not the same as being able to predict which families may harm their children (Taylor, Baldwin, & Spencer, 2008).

In the most recent analysis of SCRs (Brandon, Bailey, Belderson, Gardner, Sidebotham, Dodsworth et al., 2009), over half the children lived with current or past domestic abuse (DA), almost two thirds lived in a household where a parent or carer had a mental illness, and a substantial number of parents were misusing drugs or alcohol. Nearly three quarters of the children had lived with current or past domestic violence and/or parental mental ill health and/or substance misuse. The combination of the three problems can produce a toxic caregiving environment for the child.

Poverty

Although significant attempts have been taken to end child poverty in the UK, the proportion of children living in poverty in the UK is higher as compared to a generation ago and higher than the level experienced by most European countries (Hooper, Gorin, Cabral, & Dyson, 2007). Children living in poverty are at a higher risk of a wide range of adverse experiences and unfavourable outcomes, including maltreatment and most notably physical abuse and neglect by parents (Coulton, Korbin, Su, & Chow, 1995; Garbarino & Kostelny, 1992; Waldfogel, 2007).

The main influence of poverty on parenting appears to be the stress it causes, which in turn disrupts parenting practices and styles (Katz, 2007), though this relationship is far from straightforward. Stressed parents are more likely to use harsh parenting practices and therefore increasing negative outcomes for children (Webster-Stratton, 1990).

Cycles of Abuse

Literature on the intergenerational transmission of child physical abuse suggests that individuals physically abused in childhood are at increased risk for physically abusing their own children (Coohey & Braun, 1997; Milner, Robertson, & Rogers, 1990). Individuals (and especially women) with a history of childhood physical abuse had significantly higher rates of anxiety disorders, major depression, alcoholic dependence, illicit drug use, antisocial behaviour and were more likely to have one or more such disorders than those without such a history (MacMillan, Fleming, Streiner, Lin, Boyle, Jamieson et al., 2001).
Smith (2004) reviewed the impact of parental mental illness on children, noting how the characteristics of certain mental illness can result in physical and emotional injuries or neglect if a child is present when these symptoms are manifesting themselves. Smith also found evidence to suggest that mothers with poor mental health have a higher incidence of physically punishing their child. It is important to note, however, that most research either looks at parental mental illness from the mother’s or parent’s perspective, and although there are some studies addressing fathers, they are few and far between.

**Substance Misuse**

Approximately 30% of children under 16 years of age live with at least one binge-drinking parent (Manning, Best, Faulkner, & Titherington, 2009). Galvani (2004) interviewed 19 UK women who were victims of domestic abuse on their views of the role of alcohol on their partner’s behaviour. She found that although most women found alcohol acted as a disinhibitor for aggressive behaviour, violence and abuse usually happened as a result of other factors in addition to the alcohol consumption. Alcohol misuse can affect key aspects of family life such as roles, rituals, routines, social life, finances, communication and conflict (Velleman, 1993).

It is estimated that between 200,000 and 300,000 children in England and Wales and between 41,000 and 59,000 children in Scotland have one or both parents with a serious drug problem (ACMD, 2003, 2007). **Substance misuse is increasingly being regarded as one of the most problematic and challenging areas to tackle in the area of child abuse and child protection and accounts for the overwhelming majority of cases that remain open and/or are re-referred to social services (Forrester, 2007).**

Drug misuse can manifest itself in a variety of ways which include physical ailments such as infections, overdoses and accidental and non-accidental injuries and psychological impairments such as being dominated by the drug and addiction, withdrawal symptoms such as erratic and irritable behaviour, psychosis and serious memory lapses (ACMD, 2003). These symptoms show how it is very likely that children living with parents who engage in drug misuse are at high risk of significant harm. Negative manifestations usually start emerging when there is a combination of other factors such as mental state, physiological impact of the substance, expectations of the individual regarding oneself and others, personality, type, dosage and method of administration. Effects may include lack of care, neglect, growing up in an unstable and violent environment, criminality, lack of or hindered education and developmental and health problems. Not all people who use or misuse substances will be abusive or bad parents. Again, there is usually a combination of factors that may lead to one having aggressive and abusive behaviour.
Risk taking behaviours as a result of early abuse, e.g. drug taking, can then impact on parenting behaviours and the social environment, which can then lead to further abuse. Early interventions are thus crucial given the developing brain. However, it is important to note that intergenerational cycles of abuse are not inevitable, and there are many stages where decreasing risk factors and increasing protective factors can break this kind of cycle. Much can be learned from studies where individuals have encountered severe adversity and maltreatment in childhood, yet have not repeated this in their own parenting behaviours (Harris & Dersch, 2001).

**Domestic Abuse**

In the last national prevalence study, 26% of children and young people reported physical violence during their childhood (Cawson, Wattam, Booker, & Kelly, 2000). Results from the recent NSPCC prevalence study show that a quarter of children who live with domestic abuse experience are physically abused themselves (Radford, Corral, Bradley, Fisher, Bassett, Howat et al., 2010). It is important also to understand that the impact of domestic abuse can endure for children long after the measures have been taken to ensure their safety (Holt, Buckley, & Whelan, 2008).

We know that the rates of child abuse and neglect are 15 times higher than the national average where domestic abuse is an issue, indeed in three out of five cases of maltreatment, domestic abuse is also an issue. Not only is there a link between domestic abuse and maltreatment, domestic abuse can impact on parenting abilities; it jeopardises the developmental progress and personal abilities of children, contributing to cycles of adversity; and it disrupts broader family functioning and the home environment (Buckley, Holt, & Whelan, 2007).

The impact on their wellbeing can include a range of physical, emotional and behavioural consequences – low self esteem, depression, PTSD, aggression, running away from home and risk taking behaviour (Hester, Westmarland, Gangoli, Wilkinson, O’Kelly, Kent et al., 2006). The association between domestic abuse, harm to children’s health and use of health services is not straightforward but known adverse consequences include heightened risks of under immunisation and of risk taking behaviour in adolescence (Bair-Merritt, Blackstone, & Feudtner, 2006; Webb, Shankleman, Evans, & Brooks, 2001).

**Parental Mental Ill Health**

Approximately one in six adults in Britain has been diagnosed with a neurotic disorder such as depression, anxiety or phobias (Office of National Statistics, 2001). In addition, approximately five in 1,000 people surveyed were assessed as having a severe mental disorder such as schizophrenia or bipolar depression. It is hard to capture the effects of mental illness as it may vary and be perceived differently from case to case.

Studies have shown some of the negative effects for children who have parents with mental illness (Aldridge, 2006; Stallard, Norman, Huline-Dickens, Salter, & Cribb, 2004; Tunnard, 2004). In addition, there have been studies that have linked parental mental illness to child abuse (Walsh, MacMillan, & Jamieson,
Children Under One

Very young children particularly children under the age of two years are some of the most vulnerable in society. In statistics published by the NSPCC in December 2011 nearly half of all serious case reviews are in relation to babies under one year of age and infants aged under one year are more at risk of being killed at the hands of another person than any other age group in England and Wales. (Over 6% of all children aged under 18 years in the UK were aged under one year (2010).)

The proportion of child homicides in which the perpetrator is a parent is exceptionally high among infants.

In Ofsted's numatic evaluation report of serious case reviews in England and Wales from 1 April 2007 to 31 March 2011 “Ages of concern; learning lessons from serious case reviews”² key findings and recurring messages regarding babies less than one year of age were that in too many cases:

- There were shortcomings in the timeliness and quality of pre-birth assessments.
- The risks resulting from the parents only were underestimated, particularly given the vulnerability of babies.
- There had been insufficient support for young parents.
- The role of the fathers had been marginalised.
- There was a need for improved assessment of and support for parenting capacity.
- There were particular lessons for both commissioning and provider health agencies whose practitioners are often the main or the only agencies involved with family in the early months.
- Practitioners underestimated the fragility of the baby.

Of the 471 serious case reviews evaluated by Ofsted between 2007 and 2011 concerning 602 children, 210 (35%) children were babies under the age of one year.

The report states that this has been a consistent pattern across the four year period.

In Scotland, child protection figures i.e. children accessing the statutory child protection system is only available for the age category of 0-4 years old, but in Scotland in 2010 50% of all children on the child protection register were aged under four years.

The Scottish Children’s Reporters Administration research report “Children aged under two years referred to the Children’s Reporter³ is that in Scotland in recent years proportionately more children below the age of 2 years are being referred to the Reporter. In 2008 – 2009 this was almost one in 20 children under two years of age in Scotland (i.e. 5,651 children). In addition over the period of 2005 – 2009 more children under two years of age were needing to be placed on supervision requirements and on emergency measures (place of safety warrants...
and child protection orders) to protect them and safeguard their welfare. The research studied 50 cases of children less than two years referred to the Reporter. These children had difficult family backgrounds:

- Most parents were unemployed.
- Two thirds of the children had parents with drug and or alcohol addictions.
- Over a half of the children’s parents had mental ill health.
- Three quarters of children had parents with histories of offending and 10% of fathers had been charged with sexual offences.
- 20% of children had a parent who had been in prison.

A range of services and professionals were involved with the children and their families – pre- and post-birth of the child.

However, not all parents were prepared to engage with the services being offered and that was especially the case of parents who had very chaotic lifestyles. For 20% of the cases there were serious concerns about males in the child’s home due to their volatile, adverse and violent behaviour. Half of the families had housing problems with poor or inadequate accommodation, homelessness and transient lifestyles and there was evidence that parents chaotic lifestyles were impacting on their children.

Infants (i.e. children under the age of one year) may present with various potential child protection concerns as above and there must be a low threshold for raising concern and for suspicion of abuse particularly where infants present with injuries. For example “those who don’t cruise, rarely bruise” (Sugar, Taylor and Feldman, 1999).

A systematic review of the international literature in infants under the age of six months suggests that any bruising on an infant under six months must be fully evaluated and a detailed history taken to ascertain the consistency with the injury. Non-mobile children should not have bruises without a clear and usually observed explanation. There are a range of physical injuries, that in their own right if presented, in an infant should immediately prompt the practitioner to ensure that full history is taken, general examination and full investigations are performed, including full photography and progression to look for internal injuries.

The presence of an injury in an infant frequently indicates more severe abuse and the possibility of other internal injuries must always be considered, for example brain or abdomen or bony skeleton. Any inconsistent history for an injury must raise suspicion. Even where a potentially plausible accidental history is provided for any concerning injury in an infant the fullest information must be sought from primary, secondary and tertiary health services, as well as from social work and other agencies as appropriate, prior to discharge of a child from an inpatient or out patient health setting. Many instances have been described particularly through serious case reviews where accidental histories have been accepted from a parent or carer without attempt to validate the history via a third party or without gleaning further information. Many of these cases where this rigour has not been applied have resulted in more serious injuries occurring to those infants, sometimes within weeks and or months and some have resulted in death. These are particularly high risk cases. In light of this, some Health Boards
developed or are currently developing Board-wide policy in relation specifically to the Recognition and Management of Maltreatment in Infants (Children under the age of one year).

In an infant where an injury may or may not be apparent there may be other cumulative concerns such as described earlier in this chapter and it is critical that healthcare professionals take the utmost care and apply rigour to establishing the critical information in relation to the infant and family and communicate concerns to appropriate others to allow protection and supportive interventions at the earliest opportunity.

Teenage Pregnancy
Much attention has been given to associations between teenage pregnancy and negative outcomes: child abuse and neglect (Burghes & Brown, 1995), poor parenting (Kotagal, 1993), high stress levels, school dropout, limited educational opportunities (Furstenberg, Brooks-Gunn, & Morgan, 1987), as well as multiple pregnancies at a young age (Britner & Reppucci, 1997). In addition, children living with single parents and stepfamilies are at greater risk than other families of physical abuse (O’Connor, Davies, Dunn, & Golding, 2000) and have poorer school performance. Unfortunately, there is a lack of national statistical data on the neglect and abuse perpetrated by teenage parents and incidence is projected only from research samples.

---

Children and Young People with Disabilities

There is clear evidence that disabled children are at higher risk of abuse than non-disabled children, particularly neglect and emotional abuse. For example, in a methodologically rigorous study, Sullivan and Knutson (2000), who examined the records of over 20,000 children and young people aged 0-21 in Nebraska, found a 9% incidence of child abuse among non-disabled children compared to 31% among disabled children, meaning that the latter are 3.4 times more likely to be abused. However, it is thought that the real level of abuse is higher than this, due to under-reporting. This can result from professionals’ failure to identify, or report, abuse in disabled children, children’s own difficulties reporting abuse, or reports of abuse from disabled children being dismissed (see for example Kvam 2004). However, the direction of causality, and how far impairments caused by abuse contribute to the association, is not known.

A wide range of factors are likely to contribute to disabled children’s increased vulnerability to abuse, although these are not always recognised. Some disabled children may have less awareness or knowledge than non-disabled children about what is acceptable and non-acceptable behaviour from others – or perpetrators may assume that is the case. Some children may be targeted because they have communication impairments making it hard for them to report abuse, or mobility difficulties making it hard to remove themselves from the abuse. Others will have personal care needs which open up opportunities for abuse. Family-related factors include the stress which can arise from caring for a disabled child, particularly if sufficient support is not available, ambivalent feelings about having a disabled child or the nature of the child/parent attachment, or parents’ disciplinary approaches.

Services and systems factors can fail to protect children. Staff may not understand or communicate well with disabled children; disabled children are disproportionately represented in residential settings where risks are known to increase; having multiple carers can cause vulnerability; parents may fear losing support if they raise concerns about possible abuse, while signs of maltreatment and distress can go unrecognised in disabled children. Some professionals appear reluctant to believe that anyone would abuse a disabled child. Useful training materials produced by the NSPCC (2011) cover many of these underlying factors.

Recent research in Scotland (Stalker at al 2010) suggested that, inter alia, standard child protection procedures are not always applied to disabled children, many professionals lack the skills/confidence to communicate with disabled children, different agencies have varying views about acceptable thresholds for parental treatment of disabled children, and there is a need for better collaboration between staff working in child protection and children’s disability teams.
REFERENCES

Useful Documents

HMIE – Practice Examples:

References

The Unseen Child


High Risk Families


Humphreys, C., & Thiara, R. (2002). Routes to Safety: Protection issues facing abused women and children and the role of outreach service Bristol: Women's Aid Federation England


Tunnard, J. (2004). Parental Mental health Problems: Key Messages from Research, Policy and Practice Dartington: Research in Practice


Velleman, R., & Orford, J. (1999). Risk and resilience: Adults who were the Children of Problem Drinkers Amsterdam: Harwood Academic Publishers


References


