THE STATE HOSPITALS BOARD FOR SCOTLAND

KEEPING CHILDREN SAFE POLICY

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Lead Author	Social Work Mental Health Manager	
Contributing Authors	Lanarkshire Child Protection Committee	
Advisory Group	Child and Adult Protection Forum	
Approval Group	Policy Approval Group (PAG)	
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Accountable Executive Director	Director of Nursing & Operations	

The date for review detailed on the front of all State Hospital policies/ procedures/ guidance does not mean that the document becomes invalid from this date. The review date is advisory and the organisation reserves the right to review a policy/ procedure/ guidance at any time due to organisational/legal changes.

Staff are advised to always check that they are using the correct version of any policy/ procedure/ guidance rather than referring to locally held copies.

The most up to date version of all State Hospital policies/ procedures/ guidance can be found on the intranet: http://intranet.tsh.scot.nhs.uk/Policies/Policy%20Docs/Forms/Category%20View.aspx

REVIEW SUMMARY SHEET

No changes required to policy (evidence base checked)	☐

Changes required to policy (evidence base checked) ☒

Summary of changes within policy:

2022 Review

- Key Definitions: Links to New National Guidance. Updated definitions and categories to reflect national perspective. Now located as an appendix (see Appendix A)
- Removal of reference to Responsible Medical Officer sign off of assessments to reflect practice changes
- Updated details for Out of Hours Child Protection Concerns
- Home Visits for Assessments amended to take account of barriers e.g. Covid
- Updates throughout to recognise change to Rio recording of child contact forms / child protection summaries
- Revised flowchart for CP Notification of Concerns amended to reflect practice

Contents

1. Introduction

This operational policy and procedures provides guidance on the roles and responsibilities in ensuring that children are safe and that their interests are paramount in relation to decisions made at The State Hospital (TSH) which may affect them. Protecting children means recognising when to be concerned about their safety and understanding, when and how to share these concerns, how to investigate and assess such concerns and fundamentally what steps are required to ensure the child's safety and well-being. Key definitions can be found within Appendix A.

These procedures are under-pinned by the principles outlined in the United Nations Convention on the Rights of the Child and also those contained within the Children (Scotland) Act 1995 (1995 Act).

These are:

- Children have a right to be protected from all forms of abuse, neglect and exploitation
- Children should be listened to and their views taken into account in decisions affecting them
- Agencies should work together in providing services to meet the needs of children
- Parents should normally be responsible for the upbringing of their child and should share that responsibility
- Consideration must be given to the child's views in all decisions made about them

Three principles that govern the 1995 Act are:

1) The child's welfare is the paramount consideration
2) Consideration must be given to the child's views in all decisions made about them
3) The principle of minimum intervention

These procedures are to support staff that face, or could face, child protection issues. Social Workers, TSH staff and volunteers who come into contact with children and their families need to appreciate the important role they can play in remaining vigilant and providing robust support for child protection. This policy provides the framework for that understanding.

The operational procedures cover a range of situations where children may have contact with patients which would include child visits to TSH, facilitated within the Family Centre and child contact with patients out with TSH, for example, on home visits or community outings (Suspension of Detention (SOD). These operational procedures also address:

- Telephone contact
- Video contact
- Gifts into/out of TSH
- Exchange of photographs, letters or cards
- Patient possessions such as magazines, DVDs, posters, photographs or mail and third party information which may be passed from the patient to the child as well as any other form of potential contact between patient and child

2. Scope

The operational policy and procedures affect all children under the age of 16 and should be applied by all clinical teams involved in decisions which may affect children who either visit TSH or have other forms of contact with patients.

Persons who are aged 16 or over but have delayed development or are regarded as being particularly vulnerable for any other reason, may also have their individual circumstances considered under the terms of these procedures. This approach requires information sharing and consultation with all relevant parties.

Where a young person between the age of 16 and 18 requires protection, services will need to consider which legislation, if any, can be applied. This will depend on the young person's individual

circumstances as well as on the particular legislation or policy framework. Special consideration will need to be given to the issue of consent and whether an intervention can be undertaken where a young person has withheld their consent.

All children have a fundamental right to proper care and protection. Children may need protection when their basic needs such as food and warmth are neglected or they may need protection from harm from other people.

Everyone has a duty and responsibility to protect all Children from harm, including volunteers who may observe concerning behaviour when carrying out their role.

3. Roles and Responsibilities

The policy and procedures are intended to support staff that face, or could face, child protection issues. Social Workers, TSH staff and volunteers who come into contact with children and their families need to appreciate the important role they can play in remaining vigilant and providing robust support for child protection. This policy provides the framework for that understanding. The procedures provide specific guidance for staff groups involved in the child protection and contact work within TSH.

4. Sharing of Information

Agencies and professionals share information about children where this is necessary to protect them. Sharing information is an essential part of protecting children. Although those providing services to adults and children may be concerned about balancing their duty to protect children from harm and their general duty towards their patient or service user, the over-riding concern must always be the safety of the child. Whenever possible, consent should be obtained before sharing personal information with third parties but concerns about a child's safety will always take precedence over the 'public interest' in maintaining confidentiality. It should be borne in mind that a fairly minor concern raised by one agency may, when combined with information from other agencies, point to much more serious concerns.

5. Procedure for Reporting Child Protection Concerns

- Where any member of TSH Staff has concerns relating to Child Protection or Child Welfare, or that a Child is in immediate danger, they have a responsibility to pass their concerns to the Senior Clinical cover (SCC) the Director of Nursing & Operations, TSH Social Work Service and to complete a Datix report. The Police may also require to be informed if there is reason to believe that a crime may have been committed. Volunteers should raise their concerns immediately with a member of TSH staff, who will contact SCC. The Person Centred Improvement Lead will be made aware of any concerns shared by a volunteer and will be responsible for providing support to the volunteer.

- Where the concern arises out with office hours, the South Lanarkshire Council Emergency Social Work Service should be contacted on 0303 123 1008 or esws@southlanarkshire.gov.uk.

- After initial contact the referrer must complete a Notification of Child Protection Concern Form (see Appendix B) and forward it immediately to TSH Social Work Service for consideration of any further action required.

- On receipt of the completed Notification of Child Protection Concern Form, TSH Social Work Service will send a written acknowledgement to the referrer and forward a copy of the completed form to the Patient's Responsible Medical Officer (RMO), the Lead Nurse and the Director of Nursing & Operations, as Chair of the Child and Adult Protection Forum

- The Social Work Team Leader will immediately allocate a Social Worker to contact and, where appropriate, interview the referrer, any other relevant parties and the patient, where

appropriate. If deemed to be an urgent child protection concern, the allocated Social Worker will collate all relevant information and initiate an Initial Referral Discussion.

- Some concerns may require an urgent response because of possible immediate danger to the child. Others will require a more considered approach which allows for planning. All responsible staff need to act with the speed appropriate to the circumstances of the case.

- At the earliest opportunity, the Social Worker will liaise with the relevant local authority Social Work Services, and any other agencies as appropriate, to ensure that the referral is properly assessed and fully considered and that any further action required by TSH staff, in relation to the reported child protection or child welfare concern is taken.

- On conclusion of the Notification of the Child Protection concern at TSH, the Social Worker will complete the Child Protection Concern Initial Enquiry Report. Thereafter, record action taken or to be taken, and by whom, and forward a copy of the Notification of Child Protection Concern Form and Child Protection Concern Initial Enquiry Report to the relevant local authority Social Work Service for the child, with a covering letter confirming the closure of the referral at TSH.

- The Social Worker will forward a copy of this information to the Patient's RMO, the Lead Nurse and the Director of Nursing & Operations

- Where appropriate, the Social Worker will update the Child Protection Summary and the Child Contact Assessment/Review/Change of Circumstances Report and circulate in accordance with the Hospitals Child Contact Procedures.

- Notification of a Child Protection Concern will be dealt with on the day of receipt by TSH Social Work Service and should generally be concluded within 5 working days.

- A copy of the Notification of Child Protection Concern Flowchart is attached (see Appendix C).

6. Procedure for Child Contact Applications

- A Child Contact Application can only be made by the parent, guardian or Local Authority who have current responsibility for taking decisions on the child's behalf.

- All applications must contain:
  - The child's name, date of birth, gender, home address, contact telephone number and relationship to the patient
  - A recent photograph of the child must be included when a request for contact is made
  - The parent(s) or guardian(s) name, date of birth, gender, home address, contact telephone number, their relationship to the child and their relationship to the patient
  - The name, date of birth, gender, home address, contact telephone number, their relationship to the child and their relationship to the patient of any proposed accompanying adult(s) if different from, or, in addition to, the parent(s) / guardian(s)

- All parent(s) / guardian(s) and any other proposed accompanying adults must be approved visitors in their own right, prior to making an application for a child to visit a patient in TSH or for a patient to have a home visit or community outing where a child (ren) will be present.

- A signed, completed and approved Child Contact Application will be required for the child (ren) to visit TSH, be present at a home visit by a patient or be present at a community outing involving a patient. This requirement also applies to other forms of contact between a patient and child (ren). In certain circumstances however, other parties such as a Local Authority may be entitled to act in loco parentis and to give permission for these matters.

- Child Contact Application Packs are available within the Family Centre and Carers Reception, and also directly from the Social Work Service and the Security Department. The packs will contain the application form, a Child Contact Fact Sheet, a Smoke Free Environment Fact Sheet and The Family Centre Fact Sheet.

- All completed Child Contact Applications must be returned by the applicant directly to the Social Work Service, with a recent photograph of the child for the application to be processed appropriately.

7. Child Contact Assessment and Process

- All requests for a child to visit a patient or to have contact with a patient in TSH will be subject to an assessment by a Social Worker. The purpose of the assessment is to ensure that the proposed visit or contact would be in the child's best interest, and also to determine any level of risk which contact with the patient may present to the child.

- A separate assessment is required for each child.

- All applications for child contact will be subject to the same assessment process regardless of the patient's risk to children or schedule 1 status.

- The assessment will include discussion with the Clinical Team, interview(s) with the patient, a home visit to the child(ren), the parent(s) / guardian(s) and a home visit to any other proposed accompanying adult(s). Where home visits are not feasible as a result of extenuating circumstances e.g. infection control measures, alternative contact such as via video will take place in consultation with the clinical team and Social Work Team Leader.

- Where applicable, liaison will take place with any relevant local authorities, reference made to information contained within TSH records and any other enquiries undertaken as necessary.

- In the event that the child(ren), the parent(s)/guardian(s) or the proposed accompanying adult reside in a different Local Authority from the patient's ordinary residence, all interested local authorities must be consulted.

- It is also essential to ensure that the Clinical Team are an integral part of the process. Any issues which arise during the assessment process should be discussed with the Social Work Team Leader and appropriate members of the Clinical Team, with a view to achieving a resolution which is acceptable to all parties.

- Only in exceptional circumstances, and in consultation with the RMO, a child (ren) may be allowed access to visit a patient without the above process having been completed. In these circumstances, enquiries and checks will be undertaken and closer supervision arrangements will also be applied when the visit takes place.

- The Social Worker will carry out an initial records check and discuss the application with the patient's Clinical Team. The Clinical Team will consider the patient's risk history, the patient's Child Protection Summary, the health of the patient and any other relevant information available in considering the appropriateness of the application.

- In those instances, where the Social Worker and Clinical Team agree the application should progress, the Social Worker must discuss the application with the patient ensuring that the patient has access to Advocacy representation if they so wish. This discussion should include the patient's attitude to and motivation for the proposed child contact, rather than being limited to whether or not the patient wishes the child contact.

- Assessments should be completed and the outcome notified to all relevant parties. It is essential to ensure that all steps including the reasons why an application is supported/not supported are fully recorded in the patient's case notes.

- The Social Worker will interview the parent(s) / guardian(s) and child (ren) in the family home, another appropriate setting or via video link.

- Any other proposed accompanying adults must also be interviewed.

- Where appropriate, the Social Worker will request the permission of the parent(s)/ guardian(s) to interview the child (ren) alone.

- Any health concerns or additional support needs in relation to the child (ren) or proposed accompanying adult(s) including pregnant women should be noted and discussed with the Clinical Team.

- The Social Worker will discuss the circumstances of the request, gather relevant information and consider the interests of the child (ren).

- The Social Worker will confirm with the parent(s) / guardian(s) that only the adult(s) named in the application can accompany the child (ren).

- The Social Worker must ensure that the photo of the child which was submitted with the application is a true likeness, and certify this by signature and date on the back of the photograph.

- The Social Worker will further discuss all aspects of the proposed contact with the patient and his advocacy representative where appropriate, taking into account any relevant information gathered during the assessment process.

- In the event that it becomes evident at any stage of the assessment process that the application will not be supported for any reason, the Social Worker must advise the patient of the decision and the reason for the decision both verbally and in writing, with a copy of the letter to Advocacy (where the patient has or wishes advocacy representation) and the RMO.

- A separate outcome letter must be sent by the Social Worker to the parent(s) / guardian(s), who will be offered the opportunity to discuss the decision with the Social Worker. This letter will be copied to the RMO, Security Support Staff, the Security Liaison Manager, the patient's Mental Health Officer (MHO) and the relevant Local Authority(s).

- On completion of the assessment, the Clinical Team will discuss the content and make a decision on the appropriateness or otherwise of the child contact, confirm any additional guidance for staff supervising the proposed child contact which the Social Worker will include within the Child Protection Summary. This should include child visits, where relevant, and any other form of potential contact between the child (ren) and the patient.

- Where visits/contact are to be undertaken under restricted circumstances, the Clinical Team should clearly identify the parameters of the visit/contact, who can be present on a visit, the level of supervision and observation necessary, any areas that they would wish specifically monitored or assessed, and details of any property or items to be allowed at the visit or other form of contact.

- **It should be noted that where a patient is assessed as being a risk to children, during a child visit to the Hospital, the patient must remain within the separate restricted area designated and a member of staff will be present at all times.**

- The Child Contact Assessment/Review/Change of Circumstances Report and the Child Protection Summary recording the Clinical Team's decisions will then be updated on RiO and approved by the Social Work Team Leader. Once approved Social Work Administration staff will notify Security Support Staff by email.

- The signed Child Contact Assessment/Review/Change of Circumstances Report and the Child Protection Summary will be held in the Patient Electronic System (RiO).

- Where the Clinical Team have approved the proposed child contact, a copy of the verified photograph of the child should also be passed to the Security Information Office to enable the identity of the child to be confirmed along with other supporting identification on the child's first contact visit or outing. For Video Visits, a copy of the photograph is passed to nursing staff so that they can ascertain the identity of the child when supervising contact.

8. Child Contact Reviews

- All child contact will be reviewed on a six monthly basis to coincide with the intermediate/ annual Care Programme Approach review cycle.

- The review process will be proportionate to the level of contact being considered. The report should reference the nature of the contact which has taken place, with whom and the frequency of the contact with the patient since the last review. Any issues identified by supervising staff and/or the Clinical Team should be highlighted.

- The review report should reference the patient's, parent(s) and/or guardian(s) experience of the contact, the child's experience of the contact (where possible), as well as the experience of any other adult authorised to accompany the child on a visit with the patient. Any issues identified should be highlighted.

- Any changes to the patient's risk profile should also be highlighted and any other forms of contact which have been authorised should be reviewed in line with the relevant TSH policies and specified within the body of the updated report, noting when the review of the particular contact took place.

- Where no child contact visits have taken place over a 12 month period, the child's name may be removed from the Child Contact visitors list and a letter sent to the parent / guardian and any other proposed adult accompanying the child (ren) during a visit, by the Social Worker to this effect to advise of the requirement to re-apply should they wish to resume child contact visits with the patient. This would generally be pre-empted by an alert letter at the 9 month point, seeking confirmation from the relevant parties of their intention or otherwise to progress Child Contact Visits within the 12 month period.

- The robust assessment and review process should facilitate organisational responsibility for ensuring that children are safe and that their interests are paramount in relation to decisions made at TSH which may affect them. The Child Protection Summary and Child Contact Assessment/Review/Change of Circumstances Report held on RiO should ensure the accessibility of the Child Protection information ensuring best practice as far as practicable.

9. Child Contact Process for Suspension of Detention

- The hospitals Suspension of Detention Policy (CP10) should be supplemented by the Child Contact Procedures in those instances where a Suspension of Detention for a patient such as a home visit or community outing will have a child (ren) present.

- This would involve an assessment of all relevant parties by a Social Worker, liaison with relevant local Social Work Offices and any other agencies as appropriate.

- The provision by the parent(s) / guardian(s) of the relevant permissions and a photograph of the Child (ren).

10. Child Contact Process for Other Forms of Child Contact

- In addition to child visits and Suspension of Detention, a patient may have other forms of potential contact with a child (ren) such as telephone contact, virtual visits, gifts into/out of TSH, exchange of photographs; letters or cards, patient possessions such as magazines, DVDs, posters photographs or mail and third party information which may be passed from the patient to the child (ren).

- The nature of non face to face contact with a child (ren) can present different risks from face to face contact in terms of grooming etc. These operational procedures take full account of the potential risk to a child (ren), which may arise from all forms of contact. Non face to face, direct contact with a child (ren) will be subject to the same standards of initial assessment as all other forms of contact. Where contact is indirect, a proportionate approach to assessment and reviews, commensurate with the nature of the contact and any associated risks, may be considered in discussion with the relevant stakeholders.

- Existing TSH policies on these other forms of contact should be supplemented by the Keeping Children Safe Policy (CP35).

- This would involve an assessment of all relevant parties by a Social Worker, liaison with relevant local Social Work Offices and any other agencies as appropriate.

- **The parent (s) / guardian(s) are required to grant the relevant permissions for any proposed form of contact.**

11. Supervision of Child Contact and Feedback

- Each patient has a Child Protection Summary located within the electronic patient record, RiO. This contains guidance for supervising staff who may be required to supervise visits. Due consideration will be given to the gender of supervising and social work staff, where appropriate, when undertaking a home visit.

- The Child Protection Summary will detail for supervising staff, the parameters of the child contact whether child (ren) visits within TSH, Suspension of Detention, virtual visits or other forms of contact, and those who can be present. The level of supervision and observation necessary, any areas which they would like to be assessed or monitored and details of any property or items to be allowed at the visit or other form of contact should be outlined. These details are particularly essential in those instances where visits/contacts are to be undertaken under restricted circumstances.

- **It should be noted that where a patient is assessed as being a risk to children, during a child visit to TSH, the patient must remain within the designated restricted area, where a member of staff is present at all times.**

- **Feedback Forms are to be completed by staff supervising child contacts, whether at TSH, as part of a Suspension of Detention or via a virtual visit, and forwarded to the Social Work Service.** Guidance for identifying potential areas for consideration by supervising staff highlights factors which should be included within the Feedback Form. If there is any cause for concern, this must be reported immediately to the Lead Nurse, the RMO and the Social Work Service. If the cause for concern merits a Child Protection Concern, this should be passed to the Senior Clinical cover, the Director of Nursing and Operations, the Social Work Service, and a Datix report completed. The Police may also require to be informed if there is reason to believe that a crime may have been committed. Where child protection or child

welfare concerns arise out with office hours, the South Lanarkshire Emergency Social Work Service should be contacted.

12. The Child Protection Summary

- It should be noted that all patients will have a Child Protection Summary completed by the Social Worker, in consultation with the Clinical Team, which will accompany their admission assessment and be reviewed every six months thereafter.

- The Child Protection Summary is a dynamic document, which will detail any assessment needs, any particular needs around the patient's clinical presentation, the patient's status on the risk register, and any other information felt necessary.

- A copy of the Child Protection Summary will be held in Patient Electronic System (RiO) and will be updated by the Social Worker, in consultation with the Clinical Team, for all intermediate and annual reviews. Where necessary, the CP Summary will also be updated in advance of any Suspension of Detention which includes community outings or home visits, when considering any other forms of child contact and following any change in the patient's presentation or circumstances.

13. Equality and Diversity

The State Hospitals Board (the Board) is committed to valuing and supporting equality and diversity, ensuring patients, carers, volunteers and staff are treated with dignity and respect. Policy development incorporates consideration of the needs of all Protected Characteristic groups in relation to inclusivity, accessibility, equity of impact and attention to practice which may unintentionally cause prejudice and / or discrimination.

The Board recognises the need to ensure all stakeholders are supported to understand information about how services are delivered. Based on what is proportionate and reasonable, we can provide information/documents in alternative formats and are happy to discuss individual needs in this respect. If information is required in an alternative format, please contact the Person-Centred Improvement Lead on 01555 842072.

Line Managers are responsible for ensuring that staff can undertake their role, adhering to policies and procedures. Specialist advice is available to managers to ensure that reasonable adjustments are in place to enable staff to understand and comply with policies and procedures. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

Patient pre-admission assessment processes and ongoing review of individual care and treatment plans support a tailored approach to meeting the needs of patients who experience barriers to communication (e.g. Dementia, Autism, Intellectual Disability, sensory impairment). Rapid access to interpretation / translation services enables an inclusive approach to engage patients for whom English is not their first language. Admission processes include assessment of physical disability with access to local services to support implementation of reasonable adjustments. Patients are encouraged to disclose their faith / religion / beliefs, highlighting any adapted practice required to support individual need in this respect. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

Carers / Named Persons are encouraged to highlight any barriers to communication, physical disability or anything else which would prevent them from being meaningfully involved in the patient's care (where the patient has consented) and / or other aspects of the work of the Hospital relevant to their role. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy".

The volunteer recruitment and induction process supports volunteers to highlight any barriers to communication, physical disability or anything else which would prevent them from contributing meaningfully to patient care and / or engage in other aspects of the work of the Hospital relevant to their role. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

14. Stakeholder Engagement

Key Stakeholders	Consulted (Y/N)
Patients	Y
Staff	Y
The Board	Y
Carers	Y
Volunteers	Y

15. Communication, Implementation, Monitoring and Review of Policy

This policy will be communicated to all stakeholders within TSH via the intranet and through the staff bulletin.

The Person Centred Improvement Service will facilitate communication with Patients, Carers and Volunteers.

The Child and Adult Protection Forum will be responsible for the implementation and monitoring of this policy.

This policy will be reviewed every three years or earlier if required.

Appendix A: Key Definitions

Key Definitions

Who is a Child?
Part 1 of the Children (Scotland) Act 1995, which deals with matters relating to parents, children and guardians, a child is generally defined as someone under the age of 18, but most of the provisions which deal with parental rights and responsibilities apply only to children under the age of 16.

Chapter 1 of Part 2 deals with support for children and families and includes local authorities' duties in respect of looked after children and children 'in need'. For these purposes a child is also defined as someone under the age of 18.

The Human Trafficking and Exploitation (Scotland) Act 2015 defines a child as a person under 18 years. When s38 of this Act is implemented there will be a statutory duty on certain public bodies to notify Police Scotland about possible victims of human trafficking. The sexual abuse of trust offence applies to persons over 18 who are in a defined position of trust (such as teachers, care workers and health professionals) intentionally engaging in sexual activity towards a person under 18 years (Sexual Offences (Scotland) Act 2009, s42). The Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005 also defines a child as a person under 18 years in relation to sexual exploitation of children under the age of 18 through prostitution or pornography.

Under the Children and Young People (Scotland) Act 2014, a 'child' is defined, for the purposes of all Parts of that Act, as someone who has not yet attained the age of 18. The individual young person's circumstances and age will dictate what legal protections are available. For example, the Adult Support and Protection (Scotland) Act 2007 can be applied to over-16s when the criteria are met.

A fuller set of definitions may be found at: https://www.gov.scot/publications/national-guidance-child-protection-scotland-2021/pages/3/. For the purposes of TSH Keeping Children Safe Policy, children will be regarded as being aged under 16, unless they are defined otherwise within a specific legislative framework.

Who are Parents and Carers?
A 'parent' is someone who is the genetic or adoptive mother or father of the child. This is subject to the Human Fertilisation and Embryology Act 2008, which sets out which persons are to be treated as the parents of a child conceived through assisted reproduction.

All mothers automatically get parental responsibilities and rights (PRRs) for their child. A father also has PRRs automatically if he is or was married to the mother at the time of the child's conception, or subsequently. If a father is not married to the mother, he will acquire PRRs if he is registered as the child's father on the child's birth certificate, which requires the mother's agreement as this must have been registered jointly with the child's mother. A father can also acquire PRRs by completing and registering a Parental Responsibilities and Rights agreement with the mother or obtaining a court order.

Same-sex couples can adopt a child together. A same-sex partner has no automatic parental responsibilities and rights for their partner's children. If a child is conceived by donor insemination or fertility treatment on or after 6 April 2009, a same-sex partner can be the second legal parent. The second parent may hold parental responsibilities and rights if they were in married or in a civil partnership with the mother at the time of insemination/fertility treatment, or if the person is named as the other parent on the child's birth certificate and the birth was registered post 4 May 2006, or if the person completes and registers a Parental Responsibilities and Rights agreement with the mother. It is possible for a same sex partner to apply for parental responsibilities if none of these conditions apply.

Parental rights are necessary to allow a parent to fulfil their responsibilities, which include looking after their child's health, development and welfare, providing guidance to their child, maintaining regular contact with their child if they do not live with them, and acting as their child's legal representative. In order to fulfil these responsibilities, parental rights include the right to have their child live with them and to decide how their child is brought up. Parents continue to hold parental rights for a child unless and until these are removed. If this happens, it must be clear who does hold parental rights and responsibilities.

A 'carer' is someone other than a parent who is looking after a child. A carer may be a 'relevant person' within the children's hearing system. 'Relevant persons' have extensive rights within the children's hearing system, including the right to attend children's hearings, receive documents relating to hearings and appeal decisions taken within those proceedings. A 'kinship carer' is a carer for a child looked after by the local authority, where the child is placed with the kinship carer in accordance with Regulation 10 of the Looked After Children (Scotland) Regulations 2009.

What is Child abuse and Child neglect?
Child Abuse and Neglect is the term used to describe ways in which children are harmed and abused. The National Guidance for Child Protection in Scotland 2021 defines Child Abuse and Neglect as forms of maltreatment. Children may be maltreated at home; within a family or peer network; in care placements; institutions or community settings; and in the online and digital environment. Those responsible for may be family members, previously unknown or familiar, or in positions of trust.

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

Emotional Abuse
Emotional abuse is persistent emotional ill treatment that has severe and persistent adverse effects on a child's emotional development. 'Persistent' means there is a continuous or intermittent pattern, which has caused, or likely to cause significant harm. Emotional abuse is present to some extent in all types of ill treatment of a child, but it can also occur independently of other forms of abuse. It may involve:

- Conveying to a child that they are worthless or unloved, inadequate or valued only insofar as they meet the needs of another person.
- Exploitation or corruption of a child, or imposition of demands inappropriate for their age and stage of development
- Repeated silencing, ridiculing or intimidation
- Demands that so exceed a child's capability that they may be harmful
- Extreme overprotection, such that a child is harmed by prevention of learning, exploration and social development
- Seeing or hearing the abuse of another

Sexual Abuse
Child Sexual Abuse (CSA) is an act that involves a child under 16 years of age in any activity for the sexual gratification of another person, whether or not it is claimed that the child either consented or assented. Sexual abuse involves forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening.

The Activities involve physical contact, including penetrative or non-penetrative acts. They may include non-contact activities such as involving child in looking at or in the productions of images, in watching sexual activities, using sexual language towards a child, or encouraging children to behave in sexually inappropriate ways.

Child Sexual Exploitation (CSE)is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a person under18 years, into sexual activity in exchange for something the victim needs or wants, and/or for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child Sexual Exploitation does not always involve physical contact; it can occur through the use of technology.

Neglect
Neglect consists in persistent failure to meet a child's basic physical and/or psychological needs, which is likely to result in the serious impairment of the child's health and development. The Scottish Government's Getting It Right for Every Child (GIRFEC) sets out the essential wellbeing needs of children and young people and neglect of any of these can impact on health development. There can also be single instances of neglectful behaviour that cause significant harm. 'Persistent' means there is a pattern which may be continuous or intermittent which has caused or is likely to cause significant harm.

It may involve a parent or carer failing to provide adequate food, clothing and shelter (including exclusion from home or abandonment); to protect a child from physical or emotional harm or danger; to ensure adequate supervision (including the use of inadequate caregivers); to seek consistent access to appropriate medical care or treatment; to ensure the child receives education; or to respond to a child's essential emotional needs.

Malnutrition, lack of nurturing and lack of stimulation can lead to serious long-term effects such as greater susceptibility to serious childhood illnesses and reduction in potential stature. For very young children the impact could quickly become life threatening. Chronic physical and emotional neglect may also have a significant impact on teenagers.

Child Trafficking
Child trafficking involves the recruitment, transportation, transfer, harbouring or receipt, exchange or transfer of control of a child under the age of 18 years for the purposes of exploitation. Transfer or movement can be within an area and does not have to be across borders. Examples of and reasons for trafficking can include sexual, criminal and financial exploitation, forced labour, removal of organs, illegal adoption, and forced or illegal marriage.

Female genital mutilation
This extreme form of physical, sexual and emotional assault upon girls and women involves partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. Such procedures are usually conducted on children and are a criminal offence in Scotland. FGM can be fatal and is associated with long-term physical and emotional harm.

Forced marriage
A forced marriage is a marriage conducted without the full and free consent of both parties and where duress is a factor. Duress can include physical, psychological, financial, sexual, and emotional abuse. Forced marriage is both a child protection and adult protection matter. Child protection processes will be considered up to the age of 18. Forced marriage may be a risk alongside other forms of so called 'honour-based' abuse (HBA). HBA includes practices used to control behaviour within families, communities, or other social groups, to protect perceived cultural and religious beliefs and/or 'honour'.

What is Child Protection?
Child Protection refers to the processes involved in consideration, assessment and planning of action, together with the actions themselves, where there are concerns that a child may be at risk of harm. Child protection procedures are initiated when police, social work or health professionals determine that a child may have been abused or may be at risk of significant harm.

Child Protection is part of a continuum of duties upon agencies working with children, with Child Protection processes falling at the urgent end of a continuum of services which include prevention and early intervention.

What is Harm and Significant Harm in a Child Protection Context

Protecting children involves preventing harm and/or the risk of harm from abuse or neglect. A child protection investigation is triggered when the impact of harm is deemed to be significant.

'Harm' in this context refers to the ill treatment or the impairment of the health or development of the child, including, for example, impairment suffered as a result of seeing or hearing the ill treatment of another.

'Development' can mean physical, intellectual, emotional, social or behavioural development. 'Health' can mean physical or mental health. Forming a view on the significance of harm involves information gathering, putting a concern in context, and analysis of the facts and circumstances.

There is no legal definition of significant harm or the distinction between harm and significant harm. The extent to which harm is significant will relate to the severity or anticipated severity of impact upon a child's health and development. It is a matter for professional judgement as to whether the degree of harm to which the child is believed to have been subjected, is suspected of having been subjected, or is likely to be subjected is 'significant'. Judgement is based on as much information as can be lawfully and proportionately obtained about the child, his or her family and relevant context, including observation.

Appendix B: Notification of Child Protection Concern Form

The State Hospital

Notification of Child Protection Concern Form

- All staff working in public agencies (Council, Health, Police, Care Commission) must report all child protection or welfare concerns to Social Work Resources.
- The parent/guardian's consent is not necessary prior to making a Notification of Child Protection Concern to Social Work Resources.
- If you do not have all the information required to complete this form, do not delay sending the form. The Social Work Service will follow up your concerns and add additional relevant information.

CHILD'S DETAILS:

Name: _____ Known as: _____

Date of birth: _____

Address: _____

_____

_____

_____

Phone number: _____

Gender: _____

Ethnic Origin: _____

Religion: _____

Any known communication needs: Yes/No

If yes, please detail:

Who else is aware of this referral, have others discussed the details with the parents/guardians or the child
Please give details of the circumstances leading to this referral. Include specific incidents – dates, times, frequency, injuries, evidence such as bruising, inadequate standards of care, witnesses
Is the child capable of understanding the area of concern
What other action have you taken to ensure the child is now safe?

Details of the alleged harmer if applicable and known:

Name: _____

Address: _____

_____

_____

Relationship to child: _____

Any other relevant information, include details of any previous incidents or concerns including dates, times, actions taken and outcomes.

REFERRER DETAILS:
Name of Referrer:
Designation:
Contact Telephone Number: **Email Address:**
Address:
Date Reported:

REFERRAL DETAILS:			
SOURCE**	**METHOD****	**TYPE OF REFERRAL****	**CATEGORY****
Family Member Patient Ward Staff RMO Social Worker Child External Agency Advocacy Other TSH Staff	In person Email Letter Telephone Other	Patient/Child Staff/Child Parent/Child Sibling/Child Other family member/child Other	Physical injury Sexual abuse Physical neglect Failure to thrive Emotional abuse
****(delete those that do not apply in the above columns)***			

PATIENT DETAILS:			
NAME	**DATE OF BIRTH**	**HOSPITAL NO**	**CHI NUMBER**

Date of Referral:

Referral Completed by: **Name**
Designation

Appendix C: Notification of Child Protection Concern Flowchart