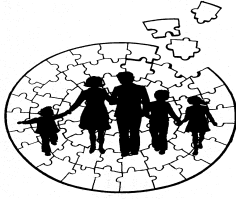


NHS FIFE

CHILD PROTECTION GUIDELINES



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NHS FIFE ~ Child Protection Guidelines

Contents

Working Together to Protect Children ~ Guidance for Health Professionals

	Page
Contents	3
Introduction	4
Principles of Child Protection	5
Risk Assessment	6
The Referral Process	7
Discharge Planning During Hospital Admission	7
Child Protection Referral Pathway	8
The Timescale for Action	9
Listening to Children and Young People: Guidance on Disclosure	10
Consent	11
Parental Responsibilities, Parental Rights and Consent	12
Medical Examination and Assessment	13
Types of Medical Examination/Assessments	13
Involvement of Staff Working within NHS Fife Child Protection Case Conferences	14
Planning and Intervention Processes	14
Record Keeping	15
Documentation and Recording for Medical Staff	16
Report Writing: Additional Guidance for Medical Staff	18
Report Writing: Guidance and Nursing & AHP Staff	20
Court Proceedings – Giving Evidence	21
Types of Witnesses in Courts	23
Golden Rules for Court	24
Files for Families on Support – Public Health Nurses & Allied Health Professionals	25
Transfer of Records where there are Child Protection Concerns for Staff Working within Community Health Partnerships:	
- Nursing and Allied Health Professionals	26
- Public Health Nurses/Health Visitor and School Nursing Service	27
National and Local References	28
Appendices	29
Appendix 1 ~ Interagency Referral Discussion [IRD] - Protocol	30
Appendix 1.1 ~ Interagency Referral Discussion – Information Sharing~All Staff	40
Appendix 1.2 ~ Interagency Referral Discussion – Information Sharing~Managers	42
Appendix 2 ~ Confidential Notification of Transfer Out of a Family where there are Child Protection Concerns	44
Appendix 3 ~ Transfer Out of Child/Children where there are Child Protection Concerns	45
Appendix 4 ~ Families on Support / Initial	46
Appendix 5 ~ Families on Support / Review	52
Appendix 6 ~ NHS Fife Operating Division – Paediatric Alert	57
Appendix 7 ~ Child Protection Order – Good Practice Protocol	60
Appendix 8 ~ NHS Fife Child Protection Report	64
Appendix 9 ~ Confirmation of Telephone Conversation	70
Appendix 10 ~ NHS Fife Child Concern/Welfare Pathway (& associated Risk Assessment Tool)	73
Appendix 11 ~ Useful Contacts	

Introduction

These Guidelines are aimed at assisting healthcare workers to understand their roles and responsibilities with respect to Child Protection.

These roles and responsibilities are fully explained in Appendix F of the Fife Child Protection Inter-Agency Guidelines 2006; in the Scottish Executive document *'Protecting Children a Shared Responsibility'* (2000) and on the Scottish Executive Web Site (www.show.nhs.scot.uk).

Where there is a suspicion or belief that a child may be in need of help or protection, all staff working within NHS Fife will:

- recognise and be alert to the signs that the child[ren] may be in need of help or protection;
- use their power to help;
- put people in touch with other professionals as necessary. (Ref: *Scottish Executive 2004, Protecting Children and Young People: Framework for Standards, Standard 2 (1)*).

NHS Fife will ensure that mechanisms are in place to assist staff in knowing what steps to take to deal with their concerns and demonstrate what action has been taken. (Ref: *Scottish Executive 2004, Protecting Children and Young People: Framework for Standards, Standard 2 (2)*).

Principles of Child Protection

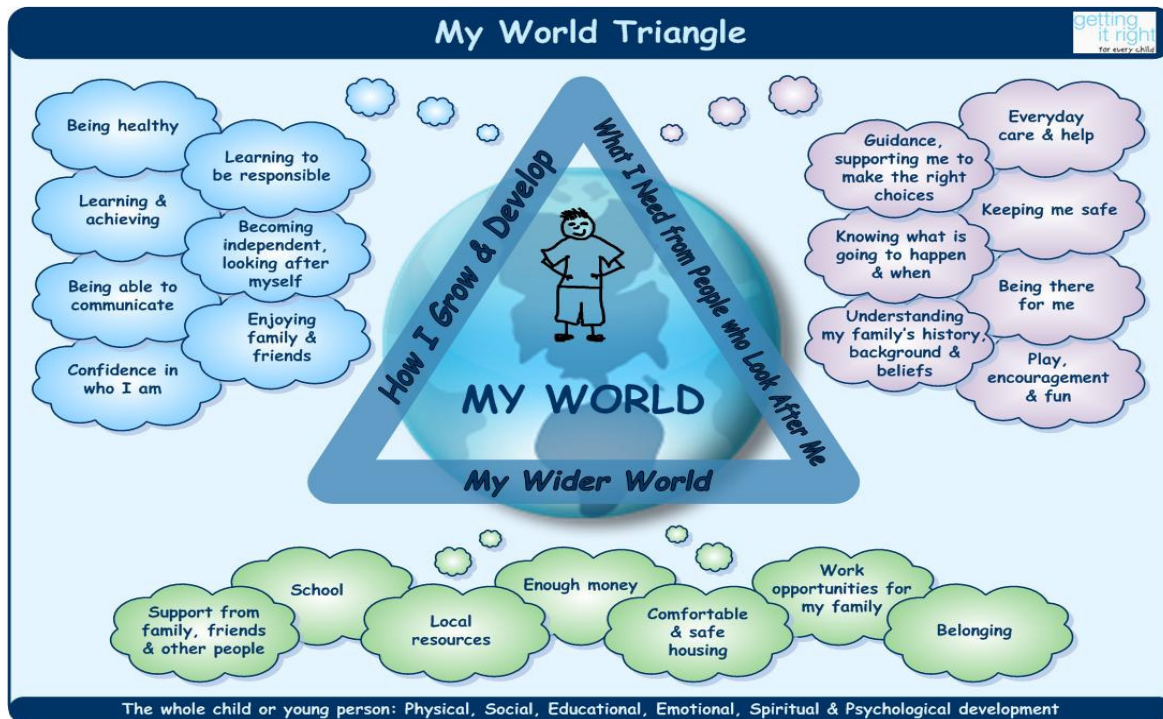
Child abuse is defined within the Fife Child Protection Committee Inter-Agency Guidelines 2006 section 3 and includes: **physical injury; sexual abuse; faltering growth; emotional abuse and physical neglect.**

- All concerns relating to the well-being of the child[ren] will be carefully considered.
- All staff within NHS Fife must be alert to the possibility of abuse of the child[ren] in families at all times, whether or not they have been alerted to a specific concern through the referral process.
- If there is reasonable concern that the child[ren] may be at risk of harm this will always override a professional or agency requirement to keep information confidential. All professionals and service providers have a responsibility to act to make sure a child whose safety or welfare may be at risk, is protected from harm. They should always tell parents this unless this puts the child[ren] or member of staff at risk of harm. *[Ref: Scottish Executive 2004, Sharing Information about Children at Risk: A Guide to Good Practice].*
- No one agency can make a risk assessment without full information and consultation with others. No single agency has a monopoly in the identification and management of child abuse. Agencies must work together in considering known medical, legal and psychosocial factors, as well as the known facts about an allegation, in order to assess the level of risk and arrive at appropriate decisions. *[Ref: Fife Child Protection Inter-Agency Guidelines 2006].*
- NHS Fife or other agencies may separately record information about the child and family over time, which may retrospectively suggest a degree of concern, which had not prompted referral to social work services or the police. All clinical staff have the responsibility for the chronological review of recorded information as well as concerns raised in relation to the current contact with the child[ren] and family.
- All allegations of child abuse or neglect, including anonymous referrals, will be taken seriously. Anonymous callers must disclose the child's [children's] name[s] to ensure the protection of the child[ren]. If the caller is reluctant to disclose the name of the child[ren] an explanation should be given to the caller to the effect that withholding such information may lead to serious harm to the child[ren] and a delay in providing vital protection.
- Professionals should consider all cases with an open mind without assuming that abuse has, or has not, occurred.
- To ensure that children are protected from abuse of all types, it is essential to have good communication and liaison between relevant professionals at all times. Communication within NHS Fife and the relevant designated Child Protection professionals is essential to address issues of concern and advise on the best measures needed to ensure that child[ren] are protected.

Risk Assessment

Children and Young People who have been harmed or may be at risk of harm are entitled to have their needs met in the most comprehensive sense [Fife Child Protection Inter-Agency Guidelines 2006]

The NHS Fife Child Concern/Welfare Pathway & associated Risk Assessment Tool (Appendix 10) has been developed using current evidence, knowledge, experience and expertise. This pathway attempts to keep the child at the centre of the assessment process. The Scottish Executive has expressed this framework in diagrammatical form as outlined below:



Risk assessment is a process which enables healthcare workers to take timely and effective action to protect children [Framework for Standards, 2.8]. There is no tool that will identify risks with absolute precision. All professionals and service providers have a responsibility to act to make sure that a child whose safety or welfare may be at risk is protected from harm. [Sharing Information about children at risk/A guide to good practice/Scottish Executive 2003].

The NHS Fife Child Concern/Welfare Pathway and Risk Assessment process [available on the NHS Fife intranet via the Child Protection button on the home page] must be used to guide you and information recorded appropriately in the child's records.

If following completion of the risk assessment you are still unable to reach a conclusion and make a decision you are advised to discuss your concerns with your CHP Link worker, Nurse Advisor (Child Protection Team) or the member of staff with responsibility for Child Protection within your work area.

The Referral Process

In all cases of suspected abuse:

- identify concerns and discuss with senior colleagues and agree way forward;
- discuss with and, if appropriate, make referral to Family Protection Unit [FPU] / Social Work Services;
- in situations where it is difficult to contact Social Work Services, the Child Protection Register should be accessed as per protocol which is available on the NHS Fife Intranet.
- inform parent [unless this puts the child[ren] or member of staff at risk of harm];
- record accurate details of history and clinical findings [with diagrams];
- complete and submit a Child Concern Form (Appendix 9)
- if uncertain, consider having a discussion with the Child Protection Team (NHS Fife)

The referral process is explained in the flowchart on page 8.

Discharge Planning During Hospital Admission

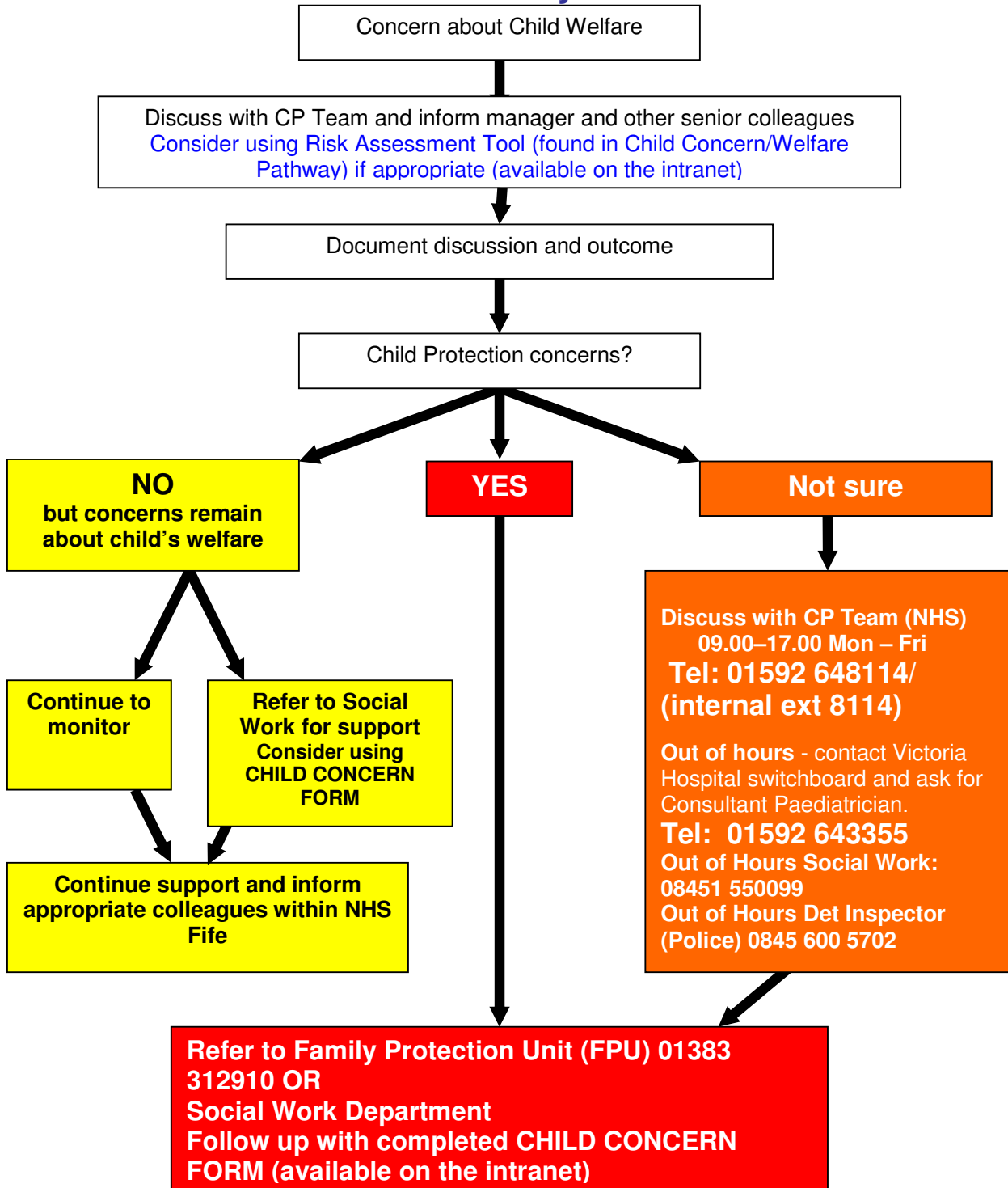
Any child admitted to hospital where there are suspected child protection concerns should receive a full physical examination. The results of the examination must be fully documented in the case notes within 24 hours of admission.

There should be a clearly documented care plan for the future before discharge. This may require multidisciplinary discussion or meetings.

When a child for whom concerns have been raised is to be discharged:

- a senior paediatrician [at least middle grade and preferably consultant or associate specialist level] must agree to both the discharge and the care plan;
- this must be discussed with Social Work Department when necessary;
- the Nurse Advisor Child Protection ~ Operating Division must be informed [prior to discharge if possible];
- primary healthcare team must be informed;
- education authorities and/or the child's school may be informed where appropriate;
- ensure appropriate medical, social work, voluntary agency, education follow up as appropriate.

Child Protection Referral Pathway



The Referral Process:

- Seek advice. Never hesitate to seek advice and share concern with appropriate colleagues

The Timescale for Action

In ALL cases the safety of the child is paramount

It is fundamental to the success of the process that health professionals ensure that their colleagues in other agencies are kept closely informed of their progress and findings, including their provisional conclusions so that decisions particularly relating to the child's immediate protection from further harm may be made appropriately.

- Accurate records must be kept of any examinations and findings.
- Information must be shared between relevant multi-agency partners.
- When Child Protection investigations are initiated, any management of health or developmental issues should take place in parallel to police and social work enquiries coordinated by relevant health professionals.

Physical Abuse

- If a child presents with signs suspicious of non-accidental physical injury it is important to arrange a medical examination as soon as possible, so that all signs of injury are documented before they fade or disappear.
- In situations where the General Practitioner is unsure whether the clinical presentation is due to abuse or illness, for example in a child with unexplained severe bruising, an urgent paediatric opinion is required that same day.

Sexual Abuse

- For any child who is the victim of recent sexual assault, an urgent medical examination must be arranged as soon as possible in order to document the injuries and to obtain forensic evidence.
- If more than 72 hours have passed since the sexual assault allegedly occurred, the examination can be planned at a time suitable for all parties concerned.
- The child and the parent or carer accompanying the child should be kept appropriately informed of the medical findings and should be supported throughout the process.

Listening to Children and Young People: Guidance on Disclosure

- When a child or young person approaches a healthcare worker, the professional should listen carefully with sympathy and understanding.
- Avoid expressing shock or disbelief.
- Avoid unnecessary questioning.
- The child may be frightened of revealing something which they have been told is a secret, whether in the context of a threat or a 'special relationship'.
- They may also be afraid that they will not be believed.
- Listen carefully and seriously to a child's report of abuse whilst keeping an open mind as to what may have occurred.
- Take into account the child's age and stage of maturity and development.
- Do not ask leading or multiple questions.
- Record as accurately as possible anything a child has said, noting exact words, time, place and context, as far as possible and avoid summarising the child's account.
- Reassure the child that he or she is right to talk to an adult about being hurt or harmed.
- **Do not** make promises to children or young people about confidentiality of information.
- State what is likely to happen, find out the child's or young person's views and wishes.

Consent

Rights of Children and Young People:

- The right to decide whether or not to agree to a health care intervention.
- If aged 16 or over children and young people are presumed to have the capacity to make their own decisions.
- If under 16 years children and young people have the legal capacity to authorise medical or dental care where, in the opinion of the practitioner looking after them they are capable of understanding the nature and consequences of the care.
- When a child cannot understand then a parent or an adult with parental responsibility can make decisions on their behalf.
- If the young person is over 16 years but lacks the capacity to make healthcare decisions they must be treated under Part 5 of the Adults with Incapacity (Scotland) Act 2000
- The child or young person has a right to receive verbal and written information on examinations, procedures and treatment.
- They have the right to make their own decisions and to understand that they can change their minds at any time.
- They have the right to be communicated with frequently about their healthcare needs and choices.

Health Professionals Responsibilities:

- Health professionals must ensure that the child or young person is aware of their rights and seek authorisation to proceed with a procedure
- Even if the examination is ordered by a Children's Hearing consent may be withheld for all or part of an examination for example the taking of photographs
- To ensure that the child or young person and their family are appropriately informed to provide consent voluntarily, providing any necessary verbal or written information
- To assess where appropriate the capacity of the child or young person to authorise or refuse consent and document the outcome.
- Where medical examination is thought necessary for the purpose of obtaining evidence in criminal proceedings but the parent or adult with parental responsibility refuses permission the Procurator Fiscal may consider seeking a warrant however where the child or young person who has the capacity declines consent a warrant will not be requested.
- If the local authority requests an examination to consider concerns about the child's safety or welfare and the parent refuses consent the local authority may apply to the Sheriff for a Child Assessment Order
- Detail of any examination, procedure or treatment including the process followed to seek consent must be recorded in the relevant clinical record.
- Where a request is made to share information the practitioner must be guided by their professional code of practice and the requirement to share information where there perceived is a risk of harm.

Parental Responsibilities and Parental Rights

The mother of a child always has parental rights and responsibilities in relation to the child, unless she has been deprived of them by a court order.

A father of a child only has parental rights and responsibilities in relation to a child if:

- a) he is married to the child's mother at the time of the child's conception or subsequently;
- b) on or after 4 May 2006, he is registered as the father of a child under any of the following enactments:
 - i) Sections 18(1)(a), (b)(i) and (c) of the Registration of Births, Deaths and Marriages [Scotland] Act 1965 (c.49);
 - ii) Sections 10(1)(a) to (e) and 10A(a) to (e) of the Births and Deaths Registration Act 1953 (c.20);
 - iii) Article 14(3)(a) to (e) of the Births and Deaths Registration (Northern Ireland) Order 1976 (S.I. 1976/1041).
- c) He is given parental responsibilities and parental rights by a court order under section 11 of the Children [Scotland] Act 1995; or
- d) He is given parental rights and responsibilities by agreement drawn up between himself and the mother under the Parental Responsibilities and Parental Rights Agreement [Scotland] Amendment Regulations 2006.

This agreement is a legal document showing that a mother who has parental rights and responsibilities and the child's father who is not married to her have both agreed that the mother should share her parental rights and responsibilities with the child's father. To make the agreement the mother and father have to complete a special form together, sign it before witnesses and register it with the Registers of Scotland.

What this means in practice:

A child's mother has parental responsibilities and rights whether or not she is married to the father.

The 2006 amendment to the Act now extends parental rights to unmarried fathers provided that the father is registered as the child's father on the birth certificate. This part of the Act only applies to those unmarried fathers who have their names on the birth certificate on or after 4 May 2006. The Act is not retrospective – thus an unmarried father of a child born in 2004 and whose name is on the birth certificate does not have parental rights or responsibilities in terms of the Act.

This may raise issues with regard to the giving of consent to medical treatment [and this includes the examination of the child for Child protection purposes]. **It may be necessary for clinicians and healthcare staff to request a copy of the child's birth certificate where there is a dispute between parents.**

Medical Examination and Assessment

Subsequent to an Interagency Referral Discussion (IRD) between FPU and Lead Clinician for Child Protection/ Consultant Paediatrician

- A medical examination/full health assessment should be conducted in all children where there is concern re suspected abuse.
- Any medical examination should be conducted in a sensitive manner with the child's views being taken into consideration and acknowledged at all times.
- A Joint Paediatric/Forensic examination [JPFE] should be conducted in cases of suspected child sexual abuse and/or physical abuse. The examination should be recorded on the JPFE form available on the NHS Fife Intranet.
- The purpose of the medical examination is:
 - to provide a full health assessment of the child's needs;
 - to establish what immediate treatment the child may require;
 - to provide an opinion on whether or not child abuse has occurred;
 - to provide evidence, where appropriate, to support a referral to the Children's Panel or criminal proceedings;
 - to secure any further medical assistance for the child if required;
 - where appropriate to reassure the child and family that no long term physical damage has occurred.
- A medical assessment will include:
 - full medical history;
 - general physical examination [including growth parameters];
 - an assessment of the emotional, developmental and health needs of the child.
- The aim is to avoid unnecessary duplication of medical examinations. Follow-up for further assessment may be required.
- **A medical examination may not provide evidence that child abuse has occurred. Absence of medical evidence does not automatically mean absence of abuse. Information from medical examinations should be considered alongside information from Social Work, Police and any other relevant agency.**

Types of Medical Examinations / Assessments

- There are three types of examinations:
 - joint paediatric/forensic examination;
 - specialist paediatric assessment;
 - comprehensive medical assessment, which may involve psychiatric, psychological and social work assessment.
- During Child Protection enquiries **all** agencies involved **must** share relevant information.

Involvement of Staff Working within NHS Fife in Child Protection Case Conferences

For detailed information about Child Protection Case Conferences please refer to the Fife Child Protection Inter-Agency Guidelines 2006.

- A Child Protection Case Conference may be called by the social work service at the conclusion of inter-agency Child Protection inquiries. All relevant information is gathered from the involved professionals and an assessment is made of the probability that abuse or neglect has occurred and the ongoing risk to the child and any siblings.
- Be prepared:
 - to interpret medical findings and relevant background information. It may be relevant for the health professionals involved in the secondary care of the child to attend;
 - to share information;
 - to contribute to the core group;
 - to contribute to the Child Protection plan.
- A report will be required from relevant health professionals involved irrespective of whether or not that person will attend the Child Protection Case Conference.
- Appropriate training, information and support to professionals in this aspect of their work should be made available. In some situations the practitioners may wish to be accompanied by a more senior member of staff but in general only those actively involved with the child and family should attend.

Planning and Intervention Processes

- NHS Fife's policy "Child Protection – Unborn Child" provides a framework for identifying an unborn child who may be deemed a child in need; the associated process from identification of risk to early intervention strategies.
- A Pre-birth Child Protection Case Conference can be convened as a result of early intervention assessment, or independently where levels of concerns are such that a formal multi-agency assessment and planning is required. This should take place before 34 weeks gestation.
- All children and young people accessing A&E and Acute paediatrics will have a Paediatric Discharge Pathway Tool completed prior to discharge.
- Identification of child welfare concerns and progression of risk/needs assessments may be processed within the Operational Division via the CPNA using Paediatric Alerts/Parental Attendance Alert - in situations where no immediate action is required and there is a capacity issue for staff in terms of processing NHS Fife needs assessment (mainly A&E).

Links:

- Paediatric Alert/Parental Attendance Alert – guidance and templates [Appendix 6]
- Issuing of a Child Protection Order - Good Practice Joint Protocol NHS Fife and Fife Council [Appendix 7]

Record Keeping

- All NHS Fife staff must record relevant information received. In accordance with NHS Fife policy and guidance from regulatory bodies [e.g. General Medical Council; Nursing & Midwifery Council etc.] all professionals must record their concerns, findings and professional opinions carefully and legibly **using black ink**. Health professionals may be required to produce records as evidence in later criminal or civil proceedings.
- Records must document the date and time that any incident occurred, also the date and time when the record was made.
- Records should include:
 - ↪ details of any concerns about the child and family, including current and previous records, drawings and other written material;
 - ↪ details of any contact or involvement with the family and any other agencies;
 - ↪ the findings of any assessment, including risk assessment;
 - ↪ any decisions made about the case within each agency or in discussions with other agencies;
 - ↪ detail of information shared with other agencies, with whom and when;
 - ↪ details of any action taken and perceived outcomes.
- The information received following a referral must therefore always be written down accurately and in detail, either at the time or immediately afterwards.
- Original notes and case records, drawings or other written material should be retained even if information is condensed into summary reports, as these original notes are regarded as 'best evidence' by the courts.

Documentation and Recording for Medical Staff

Records

It is imperative that all facts and findings are recorded with accuracy and considerable detail. The Joint Forensic/Paediatric proforma can be used and ensures that all the potential legal ramifications are apparent from the outset.

This includes a structure to cover all the important components of the assessment, including history, examination and investigations. Body plans facilitate drawings of visible lesions and injuries, including genital and anal findings. Diagrams should be included with the report as appendices and should be referred to in the text. Appropriate photography should also be performed and reference to it made in the report.

Your hand written notes and drawings may be seen by the Court. Clear, well written notes are important documents on which your formal typewritten report must be based.

Medical notes, including all diagrams, must always be dated and signed, with a time when the interview/observations are made.

Name and job title should be clearly printed beside your signature.

Include:

- a) why examination requested;
- b) who made the request;
- c) where the examination took place;
- d) who was present.

Record Keeping

The name of the consultant responsible for child protection aspects of the case should be clearly documented in the case notes.

Within a given location, health professionals should attempt to work from a single set of records for each child. Make comprehensive, contemporaneous notes. It is best to make your own notes. However, if someone else is writing in the notes for you, be clear about what you want them to record.

Document all discussions regarding a child, whether they be face to face or telephone. If you do not have the notes at the time of discussion, ensure that a note is written as soon as possible.

In cases where harm to the child is suspected, a history should be taken from the child if the doctor feels that it is in the best interests of that child [in such cases, permission from the parents is not required].

Record verbatim important information given to you by adult and child, including any disclosures. With sensitive questions, record your questions as well as the answer [e.g. Q: "*what do you think made you sore?*" A: "*Uncle Tommy touches my tinkle*"]. Courts need to make sure that you have not asked questions which lead or direct the child towards a particular answer, so the question is as important as the answer.

It is particularly important to distinguish carefully between what a child says in your presence and what a parent tells you a child has said in some other setting.

It is useful to indicate any obvious emotional accompaniment to statements made [e.g. *“Donna was obviously upset when she told me this – she avoided eye contact and was visibly shaking”*].

Record difficulties in either history taking or examination, indicating the limitations of the information you obtained. Thus it is important to say if you did not complete an adequate genital examination and only obtained a brief look [e.g. *“genital examination, owing to lack of cooperation, was incomplete and information may have been missed. However, I detected no obvious abnormality”*].

It is imperative to include all negative, as well as positive findings.

Growth Charts

Growth should be recorded using standard growth charts agreed across NHS Fife.

Inaccuracies can arise with measurement. You may be asked to comment how a measurement was obtained and its reliability.

Developmental Assessment

Development should be recorded, with further assessment carried out if required.

Report Writing: Additional Guidance for Medical Staff

Medical Reports

Where there is any concern raised about the possibility of abuse or neglect, the doctor must provide an initial medical report. Great care must be taken over construction of the report as it may well be used as medical evidence in court even if it was originally prepared for a professionals' meeting or child protection conference. It is important that the opinion given is clear and deals with all potential concerns of findings within the body of the report. It is also important for a doctor to produce a medical report whether he/she has concluded there has been abuse or not [negative findings are also important].

Writing Reports

Reports written for different purposes will be different. A medical note for the general practitioner, a referral letter to a child psychiatrist, a report for the Criminal Injuries Compensation Board, a formal statement for the Police or a report for a Child Protection Committee Significant Case Review, serve very different purposes. However, it is important to be aware that all these documents will be subject to meticulous scrutiny if the case ever goes to Court. In addition, lawyers for the defence may well use even the smallest inconsistency between the reports and notes to try and undermine any testimony you are called on to give months or even years later. Indeed, many lawyers will exploit any such inconsistency to the full even if it is more imagined than real. Anything put into a formal witness statement that is not also recorded in the notes that you wrote immediately after seeing the child may also be challenged as unreliable unless you have completed both the notes and the formal statement immediately after the child was seen. However, such reports [unlike the original case notes] do not normally need to be burdened by the inclusion of all the negative findings. The qualifications and experiences of the writer must also be recorded.

- a) The report should start with the name of the person who is writing it along with their qualifications and experience.
- b) The report should contain a detailed history and examination.
- c) Consider differential diagnosis and give reasoning for the preferred option.
- d) Make it clear that the opinion is your professional opinion.

Practical Points for Report Writing

- a) Use non-medical language where possible.
- b) Separate sections for history, examination, summary, opinion and conclusions.
- c) Include times and dates in chronology – a good chronology can have significant impact.
- d) Record results of investigations or indicate if investigations ordered or results pending.
- e) Indicate origin of any third party information given.
- f) Use child's own words where possible.
- g) Always separate fact from opinion.

Other Points to Remember

- a) Remember a normal examination does not mean "no abuse" – you may need to say so if you have concerns [e.g. clear disclosure by child and a considerable time interval between event and examination would allow healing to occur].
- b) Restrict suggestions about management to areas of responsibility [e.g. request for child protection conference, need to see siblings, need for further investigation, need for follow up].
- c) Discuss findings with the parent[s] unless he or she is involved in criminal proceedings. The parent[s] are not shown and do not usually have a copy of your report directly. [Their solicitor may provide them with the report if they are involved in proceedings under the Children (Scotland) Act 1995].
- d) Always stick to your own area of expertise. Never stray into other professionals' roles [e.g. Police investigations].
- e) Remember – **the interests of the child are paramount** when there are difficulties over confidentiality.

The report should ideally be dictated within 24 hours. It must be typed and signed as soon as possible and circulated. Less experienced doctors may wish to have their reports checked by a consultant. Discussion with a peer is often very helpful.

Send the medical report to:

- a) General Practitioner;
- b) Community Child Health Service;
- c) Social Work Department, if a child protection conference is planned;
- d) Police, if a criminal hearing is possible;
- e) appropriate personnel for the reasons of supervision and audit;
- f) a copy should be kept in the notes.

All reports should be marked **Private and Confidential**, not to be distributed without the author's permission. Do not copy or show the report to another party without the author's consent.

Medical reports are likely to be used in civil proceedings.

Additional report may be requested prior to Court appearances or for other purposes [e.g. claims for criminal injury compensation]. Always make reference to the original report when writing additional reports. Do not exaggerate or make the condition more serious than it is. Do not change the significance of the findings from one report to another.

Opinion

If less experienced, always check with senior colleagues before the report is finalised as this is a legal document. It is important that you are as accurate as possible and neither too hesitant nor too dogmatic.

Police Statements

In some cases of child abuse or neglect the Police will require a report in the form of a witness statement. The Police prefer this type of report which is more appropriate for criminal cases. This may need to be done on special witness statement paper obtainable from the Police. Some Police Forces accept a word processed version provided that the wording conforms to that on official statement forms.

Self Audit

If what is said or found later triggers legal action, every word in the case notes is likely to be subjected to legal scrutiny. Even minor flaws are sometimes used to try and undermine subsequent medical testimony, so it is wise to subject the paper record to critical self-audit. Submitting a few case records to others for scrutiny and constructive criticism on a regular basis can also be a useful discipline and it is comprehensive and unambiguous.

Report Writing: Guidance for Nursing and Allied Health Professional Staff

Staff working within NHS Fife may be required to write a report when Child Protection concerns have been raised. The following guidance should be followed in all such cases.

You should prepare a draft report and discuss this with the link/liaison worker for child protection in your area of work, or a member of the NHS Fife Child Protection Team, prior to final submission.

Remember the following key points:

To write a successful report you must be very clear about its purpose and the kind of information that is required. You must ask yourself a number of questions:

- why are you writing the report?
- who will read the report?
- when is the report needed?
- what are the facts?
- what are my recommendations for meeting the health needs of the child/family?
- what guidance do I have available?
- only include information relevant to your profession's role and responsibility to the child[ren]/family. This may mean some sections are not completed and should be marked not applicable.

Writing the report:

Reports must be factual, that is based on what was said, what was heard, what was observed and what was done. The report should contain accounts of events in chronological order – a good chronology can have significant impact. **Always be aware that your report is a legal document and should not contain abbreviations, first names and common usage terms e.g. mum or dad.** You may also be cited to appear in court and are answerable for the information and contents of your report. Involvement in civil court proceedings is not advised, unless you have child protection concerns.

The contents of your report should be shared with the family in question; however, very occasionally, you may be in receipt of information which is restricted and not relevant to share with the family but is crucial to the professionals attending the Case Conference/ Hearing. This should be documented separately and discussed with the Chair of the Panel/ Reviewing Officer beforehand.

The family name, reason for report and date should be inserted at the top of each page and pages should be numbered.

It may also help you to consider the following:

- what was the result of your recent assessment of the family?
- what are the health needs of the individuals in the family?
- what were your main concerns?
- have key events/incidents been written up in detail?
- ensure your assessment is within your professional limits.

Report writing template – Appendix 8.

Court Proceedings – Giving Evidence

Although this section is primarily aimed at medical staff, non-medical staff may also be called to give evidence in court; the 'rules' are the same.

If you diagnose abuse or neglect you may be required to give evidence in Court. Legal proceedings are divided into Family [Civil] and Criminal cases.

Family/Civil Court

- Proceedings to protect the child from harm – a range of powers are available to the Court to safeguard and promote the child's welfare.
- Heard by the Children's Reporter [in Scotland] or by a Judge or Magistrate [in England and Wales].
- Hearsay evidence is allowed. This is different from a criminal proceeding [see below] where the main implication of this rule is that witnesses must give oral evidence in court from first-hand knowledge only and may not repeat what other people have told them.
- Burden of proof – unlike a criminal proceeding where there must be a greater burden of proof, the family/civil court employs a "balance of probability". In the case of more serious allegations, the stronger the evidence needs to be.

Criminal Court

- Proceedings to prosecute an alleged offender.
- The case is brought by the Crown Office or Procurator Fiscal Service [in Scotland] and by the Crown Prosecution Services or CPS [in England and Wales].
- Hearsay evidence is **not** allowed.
- Usually heard by Judge and Jury.
- Burden of proof is greater – "beyond reasonable doubt".

Role of the Doctor

A doctor may be called as:

- witness to the fact;
- professional witness;
- expert witness.

The treating doctor will be expected to give a factual account of the history of any examination findings. Paediatricians should only give an opinion appropriate to their training, experience and specialist knowledge. Other parties or the Court may engage other expert witnesses who will have been asked to perform specific functions and to write an expert report and gather appropriate evidence based on the published literature.

Appearing in Court

Giving evidence can be stressful and doctors may need support from colleagues including designated/named professionals/lead clinicians. The adversarial system of justice in this country encourages vigorous cross-examination of testimony but the doctor is best protected if adequately prepared.

Courses on Court skills are available.

Giving evidence is never easy and requires practice and an expectation of frustration that you may not always feel you have had a fair hearing. Nevertheless, what a doctor says is important information and you are there to inform and sometimes educate.

You are there to assist the Court. You are not there to be the advocate for the child or the adult.

Guidelines for Attending Court

You must attend if asked – being a doctor does not grant you immunity from attending. Witness summonses are not usually served on doctors but if you receive one you must attend or you will be under threat of contempt [carries a prison sentence]. Witnesses must be treated reasonably in court. You may complain if you feel you have been treated badly.

Schedule with the Court – in care proceedings, the solicitor acting for the local authority should contact you for convenient dates and times. Agree in writing and ask for written confirmation of when and where. In criminal proceedings reasonable notice should be given and if you cannot attend for a good reason, contact whoever has summoned you and explain your difficulty. A more convenient time should be arranged. Ask for written confirmation. It is better to communicate early if you have or anticipate any difficulties in attending court so that the timing or date of your attendance can be altered to suit all parties.

Pre-court conferences between doctors and experts or with solicitors or barristers are intended to reduce court time and resolve as many issues as possible beforehand. Attend if possible. Your comments will be used in evidence after you have agreed and signed a written record of the meeting.

Attend on time, take copies of reports/notes as required, look presentable and prepare the case in advance, anticipating any difficult questions, checking details and references.

Stick to your knowledge and expertise area and avoid straying into other areas or speculation.

Be willing to admit that you do not know the answer to a question.

Answer the questions but also say what you feel the Court needs to know. In care proceedings, there is much more freedom to talk generally about the child and to give hearsay evidence not allowed in criminal proceedings.

Photographs of bruises, burns etc., may be used [give notice] but avoid showing genital and anal images unless ordered to do so by the Court. The Courts can obtain notes by an order of the Judge, but they are not yours to show or hand over to a solicitor who asks you for them.

Avoid appearing dogmatic in your evidence – a fair and balanced witness impresses the Court most.

Your testimony should be the same in substance, whether you are testifying at the request of the prosecution or the defence.

At the end of your evidence the Court should release you to return to your duties. In care proceedings, a formal judgement with reasons has to be made by the judge or magistrate and you should receive feedback on the case. This is not available in the same way in criminal proceedings.

Type of Witness in Courts

As a witness your role is a straightforward one – **to provide impartial evidence to help the court reach its decision**. You are not on anyone's side; you should be honest and independent. This applies to all kinds of witnesses – lay, professional or expert – but in other respects there are some important differences:

A **lay witness** simply tells the court something that they saw or claim to know about a case; they are a witness to a fact. If you appear as a lay witness you will do so in your capacity as a citizen, not because you are a doctor.

A **professional witness** tells the court factual matters about their patient. For example, where and when the patient was examined, the history that was obtained, the findings on examination, the diagnosis that was made and what treatment was given. If you appear as a professional witness you should be careful not to provide expert opinion outside your own expertise. For example, if as a GP Registrar, you were asked for an opinion as to the likely long term effects of significant neurological injuries suffered in a road traffic accident, you should decline unless you have an authoritative opinion.

An **expert witness** is usually a Consultant or an established General Practitioner with specialist knowledge and experience. Such a witness will give their opinion on the medical facts based on their own experience and reference to the literature. The opinion may relate to a patient that the doctor has never seen. For example, a Pathologist may describe an autopsy he or she has carried out and then express an opinion based on the facts from the autopsy; a Surgeon may describe his or her examination of a disabled patient and give a detailed prognosis about future recovery.

The distinction between a professional and an expert witness may sometimes be blurred but it is an important one. The golden rule is only comment on matters that lie within your own expertise. If in the future you would like to work as an expert witness, it can be an interesting experience, then you should investigate the role in more depth and perhaps consider some training. The procedural rules for an expert witness are more demanding than for a professional witness, with stricter guidelines on the format, content and timetable for producing reports.

Golden Rules for Court

- 1. Listen carefully to the question you are asked.**
When a witness fails to answer the question he/she is asked, this can give the unfortunate impression that the professional is trying to avoid the question simply because he/she has something to hide. This usually results in the question being asked again, which simply prolongs the professional's time in the witness box.
- 2. Speak clearly and slowly.**
Although this appears self-evident, some professionals find it a little disconcerting to be told, sometimes repeatedly, by a Sheriff to speak up or slow down.
- 3. Answers should be brief.**
If the answer to a question is "yes" or "no", that is quite sufficient. If the lawyer asking the questions wants further information, he/she will ask.
- 4. If you do not know the answer, say so.**
The same rule applies if you cannot remember what occurred. It will not help, at all, if the professional volunteers a version of events, which is not supported by any clinical notes and which bears no resemblance to the evidence of the relatives, which the Court will have heard first. A Sheriff will appreciate that if you have seen a patient for only ten minutes, some eighteen months previously; it is unlikely that you will remember the examination in minute detail. For this reason it cannot be emphasised too strongly that **it is essential at all times** to make notes of an examination, even if these are very brief.
- 5. If case notes about the matter are available these will be produced in Court.**
It is perfectly proper to refer to these to refresh the memory when giving evidence and all professionals should do so. What is not permitted is for professionals to produce their own notes, which were made subsequent to the event. If a witness wishes to produce personal notes, then this should be discussed with the solicitor or the Clerk to the Sheriff Court and the Sheriff's consent must be obtained before the court case starts.

Note 1: please refer to Reference numbers 4, 5, 6 and 13 on page 28.

Note 2: references numbers 4, 5 and 6 can be downloaded free of charge from the Medical Protection Society website.

Files for Families on Support – Public Health Nursing & Allied Health Professionals

These are opened and maintained for:

- families where there are children who are the subject of ongoing legal proceedings, whether to the Reporter/Case Conference/Children's Panel Hearing

or

- families where there are Child Protection concerns but as yet the child/children are not in the Child Protection system.

A family on support file [Appendix 4 – Initial] is opened and a copy must be sent to the relevant CHP Child Protection Link Worker. The original copy must be filed in Section C [Green Card] of the Family Health Record. There will be a review at six monthly intervals [Appendix 5 – Review] for all families unless circumstances change and a more urgent review is needed. Health Plan Indicators [HPI] must be reviewed, recorded in the child's notes and reported to the Child Health Department.

To aid early identification of families on Support / Review files, a list must be kept for emergency situations, for example, sick leave of case holder, in an accessible location. The Link Worker and Lead Nurse / Service Manager must be informed of the location of the list.

Transfer of Records where there are Child Protection Concerns for Staff Working within Community Health Partnerships: Nursing and Allied Health Professionals

1. Internal Transfers

If a child or young person is moving to another area in Fife and child protection concerns have been identified you should:

- contact the relevant professional to inform them of the move into their area;
- arrange to either meet with the professional and conduct a person to person hand over of records, or;
- inform the professional of your concerns and forward the records to them via internal mail system. Records transferred in this way **must** be sent in double packaging with the addressee's name and base, with the package clearly marked private and confidential;
- contact your CHP Child Protection Link Worker who will send the relevant Family Support File to his/her CHP counterpart;
- complete the Internal Transfer Out Form and send with the records [Appendix 2];
- contact the key worker in social work [if applicable] to notify them of the change;
- inform Child Health Records Department;
- inform relevant member of the NHS Fife Child Protection Team if there has been active involvement.

2. External Transfers

If a child or young person is moving outwith Fife and child protection concerns have been identified you should:

- contact the Lead Nurse Child Protection for NHS Fife who will take responsibility for the transfer of records to the Lead Nurse Child Protection in the area to which the child or your person is moving;
- transfer the records to the Lead Nurse in Fife as per the guidelines for internal transfers;
- the Lead Nurse in Fife will make contact with the Lead Nurse Child Protection in the area where the records are being transferred to;
- the Lead Nurse will complete a LNCP Transfer Out Form [Appendix 3] and the records will be sent by Recorded Delivery;
- a record of the transfer out will be kept by the Lead Nurse in Fife.

3. What to do with Records when no Forwarding Address is known

In the event of a child or young person moving area where there are child protection concerns and no forwarding address you should:

- make contact with other known professionals who may have information relating to the whereabouts of the family. **Document who you speak to in the child's notes;**
- retain the records until such time as the child or young person is located;
- inform Child Health Records of your intentions;
- inform the Lead Nurse Child Protection for NHS Fife who will initiate the Missing Family Alert Policy following discussion with the relevant health professional and Caldicott Guardian.

4. What to do with Pre-Adoptive Records

If the child is under consideration for adoption, Section 1 – Internal Transfer or Section 2 – External Transfer are applicable.

One further important consideration is that information relevant to the adoption may include details of people other than the child. In cases involving the transfer of pre-adoptive records:

- where disclosure of a child's information reveals information about other individuals, consent should normally be obtained for those individuals;
- where it is not practicable to seek consent, or the individual is not competent to give consent, or it is considered that disclosure without consent would be justified in the public interest from a risk so serious that it outweighs an individual's right to privacy, it is important to document this decision;
- in cases where there is doubt as to the correct course of action to take, consult with or seek advice from NHS Fife Caldicott Guardian, Data Protection Coordinator or Legal Services Manager.

Transfer of Records where there are Child Protection Concerns between Public Health Nurse/Health Visitor and School Nursing Service

1. All aspects of the record must be completed including detail of health care programme and whether the child is looked after by local authority or on the Child Protection Register.
2. For children on core health programmes, records can be transferred with the accompanying handover record.
3. For children on additional or intensive health programmes [including children on the Child Protection Register] the handover record must be completed and a face to face handover take place between the Public Health Nurse/Health Visitor and the School Nurse attached to the child's school. If the School Nurse is not available, handover can be made to the Public Health Nurse [Young People] who leads the team.
4. In the interest of the child/children, the Public Health Nurse/Health Visitor may continue involvement with the child/family, also working collaboratively with the School Health Service.
5. Forms must be signed and dated by both practitioners.
6. This process should be audited annually by the Public Health Nurse [Young People] and any variation to the guidance highlighted to the Lead Nurse for appropriate action.

National and Local References

1. Fife Child Protection Committee [2006] *Child Protection Interagency Guidelines*, Fife Partnership
2. Fife Child Protection Committee [2009] Significant Case Review
3. Joint Paediatric Forensic Medical Examination Template [NHS Fife Intranet]
4. Medical Protection Society [2002] Writing Reports and Giving Evidence in Court; A Complete Guide for Consultants. Available online at:
http://www.medicalprotection.org/assets/pdf/booklets/reports_consultants_complete.pdf
5. Medical Protection Society [2002] Writing Reports and Giving Evidence in Court; A Complete Guide for GPs. . Available online at:
http://www.medicalprotection.org/assets/pdf/booklets/reports_gps_complete.pdf
6. Medical Protection Society [2002] Writing Reports and Giving Evidence in Court; A Complete Guide for Juniors. Available online at:
http://www.medicalprotection.org/assets/pdf/booklets/reports_juniors_complete.pdf
7. NHS Fife Access to Child Protection Register Protocol [2008]
8. NHS Fife Child Protection Messaging Protocol [2008]
9. NHS Fife Missing Family Alert Policy [2007]
10. NHS Fife Risk Assessment Tool [2009]
11. NHS Fife Unborn Child Policy [2008]
12. Norrie, K McK (1995) *Children (Scotland) Act*
13. Royal College of Paediatrics and Child Health (2006) *Child Protection Companion, Royal College of Paediatrics and Child Health*
14. Scottish Executive (2002) *“It’s everyone’s job to make sure I’m alright”*
15. Scottish Executive (2004) *Protecting Children & Young People, Framework for Standards*
16. Scottish Executive (2007) *Getting it Right for Every Child*

APPENDICES

- Appendix 1** Interagency Referral Discussion [IRD] Protocol
 - Appendix 1.1 Information Sharing – All Staff
 - Appendix 1.2 Information Sharing – All Manager
- Appendix 2** Form for the confidential notification of internal transfer out of a family where there are child protection concerns
- Appendix 3** Form for external transfer out of child/children where there are child protection concerns
- Appendix 4** Form for families on support – initial documentation
- Appendix 5** Form for families on support – review documentation
- Appendix 6** Frequent attendees at A&E and paediatric alert form – NHS Fife Operating Division
- Appendix 7** Child Protection Order – Good Practice Protocol
- Appendix 8** NHS Fife Child Protection Report Writing Template
- Appendix 9** Child Concern Form
- Appendix 10** NHS Fife Child Concern/Welfare Pathway (& associated Risk Assessment Tool)
- Appendix 11** Useful Contacts



Fife Child Protection Committee

PROTOCOL



INTER – AGENCY REFERRAL DISCUSSION (IRD)

PROTOCOL BETWEEN

FIFE COUNCIL SOCIAL WORK SERVICE

FIFE CONSTABULARY

NHS FIFE

Guardian(s):	CPC Lead Officer
Author(s):	CPC Lead Officer
Version number:	1.0
Approved by CPC Chair	1 st July 2009
Effective from:	1 st July 2009
Due for review on:	1 st July 2010
Suitable for Publication Scheme:	Yes
ECHR compliant:	Yes
Diversity compliant:	Yes
Data Protection compliant:	Yes
FOI compliant:	Yes
Health & Safety compliant:	Yes
GPMS compliant:	Yes

Contents

1. Introduction
2. Core Agency Participants
3. Inter – Agency Referral Discussion (IRD) Process
4. Conclusion
5. Signatories
6. Appendices

1. Introduction

1.1 Throughout Fife, practitioners in all public, private and voluntary sector services and agencies must know what to do if they are worried about a child. They must understand their own service and/or agency child protection procedures, who to contact if they are worried about a child and how to make a referral to the social work service and/or the police.

1.2 Practitioners working with children must share information when a child is at risk from harm, abuse or neglect. Further Information Sharing Advice and Guidance can found at www.fifechildprotection.org.uk under Local Publications.

1.3 This protocol will set out the agreed inter – agency procedures to be followed immediately after a referral has been made to the social work service and/or the police.

1.4 Practitioners who are worried about a child, who suspects a child has suffered, is suffering, is at risk of harm or abuse, or is in need of care and protection, should raise their concerns through their established referral system to social work service and/or the police in keeping with the Fife Child Protection Committee Inter-Agency Child Protection Guidelines. The Initial Referral Discussion document is not a multi agency referral form although some agencies/services may wish to utilise it for this purpose in line with their own single agency procedures.

1.5 When a referral is made to the social work service and/or the police and it is suspected a child has suffered, is suffering, is at risk of harm or abuse, or is in need of care and protection, then the receiving service/agency (social work service or the police) will immediately initiate an Inter – Agency Referral Discussion (IRD) between the three Core Agencies.

2. Core Agency Participants

2.1 In Fife the three Core Agencies are Fife Council Social Work Service, Fife Constabulary and NHS Fife (Greenfield Clinic). Single Points of Contact for the three Core Agencies can be found at Appendix B.

2.2 Fife Child Protection Committee will monitor these arrangements in terms of the Fife Child Protection Committee Inter-Agency Child Protection Guidelines. The IRD will feature in these inter-agency guidelines and will be included in the relevant inter-agency child protection training, delivered via Fife Child Protection Committee.

2.3 Underpinning this IRD protocol there is a strong evidence-based national and local policy context which can be found at Appendix C.

3. Inter – Agency Referral Discussion (IRD) Process

3.1 Initiating an IRD

3.1.1 On receipt of a referral, the social work service or the police will immediately initiate an Inter – Agency Referral Discussion (IRD) where it is suspected a child has suffered, is suffering, is at risk of harm or abuse, or is in need of care and protection. All three Core Agencies (Social Work, Police and Health – Greenfield Clinic) will participate in the IRD process. All referrals will be supported in writing.

3.1.2 The IRD is the first stage in the process of joint investigation following a referral to the social work service or the police. It will include a need to share and exchange information, to carry out assessment and to make decisions to determine any risks to the child, any siblings of that child and any other child related to the child in question. It will also identify key workers and their specific roles and responsibilities.

3.2 IRD Discussions

3.2.1 In practice, an IRD is not a single event, but rather a series of discussions between the three Core Agencies and any other service and/or agency which may be involved with the child and/or have relevant information relating to that child.

3.2.2 An IRD is normally a virtual/electronic sharing and exchange of information, but can, on occasion, be a face-to-face discussion in more complex cases. It can include information from e-mail and fax.

3.3 Information Sharing

3.3.1 Whilst the principles of Information Sharing will be observed, the three Core Agencies will share, with each other, all of the information that is available to it, that may be relevant to assessment, including the assessment of risk and planning of further investigations. This will include information on the child who is the subject of the referral, siblings of that child, other children connected to that child and any key and/or significant adults who are involved and/or associated with the child in question. They will also seek information from and any other service and/or agency which may be involved with the child and/or have relevant information relating to that child.

3.3.2 In the event of uncertainty whether information held is relevant, it will be shared in the IRD, which will in turn agree what information is relevant. If in doubt the information will be shared.

3.3.3 There is an expectation on the part of the three Core Agencies that each Agency will thoroughly research their own information and recording systems, including all electronic databases and paper systems to enable effective decision making to take place.

3.3.4 When sharing information, each Core Agency will also share with each other any information which indicates any potential risk to practitioners.

3.3.5 In normal circumstances, it will be desirable to have complete information upon which to base joint decisions, but there may be occasions when the Core Agencies need to make decisions in the absence of complete information and only on the information available to them at the time in question.

3.4 IRD Decision Making

3.4.1 In normal circumstances, an IRD will take place before any joint investigation proceeds. Joint Investigations will not be delayed simply because an IRD cannot take place immediately between all three Core Agencies. IRD's are dynamic and ongoing processes.

3.4.2 An IRD will consider and make decisions on a number of issues including:-

- Any Immediate Legal Measures – Child Protection Order, Assessment Order, Exclusion Order etc;
- Agreeing explicit timescales, sequence of actions, roles, responsibilities etc;
- Securing additional Information and who is responsible for doing so;
- Joint Investigative Interview planning and preparation;
- Joint Paediatric and Forensic Medical Examination planning and preparation (including liaison with the Procurator Fiscal);
- Provision of further support for the child during and after the investigation;
- Risk to any other siblings and/or children connected to the child in question;
- Consent from parents/carers (if necessary) and who and how to obtain this;
- Feedback to parents, carers, the referrer and the child where appropriate;
- Reporting and any Referral to the Children’s Reporter;

3.5 Feedback

3.5.1 Throughout the IRD process, feedback will be provided to the person and/or the service/agency that made the referral in the first place. The person making the referral is also encouraged to seek feedback for themselves. Those providing feedback will ensure that it is recorded in case files.

4. Conclusion

4.1 This protocol sets out the agreed Inter – Agency Referral Discussion procedures to be followed immediately after a referral has been made to the social work service and/or the police.

4.2 The IRD is a key part of the child protection process and there is a responsibility on those taking part in the IRD to fully participate and understand their role, responsibility and contribution.

4.3 It needs to be considered in conjunction with the attached Appendices. A single page Flowchart has been included at Appendix A for quick guidance.

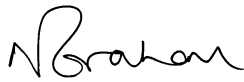
5. Signatories



Signed Roseanne Fearon, for Chief Social Work Officer

On behalf of Fife Social Work Service

Date 22 June 2009



Signed Norma Graham. Chief Constable

On behalf of Fife Constabulary

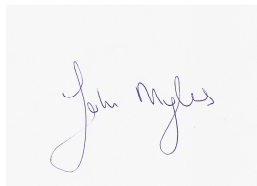
Date 22 June 2009



Signed Chief Executive, NHS Fife

On behalf of NHS Fife

Date 22 June 2009



Signed John Myles, Independent Chair

On behalf of Fife Child Protection Committee

Date 22 June 2009

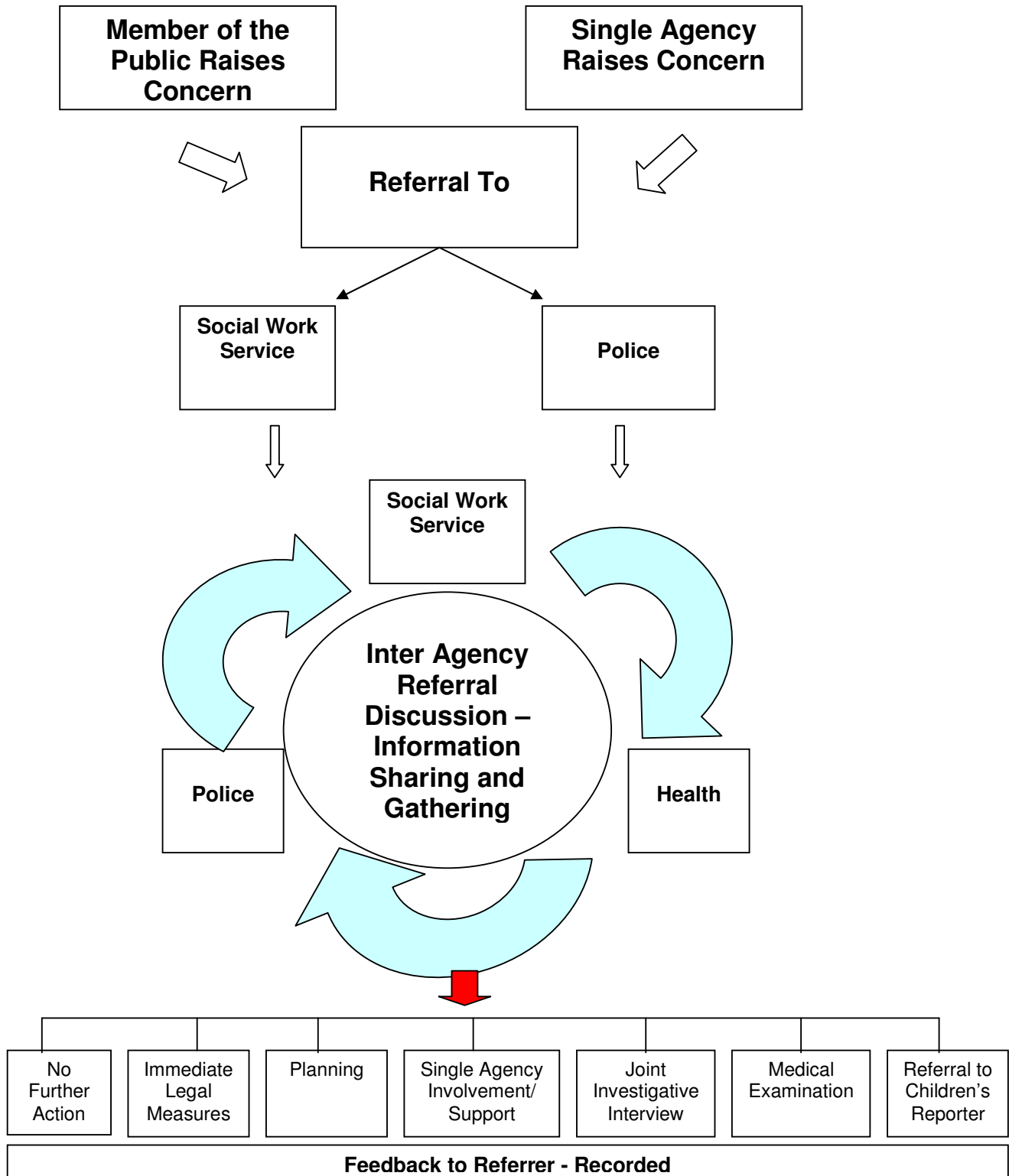
6. Appendices

Appendix A – IRD Practitioners Flowchart

Appendix B – Core Agency Points of Contact

Appendix C – Legal and Other References

Inter – Agency Referral Discussion – Practitioners Flow Chart



Core Agency Points of Contact

The Core Agency points of contact for the IRD process are:-

Social Work Service Offices

Cowdenbeath 01383 602201

Cupar 01334 659322

Dunfermline 01383 609111

Glenrothes 01592 583321

Kirkcaldy 01592 583322

Leven 01334 659323

Rosyth 01383 602203

Social Work Service (Out of Hours) Emergency Number 08451 550099

Fife Constabulary

Fife Constabulary Family Protection Unit 01383 312910

Fife Constabulary Control Room (Out of Hours) Emergency Number 0845 600 5702

NHS Fife

On Call Paediatrician via Greenfield Clinic – 01592 648114

Consultant Paediatrician Victoria Hospital

(On Call – Out of Hours) – 01592 643355

Legal and Other References (Policy and Legislative Context)

All children and young people have the right to be cared for and protected from harm and to grow up in a safe environment in which their rights and needs are respected. Children and young people should get the help they need when they need it and their welfare is always paramount.

Here in Fife we support the ethos that **“child protection is everyone’s job and everyone’s responsibility”**. We consider this to be a shared responsibility for all practitioners and managers across the public, private and voluntary sectors.

Underpinning this IRD protocol there is a strong evidence based national and local policy context.

By way of summary, the following are considered to be the most significant policy developments which Fife Child Protection Committee, Fife Council Social Work Service, Fife Education Service, Fife Constabulary and NHS Fife fully supports and endorses:-

- Scottish Office Circular SWSG 14/97 Child Protection: Local Liaison Machinery – Child Protection Committees;
- Protecting Children – A Shared Responsibility: Guidance on Inter-Agency Co-operation (Scottish Office 1998);
- Scottish Executive’s Audit and Review Report (2002) entitled *“It’s everyone’s job to make sure I’m alright”*;
- Scottish Executive Child Protection Reform Programme 2003 – 2006;
- Protecting Children and Young People: The Charter;
- Protecting Children and Young People: Framework for Standards;
- Protecting Children and Young People: Child Protection Committees;
- HMle Services for Children Unit: Self Evaluation and Quality Indicators Framework: *“How well are children and young people protected and their needs met?”*
- Getting it Right (For Every Child) Policy Initiative;
- Fife Child Protection Committee Inter – Agency Child Protection Guidelines;
- Fife Child Protection Committee Information Sharing Guidance Leaflet for all Practitioners and Managers;
- General Medical Council; Confidentiality; Protecting and Providing Information (April2004);
- Child Protection Companion; It is every Paediatrician’s responsibility to assess a child with suspected intentional harm (April2006);

It is also agreed that the contents of this IRD protocol comply with the following legislative framework, albeit this is not an all inclusive and/or exhaustive list:-

- The Age of Legal Capacity (Scotland) Act 1991
- The Children (Scotland) Act 1995
- The Human Rights Act 1998;
- The Social Work (Scotland) Act 1968;
- The National Health Service (Scotland) Act 1978;
- The Education (Scotland) Act 1980;
- The Education (Additional Support for Learning) (Scotland) Act 2004;
- The Race Relations Act 1976;
- The Race Relations (Amendment) Act 2000;
- The Sex Discrimination Acts 1975 and 1986;
- The Disability Discrimination Acts 1995 and 2005;
- The Equality Act 2006;
- The Data Protection Act 1998;
- The Freedom of Information (Scotland) Act 2002; and
- The Health and Safety at Work etc Act 1974.

Further child protection information and advice can be found at www.fifechildprotection.org.uk



Dear Colleague,

INFORMATION SHARING – ALL STAFF

Children, young people and vulnerable adults have the right to care and protection. Their welfare is paramount. All staff across the statutory, public, non statutory, private and voluntary sectors are responsible for ensuring that children, young people and vulnerable adults get the help they need when they need it.

We all appreciate the commitment and hard work which everyone involved puts in on a daily basis and we want to build on the good practice demonstrated here in Fife. We are also well aware that this is challenging work in often difficult circumstances and that, by working together, we can, and do, make a difference to the lives of vulnerable people of all ages.

The protection of children, young people and vulnerable adults in its widest context, is ***“everyone’s responsibility and everyone’s job”*** and cuts across all aspects of private life and professional business. We all have a duty, individually and collectively, to protect all vulnerable people in our communities and in our society.

On many occasions, this will require staff to seek and exchange personal information about individuals. We are however aware that questions of confidentiality can and sometimes do get in the way of ensuring the safety of children, young people and vulnerable adults. We would like to try to clarify the position and reinforce the importance of sharing and exchanging information where the care, welfare and safety of these client groups are concerned.

Children, young people and vulnerable adults have a right to privacy and the utmost care should be taken when handling information on their personal circumstances. We endorse the need for a sensitive and an ethical approach when working in partnership with children, young people and vulnerable adults, together with their families and carers.

Where we have a concern about a child, young person or vulnerable adult or we are made aware of such a concern we all have a responsibility to share and exchange relevant information with other professionals. We should do so timeously, with confidence and adhere to our own agency/service procedures when doing so.

Recent inquiry reports have highlighted many misconceptions about confidentiality and we would simply remind you that existing legislation does not prevent you from sharing and/or exchanging information where there are clear concerns about the care, safety and welfare of children, young people and vulnerable adults. This requirement also extends to all professionals working with adults where there may be substance misuse, mental health or domestic abuse issues. They must be particularly alert to the needs of any dependant children.

We would draw your attention to the Scottish document *Sharing Information About Children at Risk: A Guide to Good Practice (2003)* which states:-

"If there is reasonable concern that a child may be at risk of harm this will always override a professional or agency requirement to keep information confidential. All professionals and service providers have a responsibility to act to make sure that a child whose safety or welfare may be at risk is protected from harm."

We would also endorse the Scottish Executive's *Protecting Children and Young People: The Children's Charter* and *Protecting Children and Young People: Framework for Standards (2003)* which also provide you with good practice advice on this and wider protection matters.

You should adhere to these principles at all times in your work and practice here in Fife. We hope this will go some way to assist you in being confident and competent in the sharing and exchanging of information.

In doing so, you will add to the care and protection of children, young people and vulnerable adults in Fife and improve the quality of life for the most vulnerable in our community.

Should you require any further information we would encourage you to speak directly with your supervisors and managers.



Ronnie Hinds
Chief Executive
Fife Council



Peter Wilson
Chief Constable
Fife Constabulary



George Brechin
Chief Executive
NHS Fife



Dear Colleague

INFORMATION SHARING – ALL MANAGERS

Last year, Fife Child Protection Committee launched its revised Inter Agency Child Protection Guidelines. These have been widely distributed along with the Scottish Executive's *Protecting Children and Young People: The Children's Charter* and *Protecting Children and Young People: Framework for Standards*. Fife's Multi-Agency Vulnerable Adult Protection Procedures were circulated following revision in July 2006.

We would take this opportunity to remind you that all our staff, across the statutory, public, non-statutory, private and voluntary agencies should be familiar with these publications, should have read them and adopted them into their daily practice here in Fife.

We all appreciate the commitment and hard work that our colleagues put in on a daily basis and we want to build on the good practice demonstrated here in Fife. We are also well aware that this is challenging work in often difficult circumstances and that, by working together, we can, and do, make a difference to the lives of vulnerable people of all ages.

Children, young people and vulnerable adults have the right to care and protection. Their welfare is paramount. All our staff are responsible for ensuring that children, young people and vulnerable adults get the help they need when they need it.

The protection of children, young people and vulnerable adults, in its widest context, is **"everyone's responsibility and everyone's job"** and cuts across all aspects of private life and professional business. We all have a duty, individually and collectively, to protect all vulnerable people in our communities and in our society.

On many occasions, this will require staff to seek and exchange personal information about individuals. We are however aware that questions of confidentiality can and sometimes do get in the way of ensuring the safety of children, young people and vulnerable adults. We would like to try to clarify the position and reinforce the importance of sharing and exchanging information where the care, welfare and safety of these client groups are concerned.

Children, young people and vulnerable adults have a right to privacy and the utmost care should be taken when handling information on their personal circumstances. We endorse the need for a sensitive and an ethical approach when working in partnership with children, young people and vulnerable adults, together with their families and carers.

Where your staff have a concern about a child, young person or vulnerable adult or they are made aware of such a concern they have a responsibility to share and exchange relevant information they may have with other professionals. They should ensure that they understand that responsibility and that they do so timeously, with confidence and adhere to their own agency/service procedures when doing so.

Recent inquiry reports have highlighted many misconceptions about confidentiality and we would simply remind you that existing legislation does not prevent you or your staff from sharing and/or exchanging information where there are clear concerns about the care, safety and welfare of children, young people and vulnerable adults. This requirement also extends to all professionals working with adults where there may be substance misuse, mental health or domestic abuse issues. Staff must be particularly alert to the needs of any dependant children.

We would draw your attention to the Scottish Executive's document *Sharing Information About Children at Risk: A Guide to Good Practice (2003)* which states:-

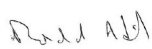
"If there is reasonable concern that a child may be at risk of harm this will always override a professional or agency requirement to keep information confidential. All professionals and service providers have a responsibility to act to make sure that a child whose safety or welfare may be at risk is protected from harm."

We would also endorse the Scottish Executive's *Protecting Children and Young People: The Children's Charter* and *Protecting Children and Young People: Framework for Standards (2003)* which also provide good practice advice on this and wider child protection matters.

Our staff should adhere to these principles at all times in their work and practice here in Fife. We hope this will go some way to assist in being confident and competent in the sharing and exchanging of information.

In doing so, you and your staff will add to the care and protection of children, young people and vulnerable adults in Fife and improve the quality of life for the most vulnerable in our community.

Should you require any further information we would encourage you to speak directly with your senior managers.



Ronnie Hinds
Chief Executive
Fife Council



Peter Wilson
Chief Constable
Fife Constabulary



George Brechin
Chief Executive
NHS Fife



Community Health Partnership

CONFIDENTIAL NOTIFICATION OF INTERNAL TRANSFER OF A FAMILY WHERE THERE ARE CHILD PROTECION CONCERNS

Child Protection Register: Yes / No

If Yes Category: _____

COMPOSITION OF FAMILY

Surname	_____	Date of Birth	_____
Mother	_____		_____
Father	_____		_____
Children	_____		_____
	_____		_____
	_____		_____

Present Address: _____

Moving to: _____

GP Practice: _____ HV: _____

CONCERNS:

Name [Please print]: _____
Designation: _____
Base: _____
Records to LNCP Date [if applicable] _____

**Please inform the CHP Child Protection Link Worker of the transfer out.
Please inform Child Health Records Department.**



Community Health Partnership

TRANSFER OUT OF CHILD/CHILDREN WHERE THERE ARE CHILD PROTECTION CONCERNS

Date: _____

I have been informed that the following child/children are now residing in your area. I am therefore transferring the relevant records to you.

Name	DOB	Relationship

Former Address: _____

New Address: _____

Previous Health Visitor: _____
Previous HV Base: _____

PLEASE RETURN.....

Records received for:

Child Health Record		
Family File		

Signed: _____ **Date:** _____

Please return to: Barbara Rowland, Lead Nurse Child Protection, Greenfield Clinic, Willow Dr, Kirkcaldy, KY1 2LF

GUIDANCE FOR OPENING & COMPLETING A FAMILY SUPPORT FILE

CHILD / FAMILIES ON SUPPORT / INITIAL

Nursing for Health in 2001 recommended family health planning be undertaken between families and Public Health Nurses. This process offers the opportunity to identify with families their needs and ensure that additional or intensive support is provided where necessary.

- The majority of the assessment process will be concentrated within the first eight weeks of life with periodic contact and review ongoing thereafter.
- Detail of the decisions made about the assessed level of need and also the agreed response are to be recorded in the family health record and also in the Parent Held Child Health Record.

Universal Core Programme:

- This programme is offered to all families who have children
- Once families have been seen for initial assessment the emphasis will be on the family accessing services.
- Through contact with the family, at any point, it may be necessary to place the family on the Additional Support Programme for a period of structured intervention or, if circumstances change and more complex issues arise, they may require an Intensive Support Programme.

Additional Support Programme:

- This is where more structured support is required for a specific reason, usually over a short period of time. This programme is suitable for episodes of care, which are time limited e.g.
 - ❖ Breastfeeding problems
 - ❖ Specific behavioural problems e.g. sleep difficulties
 - ❖ Support families with children with exacerbation of chronic health problems e.g. asthma, diabetes, eczema.

Intensive Support Programme:

This is where families have more intensive need and a more structured intervention is required. The intervention is likely to be multi agency and the families will probably have more complex enduring problems, for example

- Child is on the child protection register and a child protection plan is in place
- Midwife/public health nurse has concerns relating to child protection issues and is working with other agencies to protect the child
- Main carer has mental health problems and requires intensive support.
- Carer has a drug and/or alcohol problem and requires intensive support
- Supporting a family where there are significant health needs e.g. physical, mental or learning difficulties

The Child Protection Link Worker (CPLW) is available to all NHS staff for support and Guidance on when to open a support file. When a file is opened a copy must be sent to the relevant CPLW. The original copy must be filed in Section C [Green Card] of the Family Health Record. There will be a review at six monthly intervals for all families unless circumstances change and a more urgent review is needed.

To aid early identification of families on Support / Review Files, a list must be kept for emergency situations, for example, sick leave of case holder, in an accessible location. This could be in the front of the Birth Book or kardex system. The Link Worker and Lead Nurse must be informed of the location of the list.

Please Note: Initiating a Support File should be based on identified cause for concern for a child using the NHS Five Risk Assessment Tool.

Subject to annual review: Review date August 2010

NHS FIFE CHILD PROTECTION SERVICE

STRICTLY CONFIDENTIAL

CHILD / FAMILY ON SUPPORT FILE / INITIAL

Date:		
Family Name:		
Address:		
GP Practice:		
Mother	D.O.B	
Father	D.O.B	
Adult with Parental Responsibility:		
LAC :		
Carers Name		
Home Supervision order Yes <input type="checkbox"/> No <input type="checkbox"/>	Accommodated Yes <input type="checkbox"/> No <input type="checkbox"/>	Kinship carer Yes <input type="checkbox"/> No <input type="checkbox"/>
L.A. Carers Yes <input type="checkbox"/> No <input type="checkbox"/>	Short term <input type="checkbox"/> Long term <input type="checkbox"/>	Section 25 <input type="checkbox"/> Section 70 <input type="checkbox"/>
		"Children Scotland Act" (1995)
Children:	D.O.B / CHI	Nursery / School Attended
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

What follows is a list of seven statements which collectively help to predict the likelihood of a child's overall experience of wellbeing. Which of these statements (all, none or a selected few) are you concerned may not be true for the above named child?

Safe	The child is protected from abuse, neglect or harm at home, at school and in the community.
Healthy	The child has the highest attainable standards of physical and mental health, access to suitable health care and support to make healthy and safe choices.
Achieving	The child is being supported and guided in their learning and in the development of their skills: confidence and self esteem at home, at school and in the community.
Nurtured	The child has a nurturing place to live, in a family setting with additional help of needed or, where this is not possible, in suitable care setting.
Active	The child has opportunities to take part in activities such as play, recreation and sport, which contribute to healthy growth and development at home and in the community.
Respected/ Responsible	The child is involved appropriately in decisions that affect them, has his/her voice heard and (where age appropriate) is encouraged to play an active and responsible role in his/her schools and communities.
Included	The child is receiving help to overcome social, educational, physical and economic inequalities and in being accepted as part of the community in which they live and learn.

Child / Children on Child Protection Register: Yes No

Date Placed on Register

Category placed on the Register:

Physical Abuse	Sexual Abuse	Neglect	Non-organic failure to thrive	Emotional Abuse
----------------	--------------	---------	-------------------------------	-----------------

Risk assessment Carried Out using NHS Fife Tool: - Yes No

Identified concerns:

Protective Factors:

Adverse Factors:

Agencies involved:

Report Submitted: Yes No

Case Conference: Yes No Hearing: Yes No Reporter: Yes No

Health Professional Plan:				
ACTION	AIM OF ACTION	PERSON RESPONSIBLE	TIMESCALE	OUTCOME

Proposed HPI: Core Additional Intensive

Note: Cross reference in Child Health Notes

Signature: _____ Designation: _____

Print Name: _____

Base: _____

Date of Next Review: _____

APPENDIX 5

NHS FIFE CHILD PROTECTION SERVICE

STRICTLY CONFIDENTIAL

CHILD / FAMILY ON SUPPORT FILE / REVIEW

Date:		
Family Name:		
Address:		
Change of address since last review Yes <input type="checkbox"/> No <input type="checkbox"/>		
GP Practice:		
Mother	D.O.B	
Father	D.O.B	
Adult with Parental Responsibility:		
LAC :		
Carers Name		
Home Supervision Order Yes <input type="checkbox"/> No <input type="checkbox"/>	Accommodated Yes <input type="checkbox"/> No <input type="checkbox"/>	Kinship carer Yes <input type="checkbox"/> No <input type="checkbox"/>
L.A. Carers Yes <input type="checkbox"/> No <input type="checkbox"/>	Short term <input type="checkbox"/> Long term <input type="checkbox"/>	Section 25 <input type="checkbox"/> Section 70 <input type="checkbox"/>
Children:	D.O.B / CHI	School
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

What follows is a list of seven statements which collectively help to predict the likelihood of a child's overall experience of wellbeing. Which of these statements (all, none or a selected few) are you concerned may not be true for the above named child?

Safe		The child is protected from abuse, neglect or harm at home, at school and in the community.
Healthy		The child has the highest attainable standards of physical and mental health, access to suitable health care and support to make healthy and safe choices.
Achieving		The child is being supported and guided in their learning and in the development of their skills: confidence and self esteem at home, at school and in the community.
Nurtured		The child has a nurturing place to live, in a family setting with additional help of needed or, where this is not possible, in suitable care setting.
Active		The child has opportunities to take part in activities such as play, recreation and sport, which contribute to healthy growth and development at home and in the community.
Respected/ Responsible		The child is involved appropriately in decisions that affect them, has his/her voice heard and (where age appropriate) is encouraged to play an active and responsible role in his/her schools and communities.
Included		The child is receiving help to overcome social, educational, physical and economic inequalities and in being accepted as part of the community in which they live and learn.

Child / Children on Child Protection Register: Yes No

Date Placed on Register:

Category placed on the Register:

Physical Abuse	Sexual Abuse	Neglect	Non-organic failure to thrive	Emotional Abuse
----------------	--------------	---------	-------------------------------	-----------------

Date of Registration:

Changes in registration status:

Date of Change:

Risk Assessment Carried Out using NHS Tool: - Yes No

Current Protective Factors:

Current Adverse Factors:

Changes in agencies involved:

Significant incidents since last review:

Achieved Health Professional Plan:

Updated Health Professional Plan:

ACTION	AIM OF ACTION	PERSON RESPONSIBLE	TIMESCALE	OUTCOME

Proposed HPI: Core Additional Intensive

Note: Cross reference in Child Health Notes

Signature: _____

Designation: _____

Print Name: _____

Base: _____

Date of Next Review: _____

NHS FIFE CHILD PROTECTION SERVICE

STRICTLY CONFIDENTIAL

FAMILY ON SUPPORT FILE - CLOSURE

Family Name: _____

Children name and CHI: 1)
2)
3).....
4).....
5).....

Address: _____

Signature: _____ **Designation:**

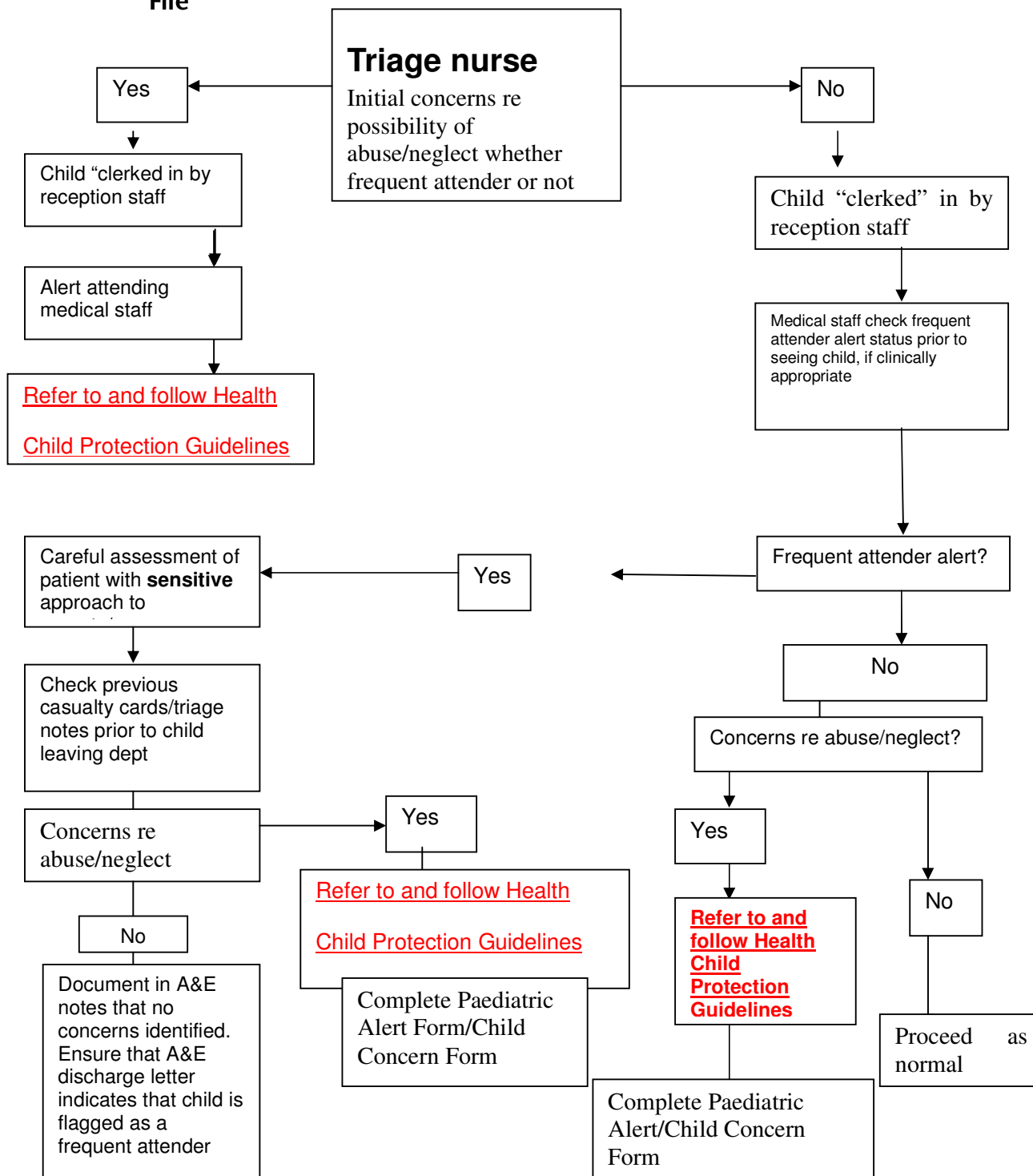
Print Name: _____ **Base:**

Date file closed: _____

To: **Child Protection Link Worker**
Fiona Ballantyne Dunfermline & West Fife CHP & Glenrothes & NEF CHP
Gillian McIntyre Kirkcaldy & Levenmouth CHP



Flowchart for Children identified on e-oasis as frequent attenders to A & E depts



At VHK site the Paediatric Alert Form should be placed in Child protection Folder in Doctor's room, FAO Cicilie Rainey, CPNA.

At QMH secretarial staff should fax a copy of the form to Greenfield Clinic Fax 01592 643348.

Ongoing liaison arising from these forms will only take place during office hours. **Staff must refer to Child Protection Guidelines for all concerns about abuse or neglect.**

Paediatric Attendance Alert /Parental Attendance Alert - NHS Fife Operational Division - Guidance

When a child protection concern is identified and actions are required to protect a child, staff should follow NHS Fife Child Protection guidance and contact social services/police. This should be followed-up with a Child Concern Form (See [child protection icon](#) on intranet) and submitted to agency contacted, with copy for notes and to the Child Protection Nurse Advisor for the Operational Division (CPNA)

If concerns are about child welfare rather than child abuse and child is deemed safe for discharge, staff can, *when there are time restrictions or case felt as complex*, make a referral to the CPNA (Paediatric Attendance Alert/Parental Attendance Alert.) The CPNA will undertake an initial assessment and determine what level of follow up is required.

Staff should advise parents/carers/young person when referring; though due consideration must be given to whether doing so could place child/member of staff at further risk, or compromise a child protection investigation

Other triggers:

- Child Protection Messaging: A CPM may be highlighted on OASIS/E-OASIS – indicating there has been a child protection event. This should inform practitioners' assessment. Any concerns please contact Greenfield Clinic during office hours or OOHs SWD (contact details available via [child protection icon](#)) out with office hours.
- Frequent Attenders: A&E staff will be alerted via "E-OASIS" if a child has attended more than 3 times/year. Staff must then review previous attendance history, which should inform current assessment of the child. Occasionally a frequent attender may trigger a referral to the CPNA.
- Non-attenders: please refer to DNA policy, but do consider possible child welfare issues
- Unborn: Please refer to NHS Fife Unborn Child Policy

Risk factors: (For signs of abuse – see i.e. www.nice.org.uk/CG089)

Parental capacity possibly compromised by:

- Mental health problems, i.e. may present to A&E with attempted suicide
- Substance/alcohol misuse
- Domestic violence
- history of violent offending
- Parental learning difficulties/disability/chronic illness
- Unemployment/poverty/homelessness/young, unsupported parents
- Parents with poor role models of their own (Observe parent-child interaction/ the demeanour of the child)

The child/young person:

- Prematurity
- Difficulty with feeding
- Disability (incl. learning difficulty)/ chronic illness
- Looked After/Accommodated Children
- Young People engaging in risk-taking behaviour

THIS LIST IS NOT EXHAUSTIVE!

References:

- **Cleaver H et al (1999) *Children's Needs – Parenting Capacity The Impact of Parental Mental Illness, Problem Alcohol and Drug Use and Domestic Violence on Children's Development* The Stationary Office London**
- NICE (2009) *clinical guideline 89. When to suspect child maltreatment* (www.nice.org.uk/CG089)
- Royal College of Paediatrics and Child Health (2006) *Child Protection Companion* RCPCH London

Paediatric Attendances Alert Form

This form should be used to highlight concerns that do not warrant immediate action. Please refer to enclosed guidance

Hospital.....Department.....
 Name.....General Practitioner.....
 Address.....Surgery.....
 Date of birth..... Health Visitor (PHN).....
 Hospital number..... School nurse (PHNYP).....
 Carer/parent name.....School.....

Reason for Attendance <i>(please photocopy and attach A&E admission details)</i>	
Date and time of incident /....../..../ ...: ... am/pm (delete as applicable)	
Date and time of attendance /....../..../ ...: ... am/pm (delete as applicable)	
Previous Attendance within 12 months YES / NO (delete as applicable)	
Details of concerns:- (issues of abuse / neglect-refer to child protection guidelines)	
Action taken by A&E staff	
Patient/accompanying adult advised of referral..... YES/NO (if not, explain why please)	
Signature (medical) Print name..... Date and time.....	Signature (nurse) Print name..... Date and time.....
Referral received by CPNA (date): Action taken by Child Protection Nurse Advisor <i>(Written feedback will be provided – please file in A&E card when received)</i>	
Signature	Signature (print)

- QMH** Step 1 Form to be faxed to (9) 01592 643348, Greenfield Clinic
- VHK** Step 1 Form to be left at A&E doctors’ room for collection by Child Protection Nurse Advisor
- BOTH SITES** Step 2 Child Protection Nurse Advisor to be contacted on ext. 8114 to advise that form has been left at reception (VHK) / faxed(QMH)

Parental Attendance Alert/child welfare

A referral may be made to the CPNA when adults are admitted/attending hospital and there are indicators that their capacity as a parent may be compromised (i.e. domestic violence, assault, mental health issues/ suicidal behaviours), so that risk/needs assessment may be progressed.

Hospital..... **Department**.....
Name..... **General Practitioner**.....
Address..... **Surgery**.....
.....
Date of birth..... **Health Visitor**.....
Hospital number..... **School nurse/school**.....

Names/DOB of dependant child/ren:

Current whereabouts (incl. phone details)

Contact details of significant adult with temporary responsibility of child/ren

Reason for Attendance (incl. date):

Concerns identified:

Action taken by A&E staff

Patient advised of referral.....YES/NO
(if not, explain why please)

Signature (medical)	Signature (nurse)
.....
Print name	Print name
Date and time	
QMH	Step 1 Form to be faxed to (9) 01592 643348 at Greenfield Clinic
VHK	Step 1 Form to be left at A&E doctors' room for collection by Child Protection Nurse Advisor
BOTH SITES	Step 2 Child Protection Nurse Advisor to be contacted on ext. 8114 to advise that
	form has been left at reception (VHK) / faxed(QMH)

(Please note – there may be a delay of several days before referral reaches CPNA)



Child Protection Order - Good Practice Protocol

1.1 Introduction

This guidance has been drafted to help foster positive working relationships between health and social work and ensure that there is clarity and a shared protocol in the serving of child protection orders on a baby or child in hospital.

It will assist social work and NHS staff when a child protection order has to be served in relation to a newly born baby (but could be applied when serving a child protection order on an older baby/child in hospital).

Child protection orders are generally planned and the agencies involved are usually aware of plans that a child protection order will be sought when there are concerns about significant harm to a baby.

1.2 Systems

Where concerns are identified about the welfare of an unborn baby, an early risk assessment as per NHS Fife Unborn Child Policy should underpin the early pregnancy management and any interagency working; and a pre-birth child protection conference should be convened before 34 weeks gestation. Much of the paperwork for the child protection order should be prepared in advance to avoid delay at the time of the birth.

A child protection alert will be sent by a named midwife or the Child Protection Nurse Advisor to all departments within Forth Park Hospital setting out child protection plans for the unborn baby. Prior to the birth a planning meeting or core group meeting will be held to discuss the detailed plans for a baby once he/she is born.

The social work out of hours service (SWOOH) will be informed of the plan and sent the relevant paperwork by fax, so that the order can be sought by them if necessary. Consideration will be given to the immediacy of the serving of the child protection order. This could be influenced by the level of cooperation with the parents, if there is a perceived risk that the baby may be removed by the parents, an immediate child protection should be sought.

Should there be a delay in the serving of the order, health staff may seek police assistance in cases where a baby requires medical treatment, and parents threaten to remove the baby against medical advice. Hence in most circumstances the serving of the order can wait until day-time hours. However it should proceed promptly as per child protection plan. The order will be served by SWOOH should birth occur during such time.

1.3 Unplanned incidents

On occasions concerns may become apparent in the hospital where no risks have been identified previously.

Midwifery staff will consult with the In-patient co-ordinator/Sister in charge of the hospital/CPNA, Operational Division, and then contact the local social work team or SWOOH, and articulate their concerns to the Duty Worker/Team Leader, ensuring timely in the maternal hospital notes.

If a child protection order has to be considered, social work will attend at the hospital to discuss the concerns fully with staff and parent/s involved and risk assess the situation.

It is essential that hospital staff document all concerns and observations that raised the cause for concern.

1.4 Process

As soon as labour is established, ward staff will inform the In-patient coordinator/Sister-in-charge of hospital and social work staff of the progress of labour and likely timescales in terms of the birth.

- The In-patient co-ordinator/Sister-in-charge of the hospital will notify social work immediately of the birth of the baby, giving details of time of birth, sex of the baby, and any pertinent medical details. All information shared will be documented in the maternal notes.
- Social work will then keep the In-patient coordinator/Sister-in-charge of the hospital informed about how the application for the child protection order is proceeding, what time they are going to see the Sheriff and what time they are likely to arrive at the hospital to serve the order. As soon as they are clear when they will attend the hospital, they will advise the In-patient coordinator/Sister-in-charge of the hospital, so that preparation for their arrival can be made.
- Social work should bring copy of the child protection order for the child's hospital file when they arrive at the hospital.
- If there are concerns about aggression from the parents, hospital security/police should be alerted.
- When arriving at FPH (See flowchart for QMH/VHK with regards to communications within paediatrics), social work staff should ask at reception for the In-patient coordinator/Sister-in-charge of the hospital and wait for the coordinator or designated staff member to accompany them to the ward. Social work staff must not arrive on the wards unannounced.
- Social workers should present their identification to ward staff and as stated above, have a copy of the child protection order that can be placed in the hospital file.
- The inpatient coordinator/Sister in charge of hospital will arrange a private room or area on the ward for the papers to be given to the parents in order to protect their privacy, promote confidentiality and also to prevent distress to other patients on the ward.
- The named midwife will accompany the social worker when they speak to the parent/s.

Further details in terms of the subsequent care of mother and baby are detailed in the attached flowcharts.

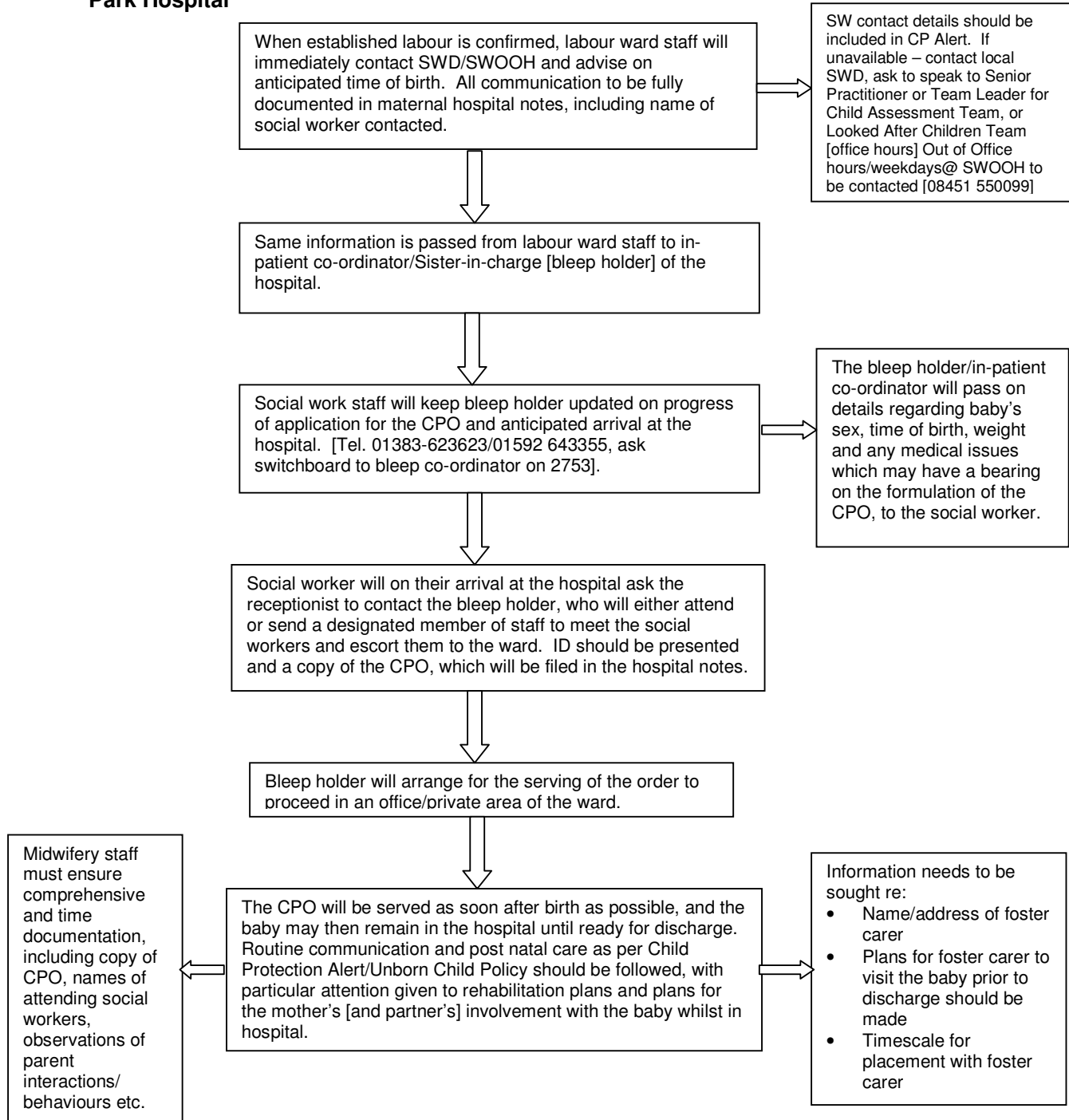
2.0 Legislative Framework

As per the Children (Scotland) Act 1995, a Children's Hearing will be held within 48 hours of the serving of the order, to ensure the grounds for compulsory measures are met and that the action is in the best interest of the child.

References:

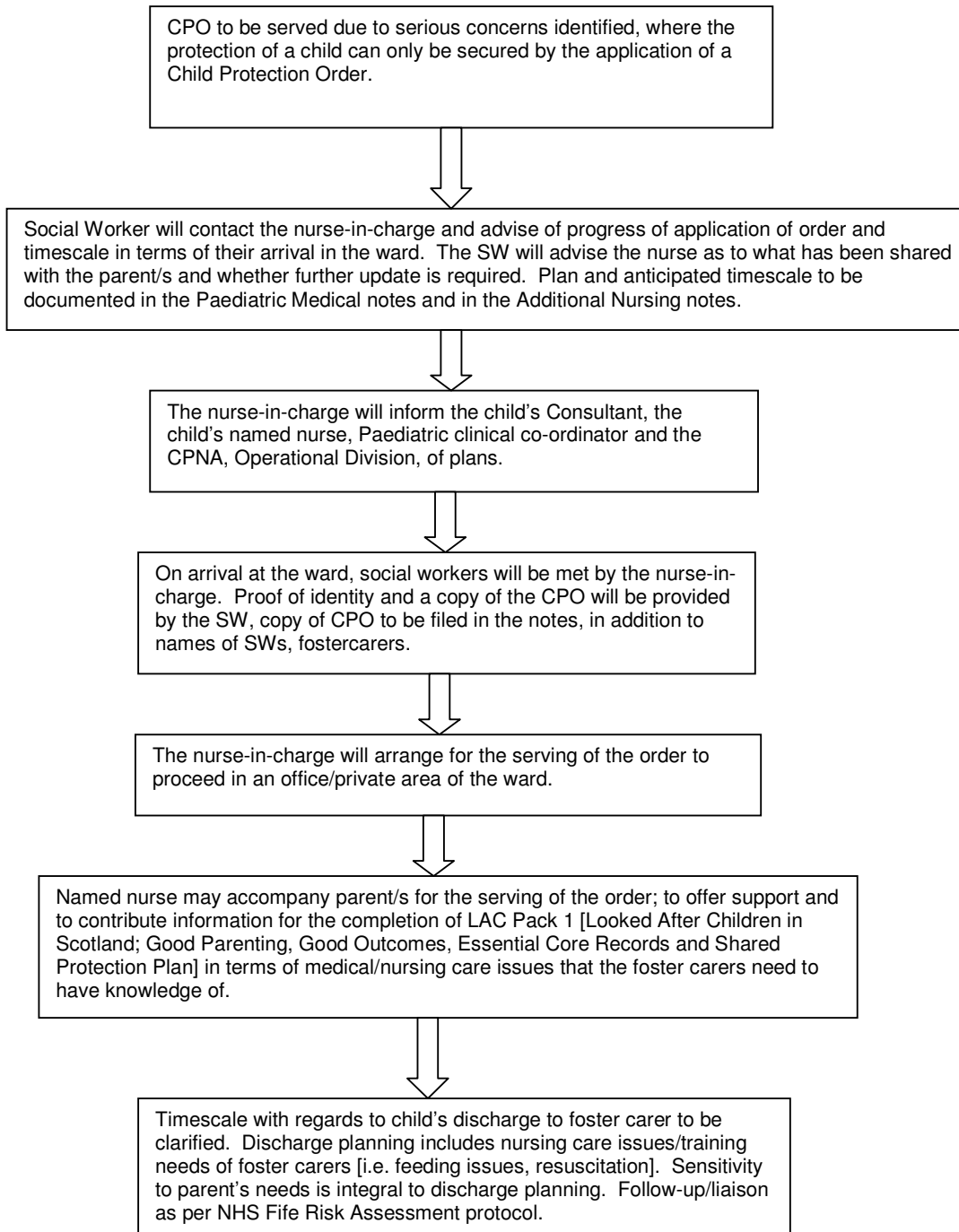
Scottish Executive (2004) Protecting Children and Young people: Framework for Standards
Edinburgh
Scottish Executive (2003) It's Everyone's Job To Make Sure I'm Alright Edinburgh
Children (Scotland) Act 1995
NHS Fife Unborn Child Policy

Shared Social Work/Health Protocol for the serving of a Child Protection Order [CPO] at Forth Park Hospital



Flowchart to be read in conjunction with “CPO – Good Practice Protocol” and any existing Child Protection Alert as per NHS Fife’s Unborn Child Policy.

Shared Social Work/Health Protocol for the serving of a Child Protection Order [CPO] for children admitted to Wards 5 or 9a or other NHS Fife Hospital settings.



Protocol to be read in conjunction with “CPO – Good Practice Protocol”.



NHS FIFE
CHILD PROTECTION REPORT
STRICTLY CONFIDENTIAL

Tick Appropriate Box

- | | |
|--------------------------|--------------------------|
| CASE CONFERENCE / REVIEW | <input type="checkbox"/> |
| REPORTER | <input type="checkbox"/> |
| HEARING | <input type="checkbox"/> |
| COURT | <input type="checkbox"/> |

Author of Report:

Designation:

Base/Department:

Telephone No:

The contents of this report are confidential and protected by the Data Protection Act 1998 for the purpose of Case Conference/Reporter/Hearing/Court only. It is not for transmission to any other agency without the explicit permission of the author.

Copyright [name] _____

NHS Fife [date] _____

**NHS FIFE
CHILD PROTECTION REPORT
STRICTLY CONFIDENTIAL**



1. FAMILY DETAILS	
Child/children being considered	DOB
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6. Unborn Baby	6. EDD
Home Address	Current Address [if different]
Adults Resident in Household	
Name[s]	Relationship to child/children
1.	1.
2.	2.
3.	3.
4.	4.

2. PROFESSIONALS INVOLVED WITH THE FAMILY	
Public Health Nurse/ Health Visitor	
Public Health Nurse – School	
GP Practice	
Named Midwife	
Other Health Professionals	
Professionals from Other Agencies	

Insert family name, reason for report and date

3. INTRODUCTION

- *Reason for report*
- *Authors involvement i.e. no of contacts and where*
- *Defaulted appointments/waste visits*

4. RELEVANT BACKGROUND INFORMATION

- *Previous child protection concerns/reports*

Insert family name, reason for report and date

5. CHILD HEALTH ASSESSMENT

Insert the name and date of birth of each child in turn and comment on the following:

- *General health*
- *Growth and development – include centile chart if relevant*
- *Behaviour*
- *Physical and emotional health*
- *A&E attendance*
- *Also comment on non-family contacts that may have significant impact [positively or negatively] on child's health and/or wellbeing*

6. PARENT / CARERS HEALTH ASSESSMENT

Detail issues relating to:

- *Substance misuse*
- *Failing to attend appointments*
- *Learning difficulties/disability*
- *Mental health*
- *Self harm*
- *Obstetric history*
- *Domestic abuse/childhood abuse*

Insert family name, reason for report and date

7. FAMILY DYNAMICS/RELATIONSHIPS

Please comment on your assessment of parents/carers/sibling relationship. Also comment if young carer present in household.

8. CURRENT SITUATION

Level of need/risk can be listed, including areas of strength and areas of concern.

Insert family name, reason for report and date

9 RECOMMENDATIONS

- *Action plan for author input*
- *Action plan for service input*
- *Child Protection Case Conference – recommendation re CPR registration*
- *Reporter to the Children’s Panel – recommendation for Compulsory Measures of Care*

Signature _____ Date _____
[PRINT] _____ Designation _____



CHILD CONCERN FORM (HEALTH)
GREY SECTIONS INDICATE MANDATORY FIELD

When to use this form

- To confirm a telephone referral (please complete box below with details of whom you spoke to)
- You have a concern about a child and need further advice from the Child Protection Team (NHS Fife)
- You are concerned that an aspect of parental behaviour may place the child at risk of harm
- You wish to refer a child you are concerned about to another agency

This form can be completed by ANY member of NHS Fife Staff. Please ensure that other professionals working with the child are aware of this concern and any outcome following referral

Is this a child you are concerned may be **AT RISK OF SIGNIFICANT HARM**
 (as per NHS Fife Child Protection Guidelines). Please tick.

No

Yes

If yes, confirm below,

Name & office of Social Worker or Police Officer/Family Protection Unit (FPU) spoken to:

Date:

Time:

Copy sent to Child Protection Team (NHS Fife): Please tick

FORM SENT TO:

Name:

Agency/Dept

Child Protection
Team (NHS Fife)

Social Work

Education

FPU

Other (please state)

Please tick

REFERRED BY:

Name (print):

Agency/Dept

Contact Details:

(1) Core Details

Section 1.1	CHI	DOB	M/F	Ethnicity (if known)
Full name of the CHILD you are concerned about				
Address & telephone number				

Section 1.2	M/F	Ethnicity (if known)	CHI	DOB	Relationship to the child
Full name/s of OTHER CHILDREN in the household (enter "unknown" if information not available)					

Section 1.3 (insert "unknown" /not applicable as relevant)

Name	Contact details		
Midwife			
Health Visitor/PHN			
Nursery/Childcare			
School			
School Nurse/PHN			
GP			
Other Professionals			
Is this child..			
Looked after?	Yes	No	Unknown
on the Child Protection Register?	Yes	No	Unknown

Section 1.4 (OPTIONAL)

Full name/s of ALL ADULTS in the household	Gender	DOB	Relationship to the child	Has Parental Rights & Resps. Y/N/not known

Section 1.5 (OPTIONAL)

Name of any PARENT who does not reside with the child	Gender	DOB	Address & telephone number	Has Parental Rights & Resps. Y/N/not known

Section 1.6 (OPTIONAL)

Names of any SIBLINGS outwith the household	Gender	DOB	Address & telephone number

(2) Description of Concern

Section 2.1 – What follows is a list of 7 statements. Collectively these help to predict the likelihood of a child’s overall experience of wellbeing. Which of these statements (all, none or a selected few) are you concerned may not be true for this child? (Getting it Right for Every Child 2008)

Safe	<input type="checkbox"/>	The child is protected from abuse, neglect or harm at home, at school and in the community
Healthy	<input type="checkbox"/>	The child has the highest attainable standards of physical & mental health, access to suitable health care & support to make healthy & safe choices.
Achieving	<input type="checkbox"/>	The child is being supported & guided in their learning & in the development of their skills: confidence & self esteem at home, at school & in the community.
Nurtured	<input type="checkbox"/>	The child has a nurturing place to live, in a family setting with additional help if needed or, where this is not possible, in a suitable care setting
Active	<input type="checkbox"/>	The child has opportunities to take part in activities such as play, recreation & sport, which contribute to healthy growth & development at home & in the community
Respected & Responsible	<input type="checkbox"/>	The child is involved appropriately in decisions that affect them, has their voice heard & (where age appropriate) is encouraged to play an active and responsible role in their schools & communities
Included	<input type="checkbox"/>	The child is receiving help to overcome social, educational, physical & economic inequalities & being accepted as part of the community in which they live & learn

**Section 2.2 - Describe the issues which give you cause for concern, and why. This includes parental behaviour that is cause for concern (e.g. substance misuse, domestic abuse, mental ill health etc)
Include how many occasions or how long this has been happening, and the possible impact on the child.**

Section 2.3 - Describe any discussions and/or actions that have taken place regarding this concern.

Section 2.4 – Describe any assistance that the child or any family member might require (e.g. English not first language, interpreter required, mobility issues, deaf, visually impaired etc.)

Section 2.5 - Information Sharing.

Have your concerns been discussed with the parent/carer Yes No

Have your concerns been discussed with the child/young person Yes No

If NO please state why not

Please ensure that the child/young person is aware that information will be shared as appropriate

Signature:

Date:



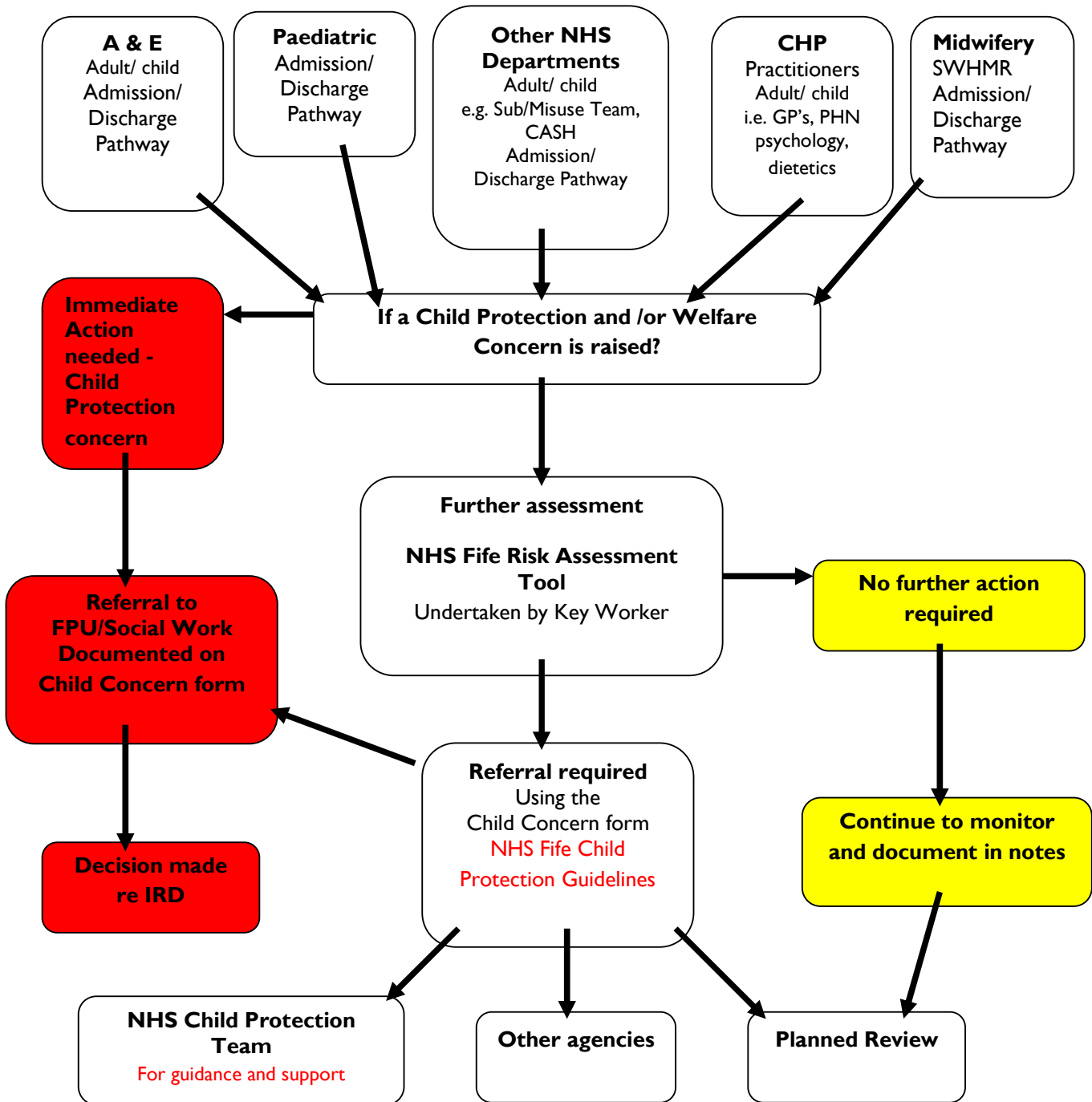
NHS FIFE CHILD CONCERN/WELFARE PATHWAY

**January 2010
Review Date January 2011**

NHS Fife Child Concern / Welfare Care Pathway

The NHS Child Concern / Welfare Care Pathway has been developed to guide practitioners in linking current processes within their particular part of the service into the NHS Fife Risk Assessment Tool, thereby linking the overall process together

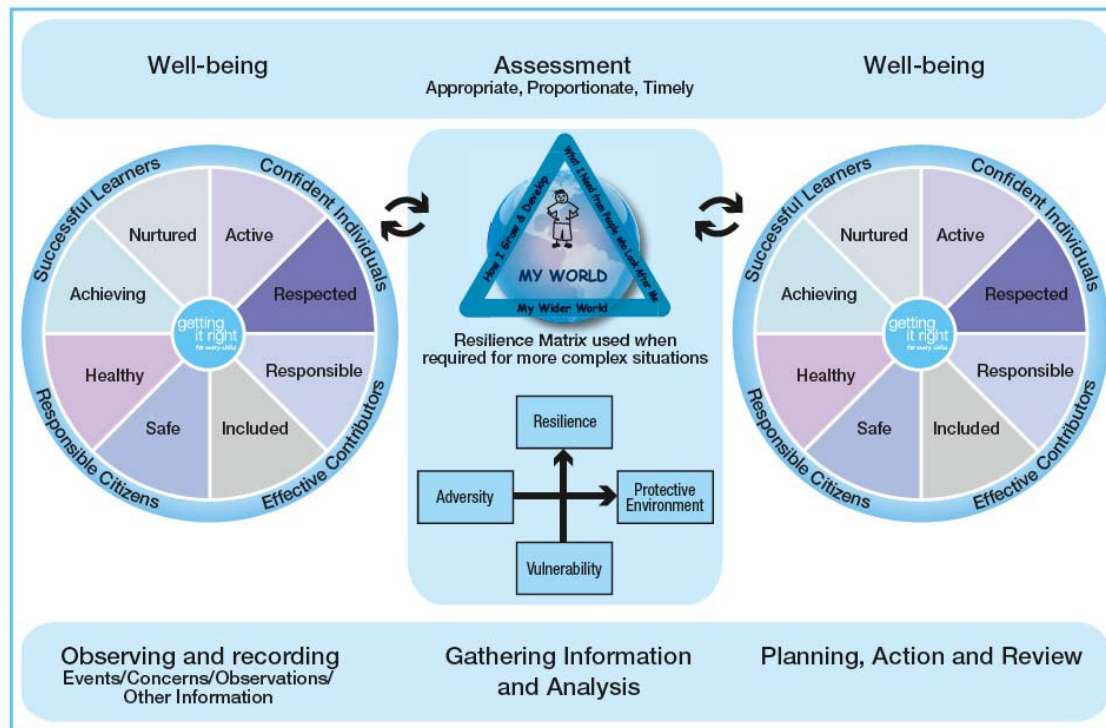
Figure 1



Please Note: All concerns and outcomes must be documented in child's notes

Guidance for staff

NHS Fife Child Protection Risk Assessment Tool



The tool is based on the getting it right for every child practice model:

The three main components in the practice model:

- My World Triangle which identifies specific factors in a child's life and in their family's wider world. It takes account of developmental and ecological factors affecting the child's wellbeing. It helps practitioners to understand a child or young persons whole world.
- Eight Well-being Indicators (SHANARRI). These have been identified as areas in which children and young people need to progress in order to do well in their future.
- The tool also uses a resilience model in order to identify protective and adverse factors thereby highlighting strengths and vulnerabilities. This approach to assessment of risk allows for a more comprehensive assessment to take place (Jones et al 2006). It supports practitioners to analyse the information they have gathered.

Aims of the assessment tool

Assessment should be a **continuous process**, not a single event and:

- Should ensure all aspects are explored
- Should clearly identify risks and needs
- Should clearly identify outcomes.
- Involve the child/family where possible.

Recognition of Adverse factors

Adverse factors are life events and circumstances which combine to threaten healthy development. This tool should not be used in isolation but as an integral part of health care delivery including the professional judgement of the practitioners involved.

Recognition of Protective Factors

An equally important part of the risk assessment is the recognition of protective factors, which include the child's level of resilience. It is possible to identify both the risks that lead to vulnerability and the assets that the children use to cope with, adapt to and overcome risks.

Resilience

Children who are resilient tend to display certain characteristics:

- They are good natured and responsive, with a capacity for self expression.
- They are advanced in their communication, mobility & self help skills.
- They have developed coping strategies that combine autonomy with the ability to ask for support.
- They have the ability when older to make & sustain friendships.

Additional Protective Factors

These can include the following:

- Evidence of a secure attachment to at least one parent or regular carer.
- Extended family support (This may enhance the parent's own coping skills and self esteem – or, may be of support in the provision of alternative, good quality care for the child).
- Community support for parent or child.
- Willingness of parent to engage with professionals.
- Support for the parent from a partner.

Using the tool to create a profile

The tool is there to help you create a profile which will inform care planning.

Keep a copy of the completed profile in case notes.

Discuss the profile with the parent/carer where it is appropriate to do so.

Assessment process

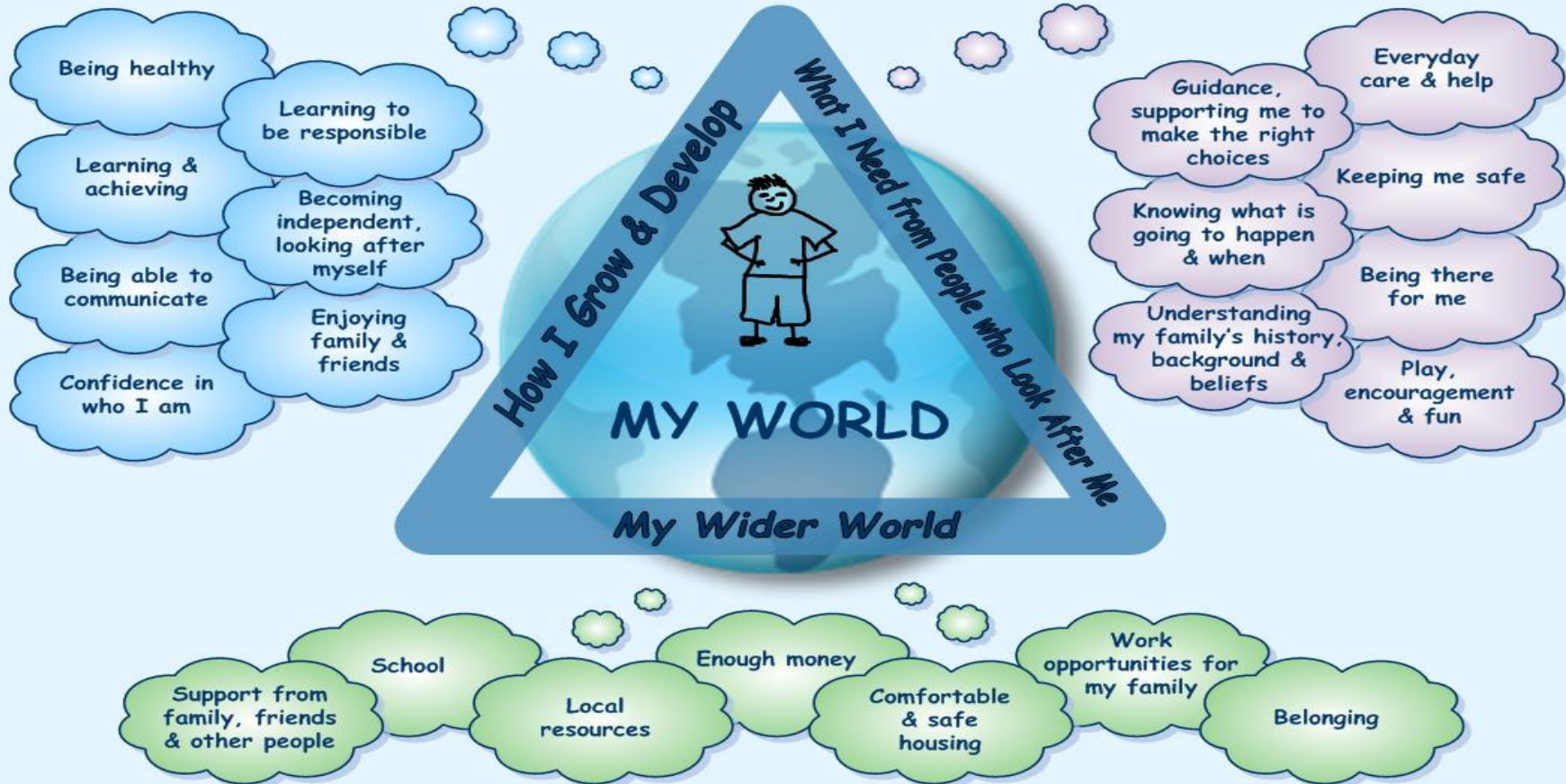
- Identify strengths in the family, and factors contributing to a protective environment.
- Identify factors which have the potential to make a child vulnerable. You should seek supporting evidence that these adverse factors exist.
- Assess what impact the adverse factors are having on the child.
- Document the assessment and your subsequent plan for each child.
- Evaluate & review care plan regularly – at least every 3 months.
- Reassess vulnerability.
- Complete referrals to other agencies, photocopy and file in records.

References

1. Aldgate, J and Rose, W (2008) "Assessing and Managing Risk in "Getting it right for every child" Edinburgh, Scottish Government
2. Daniel, B. and Wassell, S. (2002) *Assessing and Promoting Resilience in Vulnerable Children*, London and Philadelphia, Jessica Kingsley Publishers
3. Scottish Government (2008) *A Guide to Getting it right for every child*, Edinburgh, Scottish Government

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My World Triangle



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



Risk Assessment Tool



Date completed: _____ Name of Child: _____

Completed by: _____ Address: _____

Designation: _____

D.O.B./CHI _____

E.D.D. _____

School/Nursery _____

What follows is a list of seven statements which collectively help to predict the likelihood of a child's overall experience of wellbeing. Which of these statements (all, none or a selected few) are you concerned may NOT be true for the above named child?

Safe	The child is protected from abuse, neglect or harm at home, at school and in the community.
Healthy	The child has the highest attainable standards of physical and mental health, access to suitable health care and support to make healthy and safe choices.
Achieving	The child is being supported and guided in their learning and in the development of their skills: confidence and self esteem at home, at school and in the community.
Nurtured	The child has a nurturing place to live, in a family setting with additional help if needed or, where this is not possible, in suitable care setting.
Active	The child has opportunities to take part in activities such as play, recreation and sport, which contribute to healthy growth and development at home and in the community.
Respected/ Responsible	The child is involved appropriately in decisions that affect them, has his/her voice heard and (where age appropriate) is encouraged to play an active and responsible role in his/her schools and communities.
Included	The child is receiving help to overcome social, educational, physical and economic inequalities and in being accepted as part of the community in which they live and learn.

Have you informed parents/carers of this risk assessment?

Yes No

If no then why?

Section I: PROTECTIVE FACTORS

<p>What follows is a list of protective factors expressed as a number of needs, components of healthy psychosocial development and family attitudes to help. In which of these categories do the protective factors appear to be present? Answer present, absent or not known</p>	Present	Absent (enhanced concerns about risk)	Not known
<p>What I need from people who look after me (parents/ carers): Emotional warmth and stability Safety and protection Guidance, boundaries and stimulation Community support for child/parent/carer Extended family support formal/informal</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<p>How I grow and develop (child/young person): Normal physical development (nourishment, activity etc) Normal emotional and social development (age appropriate emotional self regulation, self awareness and general sociability) Awareness of consequences of risk taking behaviour Ability to problem solve Regular attendance at school/nursery (where applicable) Age appropriate self confidence Normal behavioural development (age appropriate behavioural self regulation, assertiveness and social compliance)</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<p>My Wider World / Family background: Mother describes positive pregnancy/birth experience Stable relationships within home/community Secure attachments to at least one parent/carer Identified community/social network of support Willingness of parent /carer to engage with professionals to meet needs/overcome difficulties Secure housing base Easily accessible child care and other services</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Comments:

Section 2: ADVERSE FACTORS

What follows is a list of adverse factors expressed as specific historical events, social difficulties, health problems and negative attitudes. In which of these categories do the adverse factors appear to be present? Answer <i>present, absent or not known</i>	Present (enhanced concerns about risk)	Absent	Not known
How I Grow and Develop: (Child/Young person):			
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Early prolonged separation from mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe disability or minor illness/disability causing concern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurring illness or hospitalisation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of school refusal or truancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of ill-treatment of animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Failure to achieve milestones for development and growth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My Wider World / Family background:			Not known
Evidence / suspicion of abnormal relationships in family (including abused parents)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Socio-economic problems, incl. unemployment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing problems / frequent change of address	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship problems (parent/child) or (parent/partner)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social isolation (including experience of ethnic/racial tension)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous suspicion/evidence of child abuse in family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adult male in household other than father of the child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sibling with chronic illness / disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of adult in household ill-treatment of animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

My Wider World (parent/carers):			
Significant mental or physical illness (past or current)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of substance misuse (Alcohol or Drugs including prescribed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20 years or less at time of birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Negative attitude to pregnancy / birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of domestic abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of criminal activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parents resistant to professional intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive/inappropriate use of health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Baby/child perceived as difficult by parent/carer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal/unrealistic expectations of baby/child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rough or inappropriate handling of child in household	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent/carer intolerant or over-anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parenting or caring skills questioned by professionals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of emotional attachment between parent and child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent non-attendance at child health appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Risks and needs:

Risks

Needs

What is your assessment?

Other professionals involved

Name
Tel No

Organisation

Name
Tel No

Organisation

Name
Tel No

Organisation

Useful Contacts

APPENDIX 11

Health Professionals / Facilities

Lead Manager Children's Services	01383-565455
Lead Clinician for Child Protection - NHS Fife	01592 648114
Lead Nurse for Child Protection - NHS Fife	01592 648114
Child Protection Support and Development Nurse	01592 648114
Child Protection Training Co-ordinator	01592 648114
Child Protection Link Worker:	
Dunfermline & West Fife	07824 461 572
Glenrothes & North East Fife	07717 541 091
Kirkcaldy & Levenmouth CHP	07824 597 691
Drug Liaison Midwife Forth Park Hospital	01592-643355 ext 2721
Nurse Advisor Child Protection ~ Operating Division	01592 648114 01592-643355 ext 8558
A & E Victoria Hospital	01592-643355 ext 8234
A & E Queen Margaret Hospital	01383-623623 ext 2027
Ward 5 [Paediatric Ward] Victoria Hospital	01592-648005 [direct dial]
Ward 5a [Paediatric Ambulatory Care Unit] Victoria Hospital	01592-643355 ext 8224
Children's Surgical Ward [Ward 9a] Queen Margaret Hospital	01383-623623 ext 7020
Gender Based Violence Nurse Advisor NHS Fife	08451-555555 ext 442080
Social Services ~ Local social work assessment teams:	
Cowdenbeath	01383-602201
Cupar	01334-659322
Dunfermline	01383-609111
Glenrothes	01592-583321
Kirkcaldy	01592-583322
Leven	01334-659323
Rosyth	01383-602203
Social Work [Emergency Out of Hours]	08451-550099
Family Protection Unit	01383-312910
Children's Reporter	01592-583314 or 08451-555555 ext 444583
Child Protection 24 hour Advice Line	08000-223222

