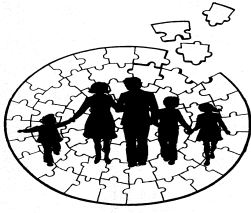


NHS FIFE

CHILD PROTECTION

GUIDANCE



NHS FIFE

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GUIDANCE

“child protection is everyone’s job.....its our job”
www.fifechildprotection.org.uk

Date: September 2011
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NHS FIFE ~ Child Protection Guidance

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Fife Child Protection Committee Vision Values and Aims

Our Vision

- All children in Fife are safe and protected from harm.

Our Values

- Treat children as individuals considering any diversity need
- Ensure we use the least intrusive interventions
- Hear Children
- Maximise the strengths within families and communities

Our Aim

- To see all of Fife's children achieve their full potential by providing them with a safe and supportive environment.



Fife Child Protection Committee

Introduction

This Guidance are aimed at assisting healthcare practitioners to recognise and respond effectively to situations involving children and young people who have been harmed or may be at risk of harm. These should be read alongside guidance contained within the Fife Child Protection Committee Inter-agency Guidance (2006) (current draft 2011)

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)*).

The guidance is produced in accordance with legislation and national guidance, including:

The Children (Scotland) Act 1995
The UN Convention on the Rights of the Child
Protecting Children - A Shared Responsibility – Guidance on Inter-Agency Co-operation 1998
The Human Rights Act 1998
The Data Protection Act 1998
"It's Everyone's Job to make sure I'm alright": Report of the Child Protection Audit and Review 2002
Getting our Priorities Right 2003
"Getting it Right for Every Child": Scottish Executive 2004
Protecting Children and Young People: Children's Charter, Framework for Standards and Child Protection Committees 2004
Prohibition of Female Genital Mutilation (Scotland) Act 2005
National Guidance for Child Protection in Scotland 2010
The GIRFEC implementation guide
Age of Legal Capacity (Scotland) Act 1991
National Guidance for Underage Sexual Activity 2010

Child Protection in Context

GIRFEC is the overarching framework for children's services in Scotland and child protection sits within that framework. Therefore all policies, procedures, practice and future developments within child protection should utilise the GIRFEC framework to ensure there is consistent approaches within children's services which includes the integration of child protection. Throughout this guidance the GIRFEC framework is continually referenced in all phases within the child protection process. This allows practitioners to make the links, see the relevance and gain an understanding of the role of GIRFEC in child protection.

GIRFEC has a number of key components:

- a focus on improving outcomes for children, young people and their families based on a shared understanding of well-being;
- a common approach to gaining consent and sharing information where appropriate;
- an integral role for children, young people and families in assessment, planning and intervention;
- a co-ordinated and unified approach to identifying concerns, assessing needs, agreeing actions and outcomes, based on the well-being indicators;
- streamlined planning, assessment and decision-making processes that result in children, young people and their families getting the right help at the right time;
- consistent high standards of co-operation, joint working and communication, locally and across Scotland;
- a Named Person in universal services for each child and a Lead Professional to co-ordinate and monitor multi-agency activity where necessary;
- maximising the skilled workforce within universal services to address needs and risks as early as possible;
- a confident and competent workforce across all services for children, young people and their families; and
- the capacity to share demographic, assessment and planning information electronically within and across agency boundaries.

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

- 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*]. Also Appendix 1
- 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.

- 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 previously 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 protect children 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

Identifying and responding to concerns about children

Risk Assessment

It is well known that identifying children who may be at risk of harm is integral to child protection practice. However it is also acknowledged that assessing risk is a highly complex task that is dependent upon staff that are confident to use their professional judgement in an ever changing environment. Supporting the early intervention and least intrusive principles of GIRFEC depends on robust risk assessment and professional analysis and decision making. Sadly we know that failure to identify risk can lead to poor outcomes for children in both the short and long term.

This section of the Guidance is intended to provide a framework for identifying and managing risk and outlines the NHS Fife approach to risk assessment incorporated into a pathway that considers the whole child and their welfare.

The nature of risk

Risk is part of everyday life and can be positive or negative and the concept of “risk” is very visible in social and health policy such as Equally Well and the Early Years Framework. From a child protection perspective it is the risk of “significant harm” that is important (Scottish Government 2010). Unfortunately there are no definitive criteria for deciding what significant harm is; it can be a single event or it can be a combination of events that cumulatively lead to a level of concern and consideration of risk. The real challenge is deciding at what point a child needs protection.

It is important therefore to consider the following questions when you become concerned about the safety of a child;

- Is the child at **immediate** risk?
- What or who is placing this child at **immediate** risk?
- What needs to happen now? (i.e. do I need to take **immediate** action?)

Needs and Risks

GIRFEC underlies the importance of understanding needs and risks in relation to the child’s whole world and well-being.

The distinction between ‘needs’ and ‘risks’ can, on occasion, cause some confusion. The following aims to clarify this whilst acknowledging the continued need for individual professional judgment to be exercised.

A **NEED** is something a child requires to enable them to reach their highest attainable standard of health and well being.

A **RISK** is what may happen if a particular **NEED** is not met.

Note that a **RISK** can be reduced, for example, through support or an intervention being in place. However the **NEED** may still remain.

The following example provides one illustration of the continuum of need and risk.

A child with a long term condition (e.g. asthma/eczema) **NEEDS** to attend for follow up appointments. If the child does not attend for follow up appointments there is a **RISK** that their health will deteriorate and they may become ill.

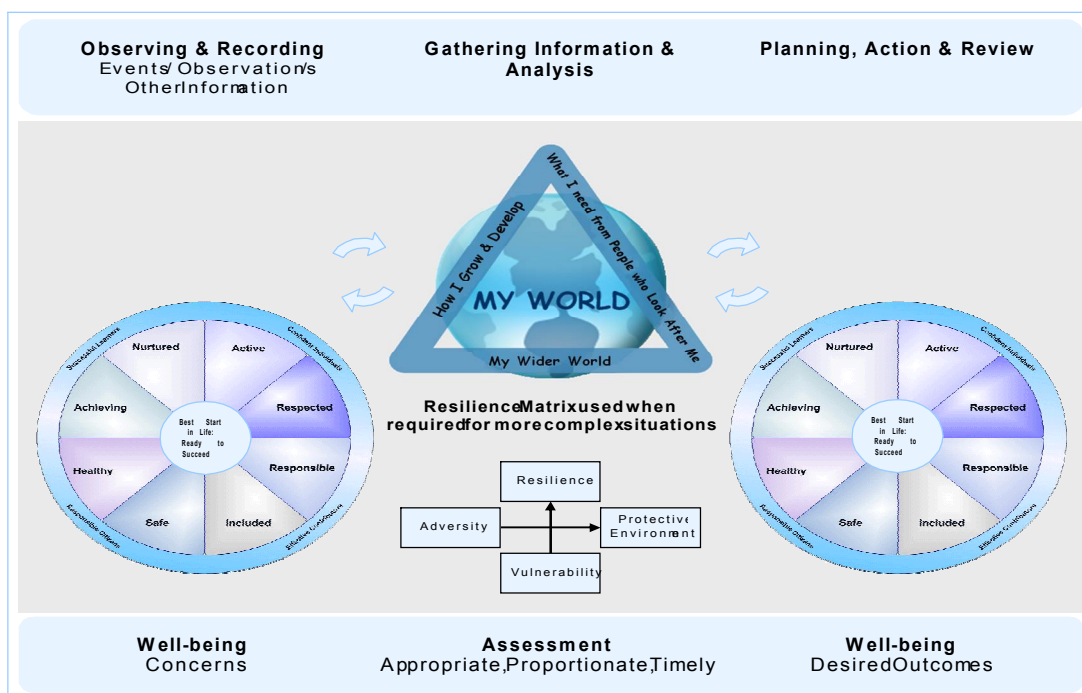
In this example, if the child misses one appointment, there is little **RISK**. However if the child continually misses appointments, this **NEED** then becomes a **RISK**.

Tools for assessing needs and risk

When assessing a child you may find the tools from the GIRFEC “practice model” helpful.

These include the **Well-being indicators** (Safe, Healthy, Achieving, Nurtured, Active, Respected & Responsible, and Included SHANARRI). These provide a broad framework for considering the needs of the child and help to create a common language across all agencies. This common language supports the single Child’s Plan and helps all agencies to identify what needs to change for the child and also provides a framework for measuring progress against outcomes created for the child. You will notice that the NHS Fife paperwork uses the Well-being indicators as part of this common approach to assessment and planning.

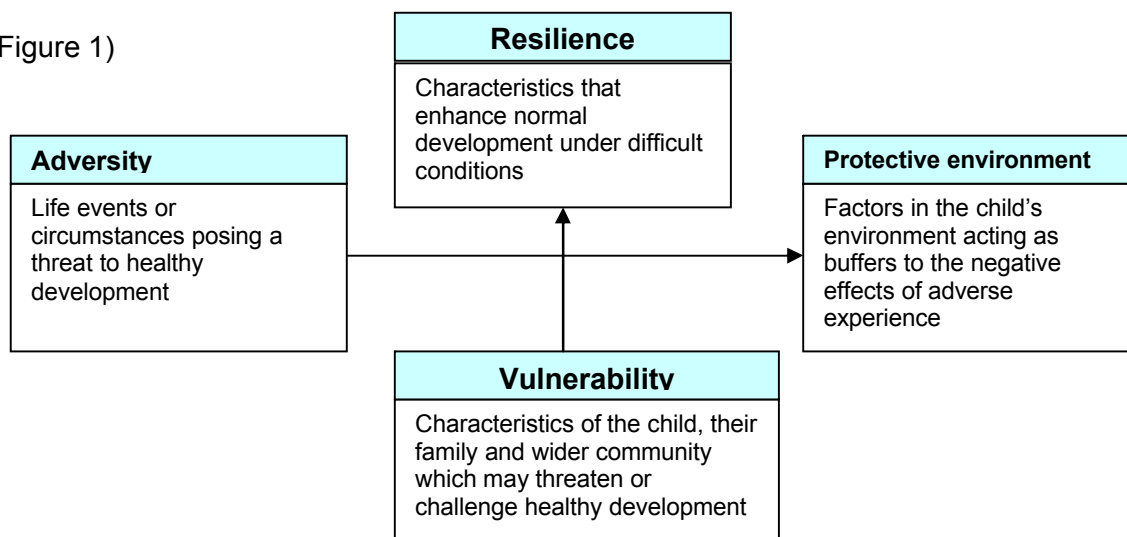
The **My World Triangle** is a useful starting point for identifying; assessing and managing which risks may be present in the child’s life. The triangle considers three dimensions of a child’s world that are essential to enable them to reach their fullest potential; how they grow and develop, their wider world and what they need from people who look after them.



Identifying vulnerabilities

Risk assessment is a continuous process and identifying risk factors is the first step. The next step would be to analyse the impact on the child, (the “so what?”). The Resilience Matrix (fig 1) developed by Daniel and Wassell (2002) helps to consider the impact on the child by helping to make sense of the relationship between the child’s vulnerability or resilience and their wider world (Fig 2)

(Figure 1)



(Figure 2)

Resilience/Vulnerability	Environment/Circumstances	Risk
Resilient	Protective	Low risk
Resilient	Adverse circumstances	Medium risk
Vulnerable	Protective	Medium risk
Vulnerable	Adverse circumstances	High risk

This is dependent on the **analysis** and professional judgement of the practitioner. To help with this judgement and analysis NHS Fife has developed a Risk Assessment tool as part of our **Child Concern/Welfare Pathway**. This pathway asks practitioners in all services to consider the welfare of the child and the associated risk assessment tool considers Well-being indicators and the My World Triangle to develop Protective and Adverse factors that may be considered when assessing the risks for the child.

However this tool remains just that, a tool to aid and assist professional judgement and decision making. Undertaking risk assessment is a complex and demanding process. While completion of the tool itself is self explanatory this is only part of the process. Professional analysis and evidenced based decision making are integral to effective assessment of risk. It is absolutely essential that we consider what the latest research is telling us about how risk factors affect children; how they interact together and how best we can support children in these circumstances.

[http://intranet.fife.scot.nhs.uk/uploadfiles/publications/Child%20Concern%20Welfare%20pat hway%20Jan%202011%20update.doc](http://intranet.fife.scot.nhs.uk/uploadfiles/publications/Child%20Concern%20Welfare%20pat%20hway%20Jan%202011%20update.doc)

Risk Assessment of a single event

It is clearly understood that in some circumstances urgent action may be needed to protect children. This may happen for example where there is a verifiable concern such as an obvious injury. Risk assessment must be carried out straight away to make sure that the child is safe. This will be often need to be a quick process however once the child is safe you

will need to consider the longer term. An investigation may be needed to ensure balance between exploring what has happened and what may happen. The risk assessment tool can be very useful in this instance once the child's safety is ensured.

Risk assessment of increasing, ongoing concerns

Sometimes children are identified as being at risk of significant harm because of increasing ongoing concerns. Each incident on its own can be explained, however considered cumulatively you feel that they have reached a point where you feel you need to act. Again the risk assessment tool combined with the Resilience Matrix can be helpful to articulate concern.

What tools are available to aid assessment and management of risk?

NHS Fife has developed a risk assessment tool that is an integral part of the Child Concern/Welfare pathway. This pathway can be used by any practitioner working in any department within NHS Fife.

Where can I find a copy of the Child Concern/Welfare pathway and associated Risk Assessment tool?

You can access this on the Child Protection page on the intranet. There are two documents, one has guidance for completion and one is a "stand alone" document and does not include guidance and is intended for use by those already familiar with the tool.

If you feel you need support to complete the tool or have any specific questions, please do not hesitate to contact the Child Protection team. There is also an electronic version of the tool available on the intranet for those who prefer electronic completion.

Responding to concerns about children

In general staff are alert to signs that a child may be experiencing significant harm however they may be less sure of how to respond. All staff have a responsibility to respond by following local procedures for reporting and sharing these concerns.

In all cases of suspected abuse and/or neglect:

- identify concerns and discuss with senior colleagues and agree way forward;
- discuss with and, if appropriate, make a referral by telephone to the Public Protection Unit [PPU] / Social Work Services;
- in situations where it is difficult to contact Social Work Services, the Child Protection Register can be accessed as per protocol (available on the NHS Fife Intranet).
- inform parent/carer of referral [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 Notification of Child Concern Form (Appendix 9)

- if you are uncertain, consider having a discussion with the Child Protection Team (NHS Fife)

The referral pathway on the following page is intended to simplify the process. It is important to note that all children may leave or enter the pathway at different points.

Please do not hesitate to contact the Child Protection Nursing Team for advice and support.

They can be contacted on **01592 648114** (Mon-Fri 9-5pm)

If you need advice out of hours you can contact the On call Paediatrician by contacting switchboard (**01592 643355 ask for On Call Paediatrician**) or you may wish to contact Out of Hours Social Work or the Police Contact Centre. (See Appendix 2)

The Referral Process

In all cases of suspected abuse:

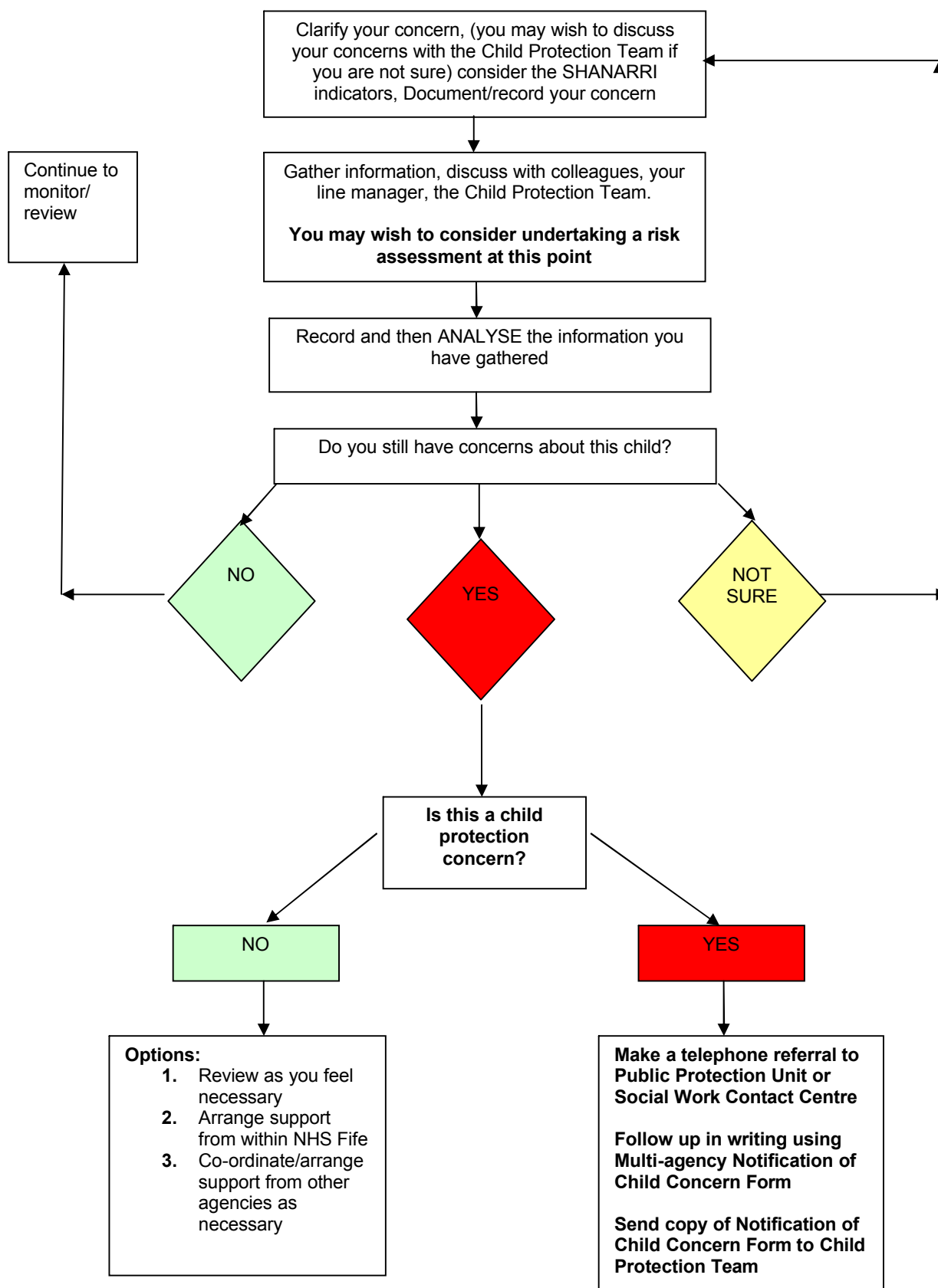
- identify concerns and discuss with senior colleagues and agree way forward;
- discuss with and, if appropriate, make referral to Public Protection Unit [PPU] tel; 01592 776767 / Social Work Contact Centre tel; 01383 44 11 77;
- in situations where it is difficult to contact Social Work Services, the Child Protection Register should be accessed as per protocol which is available on the NHS Fife Intranet. <http://intranet.fife.scot.nhs.uk/uploadfiles/publications/C-02v2signed.pdf>
- inform parent [unless this puts the child[ren] or member of staff at risk of harm];
- record accurate details of history, action taken and clinical findings [with diagrams];
- complete and submit a Multi-agency Notification of Child Concern form to PPU/Social Work Contact Centre
[http://intranet.fife.scot.nhs.uk/uploadfiles/publications/Fife%20Multit%20Agency%20Child%20Concern%20Referral%20Form_D03_03032010_CJR_CPC\[NHS\]FINAL.doc](http://intranet.fife.scot.nhs.uk/uploadfiles/publications/Fife%20Multit%20Agency%20Child%20Concern%20Referral%20Form_D03_03032010_CJR_CPC[NHS]FINAL.doc)
- if uncertain, consider having a discussion with Public Protection Unit [PPU] before sharing detailed information.

The referral process is explained in the flowchart on page 14

Child Protection Referral Process

If the child is in IMMEDIATE danger take IMMEDIATE action.....Call the POLICE

I have a concern about a child



**USEFUL NUMBERS: NHS Fife Child Protection Team 01592 648114
 Fife Police Public Protection Unit 01592 776767
 Fife Council Social Work Contact Centre 01383 441177**

Consent

Sensitivity to the needs of children and their families must always be shown when undertaking child protection work. Children and their carers are entitled to expect an honest approach, to be provided with explanations for actions or decisions taken and be given the opportunity to express their views.

It is the responsibility of the Police and the Social Workers carrying out the investigation to:

- arrange for the relevant parent/carer, and child if appropriate, to be informed of an alleged child protection concern;
- obtain their consent for any interviewing;
- ensure that parents are aware that their consent will normally be required for any medical examination of their child;
- ensure that interpreters and/or translators are used when required;
- ensure that the religious/cultural upbringing of the child and family are taken into consideration when decisions are being made.

NB: It is the responsibility of the medical practitioner to ensure that consent is obtained for the medical examination of the child.

Parental consent will be obtained unless:

- the child is mature enough to give his/her own consent taking into consideration the Age of Legal Capacity (Scotland) Act 1991;
- to do so would seriously impede the criminal investigation;
- to do so would significantly increase the risk of immediate harm to the child.

It should also be noted that **Consent is not legally required** from parents or children before interviewing them or before visually recording the interview.

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 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.

The **joint paediatric/forensic examination** combines a comprehensive medical assessment with the need for corroboration of forensic findings and the taking of appropriate specimens for trace evidence including, for example, semen, blood or transferred fibres. While the paediatrician is responsible for assessing the child's health and development and ensuring that appropriate arrangements are made for further medical investigation, treatment and follow-up, the forensic physician (also known as forensic medical examiner, child medical examiner, or police casualty surgeon) is responsible for the forensic element of the examination and fulfils the legal requirements in terms of, for example, preserving the chain of evidence. The presence of two doctors in the joint paediatric/forensic examination is important for the corroboration of medical evidence in any subsequent criminal proceeding and is also good medical practice.

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

A **comprehensive medical assessment** should be considered in cases of child abuse and neglect, even when information from other agencies show little or no obvious health needs. Accurate and comprehensive entries made in the health records are essential. In some cases of child abuse and neglect, there will be no obvious signs or symptoms and some children will require diagnostic procedures only available in a well-equipped hospital or clinic.

The type of medical examination, the venue and the timing should be fully discussed with police and social workers. Social work services or the police should ensure that the child and parent(s) (and/or any other trusted adult accompanying the child) are fully informed of the arrangements and likely timescale of the investigation as soon as possible

- **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.**

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 Guidance (2011).

- A Child Protection Case Conference may be called by the social work service at the conclusion of inter-agency Child Protection enquiries. 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.
- When the conference decides to place a child's name on the Child Protection Register, a plan must be agreed by the conference to reduce the risk to the child and provide support to the child and family. This will be referred to as the Child Protection Plan
- Individual points of the Child Protection Plan should be listed, numbered and clarity must be provided relating to the roles and responsibilities of the various people involved in the plan, including agency staff and family members.
- There may be circumstances (e.g. where the child is looked after or there continues to be significant identified needs) where a Child's Plan, including an element of protection is created for the child and family, but where the child's name is not placed on the register. This will not be referred to as a Child Protection Plan. The template for Child's Plan and Child Protection Plans will remain the same the difference will be that the Child Protection Plan will have a greater focus on safety issues and the child's name will be placed on the Child Protection Register. Changing the name of the plan will be administered by the Social Work Reviewing Service.
- 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.

The Child's Plan and The Child Protection Plan

The Child's Plan

Every child living in Fife is entitled to access service provision as detailed by the principles of GIRFEC (see www.girif.com).

The national GIRFEC approach is focused on how "all services for children and adults meet the needs of children and young people, working together where necessary to ensure they

reach their full potential” (The Scottish Government, 2008). GIRFEC introduces the concept of Named Person and Lead Professional. These are outlined below.

Named Person:

Agreement has been reached to ensure that in Fife every child and young person has a **Named Person** in health or education from birth to school leaving.

The **Named Person** is the identified first point of contact for the child or family to facilitate access to additional support and early intervention. These individuals (detailed below) will be responsible for making sure that the child has the right help in place to support his or her development and well-being across the following life stages:

- Pre-birth to 10/14 days - Midwife (hospital or community)
- 10/14 days to school entry - Health Visitor
- Primary School - Head Teacher
- Secondary School Guidance or Pupil Support

Where the information available and the risk assessment undertaken suggest that either the needs or the risks are escalating, a professional support discussion should be called by the Named Person to further consider the factors surrounding the child and agree whether multi-agency planning (i.e. a Child’s Plan) is required.

This may be overtaken in some circumstances as the requirements for more rapid multi-agency planning become evident e.g. child abuse or significant child health situations.

Lead Professional

At the meeting to develop the plan actions from all services will be considered and a multi-agency plan developed. A key action at this meeting will be to identify a Lead Professional to co-ordinate the ongoing multi agency planning.

The role of the Lead Professional is to ensure service provision is co-coordinated, coherent and progressing to achieve the agreed outcomes for the child in keeping with the timescales specified.

Within the staged model of intervention a Lead Professional must be agreed by the services when the child’s assessed needs move from Universal and Additional to the extended level of provision. This may include situations where specialist service provision is required, for example, from child psychology or Community Paediatrics.

The Child Protection Plan

When assessment, either from a single event or from accumulative concerns indicates that a child is at risk the next step is to consider strategies and interventions for reducing those risks. This will form part of the **Child Protection Plan**. This *may* build on previous work undertaken as part of a Child’s Plan. It is important the Child Protection Plan reflects all the child’s needs not just their child protection needs.

Child Protection Plans should also clearly identify:

- key people involved and their responsibilities;
- timescales;
- support and resources required and, in particular, access to specialist resources;
- the process of monitoring and review; and
- any contingency plans

On some occasions a Child's Plan may be converted into a Child Protection Plan. The responsibility for the plan is shared. Each person involved will have their role and responsibilities clearly set out.

Planning and Intervention Processes

- NHS Fife's Unborn Child policy (currently under review) 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 28 weeks gestation.
- All children and young people accessing A&E and Acute paediatrics will have an initial risk assessment completed prior to discharge.
- A Pre-discharge Planning Meeting may be convened prior to hospital discharge to ensure a co-ordinated response in complex cases or where there are child protection/welfare concerns.
- 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 Cause for Concern - 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 Cause for Concern – guidance and templates <http://intranet.fife.scot.nhs.uk/subjects/index.cfm?fuseaction=publication.sitepubs&pageid=4296A97F-5056-8C6F-C07AFA549A47F271&subjectid=6F6D0E9F-9160-AC1B-D0E599192F1A00D8>
- Issuing of a Child Protection Order - Good Practice Joint Protocol NHS Fife and Fife Council http://intranet.fife.scot.nhs.uk/uploadfiles/publications/CPO_Good_Practice_Guidance_review_2011.doc

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. If a child presents in the night and is admitted, it is possible to delay the consultation until the next day. In these circumstances, consideration must be given to potential safety issue of any siblings.

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. If a parent wishes to discharge the child from hospital against medical advice and there are concerns for the welfare of the child, Social Work Services must be contacted urgently. Hospital staff cannot prevent the parent from leaving the ward with his/her child, but police and SWS must be contacted immediately;
- the Nurse Advisor Child Protection ~ Operating Division must be informed [prior to discharge if possible];

- Named Person must be informed and/or the Lead Professional, should a Child's Plan be in place;
- where the needs are complex or a co-ordinated response is required, a Pre-Discharge Planning Meeting can be held. This can be chaired either by a senior Paediatrician, a senior Social Worker or the Child Protection Liaison Worker/Nurse Advisor as appropriate. It is the responsibility of the chair to ensure the meeting is minuted and distributed accordingly. It is good practice to ensure parents/young person is invited to the meeting. If there is a need for a professional's only meeting, family will be informed of the outcome;
- primary healthcare team must be informed. No child about whom there are concerns about abuse or neglect should be discharged from hospital without an identified GP. The nurse in charge must ensure that the hospital Consultant Paediatrician knows if a child is not registered with a GP so that Practitioner Services can be contacted. Alternatively, information must be shared with the area PHN that covers families not registered with a GP (most areas have an identified PHN who will visit families not registered with GP).
- 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.

Record Keeping and Report Writing

Record Keeping

All NHS Fife staff must record relevant information received. In accordance with NHS Fife policy and guidance from regulatory bodies [e.g. Nursing & Midwifery Council, Health Professionals 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; include the date and time when the record was made (i.e. date and time of signing)

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 child's views (if old enough) and emotional well-being;
- ↳ the findings and analysis of any assessment, including risk assessment (you can cross reference to the risk assessment tool);
- ↳ 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;

- ↳ a chronology of significant events involving the child. Chronologies can help identify patterns of events of accumulation of concerns (or positive developments).
[http://intranet.fife.scot.nhs.uk/uploadfiles/publications/guidance%20for%20chronology\[1\].doc](http://intranet.fife.scot.nhs.uk/uploadfiles/publications/guidance%20for%20chronology[1].doc)

The information received following a referral must therefore always be written down accurately and in detail, either at the time or as soon as possible 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.

Fact vs Opinion

There can on occasion be some confusion between fact, opinion and professional opinion/judgement. The following provides a basic overview of the difference between these.

Fact

A fact is a "**provable truth**", that is something that can be verified and backed up with evidence. E.g. you may be able to prove that a baby's hearing is normal and can verify this by providing evidence of their new born hearing screening result.

Facts are essential and will inform professional judgement but taken alone will provide a fairly bland picture of what is happening. If we consider the example above and use the example of a child whose hearing is impaired and parents do not attend for follow up appointments, while you can provide the **facts** it is important that there is the analysis, the "so what?"

This is where **Professional Opinion/Judgement** is essential. Your professional opinion/judgement of what this means for the child is required; e.g. do you consider (in your professional opinion/judgement) that this may have an effect on the child's long term speech and language development?

Report Writing

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.

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. Remember that the letter that you receive asking for the report will detail why it is required. Ask yourself the following questions:

- why are you writing the report?
- who will read the report?
- when is the report needed?
- what are the facts?
- what is my analysis of 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. Include the analysis and the impact for the child. 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.

Your report should be type-written and saved onto a secure drive on the computer. It should NEVER be saved to “Desktop”.

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.

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.

What sources of information can be used for writing the report?

You have been asked for a report in your role as a health professional. Remember that your report will form *part* of the assessment. You may use information you have within your records. If you want to include information from GP records, for example you must seek the permission from the GP to include this.

What sources of help are available to support report writing in Child Protection?

It is understandable that writing a report for child protection can seem a daunting task. To support this NHS Fife has developed a template that should be used for all child protection reports. This template is available as a “stand alone” document on the intranet. This template is based on the values and principles of *Getting it Right for Every Child* (GIRFEC) and therefore enables NHS staff to contribute to the development of the Child’s Plan should this be considered necessary to support the child and their family.

Each service should have a system in place for checking reports if required; this may be a senior colleague, team leader or line manager.

Remember that your report is an important part of the child protection process and assists the Case Conference/Panel members to make the most appropriate plans to support and protect the child concerned.

<http://intranet.fife.scot.nhs.uk/uploadfiles/publications/CP%20Report%20Template%20ONLINE1.doc>

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. In cases of physical abuse appropriate photography by Scenes of Crime Officer should be performed. In cases of sexual abuse, a DVD should be made of findings seen at the examination. This DVD should be properly identified by use of the CHI number only, then stored securely. It can be viewed by a court appointed expert witness in sexual abuse should this be necessary. Due process before release of the DVD to the appointed doctor must be followed.

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 doctor 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) Police
- b) Social Work
- c) Copy in the child's records

The GP should receive a brief resume of the history, conclusion reached after the examination has taken place, and the plan for any identified needs which the child may have.

The GP's report may be copied to the child's Health Visitor or Public Health Nurse, OR the author may prefer to write a separate letter to them.

All reports should be marked Private and Confidential and placed in an envelope to the addressee which is also marked Private and Confidential. This envelope should be placed in a plain envelope to the addressee, with no external markings regarding confidentiality. The report should not be distributed to anyone else without prior discussion with the author.

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.

Court Proceedings – Giving Evidence

If you, as a health practitioner are involved with a child where abuse or neglect is suspected/ diagnosed 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 Sheriff [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 and other Health Professionals

You 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 practitioners 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 practitioner 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 you say 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.

Guidance for Attending Court

You must attend if asked – being a health professional 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 health professionals 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 (permission must be sought prior to court sitting from the Clerk of the Court), 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 Sheriff. 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 Guidance on the format, content and timetable for producing reports.

Golden Rules for Court

1. **Mode of dress.**

Type of clothes worn should reflect the esteem in which the court is held, e.g. smart suit, tie for men; smart suit (dress or trouser) for women.

No handbags, briefcases or mobile phones are allowed to be taken into court. No personal notes are permitted to be taken into court. All relevant documentation will be provided by the court and given to you during cross examination.

2. **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.

3. **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.

4. **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.

5. **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.

6. **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.

The following links can be used as reference:-

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

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

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

Royal College of Paediatrics and Child Health (2006) *Child Protection Companion*, Royal College of Paediatrics and Child Health

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;
- complete and send with the records to CPNA at Greenfield Clinic <http://intranet.fife.scot.nhs.uk/uploadfiles/publications/appendix%20%20transfer%20out1.doc>
- contact the key worker in social work [if applicable] to notify them of the change;
- inform Child Health Records Department;

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 Guidance 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 and the records will be sent by Recorded Delivery
- an electronic record of the transfer out will be kept by Greenfield Clinic.

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

In the event of a child or young person who has moved out of the area and 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;
- 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 NHS Caldicott Guardian.
<http://intranet.fife.scot.nhs.uk/uploadfiles/publications/NHS%20Fife%20MFA%20Policy%20Final%20Feb2010.pdf>

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.

The Family Section and Section C should be separated from the Child Health Record for those children going for adoption. Only the Child Health Section should follow the child/ren. For storage of Family Sections and Section C please refer to NHS Policy GP/R8: Health Records Retention and Destruction.

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 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 Team Leader.
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.

National and Local References

1. Fife Child Protection Committee [2006] *Child Protection Interagency Guidance, Fife Partnership*
2. Fife Child Protection Committee [2008] *Significant Case Review*
3. NHS Fife Access to Fife Council On-Line Child Protection Register [2011]
4. NHS Fife Child Protection Messaging Protocol [2008]
5. NHS Fife Missing Family Alert Policy [2010]
6. NHS Fife Unborn Child Policy [2008] (Under Review)
7. Norrie, K McK [1995] *Children (Scotland) Act*
8. Scottish Executive [2002] *“It’s everyone’s job to make sure I’m alright”*
9. Scottish Executive [2004] *Protecting Children & Young People, Framework for Standards*
10. Scottish Executive [2007] *Getting it Right for Every Child*
11. National Guidance for Underage Sexual Activity [2010]
12. Age of Legal Consent and Capacity (Scotland) Act 1991
13. National Guidance for Child Protection [2010]

APPENDICES

- Appendix 1** Information Sharing - Information
- Appendix 2** Useful Contacts

Appendix 1 – Letter of Chief Officers Public Safety Group



Dear Colleague,

INFORMATION SHARING

The protection of children, young people and vulnerable adults in its widest context, is **“everyone’s responsibility and everyone’s job”** This cuts across all aspects of private life and professional business. We all have a duty, individually and collectively, to protect 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 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 you have a concern about a child, young person or vulnerable adult or you are made aware of such a concern you have a responsibility to share and exchange relevant information with other professionals. You should do so timeously, with confidence, and adhere to your own agency/service procedures when doing so.

Practitioners should be aware that their own agency will support them if they have shared, in good faith, using professional judgment, even if the assessment subsequently was found to be inaccurate.

Recent inquiry reports have highlighted misconceptions about confidentiality. 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 extends to all professionals working with adults where for example there may be substance misuse, mental health or domestic abuse issues. In all circumstances staff must be particularly alert to the needs of any dependant children.

We would draw your attention to the Scottish Executive 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 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 provide you with good practice advice on this and wider protection matters.


The Adult Support and Protection (Scotland) Act 2007 also places a duty on all agencies to

“co-operate with inquires into adults thought to be at risk of harm and any other person or organisation to allow records to be provided if this would help such an enquiry.”

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 advice or guidance 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



Appendix 2

Useful Contacts

Health Professionals / Facilities

Greenfield Clinic	01592 648114
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
Nurse Advisor Child Protection ~ Operating Division	01592 648114
Child Protection Support and Development Nurse	01592 648114
Child Protection Training Co-ordinator	01592 648114
Child Protection Link Worker - Dunfermline & West Fife CHP Glenrothes & North East Fife CHP	07824 461572 07717 541091
Drug Liaison Midwife Forth Park Hospital	01592 643355 ext 22721
A & E Victoria Hospital	01592 643355 ext 28108
A & E Queen Margaret Hospital	01592 643355 ext 23027
Ward 5 [Paediatric Ward] Forth Park Hospital (temporary)	01592 643355 ext 28005
Ward 5a [Paediatric Ambulatory Care Unit] Victoria Hospital	01592 643355 ext 28224
Children's Surgical Ward [Ward 9a] Queen Margaret Hospital	01592 623623 ext 27020
Domestic Abuse Co-ordinator NHS Fife	07789 273572
Specialist Public Health Nurse, Fife NHS Addiction Services	01592 716446
Social Work - Contact Centre (SW.ContactCtr@fife.gsx.gov.uk) - Child Protection Team	01383 441177 08451 555555 ext 446911
Social Work [Emergency Out of Hours]	08451 550099
Public Protection Unit	01592 776767

Children's Reporter

0300 200 1366

Child Protection 24 hour Advice Line

08000 223222