**Child Protection Procedures**

**Edinburgh, Lothians and Scottish Borders**

**2023**

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# 1. Introduction

1.1 These procedures describe responsibilities, expectations and actions for all involved in protecting children from significant harm in City of Edinburgh, East Lothian, Midlothian, West Lothian, City of Edinburgh and Scottish Borders.

1.2 Everyone has a role in making sure children are safe. The welfare of the child is the paramount consideration in action to ensure children’s safety.

1.3 Child protection is not the responsibility of any single agency. Professionals working with children and adults must work together to share information, assess and analyse needs and risks, and plan and deliver services jointly in a co-ordinated manner. In doing so, professionals can reduce the risk of harm to children and promote their welfare.

1.4 These procedures align with themes in the National Guidance for Child Protection in Scotland 2021, which reflect changes in legislation, standards and policy, developments in practice as well as findings from research, Significant Case Reviews/Learning Reviews and Inspections.

## 2. Principles underpinning the procedures

* 2.1 Children should get the right help, at the right time, from the right people (GIRFEC). Early interventions through Universal Services and multi-agency supports can provide proportionate responses to reduce the risk and impact of harm before it becomes “significant” and a Child Protection intervention is required.
* 2.2 Child Protection procedures must be considered for a person up to the age of 18. ‘Child’ is defined as a person up to 18 years of age in line with the United Nations Convention on the Rights of the Child (UNCRC) definition. In general terms, while respecting the implications of different legal definitions of a ‘child’, this procedure applies to unborn babies and children under the age of 18 years. For some children aged 16 and over, Adult Support and Protection legislation may be a more appropriate way to address risk, and this should be considered at the point of Inter-agency Referral Discussion (IRD).
* 2.3 The incorporation of the UN Convention on the Rights of the Child (UNCRC) into Scots law. Children’s rights provide the foundation for a holistic approach to ensuring children’s safety and wellbeing. Effective child protection involves promoting resilience and providing practical, collaborative family support.
* 2.4 Recognition that we need to understand and respond to young people’s experiences of significant harm beyond their family environment and that young people are exposed to violence/exploitation in their school, community or peer group, which makes it hard for parents/ carers to keep them safe.
* 2.5 The National Trauma Framework, which emphasises the need for a trauma informed, and responsive workforce.

## 3. Involving children and families in child protection processes

3.1 The protection and welfare of children must be at the heart of all considerations and decisions. Children and their main care givers should be involved and included at every stage of the child protection process, unless there is a clear and demonstrable reason why this would increase the risk to a child.

### 4. Working with children and young people

4.1 Children and young people must:

* Be helped to understand what the child protection process is, who and what is involved and how they can contribute to decisions.
* Have their views sought, listened to and considered at every stage of assessment, planning and intervention. Where professionals disagree with the child’s view of what action should or should not be taken, this must be explained to the child.
* Be supported to contribute to and understand their child protection plan and receive an accessible copy appropriate to their age, stage and understanding (any additional support needs, communication barriers and trauma suffered should be considered).
* Have access to advocacy.

### 5. Working with parents/carers

* The views of parents and carers should always be listened to and considered.
* They should be given as much information as possible about what is happening and be involved in decision making unless this increases the risk to the child.
* They should be supported to understand what the concerns are and what their role is in any meeting or plan.
* Working in partnership with family members is key to the long-term beneficial outcomes for the child, and staff must take account of a family’s strengths as well as its weaknesses.

Practitioners must seek to achieve a shared understanding with parents about concerns and about actions needed to reduce risk and build on strengths

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**Source: National Guidance for Child Protection in Scotland (2021)**

# 6. What is child protection?

6.1 Child protection refers to the processes involved in consideration, assessment and planning of required action, together with the actions themselves, where there are concerns that a child may be at risk of harm. (National Guidance for Child Protection in Scotland, 2021)

**6.2Child protection procedures** are triggered when police, social work or health professionals determine that a child may have experienced or be at risk of significant harm.

**6.3 ‘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.

**6.4 ‘Significant harm’** is not defined in law. The extent to which harm is significant relates to the severity or anticipated severity of the impact on a child’s health and development. Professional judgement about the significance of harm will take into account:

* the child’s experience, needs and feelings as far as they are known;
* the nature, degree and extent of physical or emotional harm;
* the duration and frequency of abuse and neglect;
* overall parenting capacity;
* the apparent or anticipated impact given the child’s age and stage of development;
* extent of any premeditation; and
* the presence or degree of threat, coercion, sadism and any other factors that may increase risk to do with the child, family or wider context.

**6.5 A single traumatic event** may cause significant harm – for example a violent assault, suffocation or poisoning. More often, significant harm results from an accumulation of events, both acute and long-standing, that interrupt, change or damage the child’s physical and psychological development.

# 7. Definitions

## What is child abuse and child neglect?

7.1 Abuse or neglect may involve inflicting harm or failing to act to prevent harm. Children may be abused or neglected in any setting, and online (for example social media and gaming forums). Those responsible may be previously unknown or familiar, or in positions of trust. They may be family members. Harm may occur pre-birth, for instance by domestic abuse of a mother or through parental alcohol and drug use.

7.2 Systemic pressures, such as poverty or homelessness, may exacerbate many forms of child abuse or neglect. The way in which risk to a child is impacted by their wider circumstances should always be considered as part of an assessment and plan.

7.3 Physical abuse is causing 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. All forms of physical punishment of children are against the law in Scotland regardless of personal attitudes towards reasonsable discipline.

7.4 Emotional abuse is persistent emotional neglect or ill treatment of a child causing severe and lasting adverse effects on the child’s emotional development. ‘Persistent’ means there is a continuous or intermittent pattern, which has caused, or is 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:

* Making a child feel that they are worthless or unloved, inadequate or valued only because they meet the needs of another person;
* Having unrealistic expectations or imposing demands inappropriate for their age or stage of development;
* Repeated silencing, ridiculing or intimidation;
* Extreme overprotection, such that a child is harmed by prevention of learning, exploration and social development; and/or
* Seeing or hearing the abuse of another (in accordance with the Domestic Abuse (Scotland) Act 2018).

7.5 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. Children under the age of 13 do not have capacity to give consent to sexual activity.

7.6 For those who may be victims of sexual offences aged 16-17 and who are at risk of significant harm, child protection procedures should be considered, and must be applied when there is concern about sexual exploitation or trafficking.

7.7 Sexual abuse may involve physical contact, including penetrative or non-penetrative acts or may involve non-contact activities, such as involving children in looking at, or in the production of, indecent images, or in watching sexual activities, using sexual language towards a child, or encouraging children to behave in sexually inappropriate ways.

7.8 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 under 18 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 also occur online.

7.9 It is important to remember that victims of child sexual exploitation (CSE) may not recognise the abuse and may regard themselves as being in a consensual sexual relationship.

7.10 Criminal exploitation An individual or group may use an imbalance of power to coerce, control, manipulate or deceive a child under the age of 18 into any criminal activity in exchange for something the victim needs or wants, or for the financial or other advantage of the perpetrator or facilitator. Violence or the threat of violence may feature. The victim may have been criminally exploited, even if they appear to have agreed to the activity. Child criminal exploitation may happen in person or online. It may involve gangs and organised criminal networks, for example using children to store, move or sell drugs or money (known as ‘county lines’). Coercion, intimidation, violence (including sexual violence) and weapons may be involved.

7.11 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. Reasons for trafficking include sexual, criminal and financial exploitation, forced labour, removal of organs, illegal adoption, and forced or illegal marriage.

7.12 Neglect is the 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 or development. Single instances of neglectful behaviour may cause significant harm. Early signs of neglect indicate the need for support to prevent harm.

7.13 Once a child is born, neglect may involve failing: to provide adequate food, clothing and shelter (including exclusion from home or abandonment); to protect a child from physical and 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.

7.14 Female genital mutilation is an extreme form of gender-based abuse, which causes significant and lifelong physical and emotional harm and 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 carried out on children and are a criminal offence in the UK. Cultural considerations and sensitivities should not override the need of professionals to take action to protect a child at risk.

### 7.15 Forced marriage

A forced marriage is where one or both people do not or cannot consent to marriage and undue pressure or coercion is used. It is recognised in the UK as a form of violence against women, men and children and is a fundamental abuse of human rights. The pressure put on people to marry against their will can be physical (including threats, actual physical violence and sexual violence) or emotional and psychological (for example, when someone is made to feel they are bringing shame on their family). Financial abuse (taking wages or not giving the person any money) can also be a factor. Parents who force their children to marry often justify their behaviour as protecting their children, building stronger families and preserving cultural or religious traditions. However, forced marriage cannot be justified on religious grounds; every major faith condemns it.

# 8. Agencies’ Roles and Responsibilities

8.1 Child Protection is everyone’s business. Everyone has a responsibility to ensure that children are safe and cared for. All staff, carers and volunteers in all agencies, whether their primary focus is working with children or with adults have a responsibility to be alert to the possibility of children being abused or neglected and have a responsibility to pass their concerns to one of the core agencies (Police, Health or Social Work) and provide relevant information.

8.2 All services/agencies should have their own processes for identifying, sharing and acting upon concerns about risk of harm to a child, which must comply with these procedures.

8.3 Single agency guidance may identify a ‘responsible person’, ‘child protection advisor’ or ‘designated member of staff’ who can be contacted for guidance. They will listen to concerns and give advice on what action needs to be taken. In appropriate situations, they will recommend referring the matter to one of the core agencies.

8.4 Where such a ‘responsible person’ or senior member of staff is not available for consultation, the member of staff must not delay but should contact agencies directly. If they are not satisfied with the response from the ‘responsible person’, the member of staff should contact one of the core agencies directly (See [Reporting Child Protection Concerns](#_Reporting_child_protection)).

8.5 Each practitioner is accountable for their own practice and must adhere to their own professional guidelines, standards and codes of conduct. All staff should undertake training, learning and development appropriate to their role and level of responsibility in child protection.

8.6 If asked, **all** agencies must provide relevant information to assist any child protection investigation.

8.7 If invited, **all** agencies must provide a report for an initial Child Protection Planning Meeting and attend.

## Local Authorities

8.8 .Local authorities have a legal duty [Children (Scotland) Act 1995] to safeguard and promote the welfare of children in need. The local authority must make all necessary inquiries into the child’s circumstances if it appears that the child needs protection, guidance, treatment or control, or a Compulsory Supervision Order may be required. This responsibility extends to all children, whether they are in the community with their parents, in the care of others or being looked after by the local authority. This duty applies to all local authority services.

8.9 Children and families Social Work Services play a key role in investigating child protection concerns and supporting children and families. Designated managers are responsible for discussing child protection referrals with Police and Health (Inter-agency Referral Discussions – IRDs) and specially trained social workers and police officers interview children who may have suffered abuse or neglect. A Social Worker is always the Lead Professional if a child’s name is placed on the Child Protection Register

### Education

8.10 All staff working in education establishments, including early learning and childcare (ELC) settings, have a key role in the support and protection of children. Every school has a Designated Member of Staff (DMS) taking lead responsibility for child protection in the school, in liaison with the head teacher/head of establishment.

8.11When concerns about risk of harm arise, education services are well placed to notice and respond to:

* additional needs or factors that may impact on a child’s ability to voice concern;
* physical and emotional changes in a child that could indicate abuse or neglect;
* family, school, cultural and community context of concerns about a child or children;
* escalating support needs of a child and their family; and
* risks and stresses for some children in transitional stages as they move into a new school or on to adult life and services.

8.12 Education staff have a key role in building supportive relationships with children. This can help children understand how to keep themselves and others safe, as well as helping them to learn how to get help and support if they need it.

## Police

8.13 Police Officers have a statutory duty to detect and prevent crime and have a key role in Child Protection and community safety. Every policing division has a dedicated Public Protection Unit staffed by specialist officers, with investigation teams and a Divisional Concern Hub. These Officers have a key role in the assessment, investigation and planning around child protection. Police Scotland is a core agency involved in Inter-agency Referral Discussions (IRDs) and undertake the investigative interviews of children who may have been abused, alongside specially trained social workers. Police have a statutory duty to refer the facts to the Procurator Fiscal where a criminal offence may have been committed, and to refer children to the Scottish Children’s Reporter Administration when they may be in need of compulsory supervision. Police have emergency powers to remove a child from harm or risk of harm.

## Health

8.14 Health professionals are often the first to be alerted to cases of child abuse, particularly in suspected cases of physical abuse and neglect. Health staff may have contact with parent(s)/carer(s) of children in circumstances that suggest the child may be at risk.

8.15 Health professionals offer children a trauma informed health assessment, which satisfies both the child’s needs and any forensic requirements.

8.16 The health service may also offer ongoing physical and psychological care.

8.17 Universal health service professionals such as Midwives, Health Visitors and GPs play an important role in child protection investigations as they often know children and families well and have important information to share to assist any child protection investigation and offer ongoing support, in any plan, to reduce risk.

## Third sector and independent organisations

8.18 The third sector is made up of various types of organisations, which are non-governmental e.g., voluntary and community organisations, charities, social enterprises, co-operatives. Other organisations may include sports clubs, faith groups such as churches or mosques and private childcare providers. The third sector and other organisations play a significant role in engaging with children and young people and their families. Staff and volunteers have a responsibility to be alert to the possibility that a child is being abused or neglected and know how to raise these concerns. These organisations may know children and families well and have important information to share to assist any child protection investigation and offer ongoing support, in any plan, to reduce risk.

8.19 Further and Higher Education establishments and Independent Schools are expected to incorporate these procedures into their own organisation’s child protection policies, procedures and guidance. Where a child protection concern arises in relation to a child who attends an independent school, college or university out with their own area, the establishment must liaise with the local authority where the child usually lives.

## Children’s Reporter

8.20 Children’s Reporters are responsible for investigating the circumstances of a child who has been referred, and who may need compulsory measures of supervision (CSO). Any person or agency can refer a child to the Principal Reporter but local authorities and the police must refer a child when they consider that a child is in need of protection, guidance, treatment or control and that a CSO might be necessary. The Principal Reporter’s role is to decide (a) whether one of the grounds of referral in section 67 of the Children’s Hearings (Scotland) Act 2011 apply in relation to the child and (b) if so, whether it is necessary for a CSO to be made in respect of the child.

8.21 The Principal Reporter’s investigation can take place at the same time as any on-going criminal investigation or criminal court case, but the focus for the Principal Reporter and the children’s hearing is centred on the needs and wellbeing of the child or young person who has been referred.

# How concerns may arise

8.22 Anyone working with children or families may become aware of a potential child protection concern. This may be a one-off event or an accumulation:

* When a child says something that is concerning (e.g. a young person says they are meeting up with an adult they met online).
* When the child’s presentation changes, either suddenly or over time (e.g. a child appears tired, hungry or unkempt, or they are more withdrawn).
* When a child has visible injuries, which are not explained adequately (e.g. a baby with bruising or broken bones).
* When information is shared by another person, service or anonymous source (e.g. reports from neighbours that a young child is out alone at night).
* When a child tells an adult that something has happened to them (e.g. a child tells their teacher that they have been hit by an adult).
* Concerns about colleagues, volunteers, or professionals in other agencies.
* Concerns arising out with the family - such as exploitation, peer-on-peer or online abuse.

## Concerns about employees, carers, volunteers and service providers

8.23 Concerns may arise about people who work with children either in relation to their behaviour at work or in their private life. **If you have a child protection concern about a colleague or a member of staff in another organisation, this should be shared according to these child protection procedures.**

8.24 In these situations, the paramount consideration is the welfare of the child concerned and any other children who may be at risk. Child Protection procedures should be followed and take precedence over disciplinary processes or complaints procedures.

8.25 Where a concern about a person who works/volunteers with children or adults arises out with their work, the IRD should consider when to inform the employer/organisation.

# Information sharing

8.26 Sharing relevant information as soon as possible is essential to protecting children from harm. All staff and volunteers should be supported by their organisation to be confident in sharing information appropriately and be guided in working and applying the law by their organisation’s procedures. Information sharing should be lawful, fair and transparent.

8.27 Each agency is responsible for maintaining accurate and secure records.

 **8.28 If there is a child protection concern, information must always be shared**

**8.29 Where there is a child protection concern, relevant information must be shared with one of the core agencies without delay.** The person sharing the information must be aware of the lawful basis for doing so (see table below), and agency data protection leads should be able to advise where doubt about the appropriate lawful basis exists.

**8.30 Staff and volunteers do not need to be certain that a child has been harmed or is at immediate risk before sharing information.** Where someone has reason to believe that a child may be at risk of harm, they must share relevant information with one of the core agencies to support analysis and decision-making.

|  |
| --- |
| **Summary of lawful bases for sharing personal information in a child protection context** |
| ***Public interest or public task***  | necessary for performance of a task carried out in the public interest which is laid down by law, or in the exercise of an official authority, for example, a public body’s tasks, functions, duties or powers. |
| ***Vital interests***  | necessary to protect someone’s life or, for example, if a child is deemed to be at risk of significant harm.  |
| ***Legal obligation***  | necessary to comply with a common law or statutory obligation.  |
|  Reference: Lawful basis for processing | ICO |

8.31 It is the role of designated police, social work and health staff to consider whether there may be a risk of significant harm, and if so, to progress child protection procedures. (See [Child Protection Assessment and Planning](#_Child_protection_assessment)). If asked for information as part of a child protection investigation by one of the core agencies, organisations must comply.

### Consent when sharing information

8.32 It is not necessary to seek consent from a child or their parents before sharing information when there is a child protection concern.

8.33 Consent requires people to have real choice and control about the sharing of their personal data. In most situations where there is a child protection concern, parents will not have real choice or control – the welfare of the child is the paramount consideration and overrides all other duties. Seeking consent may place the child at increased risk.

### What is relevant information?

8.34 Information shared must only be that which is necessary for child protection purposes.

8.35 Information gathering is an essential part of the child protection process, enabling robust risk assessment and planning.

8.36 Examples of relevant information include:

* Basic factual information about the child such as name, date of birth, address.
* The nature and degree of the actual or likely harm
* The impact or potential impact of the harm on the child’s health and development
* Whether other children are affected
* The child’s experience, needs and feelings.
* Any additional needs, medical condition, communication impairment or disability that may affect their health, wellbeing, vulnerability and care needs.
* The parent or carers’ response to concerns
* Past events or concerns.
* Frequency or patterns of harm or suspected harm
* The parents or carers capacity to protect and care for the child
* The child’s culture, family network, community
* Strengths or protective factors
* The likelihood of risk of harm continuing or reoccurring

**8.37 If in doubt about information sharing, seek advice from line managers, or those in the organisation with responsibility for child protection or information governance.**

8.38 When a child shares a concern:

* They must be taken seriously and supported.
* Information must be recorded in the child’s own words.
* Open-ended questions should be used (for example “what happened next?”).
* Closed or leading questions must be avoided (for example “Did dad hit you?”).
* “Why” questions must be avoided. These may make the child feel responsible for what has happened.
* Explain to the child that the information must be shared. Do not promise to keep anything secret.

8.39 Further detailed guidance on information sharing can be found in the [GIRFEC Practice Guidance (Scottish Government, 2022)](https://www.gov.scot/publications/getting-right-child-girfec-practice-guidance-4-information-sharing/pages/1/)

## Recording concerns

9.1 Any professional or volunteer who becomes aware of a child protection concern must record the basic facts as soon as possible. This should include **who** is involved, **what** happened, **where** and **when**.

* All practitioners should ensure that they adhere to their own agency’s recording protocols.
* Information should be recorded as soon as possible after the event
* Recording should be concise, factual and accurate.
* Any opinion should be recorded as such.
* Clear reasons for decisions should be stated.

9.2 Everyone should be aware that records may be used as evidence in Court, and the child and/or their family may request access to their records.

# Reporting child protection concerns

10.1 Anyone working with children, families or adults who becomes aware of a potential child protection concern should report the circumstances at the earliest possible opportunity. It is not necessary to be certain that a child has been harmed or is at immediate risk of harm before reporting a concern.

**Dial 999 if a child is in immediate danger or requires urgent medical assistance.**

10.2 In other circumstances, depending on role, reporting a concern may mean:

1. **Informing a designated person (child protection advisor” or “responsible person”) within the agency or organisation** [See [Agencies’ Roles and Responsibilities](#_Agencies’_Roles_and)*).*
	1. The designated person will listen to concerns and give advice on what action needs to be taken. If appropriate they will make, or recommend making, a Child Protection Referral.
	2. Where a member of staff or volunteer is unable to contact their designated person or they are not satisfied that the response is not adequate to address the risk of harm to the child, they should make a Child Protection Referral without delay.
2. **Making a** [**Child Protection Referral**](#_Making_a_Child) **directly to one of the core agencies.**

10.3 Staff and volunteers across all agencies and sectors should ensure that they are clear as to the specific reporting policies of their organisation or service.

## Making a Child Protection Referral

11.1 A Child Protection Referral is when information is shared with designated people in one of the core agencies if the referrer knows or suspects that a child is at risk of significant harm.

**This should be done without delay.** A Child Protection Referral should include all [relevant information](#_What_is_relevant) known by the referrer.

[INSERT LOCAL INFORMATION *NB: in Borders this will include “Confirmation of Referral” form*]

11.2 Following a Child Protection Referral, the receiving agency will make an initial assessment of the information to determine how to proceed in the best interest of the child.

1. Where the information indicates a **low level of risk**, the matter may be diverted to services for Universal Service or multi-agency support
2. Where the information indicates a **risk of significant harm**, the receiving core agency should initiate an [Interagency Referral Discussion](#_Interagency_Referral_Discussion)
3. Where the information indicates that the child is at **immediate risk of significant harm**, [emergency legal measures](#_Emergency_legal_measures) to remove the child to a place of safety may be used.

11.3 A professional from one of the core agencies will be identified to provide feedback to the referrer, about the action taken and what information may or may not be passed to the child and/or family.

## Escalation

12.1 Robust discussion, challenge and differences of opinion are a valuable part of the child protection process and enable professionals to reach consensus about the best way forward.

12.2 If at any point in the child protection process a professional is not satisfied that actions taken are sufficient to reduce risk to a child, they should first speak with their line manager and refer to their area’s escalation policy.

12.3 For Child Protection Planning Meetings, see [Professional Dissent at CPPM](#_Professional_Dissent_at).

# Child protection assessment and planning

## Interagency Referral Discussion (IRD)

13.1 An IRD is the start of the formal process of information sharing, assessment, analysis and decision making where one or more of the core agencies assess that there is a risk of significant harm to a child up to the age of 18 years. This may be in relation to familial and non-familial concerns, concerns about siblings or other children within the same context and unborn babies.

13.2 An IRD ensures a coordinated inter-agency response to a child protection concern. It facilitates sharing of relevant information at an early stage and ensures that decision making is informed by the perspective of all core agencies. An IRD will determine appropriate investigations, assessments and immediate action to be taken to ensure the safety of any child at risk of significant harm.

13.3 An IRD is a process, rather than a single meeting or discussion.

13.4 Where information is received by police, health or social work that a child may have experienced or may be at risk of significant harm an IRD must be convened as soon as reasonably practical.

13.5 An IRD may begin out with normal office hours, with a focus on immediate protective actions and interim safety planning.

13.6 An IRD will continue until the point that a decision is made to hold a [Child Protection Planning Meeting](#_Child_Protection_Planning) (CPPM) or that alternative action is appropriate.

### Participants

13.7 Police, social work and health must always be part of an IRD. Members of other services or organisations may be considered as appropriate to the individual child. Where an IRD considers a child aged 16 or 17, adult social work services should be involved in the IRD for the purpose of supporting analysis and decision making about whether the risks are better addressed by Adult Support and Protection Procedures or other legal frameworks and whether appropriate support would be better provided by Adult Services.

13.8 IRD participants must be sufficiently senior to assess and discuss available information and make decisions on behalf of their agencies.

13.9 Participants are responsible for checking their agency’s information systems and sharing all relevant information. The IRD may request information from any service or organisation. When information is requested, this must be provided.

### Initiating an IRD

13.10 Any one of the core agencies can initiate an IRD where they believe that a child is at risk of significant harm, and inter-agency discussion and decision-making is required. The person initiating the IRD should make this clear to the other participants, who must engage with the process.

13.11 The initiating agency must open a record on the electronic IRD system, known as eIRD.

### Undertaking an IRD

13.12 At any point during the IRD process it may become apparent that [emergency measures](#_Emergency_legal_measures) are required to protect the child.

IRD participants should share relevant information about:

* The individual child (including any additional support needs, relevant cultural context, child’s views etc.)
* Any other children potentially impacted (e.g. in the family, household, educational, care or community setting)
* All relevant adults, including those who present a potential risk to the child or who may provide protection
* Details of the concern (See [relevant information](#_What_is_relevant))

13.13 IRD participants should make sense of this information (i.e. analyse) to understand the impact on the individual child and the child’s lived experience.

13.14 IRD participants should identify any gaps in information and decide who is responsible for getting this information.

### Decisions and Planning

13.15 Decision-making is not a one-off event, but happens throughout the process as an understanding of the child’s experience and circumstances develops.

13.16 Further investigations or assessments may be required to inform decision-making. These may include:

* a [joint investigative interview](#_Joint_Investigative_Interview)
* a [medical assessment](#_Medical_assessment_and)

13.17 The IRD must decide whether there is a risk of significant harm and an Interim Safety Plan and Child Protection Planning Meeting is required.

13.18 If not, the IRD should decide whether:

* Universal services should continue to support the child
* Multi-agency support through a Child’s Plan is required and identify the agency responsible for arranging a Child’s Planning Meeting,
* A Referral to the Children’s Reporter for consideration of compulsory measures is required

13.19 Whatever the outcome, the IRD should clearly identify who is responsible for progressing the follow-on action, and discussing with relevant agencies, services and people.

13.20 The IRD should clearly identify:

* What feedback to the referrer is appropriate, and who is going to provide this.
* Who will inform the family of the outcome of the IRD

### Interim Safety Plan

13.21 A multi-agency interim safety plan shouldbe in operation throughout an IRD, proportionate to the current assessment of risk. The plan must be agreed by the IRD participants and followed until conclusion of the IRD or the outcome of a CPPM. The interim safety plan must be shared with the people who are expected to deliver it and the child and family as appropriate.

13.22 The plan should:

* Details of who is doing what to ensure a child’s immediate safety
* Identify who has lead responsibility for monitoring the plan.
* Detail who will see and speak to the child and how often.

### IRD Record

13.23 All aspects of the IRD must be recorded on the eIRD system. The record should be updated as information is shared, and decisions are made. The rationale for decisions should be clearly recorded.

### IRD Review and Sign Off

13.24 Every IRD record will be:

* Reviewed within two weeks of the date of referral; and
* Signed off within two weeks of the final outcome of the IRD by the local area’s IRD Review Group.

13.25 The IRD should be closed when there is multi-agency agreement about the level of assessed risk; the need for a CPPM or other action, and an interim safety plan (where required) has been devised.

## Timescales for stages in child protection processes.



FLOWCHART/PROCESS MAP TO BE DEVELOPED. Click into each step for further information.

## Joint Investigative Interview (JII)

14.1 An IRD will decide whether a Joint Investigative Interview (JII) is needed. Joint Investigative Interviews are carried out by Social Workers and Police who are specifically trained to interview children and vulnerable witnesses. JIIs are conducted using the [Scottish Child Interview Model (SCIM).](https://www.cosla.gov.uk/about-cosla/our-teams/children-and-young-people/joint-investigative-interviews-of-child-victims-and-witnesses) The Joint Interview process will be co-ordinated and supervised as determined within local structures.

14.2 The purpose of a JII is to:

* learn the child’s account of the circumstances that prompted the enquiry
* gather information to permit decision-making on whether the child, or any other child, needs protection
* gather sufficient evidence to suggest whether a crime may have been committed against the child or anyone else
* Secure evidence, as appropriate for court proceedings, for example, a criminal trial or a Children’s Hearing proof.

14.3 Joint Investigative Interviews must be trauma informed and consider the child’s needs for support before, during and after the interview. This includes consideration of the child’s:

* experience before the interview and the context of the interview
* motivation to share/ participate
* strengths and resources
* interests (to aid rapport building)
* complex needs and level of understanding
* experience of trauma and adversity
* speech, language/interpreting and communication support needs
* relationships, including sources of reassurance and anxiety
* accompanying support, transport and care arrangements

14.4 When arranging the time of an interview, the needs of the child must be considered. Relevant professionals who have a relationship with the child may support the child or provide necessary information to aid the process. Parents/carers will also be consulted about their views during the planning of an interview where appropriate.

### Consent

14.5 The child must be helped to understand the purpose and process of the interview as part of preparation in order to support willing engagement and informed consent.

* The JII will not proceed without the child’s informed consent.
* It is good practice to always seek the consent of parents/care givers however, the consent of a parent or guardian is not required prior to undertaking a Joint Investigative Interview. Parents/carers should be made aware that the interview is taking place unless there is a good reason not to, for example, where there are strong grounds to suspect that they are involved in the abuse.
* Separate consent must be obtained for a medical examination to take place.

|  |  |  |
| --- | --- | --- |
| **Issue** | **Consent of Parent** | **Consent of Child** |
| Joint Investigative Interview. | Desirable but not legally required.Do not seek if parent is suspected as source of risk/harm. | Formal consent not required. |
| Medical examination.Where child is deemed by doctor not to have capacity to consent to medical examination. | Required.Written parental consent will be required prior to any child protection medical examination, unless the child or young person is considered, by the examining medical practitioner, to have capacity to give consent on their own behalf The written consent must be taken by the examining physician. | Not formally sought.Medical practitioner will only proceed if in the child’s best interests  |
| Medical examination.Where child is deemed by doctor to be **capable** of understanding the reason for medical examination and of comprehending consequences of consenting. This will be determined by the health professional. | Not required. | Always required, even where a condition of a warrant/ order or supervision requirement is for the child to submit to a medical examination or treatment. |

##

## MEDICAL ASSESSMENT

**15.1 The purpose of a child protection medical assessment is**:

* to establish what immediate treatment the child may need
* to provide a specialist medical opinion on whether or not child abuse or neglect is a likely cause of the child’s presentation.
* to support multi-agency planning and decision-making
* to establish if there are unmet health needs, and to secure any on-going health care (including mental health), investigations, monitoring and treatment that the child may require

15.2 Consideration will be given to how the child may be examined in child-friendly surroundings, with the right support for their age, stage and understanding.

**15.3 The decision** to carry out a medical assessment and the decision about the type of medical examination is made by a paediatrician informed by the IRD. The number of examinations will be kept to a minimum.

**15.4 The main types** of medical examination are:

* **Comprehensive Medical Assessment. (CMA)** This type of examination is often undertaken when there is concern about neglect and unmet health needs.
* **Joint Paediatric Forensic Examination** **(JPFE).** Examination by a paediatrician and a forensic physician. This is the usual type of examination for sexual assault and is often undertaken for physical abuse, particularly infants with injuries or older children with complex injuries. Specialist medical examinations, for example by neurologists, may form part of the JPFE

15.5 As far as can be achieved in the circumstances, the IRD should ensure the examining doctor is provided with:

* all relevant information about the cause for concern
* information on previous concerns about abuse or neglect
* the inter-agency plan to meet the child’s needs at this stage
* relevant known background of the family or other relevant adults
* information from joint investigative interview if available
* preparatory discussion with the relevant social work and police officer
* preparatory meeting with parent or carer and child

### Chaperones

15.6 In all cases, a chaperone of the same sex as the victim must be present throughout any medical examination. This is essential not least in terms of General Medical Council guidelines, but also from a victim support and accountability perspective.

15.7 Where medical on call arrangements do not support this position, a police officer of the same sex as the victim will be provided as a chaperone.

15.8 Wherever possible, the wishes of children should be considered and supported in respect of choice of sex of examiner (Clinical Pathways NHS Scotland 2020).

### Consent for medical examinations

15.9 Consent must be obtained in one of the following ways:

* from a parent or carer with parental rights
* from a young person assessed to have capacity
* through a court order

15.10 The Age of Legal Capacity (Scotland) Act 1991 allows a child under the age of 16 to consent to any medical procedure or practice if in the opinion of the qualified medical practitioner the child is capable of understanding the nature and possible consequences of the proposed examination or procedure.

15.11 Children who are assessed as having capacity to consent can withhold their consent to any part of the medical examination, for example, the taking of blood, or a video recording. Consent must be documented within medical notes and must reflect which parts of the process have been consented to and by whom. This includes consent to forensic medical examination.

15.12 In order to ensure that children and their families give properly informed consent to medical examinations, it is the role of the examining doctor, assisted if necessary by the social worker or police officer, to provide information about all aspects of the procedure and how the results may be used; and to ensure informed consent has been obtained.

15.13 Where a medical examination is thought necessary for the purposes of obtaining evidence in criminal proceedings but the parents/carers refuse their consent, the Procurator Fiscal may, in exceptional circumstances, consider obtaining a warrant for this purpose. However, where a child who has legal capacity to consent declines to do so, the Procurator Fiscal will not seek a warrant.

15.14 Where parental consent is not given, the local authority may apply to a Sheriff for a Child Assessment Order, or a Child Protection Order with a condition of medical examination. This is still subject to child’s consent (under section 186 of the 2011 Act).

### Timing of medical examinations

15.15 The provisional timing of the examination is agreed during the IRD discussion and will always be informed by the best interests of the child and with a trauma informed approach. If injuries are not acute, it is usually best to await the results of the SCIM interview to ensure most appropriate examination can be conducted (and minimise the risk of child requiring multiple examinations).

15.16 It is also important to ensure appropriate emotional support is available for the child and a child friendly environment.

15.17 Where involvement of a Forensic Physician is required, the police will contact the on-call Forensic Physician.

### Following examination

15.18 At the end of the examination, the examining doctor(s) share their initial conclusions with the attending police and social workers, including any plans for further investigation, e.g. x-ray, haematology and the implications of those. They contribute to the immediate safety planning for the child and any other children who are potentially at risk.

15.19 The paediatrician will ensure all appropriate medical investigations and treatments are organised and actioned and any necessary follow up referral made including for psychological support.

### Reports

15.20 An immediate opinion (subject to revision) will be provided after the examination to police and social work. The appropriate report (single doctor letter or soul and conscience report) providing an opinion of the likelihood of abuse will be made available within 4 weeks and shared with participants of the IRD

## Risk Assessment

16.1 Risk Assessment is not a one-off event but an ongoing process which is dynamic and leads to the plan changing and adapting as new information comes to light or our interventions are successful or unsuccessful. Practitioners should use the range of tools available to them which may be multi-agency (such as the National Risk Assessment Framework, National Practice Model) or specialist (such as DASH-RIC, Graded Care Profile).

## Child Protection Planning Meeting

17.1 A Child Protection Planning Meeting (CPPM) is a formal multi-disciplinary meeting to decide whether the child is at risk of significant harm and devise a plan to reduce the risk.

17.2 This is achieved by ensuring all relevant information is shared and analysed.

17.3 If the CPPM decides that the child is at risk of significant harm, their name must be added to the Child Protection Register and a multi-agency Child Protection Plan put in place. A CPPM is the only forum which can add or remove a child’s name from the Child Protection Register.

17.4 Where the CPPM has identified immediate risk of significant harm to the child, action should be taken without delay, using [emergency measures](#_Emergency_legal_measures).

17.5 In addition, CPPMs must always consider whether a referral to the Children’s Reporter is required. This should be based on consideration of the possible [Grounds of Referral](http://www.scra.gov.uk/wp-content/uploads/2016/03/Guidance-on-Referral-to-Reporter.pdf). If a referral is to be made, the CPPM should agree who will do this and by when. A referral to the Reporter is not a suitable contingency plan to manage or mitigate risk; bringing the child into another system or process will not in itself make them safer.

17.6 CPPMs must include representation from the core agencies (social work, health and police) and any other agencies currently working with the child and their family. This includes any early years, school or other education setting, which the child attends. The child and relevant family members should be invited and supported to participate. Where they are unable to participate in person their views must be sought and represented at the meeting.

### TYPES OF CPPM

17.7 There are four types of CPPM, each with their own specific focus:

* Initial
* Review
* Transfer
* Pre-birth

#### Initial CPPM

17.8 The purpose of an Initial Child Protection Planning Meeting (ICPPM) is to share the information held by each agency, including initial assessments, to carry out a multi-agency analysis of risk and reach a decision about whether a child is at risk of significant harm.

An ICPPM must take place within 28 calendar days of the concern being raised (i.e. the date on which the IRD started).

#### Review CPPM

17.9 Review CPPMs should be held within six months of the Initial CPPM. The purpose of a RCPPM is to review the impact of the Child Protection Plan, determine whether the child remains at risk of significant harm and whether Child Protection Registration is still required. If Registration is still required, subsequent reviews should take place at least six-monthly.

17.10 A Core Group can request an early review by referring the case to the CPPM Chair.

 17.11 Where a child is no longer considered to be at risk of significant harm, their name should be removed from the Child Protection Register (referred to as deregistration). Removal of a child’s name from the Register can only happen at a Review CPPM. The child and their family may still require ongoing support, and this will be managed through a multi-agency child’s plan.

17.12 There must be a Review CPPM for any child approaching their 18th birthday to ensure that appropriate ongoing support is in place, if required.

#### Transfer CPPM

17.13 The purpose of a transfer CPPM is to formally place a child’s name on the receiving area’s child protection register. A transfer CPPM cannot remove a child’s name from the Register.

Where a child and their family move from one authority to another and the child’s name is on the child protection register, a transfer child protection planning meeting will be held within 28 calendar days from the date of request for transfer and all relevant multi-agency information must go with the child.

#### Pre-birth Child Protection Planning Meetings

17.14 Pre-birth CPPMs consider whether serious concerns exist about the likelihood of significant harm to a baby once they are born.

PBCPPMs should take place wherever possible by the 28th week of gestation.

Where an unborn child’s name is placed on the Child Protection Register, the Child Protection Plan should focus on assessing and reducing risks to the child both before and after birth. Actions such as referral to the Children’s Reporter and any emergency legal measures can only be taken after a child is born.

#### Discharge Planning Meetings

 17.15 Where a Child Protection Plan is in place prior to a child’s birth, the child must not be discharged from hospital until a pre-discharge meeting has been held. This meeting should include the Core Group members and the child’s relevant family members, as well as hospital-based maternity ward staff.

17.16 The purpose of this meeting is to agree arrangements for the care of the child following discharge from hospital. This should include consideration of the role and level of involvement of community-based supports. Where the decision of this meeting is that the child would be at risk of significant harm by being discharged to the care of their parent/s, the Child Protection Plan should be amended to reflect this, and proportionate action should be taken to keep the child safe for example using emergency legal measures.

Where a child is not born in hospital, a core group meeting should take place within 3 calendar days of the child’s birth. This meeting has the same purpose as a discharge planning meeting.

Thereafter, a core group meeting must take place within 15 calendar days. Subsequent core groups meetings must take place within 6 weeks.

Reviews of pre-birth CPPMs: A review should be held no later than 6 months after the child’s birth.

### Child Protection Plan

17.17 When a child is considered to be at risk of significant harm by a CPPM, their name must be added to the Child Protection Register and a multi-agency Child Protection Plan put in place.

17.18 A Child Protection Plan should be focused on addressing the identified risks to the child, both immediate and longer term.

17.19 A Child Protection Plan must be written in plain language which can be understood by everyone involved, including children and families.

17.20 Actions within a Child Protection Plan should be SMARTER:

|  |  |
| --- | --- |
| **Specific** | * Use clear everyday language
* Actions should address the identified risk - a list of referrals to services is not a plan
* Include the detail – who is going to do what by when?
 |
| **Measurable** | * Be clear about what improvement looks like and what evidence demonstrates that the plan is working.
* What will it look like for the child when the plan is working?
* The outcomes should reflect the impact of the actions on the child.
 |
| **Achievable** | * Consensus reached with involved professionals and the family.
* Actions must be in the control or influence of the core group members.
* Outcomes should not be out of reach and set the child or family up to fail.
 |
| **Relevant** | * Child protection plans are dynamic and must address current risks and concerns.
* The core group is responsible for reviewing and adapting the plan as it progresses.
 |
| **Time-bound** | * All actions need to have clear timescales (not “ongoing”).
* Some timescales may be critical depending on the age of the child; these should be based on the child’s needs.
 |
| **Evaluated and****Re-evaluated** | * Is the plan working/ what has been achieved/what is outstanding?
* Is the plan reducing the risk of harm?
* Is the plan current?
 |

17.21 There should only be one multi-agency plan for a child at any given time. If there is already a multi-agency child’s plan in place at the point a child’s name is placed on the Child Protection Register, this should be incorporated into the Child Protection Plan and reviewed by the core group.

#### Outcomes

17.22 It is important that child protection plans have measurable outcomes and that these are outcomes for the child. No matter who the intervention is with, it is the impact of interventions on the child that is important.

### Chairing of CPPMs

17.23 CPPMs are chaired on behalf of the local Child/Public Protection Committee. As such, the Chair exercises their responsibility as a devolved function of the Committee.

17.24 CPPM chairs will:

* be independent of the case being considered, having no supervisory or line management responsibility for any practitioner involved.
* have the authority, skill and experience to challenge those contributing, including agencies’ assessment or the progress of the child protection plan.

17.25 To provide consistency, wherever possible, the same person should chair the initial and all subsequent reviews for a child.

17.26 The Chair has the following responsibilities in relation to organisation and administration of the CPPM:

* To meet with children and their parents/carers before the CPPM to explain the purpose of the meeting, and possible outcomes
* To ensure that the parents/carers and child’s views are considered and taken seriously
* To ensure all attendees are clear about the accepted standards of behaviour in the meeting.
* To ensure that where a child’s name is placed on the Register a Lead Professional and Core Group members are identified, and their details recorded in the minute.
* To ensure that relevant timescales are adhered to in the planning of subsequent core group meetings and RCPPMs.
* To ensure that the CPPM is [quorate](#_Quorate) and that any decisions to proceed in the absence of key agencies are clearly recorded in the minute.
* To ensure that arrangements are made for any member of the core group who is not present at the CPPM to be informed of the outcome and any decisions made.
* To ensure all professionals are aware of the [dissent process](#_Professional_Dissent_at)
* To ensure that a referral to the Children’s Reporter is considered, as well as any immediate action required to protect the child.
* Where a CPPM considers more than one child, ensuring that the scheduling, administration and process of the meeting takes account of the needs and rights of each individual child. This may include inviting relevant adults into the meeting at different times, depending on which child(ren) for whom they have parental rights and responsibilities.

17.27 The Chair’s role is to facilitate information sharing, analysis and decision-making. The Chair must ensure that:

* The discussion at the CPPM focuses on understanding and analysing the risk to the child.
* All relevant information is shared and analysed.
* All agencies contribute to the [analysis](#_Analysis_within_the) and [decision making](#_Reaching_decisions_in)
* The [child protection plan](#_Child_Protection_Plan) focuses on reducing identified risk to a child.
* Any lack of progress in a Child Protection Plan is challenged and suitably escalated with the relevant agency.

### Organisation and Administration of CPPMs

17.28 Each area must ensure that the organisation of CPPMs is adequately resourced. This includes:

* Ensuring there is adequate administrative support for CPPMs and a minute taker is provided;
* Ensuring that the child, all relevant family members and all agencies involved with the child and their family are invited;
* Ensuring that all attendees (including the child and their family) receive the necessary reports in advance of the meeting; and
* Ensuring that the support needs of any children and family members are taken into consideration in the CPPM (for example, through provision of an interpreter, advocacy or other communication aids).

17.29 The people involved in a CPPM should be those who are essential to the multi-agency risk assessment and planning. Participants should take an active part, represent their agency, and share relevant information to ensure that risks can be identified and addressed.

17.30 Participants need to understand the purpose and functions of the CPPM, and the relevance of their particular contribution.

### Expectations of Professionals

17.31 Every agency invited to attend a CPPM is expected to be represented. Everyone is expected to stay until the decision-making is complete. Where a CPPM considers more than one child, all professionals are expected to be present for the full discussion and to contribute to information sharing, analysis and decision-making.

17.32 Agencies must ensure that their representative is fully informed and able to bring all relevant information to the CPPM, including relevant information about parents and significant adults.

17.33 Professionals will be expected to identify:

* Risk factors (Who or what is presenting a risk to the child).
* Child’s vulnerabilities (anything about the child that increases the impact of the risk);
* The impact of risk factors on the child.
* Any factors which reduce the risk (protective factors); and
* Evidence to support their risk analysis (what they have seen or heard or their professional knowledge based on research/experience).

17.34 Professionals will be expected to weigh up this information and analyse the risk to the child i.e. whether the child is at risk of significant harm.

17.35 At review, CPPMS professionals will be expected to evidence:

* How the CP plan has addressed the risks to the child (what improvements to the child’s circumstances can be evidenced?)
* If there are no or minimal improvements what further work is required
* Professionals will be expected to weigh up this information and analyse the risk to the child i.e. is the child at ongoing risk of significant harm?

17.36 The following people/agencies should always be invited to a CPPM:

* The child
* Parents, carers and family members, including all those with parental responsibility, and if required, a support person or advocate for the child and/or family
* Social Work
* Police
* NHS
* Education/early Years (for all cases where a child attends)
* Any other services involved with the child and/or their family

### Involvement of children and their families

18.1 The views of the child must always be represented and considered by the CPPM.

18.2 Disability, age or where English is not a child’s first language must not be a barrier to involvement.

18.3 Where a child is too young or unable to verbalise their views, they may express them through their presentation and behaviour.

18.4 Independent advocacy should be considered for all children in the Child Protection process. In all situations where a child’s name is placed on the Child Protection Register, independent advocacy should be offered and where accepted must be in place for all subsequent Reviews.

18.5 Parents/carers and anyone else with parental rights and responsibilities for a child should be invited to attend. Parents/carers may wish to bring a support person with them to attend a CPPM. This person is there solely to support the parent/carer and has no other role within the CPPM. By bringing a support person, the parent/carer should be made aware that they would be party to potentially sensitive information discussed within the meeting.

18.6 In exceptional circumstances, the Chair may determine that a parent or carer should not be invited to, or should be excluded from attending, the CPPM (for example, where bail conditions preclude contact or there are concerns that they present a significant risk to others attending, including the child or young person). The reasons for such a decision need to be clearly documented. Their views should still be obtained and shared at the meeting and the Chair should identify who will notify them of the outcome and the timescale for carrying this out. This should be noted in the record of the meeting.

18.7 In certain circumstances – for example in cases where domestic abuse is a consideration – it may be appropriate for a split meeting to be held. These arrangements are a matter for the Chair and the involved agencies to consider.

18.8 Information about CPPMs should be made available to children and parents/carers in advance of the meeting.

### Quorate

18.9 There must be enough professionals in attendance at a CPPM to support information sharing and analysis and to enable decision-making and effective planning.

18.10 As a minimum, for an ICPPM or PBCPPM to be quorate there must be representation from the core agencies (Social Work, NHS, and Police).

18.11 For an RCPPM, as a minimum there must be representation from the agencies who are part of the core group.

18.12 Where a CPPM is not quorate another CPPM must take place within 14 calendar days.

### Minute of the CPPM

18.13 There must be a dedicated minute taker for every CPPM. The minute and plan will provide essential information from the meeting in a form that all involved can understand. It is not a verbatim record of the discussion.

18.14 The child protection plan will be circulated within 7 calendar days. A minute of the CPPM will be circulated within 14 calendar days.

### 18.15 Provision of reports

* Each agency invited to the CPPM will submit a report, including a chronology of significant events, using the appropriate format, detailing involvement with the child and significant adults in the child's life.
* Reports will be submitted ten days prior to the scheduled date of CPPM (except where the urgent arrangement of a CPPM does not permit)
* ['Restricted Access Information'](#_Restricted_access_information) will not be circulated in writing prior to CPPM although will be shared verbally with those professionals/agencies who need to know
* [Restricted Access Information](#_Restricted_access_information) shared or discussed during CPPM may NOT be shared with any other person, including the child and/or family, without the prior permission of the provider
* All information, other than [Restricted Access Information](#_Restricted_access_information), contained in reports will be shared openly with the parent(s)/carer(s) and the child
* All information shared by professionals must be used and stored appropriately by those receiving it. Where agencies cannot undertake the secure storage of information, they should not keep it

#### 18.16 For RCPPM:

* Consideration should be given to the core group providing a multi-agency report, detailing the progress of the child protection plan and including a recommendation about whether the child’s name needs to remain on the child protection register.
* A multi-agency chronology should be produced alongside the report, detailing significant events since the previous CPPM

### Restricted access information

18.17 Restricted access information is information that cannot be shared freely with the child or parent/carer, or anyone supporting them.

Restricted information includes:

* sub-judice information which could compromise legal proceedings;
* information from a third party that could identify them if shared;
* information about an individual that may not be known to others, even close family members, such as medical history and intelligence reports; and
* Information that, if shared, could place any individual(s) at risk, such as a home address or school which is unknown to an ex-partner.

18.18 The information will be shared with the other participants at the CPPM, where it is proportionate to do so. Restricted access information will be discussed without the family present. The Chair will explain to the family the reasons why this will happen to the family.

18.19 Such information may not be shared after the meeting with any other person without the explicit permission of the provider.

### Analysis at the CPPM

18.20 CPPMs must focus on analysis. They are not about repeating the information contained within reports or simply going over what is already known. It is expected that all attendees will have read the reports in advance and will be prepared to contribute to this analysis.

18.21 Analysis is about making sense of information in order to inform decisions and next steps. CPPMs should consider:

* Why risks may have arisen - the reasons, triggers, history
* What they mean for the child(ren) - their significance and impact
* How, if possible, they may be addressed - how best to manage, minimise and resolve

18.22 Underpinning all analysis is the core question: what is this information telling me about the risk to the child?

### Reaching decisions in the CPPM

18.23 All CPPMs will reach decisions by consensus.

18.24 Consensus means ‘general or widespread agreement’. It does not mean a majority vote, nor does it mean unanimity is required and that one person who dissents can control the overall decision-making process. Consensus means that irrespective of the view of any agency representative of the decision, all involved will abide by it. This includes implementing any child protection plan agreed at the meeting.

18.25 The role of the Chair is an important one in eliciting key assessment information and supporting the CPPM participants to reach consensus about whether a child is at risk of significant harm, based on the facts and professional judgement. If a child is at risk of significant harm their name will be added to or remain on the CPR. If the child is not at risk of significant harm, their name will not be added to, or will be removed from, the CPR.

18.26 CPPMs are not mandated by legislation and no right of appeal exists for children and/or parent(s)/carer(s) in relation to decisions taken.

18.27 Where parent(s)/carer(s) and/or a child have a complaint about an individual professional’s conduct, the matter should be raised with the agency responsible using their complaints procedure.

### Professional Dissent at Child Protection Planning Meetings (CPPMs)

19.1 Robust discussion, challenge and differences of opinion are a valuable part of CPPMs and enable professionals to reach consensus about the best way forward.

19.2 All professionals should be clear about the distinction between personally disagreeing with the outcome of the CPPM and making a professional judgement to uphold that decision, and formally dissenting; this is the process by which disagreement is formally recorded in the minute and taken further.

19.3 Concerns must be raised during the meeting and the Chair must explore the reasons for the concerns with all present in an attempt to reach consensus.

19.4 In the very few cases where no consensus can be reached and a professional(s) believes that the decision of the meeting or the plan leaves a child at risk of significant harm, dissent, and the reason for it, should be formally recorded in the minute. The status quo should remain. This means that for ICPPM, the Interim Safety Plan remains in place and the child’s name is not placed on the Register, and for RCPPMs, the child’s name remains on the Register.

* The Chair of the meeting must advise the Lead Officer for Child Protection of the dissent immediately after the meeting, or at the latest the next working day;
* The Lead Officer will ensure that a multi-agency Review Group identified by the Child Protection Committee/Public Protection Committee is advised and receives appropriate paperwork (i.e. all reports submitted to the CPPM and a copy of the draft minutes) within 72 hours;
* The Review Group will meet with the Chair of the CPPM and the professional who has dissented within 10 working days of the CPPM. The purpose of the meeting is to consider all information, explore the reasons for the decisions made, and the concerns raised.
* The Review Group will produce an advisory note for the reconvened CPPM either:
	+ Identifying gaps or areas for further consideration, or
	+ Agreeing with the original assessment of risk.
* A reconvened CPPM should take place within 15 working days of Review Group meeting.

### Child Protection Registration

20.1 All local authorities are responsible for maintaining a central register, known as the Child Protection Register, of all children, including unborn children, who are the subject of an inter-agency Child Protection Plan. It has no legal status but provides an administrative system to alert practitioners that the child is deemed to be at risk of significant harm.

20.22 When a child’s name is placed on the Child Protection Register, the Chair will ensure that this is recorded on the local area’s register immediately following the CPPM.

20.23 CPPM attendees should also consider the ways in which the child is or may be impacted, as well as the relevant vulnerability factors. These must be recorded on the local area’s social work information system. When registration is continued, these should be reviewed to ensure they remain relevant.

INSERT FINALISED LIST

Impact on/ abuse of the child identified – Physical Abuse

Impact on/ abuse of the child identified – Emotional Abuse

Impact on/ abuse of the child identified – Sexual Abuse

Impact on/ abuse of the child identified – Criminal Exploitation

Impact on/ abuse of the child identified – Child Trafficking

Impact on/ abuse of the child identified – Neglect

Impact on/ abuse of the child identified – Female Genital Mutilation (FGM)

Impact on/ abuse of the child identified – Honour-based abuse and/ or Forced Marriage

Impact on/ abuse of the child identified – Child sexual exploitation

Impact on/ abuse of the child identified – internet-enabled sexual offending

Impact on/ abuse of the child identified – Underage sex

Vulnerability factor – services finding it hard to engage

Vulnerability factor – Parent(s)/ Carer(s) with Learning Disability

Vulnerability factor – Child affected by parent/ carer mental ill-health

Vulnerability factor – Child experiencing mental health problems

Vulnerability factor – Domestic Abuse

Vulnerability factor – Parental alcohol use

Vulnerability factor – Parental drug use

Vulnerability factor – Child displaying harmful sexual behaviour

Vulnerability factor – Online safety

Other concern(s)

## CORE GROUP

21.1 When a child’s name is placed on the Child Protection Register, a Core Group will be formed. The Core Group is responsible for day-to-day implementation, monitoring and review of the Child Protection Plan in partnership with children and their families. All members of the core group have responsibility for the child protection plan and must work together to ensure its success.

21.2 The Core Group are those who have direct and on-going involvement with the child and/or family. The membership of the Core Group should be agreed at the CPPM and recorded in the minutes.

21.3 The Core Group should:

* be co-ordinated by the lead professional (the social worker)
* meet on a regular basis, the first time within 15 days of the CPPM and at least every 6 weeks until the RCPPM.
* Agree who is responsible for seeing and speaking to the child on a regular basis.
* review the progress and update the child protection plan
* consider any new information and significant events, updating and analysing the multi-agency chronology
* communicate regularly between meetings, sharing relevant information as required.
* Review and add to the multi-agency chronology
* activate contingency plans promptly when progress is not made or circumstances deteriorate.
* request an early RCPPM if appropriate

### When registration is not required

21.4 When a child’s name is not placed on the Child Protection Register, there may still be issues that require support and assessment. In all cases where a child is not registered, consideration must be given to developing a multi-agency child’s plan.

21.5 Child protection registration must not determine access to services or support. It is not appropriate for services to withdraw based only on the decision not to register.

### Parallel processes

21.6 A child may be involved in multiple professional processes at the same time - for example, a child who is both subject to Child Protection Registration and is living away from home in foster, kinship or residential care. In addition, a child may be subject to a supervision order and their name may be on the Child Protection Register at the same time.

21.7 In all such instances, there should only be one plan and one multi-agency review process for the child.

21.8 Where a child is considered to pose a risk of harm to others, the IRD should consider whether local Care and Risk Management (CaRM) processes should be followed.

21.9 In addition, where risks such as sexual exploitation are identified or in cases involving multiple unrelated children, there may be a need to hold a strategy meeting for professionals to share information about networks/perpetrators or to plan a response to a known risk. Such meetings are not a substitute for a CPPM; where an IRD identifies potential risk of significant harm to a child – regardless of whether this comes from within their home, family or out with – a CPPM should always be considered.

# Emergency legal measures to protect children at risk of significant harm

**22.1 Emergency legal measures can be used at any time if a child is at risk of significant harm, or has suffered significant harm, and needs to be removed to a place of safety.**

Parents must be supported to understand the reasons why these measures are required and be made aware they can seek legal advice.

### Section 25 Children (Scotland) Act 1995

22.2 Under this section, a parent/carer gives their consent to the child being placed out with the family home. None of the parent’s rights is removed. This can be used in an emergency situation to safeguard or promote the child’s welfare. For example; to keep the child safe while concerns about abuse or neglect are assessed and/or investigated further. This section also applies to any child requiring accommodation because no one has parental responsibility for them, or they have been lost or abandoned.

### Child Protection Order (Section 37 of the Children's Hearing (Scotland) Act 2011)

22.3 Any person can apply to the Sheriff for a Child Protection Order if they reasonably believe a child is likely to be harmed or has suffered significant harm and needs to be moved to a place of safety.

The Sheriff hears evidence from the applicant and decides whether there are sufficient grounds to grant the order. The order gives authority for the child to be removed to a place of safety, or prevent the removal of the child from a place of safety, for example, a hospital or other family member’s home. It must be implemented within 24 hours or it expires.

Once an order is implemented, a Children’s Hearing will be held within two working days, if the Reporter determines that the Grounds for making the Order are still met. The purpose of this Hearing is to consider if the Order is still required.

Reporter can terminate the Child Protection order before the second working day hearing.

Where the application is made by a local authority under section 38, the sheriff may grant the order if satisfied that:

1. the local authority has reasonable grounds to suspect that:

• the child has been or is being treated in such a way that the child is suffering or is likely to suffer significant harm,

• the child has been or is being neglected and as a result of the neglect the child is suffering or is likely to suffer significant harm, or

• the child will be treated or neglected in such a way that is likely to cause significant harm to the child, and

2. the local authority is making enquiries to allow it to decide whether to take action to safeguard the welfare of the child, or is causing those enquiries to be made, and 3. those enquiries are being frustrated by access to the child being unreasonably denied, and

 4. the local authority has reasonable cause to believe that access is required as a matter of urgency.

### Police Emergency Powers – (Section 56 of the Children's Hearing (Scotland) Act 2011)

22.4 Police Emergency Powers can be used to remove a child to a ‘place of safety’ where the same grounds for applying for a Child Protection Order exist, but there is a need for emergency action to protect the child.

The power to remove a child only lasts for 24 hours. Then the police (or another person) must apply to the Sheriff for a Child Protection Order to secure the child’s place of safety if it is still necessary.

### A Child Assessment Order (Section 35 (1) of the Children's Hearing (Scotland) Act 2011)

22.5 A Child Assessment Order is a court order granted by a Sheriff to allow access to a child in order to assess their health and development to establish if the child is suffering, or is likely to suffer, significant harm. An order can be applied for by the local authority and lasts up to 3 days. Under the Age of Legal Capacity (Scotland) Act 1991, depending on their age and understanding, a child has the right to agree or refuse to have a medical examination, assessment or treatment and their consent will be required before any medical assessment will be carried out.

### An exclusion order - (Section 76 of the Children (Scotland) Act 1995)

22.6 This order has the effect of removing an abuser from the family home and may be used as an alternative to a Child Protection Order, which removes the child.

### Refuge (Section 38 of the Children (Scotland) Act 1995)

22.7 A child may request refuge and if the child appears to be at risk of harm may be provided with short-term refuge either by the local authority or by a person who provides a care home service. This would usually last for up to seven days or in exceptional circumstances up to fourteen. The agency providing refuge should consider other legal measures once this period ends.

# Appendices

To be determined

Part 4 specific concerns and issues

### Local area escalation / dispute resolution policy