

Child Protection



Inter-agency Child Protection Procedures Edinburgh and the Lothians

Foreword	5
Summary of Child Protection Referral	7
Key Timescales	8

Section Contents	Page
S1 Introduction	
1.1 General.....	9
1.2 Status of procedures	9
1.3 Maintenance of procedures	9
1.4 Public information	10
1.5 Context.....	10
S2 Principles	
2.1 Overarching principle	11
2.2 Joint working	11
2.3 Equality and diversity.....	12
2.4 Consent	13
S3 Definitions	
3.1 Child	14
3.2 Parents/Carers	14
3.3 Abuse	15
3.4 Categories of abuse.....	15
S4 Agency roles and responsibilities	
4.1 Social work.....	18
4.2 Police.....	19
4.3 Health.....	19
4.4 Education	19
4.5 Third Sector and other relevant organisations	20
4.6 Procurator Fiscal	21
4.7 Authority Reporter	21
S5 Child protection referrals	
5.1 General.....	22
5.2 Advice	22
5.3 Making a child protection referral.....	22
5.4 Action to be taken	22
5.5 Information required	23
5.6 What to expect from the core agencies	23
5.7 Initial responses	24
5.8 Initial questioning.....	24

S6	Agency specific procedures	
6.1	Health staff	26
6.1(i)	Advice	26
6.2	Police	26
6.3	Social work and other local authority services (except Education)	27
6.4	Education	27
6.4(i)	Action for the Designated Member of Staff/Management Team.....	28
6.5	Third Sector	29
S7	Inter-agency Referral Discussions (IRD)	
7.1	General	30
7.2	Who participates.....	30
7.3	Accountability	31
7.4	Information sharing.....	31
7.5	Decision making.....	32
7.6	Report to the Child Protection Register	33
7.7	Notification to other agencies/bodies.....	33
7.8	Recording of IRD	33
7.9	Further discussions.....	33
7.10	Actions from IRD	34
7.11	Reporting back.....	35
7.12	Review and sign off.....	35
S8	Consent	
8.1	Parental consent	36
8.2	Consent of the child	37
8.3	Inter-agency Referral Discussions (IRD)	38
8.4	Reference table	38
S9	Joint Investigative Interviews (JII)	
9.1	General	39
9.2	Purpose of interview	39
9.3	Planning.....	40
9.4	Briefing, debriefing and further actions.....	40
9.5	Recording.....	41
9.6	The interviewers.....	41
9.7	Preparation for interview	42
9.8	The interview	42
9.9	Consent.....	43
9.10	Competency testing	44
9.11	Other people present at interview.....	44
9.12	Departure from procedures.....	45

S10	Medical assessment and care of children where child abuse and/or neglect is suspected	
10.1	General	46
10.2	Levels of examination	47
10.2(i)	Comprehensive Medical Assessment (CMA)	47
10.2(ii)	Joint Paediatric/Forensic (JPF) Examination or specialist paediatric examinations	47
10.3	Timing	47
10.4	Location	48
10.5	Chaperones	48
10.6	Recording	48
10.7	Following examination	48
10.8	Reports	49
10.9	Ongoing care	49
10.10	Flowchart for medical assessment of children with suspected abuse or neglect	50
S11	Child Protection Case Conferences (CPCC)	
11.1	Purpose of a Child Protection Case Conference	51
11.1(i)	Pre-birth CPCC	51
11.1(ii)	Initial CPCC	51
11.1(iii)	Review CPCC	52
11.1(iv)	Transfer CPCC	52
11.2	When to hold a CPCC	52
11.2(i)	General	52
11.2(ii)	Pre-birth CPCC	53
11.2(iii)	Initial CPCC	53
11.2(iv)	Review CPCC	54
11.2(v)	Transfer CPCC	54
11.3	Chair of CPCCs	54
11.3(i)	General	54
11.3(ii)	Review CPCC	55
11.3(iii)	Transfer CPCC	55
11.4	Provision of reports	55
11.5	Chronologies	56
11.6	Restricted Access Information (RAI)	57
11.7	Preparation for CPCC	57
11.7(i)	Preparation by the Chair	57
11.7(ii)	Quorum	57
11.7(iii)	Preparation by invitees	58
11.7(iv)	Preparation by social worker	58
11.8	Attendance	58
11.8(i)	General	58
11.9	Process of CPCC	59
11.9(i)	General	59
11.10	Decisions and actions	60
11.11	Recording	61
11.12	Disagreement with decisions	62
11.12(i)	Disagreement by professionals	62
11.12(ii)	Action for Chair of Child Protection Committee	63
11.13	Complaints by parent(s)/carer(s) and/or child	63
11.13(i)	Complaints	63

S12	Core Groups and the Child Protection Plan (CPP)	
12.1	The Lead Professional	64
12.2	Core Groups	64
12.2(i)	Function of Core Groups.....	64
12.2(ii)	Purpose.....	65
12.2(iii)	Membership.....	65
12.2(iv)	Attendance/Conduct	65
12.2(v)	Frequency	65
12.2(vi)	Chair	66
12.2(vii)	Recording.....	66
12.3	The Child Protection Plan	66
12.3(i)	General	66
12.3(ii)	Purpose.....	66
12.3(iii)	Content	67
12.3(iv)	Considerations	67
S13	The Child Protection Register (CPR)	68
S14	Provision of information to the Authority Reporter	
14.1	General	69
14.2	Case Conference Referrals to the Authority Reporter	69
14.3	Investigation by the Authority Reporter	70
14.4	Decisions by the Authority Reporter.....	70
14.5	Children’s Hearing.....	70
14.6	The Sheriff	70
14.7	Safeguarder	71
S15	Allegations against current or previous employees/carers/volunteers	
15.1	General	72
15.2	Historical abuse	73
15.3	Recording.....	73
15.4	Management of staff	73
15.5	Flowchart: Allegations against current/previous employees/carers/volunteers.....	74
Appendices		
Appendix A - Contact Details		75
Appendix B - Glossary of Terms and abbreviations		83
Appendix C - Alerting signs of child abuse and child protection in specific circumstances		86
Appendix D - Military Welfare Services.....		110
Appendix E - Legislation and other linked documents.....		113

Foreword by Edinburgh, Lothians and Borders Executive Group-Public Protection (ELBEG-PP)

The Inter-agency Child Protection Procedures for Edinburgh and the Lothians are evidence of our enduring commitment to deliver high quality services for vulnerable children and young people and to maintain good professional standards in doing so. This document complies with the National Guidance for Child Protection in Scotland (2010).

Scottish Borders Council and NHS Borders have their own child protection procedures, which can be accessed via their Child Protection Committee website <http://www.online-procedures.co.uk/scottishborders>.

The Scottish Government has set a clear vision for Scotland's children, in the publication of the National Guidance for Child Protection in Scotland (2010), setting out that all children and young people have the right to be cared for and protected from harm and abuse and to grow up in a safe environment in which their rights are respected and their needs met. Children and young people should get the help they need, when they need it, and their welfare is always paramount.

Child protection has to be seen in the context of national drivers and policies, including: Early Years Framework (2009); Getting it right for every child (GIRFEC); and How Well Do We Protect Children and Meet Their Needs? (HMIE 2009).

Edinburgh, Lothian and Borders Executive Group - Public Protection (ELBEG-PP), on behalf of the Chief Executives of the local authorities of East Lothian, Midlothian, City of Edinburgh, Scottish Borders and West Lothian, along with the Chief Executives of NHS Lothian, NHS Borders and the Chief Constable of Lothian and Borders Police, provide strategic leadership and vision across public protection. This includes child protection, protection of adults at risk of harm and Multi Agency Public Protection Arrangements (MAPPA).

Accountability and governance rest with individual Chief Officers, and local structures reflect this. However, it is also clear that there are advantages in pursuing a shared services agenda, which seeks to reduce duplication and effort and to maximise efficiency savings.

In public protection this approach applies to:

- multi-agency training
- development of multi- agency procedures, protocols and guidance
- sharing best practice, and
- raising public awareness regarding public protection issues

We have undertaken to work closely together with other statutory and voluntary bodies and with the communities we serve jointly to deliver services for the protection of children.

For all services, this document provides the procedures and processes that will be followed in dealing with child protection concerns.

The procedures reflect our collective commitment to inter-agency collaboration and joint

responsibility in this vitally important area of work, and are mandatory for all staff from all agencies.

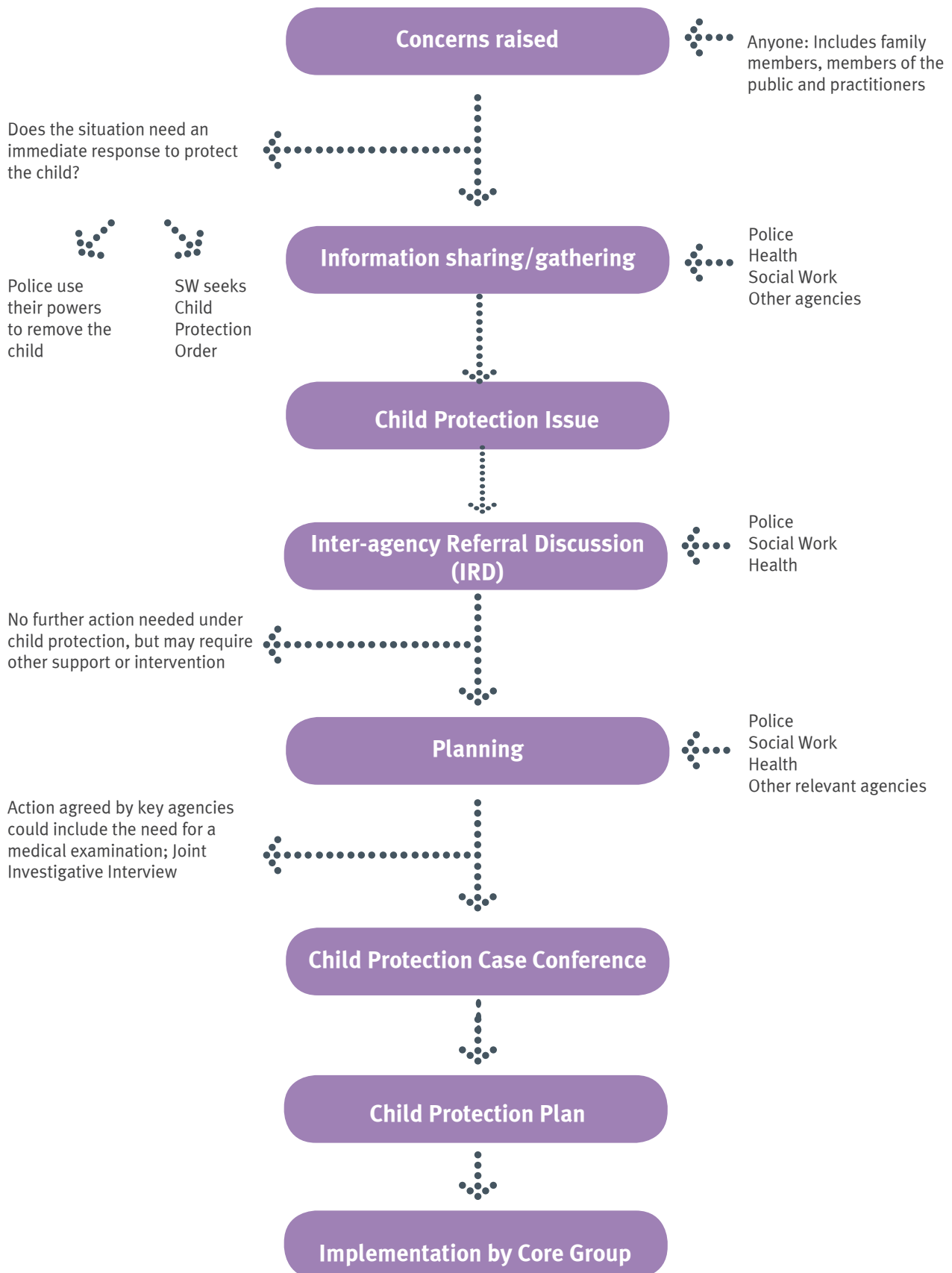
For children, young people and their families, these procedures set out what can be expected from the professionals who have a responsibility for their protection. They set out how children and their parents/carers will be consulted, receive help and support in a timely manner, and be treated and kept informed of decisions concerning them. Furthermore, it is expected that professionals will work effectively and jointly, sharing information with each other when it is necessary to ensure the protection and welfare of children and young people.

In doing so, we can be more confident that our individual and collective efforts will become even more effective in protecting vulnerable children and young people across Edinburgh and the Lothians.

Evaluation and revision of these procedures are essential and will be undertaken when necessary to ensure best practice and the incorporation of changes in legislation, policy and guidance.

Edinburgh, Lothians and Borders Executive Group - Public Protection (ELBEG-PP)

Summary of child protection referral



Key Timescales

Pre-birth CPCC

The CPCC should take place **no later than at 28 weeks of pregnancy** or, in the case of late notification of pregnancy, as soon as possible after the notification of concern and in any case within **21 calendar days**. Where it has not been possible to hold a pre-birth CPCC prior to birth, an initial CPCC must take place prior to the baby's discharge from hospital.

Where a pre-birth CPCC has taken place, and the child's name has been placed on the Child Protection Register, the review CPCC will take place **21 calendar days** after birth, not after registration.

Notification of concern to initial CPCC

The initial CPCC should be held as soon as practicable and **no later than 21 calendar days** from the notification of concern.

Invitations

Participants should be given a minimum of **five calendar days** notice of the decision to convene a CPCC whenever possible.

Reports

Where possible reports will be submitted **ten calendar days** prior to the CPCC (except where the notice of invitation or urgent need for CPCC does not permit this).

Review CPCC

The first review CPCC should be held **within three months** of the initial CPCC. Thereafter, reviews should take place **six monthly** or earlier if circumstances change.

Transfer CPCC

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 CPCC will be held **within 21 calendar days**.

Core Group

The initial Core Group meeting should be held **within 15 calendar days** of the initial CPCC.

Record of key decisions and agreed tasks agreed at CPCC

Within **one day** of the meeting, the chair should produce a record of key decisions and agreed tasks and distribute this to invitees as well as attendees of CPCC.

Child Protection Plan

Participants should receive a copy of the agreed Child Protection Plan **within five calendar days** of the CPCC.

Minutes

Participants should receive a copy of the minutes **within 15 calendar days** of the CPCC.

Accuracy of the minute

Invitees will raise any issue of accuracy of the minute with the Chair of the CPCC **within 15 calendar days** of the date of the CPCC.

Changes to the Child Protection Plan

Where a Core Group identifies the need to make significant changes to the Child Protection Plan, they should notify the CPCC Chair **within three calendar days**.

Referral to the Children's Reporter

The person nominated by the CPCC to submit a referral to the Children's Reporter will do so **within ten calendar days**

1. Introduction

1.1 General

The National Guidance for Child Protection in Scotland (2010) is explicit that everyone in Scottish society has an important part to play in preventing the abuse and neglect of children and young people, and in responding to any situation where they think a child may be at risk of abuse or harm.

The Scottish Government's vision for Scotland's children is called 'Getting it right for every child' and threads through all existing policy, practice, strategy and legislation affecting children, young people and families. It impacts on all services for children: building from universal services, providing early intervention and crisis intervention and thereby streamlining process to support best practice and outcomes for children.

'Getting it Right for Children and Families Affected by Parental Problem Alcohol and Drug Use': Guidance for Agencies in Edinburgh and the Lothians [hereafter referred to as CAPSM (Children Affected by Parental Substance Misuse)] sets out best practice for professionals working with families where drugs and/or alcohol are issues, and complies with these procedures.

1.2 Status of procedures

These procedures direct professionals in their responsibilities and action(s) in dealing with concerns about the safety and wellbeing of children.

Each set of circumstances is different and needs to be considered on its own merits. These procedures seek to support appropriate professional judgement. Experienced practitioners and managers may, on occasion, determine a course of action, which, for the welfare of the child, differs from that required by these procedures.

Child Protection Committees should be advised, through exception reporting, of the circumstances of non-compliance, where this arises and suitable alternatives to secure good outcomes for children must be in place.

On the rare occasions when this might be the case, there must be joint agreement with partner agencies. The reason for this (and who made the decision) must be recorded in detail.

Agencies and groups who provide services to children and families across Edinburgh and the Lothians, and who produce their own internal procedures or guidance relating to child protection, must ensure that they comply with these procedures.

1.3 Maintenance of procedures

These procedures will be reviewed, as determined by ELBEG-PP to incorporate developing national guidance and best practice. Control of the review, maintenance and reproduction of

the procedures is retained by ELBEG Public Protection Partnership Office (see Appendix A for contact details).

1.4 Public information

Anyone who has concerns about the safety or welfare of a child (or children) should, without delay, contact the local authority social work services or Lothian and Borders Police (see Appendix A for contact details).

Members of the public may prefer to contact a health professional to pass on their concerns. Where this is the case, the health service professional will contact one of the core agencies: social work services, Lothian and Borders Police or the Paediatrician on-call for Child Protection in health, following which, information will be shared through an Inter-agency Referral Discussion (IRD).

Public information is available from the agencies responsible for child protection.

1.5 Context

These procedures have been developed in accordance with:

- The United Nations Convention on the Rights of the Child
- The European Convention on Human Rights
- Protecting Children and Young People: The Charter (Scottish Executive, 2004)
- Protecting Children and Young People: Framework for Standards (Scottish Executive, 2004)
- The Children (Scotland) Act, 1995 and other relevant legislation
- Public Inquiry reports
- Learning from Significant Case Reviews
- National Guidance for Child Protection in Scotland (2010) (Scottish Government, 2010)
- Getting it right for every child
- Under-age Sexual Activity: Meeting the needs of Children and Young People and Identifying Child Protection concerns (Scottish Government, 2010)
- Under-age Sexual Activity Guidance for practitioners (ELBEG, 2011)
- Children Affected by Parental Substance Misuse (CAPSM)
- National Guidance on Joint Investigative Interviewing of Child Witnesses in Scotland (Scottish Government, 2011)

2. Principles

2.1 Overarching principle: The welfare of the child is paramount

These procedures set out what agencies will do when children or young people may be at risk of abuse or neglect or have been harmed. The protection and wellbeing of the child must remain at the heart of all considerations and decisions. Professionals must constantly demonstrate this throughout their planning and actions.

Professionals must consider the child who is the subject of the referral, but must also consider the safety and wellbeing of any other child who may be at risk of harm.

Vulnerability is ‘contextual’ and needs to be balanced against risk and protective factors on a case-by-case basis. Actions to protect children must be proportionate to the available information and circumstances, and must not cause the child avoidable distress or difficulty. To assist practitioners, the Edinburgh Lothian and Borders Child Protection Office Risk Assessment Framework (now the Edinburgh, Lothians and Borders Executive Group Public Protection Partnership Office) has been developed and can be accessed from agency websites (see Appendix A for contact details).

Children should be given the opportunity to express their views, if they wish, on matters affecting them, and professionals need to consider these views in arriving at decisions.

2.2 Joint working

Child protection is not the responsibility of any single agency. Professionals working with children are required to work together to share information, assess 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 also promote their welfare.

Measures to protect children need to be considered in view of the wider range of support services that are already provided to meet the needs of children and parents/carers. Child protection investigations may identify gaps in services for children, parents or carers, even if it is established that there is no risk of significant harm. Where this is the case, the principles of Getting it right for every child (GIRFEC) should be followed to identify need and to secure appropriate services. GIRFEC principles promote action to improve the wellbeing of all children, and state that children and young people must be healthy, achieving, nurtured, active, respected, responsible, included and safe. For further information see <http://www.scotland.gov.uk/Publications/2010/07/19145422/0>.

Professionals can help to achieve better outcomes for children by ensuring that the plans to protect the child are based upon wide-ranging inter-agency assessments. This must include the parents’ capacity to care for the child, along with their family circumstances.

Sharing information is essential to child protection. Scottish Government and agency expectations are explicit:

‘Where there is reasonable cause to suspect or believe that a child may be at risk of

harm, this will always override a professional or agency requirement to keep information confidential’.

The basis for information sharing can be found in:

- National Guidance for Child Protection Scotland (Scottish Government, 2010)
- The United Nations Convention on the Rights of the Child
- Getting it right for every child
- Under-age Sexual Activity: Meeting the needs of Children and Young People and Identifying Child Protection Concerns (Scottish Government, 2010)
- Children Affected by Parental Substance Misuse (CAPSM)
- Sharing Information about Children at Risk of Abuse or Neglect: A Brief Guide to Good Practice (The Chief Medical Officer in Scotland, 2004)
- The European Convention on Human Rights
- The Data Protection Act 1998

‘The safety, welfare and wellbeing of a child are of central importance when making decisions to lawfully share information with or about them’ National Guidance for Child Protection Scotland (2010)

2.3 Equality and diversity

Children and young people have a wide variety of needs and characteristics, which may require special consideration.

These include age, race, ethnicity, religion, culture, sexual orientation, ability and social difference. It is vitally important that the diverse needs of children and young people are considered explicitly when making decisions regarding their care and protection.

Access to, and delivery of, child protection services should be fair, consistent, reliable and focused on individual outcomes and enablement. Service users should be listened to, respected and responded to. There should be no discrimination on the grounds of race, disability, gender, age, sexual orientation, religion or belief, gender reassignment or on the basis of pregnancy and maternity status.

The Equality Act (2010) restates, streamlines and harmonises equality legislation. It replaces a number of acts, including the Race Relations Act 1976, the Sex Discrimination Act 1975 and the Disability Discrimination Act 1995. The majority of the Equality Act 2010 came into force on 1 October 2010.

All communication with children and/or families must be appropriate to their level of understanding. Professionals must ensure their decision making is explicit and clearly recorded when considering issues of diversity.

2.4 Consent

Professionals should, wherever possible, engage with parent(s)/carer(s) to gain their full co-operation in decisions regarding protecting children. There will, however, be circumstances where consent is refused or where attempts to obtain consent could cause further risk to a child. These circumstances must never be allowed to endanger a child.

A fuller explanation of consent issues is detailed within Section 8 of these procedures.

3. Definitions

A further glossary of terms is available in Appendix B.

3.1 Child

For the purposes of these procedures all references to children and young people mean:

- A person under 16 years of age

Where protective action is believed to be appropriate for persons over the age of 16 (such as young people with additional needs), the agencies involved may find the processes and principles contained in these procedures helpful in considering their roles and responsibilities. Reference to the Adult Support and Protection Scotland Act (2007) may also be helpful for professionals in these circumstances.

3.2 Parents/Carers

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

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

A 'carer' is someone other than a parent who has rights and responsibilities for looking after a child or young person.

'Relevant persons' have extended rights within the Children's Hearing system, including the right to attend Children's Hearings, receive all relevant documentation and challenge decisions taken within those proceedings. A carer may be a 'relevant person' within the Children's Hearing system.

A 'kinship carer' can be a person who is related to the child or a person who is known to the child and with whom the child has a pre-existing relationship ('related' means related to the child either by blood, marriage or civil partnership). Regulation 10 of the Looked After Children (Scotland) Regulations 2009 provides that a local authority may make a decision to approve a kinship carer as a suitable carer for a child who is looked after by that authority under the terms of section 17(6) of the Children (Scotland) Act 1995.

Before making such a decision the authority must, so far as reasonably practicable, obtain and record in writing the information specified in Schedule 3 to the Regulations and taking into account that information, carry out an assessment of that person's suitability to care for the child.

Local authorities' duties are designed to ensure they do not make or sustain placements, which are not safe or in the child's best interests and that placements are subject to regular review.

3.3 Abuse

Abuse and neglect are forms of maltreatment of a child. A person may abuse or neglect a child by inflicting, or by failing to prevent, harm to the child.

There are varied settings in which abuse can occur, e.g. in the home, in institutional settings, online, encounters with strangers, child trafficking, children cared for or accommodated, etc. While the setting in which abuse occurs may require special consideration, and professionals should demonstrate and record that they do so, all suspected abuse must be addressed primarily as a child protection matter. Children who abuse other children present particular challenges for professionals. In such circumstances an agency may have a local protocol in place and this should be consulted in conjunction with these procedures.

3.4 Categories of abuse

To define an act as abusive and/or presenting future risk, either by commission or by omission, a number of elements must be taken into account. These include demonstrable or predictable harm to the child, which must have been avoidable because of action or inaction by parent, other carer or any other person with involvement in the child's life.

While it is not necessary to identify a specific category of abuse when adding a child's name to the Child Protection Register (see Section 13), it is still helpful to consider and understand the different ways in which children can be abused.

The following are categories of abuse which, although presented as discrete definitions, in practice may overlap. This list is not exhaustive, as the individual circumstances of abuse will vary from child to child:

Physical abuse

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. While the law recognises some physical chastisement of children as reasonable, any blow to the head, shaking or use of an implement is against the law (Criminal Justice (Scotland) Act 2003, Section 51 – physical punishment of children).

Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child, known as Fabricated, sometimes Factitious or Induced illness.

Sexual abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual

activities, including prostitution, whether or not the child is aware of what is happening.

Sexual abuse is any act that involves the child in any activity for the sexual gratification of another person, whether or not it is claimed that the child either consented or assented.

Sexual abuse involves forcing or enticing a child to take part in sexual activities, which may involve physical contact, including penetrative or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or in watching sexual activities, grooming, using sexual language towards a child or encouraging children to behave in sexually inappropriate ways.

Local guidance on underage sexual activity provides professionals with important information where young people are involved in sexual activity under the age of 16 years (ELBEG, 2011) and complements the National Guidance on Under-age Sexual Activity: Meeting the Needs of Children and Young People and Identifying Child Protection Concerns (Scottish Government, 2010).

Not all children are able to tell parents that they have been sexually abused or victimised. Changes in behaviour may also be a signal that something has happened, although these may also be indicators that the child may be troubled though not necessarily about sexual abuse. The child may have some of these problems or none at all. It is the combination, frequency and duration of signs that will alert you to a problem. Pay attention to all changes in usual behaviour.

It is important to remember that in sexual abuse there may be no physical or behavioural signs.

Neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. CAPSM Guidance provides a framework for protecting children affected by all types of problem substance use by parent(s)/carer(s).

Once a child is born, neglect may involve a parent or carer failing to:

- Provide adequate food, clothing and shelter (including exclusion from home or abandonment)
- Protect a child from physical and emotional harm or danger
- Ensure adequate supervision, including the use of inadequate care-givers
- Ensure access to appropriate medical care or treatment
- Respond to a child's basic emotional needs

Neglect may also result in the child being diagnosed as suffering from 'non-organic failure to thrive', where they have significantly failed to reach normal weight/growth or developmental milestones, and where physical and genetic reasons have been medically eliminated.

In its extreme form, children can be at serious risk from the effects of malnutrition, lack of nurturing and stimulation. This can lead to serious long-term effects, such as greater susceptibility to serious childhood illnesses and reduction in potential stature. With young children in particular, the consequences may be life-threatening within a relatively short period of time.

Emotional abuse

Emotional abuse is the persistent emotional neglect or ill-treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only in so far as they meet the needs of another person.

It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as over protection and limitation of exploration and learning, or preventing the child participating in normal social interaction.

It may involve seeing or hearing the ill-treatment of another exposed to domestic abuse. It may involve serious bullying, causing children frequently to feel frightened or in danger, or the exploitation or corruption of children.

Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Alerting signs of child abuse

See Appendix C for further information on the alerting signs of child abuse, child protection in specific circumstances and indicators of risk.

4. Agency roles and responsibilities

4.1 Social work

Child protection responsibilities apply to all departments and services of the local authority, which has a legal duty, [under the Children (Scotland) Act 1995] to safeguard and promote the welfare of children in need and to enquire into the circumstances of children and young people who may need compulsory measures of supervision, who may have been abused or neglected or be at risk of abuse or neglect, and to take all measures to protect them from further harm. 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.

Social work services undertake a key role in the investigation of child protection enquiries. These measures include referring the child to the Authority Reporter where there is reason to believe that the child may be in need of compulsory measures of supervision.

In every case, social work services seek to involve parents, carers, and where appropriate, the child actively in discussions and decisions that may affect their lives. They will also consult with other professional agencies that know the family, or have an interest in the case.

Where a child protection referral is received and a decision is made during Inter-agency Referral Discussions (see Section 7) to hold a Child Protection Case Conference (see Section 11), social work services will organise this. All those involved, including the parents and where appropriate the child, will be invited.

In most cases children can continue to be cared for safely by immediate or extended family. In some situations it may be necessary to seek the authority of a court to impose a statutory order for the protection of the child.

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

Social work services' responsibilities include the identification and assessment of risk, monitoring and support of children at risk of abuse and the provision of services to enable children and families to overcome the effects of abuse.

Social work services are available in a number of community and hospital units. In addition, emergency services or out of hours social work services are available in the evening, at weekends and during public holidays to respond to referrals (see Appendix A for contact details).

Social work services operate an Open Access policy, and the minutes of Child Protection Case Conferences (with the exception of restricted access information) will usually be made available to parents. Information is only restricted when it is about a third party or it is considered that certain details, if revealed, would place the child or others at greater risk, or compromise any criminal investigation or prosecution.

4.2 Police

In cases of child abuse, a criminal offence may have been committed. The police have a statutory duty to investigate the circumstances and to report the facts to the Procurator Fiscal. This duty is always balanced with the fact that the welfare of the child is paramount. Whenever there is a suspicion that a crime or offence has been committed against a child, or is still being committed, the police should be informed immediately.

There is a distinction between the investigative role of the police and any decision to prosecute individuals, which is the remit of the Procurator Fiscal. Police involvement does not automatically result in an alleged offender going to court.

The police will share information and consult as part of an inter-agency assessment to determine whether the matter is a child protection concern, and if so, will share information with other core agencies, health and social work, as part of the Inter-agency Referral Discussion (IRD) and will attend child protection case conferences.

Where the police have reasonable cause to believe that a child may be in need of compulsory measures of supervision, they will pass information to the Authority Reporter, whether or not there are grounds for criminal prosecution.

4.3 Health

Health staff may have dealings with parent(s)/carer(s) of children in circumstances which suggest the child may be at risk. Health professionals offer children and their families a comprehensive assessment, which satisfies both the child's clinical needs and also any forensic requirements. The health service also offers ongoing physical and psychological health care for the abused child.

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 are committed to protecting children from abuse by identifying children at risk, actively participating in the inter-agency process of dealing with cases of suspected or actual abuse, attending Child Protection Case Conferences and providing child-centred care that is suited to each child's requirements.

NHS Lothian has developed Child Protection Procedures for health care professionals, which supplement these procedures. Health care professionals can access the NHS Lothian Child Protection Procedures from their intranet.

4.4 Education

All education staff have important roles in protecting children from abuse and neglect and in identifying children who may be at risk of abuse. Managers have a responsibility to keep staff informed and updated on child protection policy and procedures.

Attendance at and participation in Child Protection Case Conferences are the responsibility of appropriate education staff who are likely to have knowledge of the child on a daily basis.

Community Education Services employ youth and children's workers who also provide support to children and young people in a variety of different settings. Children and young people can seek advice and guidance from staff on issues of a personal nature, including abuse. Community Education staff also have an important role in identifying, monitoring and supporting children and young people where child abuse is a concern, and reporting any suspected abuse.

4.5 Third Sector and other relevant organisations

The third sector is made up of various types of organisations, which are non-governmental. It encompasses voluntary and community organisations, charities, social enterprises, co-operatives and mutuals, both large and small. This is not an exhaustive list and further information can be found in the National Guidance for Child Protection in Scotland (Scottish Government, 2010).

The third sector plays a significant role in engaging with and improving outcomes for children and young people who are vulnerable or disadvantaged for a wide range of reasons, including poverty, neglect and disability. Voluntary organisations are often in an ideal position to win the trust and confidence of those children and families who are suspicious of statutory interventions.

Many organisations will have direct or indirect engagement with children, young people and parents, even if this is not their principal activity. Providers of services to adults, e.g. in relation to housing/tenancy support, mental health, disability, drug and alcohol abuse, may become concerned about children within a family, without necessarily having seen the children.

It is expected that organisations and individuals providing childcare or related services will fulfil their responsibilities in line with the principles and practice outlined in these procedures.

If a voluntary or private sector organisation or individual becomes aware that a child may be abused, or that a person may be abusing a child or children, they should, as soon as possible, contact or consult with the appropriate local social work or emergency social work services (see Appendix A for contact details).

Where any member of staff of a voluntary or private sector organisation becomes aware, or suspects, that a child is being abused or has been the victim of abuse, they must report this matter to one of the core agencies (health, police, social work services) without delay.

When dealing with cases of abuse/suspected abuse, any organisation must seek advice from one of the agencies above before informing parent(s)/carer(s) to ensure that the safety of the child is paramount and any investigations are not compromised. It is appreciated that as these organisations work closely with children and families, such actions may prove challenging, but the interests and safety of the child must take precedence.

The voluntary and private sectors may be faced with situations that are ambiguous or uncertain, and that those working in this context may be reluctant to alienate their clients or to be seen to be overreacting. The interests of individual children and their safety must be put before such considerations. Organisations and individuals are encouraged to hold general discussions on child protection matters, including relevant training and consultation, with the Edinburgh, Lothians and Borders Executive Group Public Protection Partnership Office (ELBEG PPPO) or appropriate staff in the statutory agencies.

They should also have their own detailed internal procedures in place relating to child protection matters, which reflect the arrangements and principles contained in these procedures. Advice on preparing internal child protection policies is available from the ELBEG PPPO (see Appendix A for contact details).

4.6 Procurator Fiscal

The Crown Office and Procurator Fiscal Service (COPFS) is responsible for the investigation and prosecution of crime in Scotland, the investigation of sudden or suspicious deaths and complaints against the police.

In child protection matters the police carry out an initial criminal investigation and submit a report to the local Procurator Fiscal. The Procurator Fiscal considers this report and decides whether criminal proceedings should take place.

This decision is taken in the public interest. The Procurator Fiscal will consider whether there is enough evidence in the case. Where there is enough evidence, the Procurator Fiscal will consider a number of additional factors when deciding whether criminal proceedings should take place. These include: the seriousness of the offence; the length of time since the offence took place; the interests of the victim and other witnesses; the age of the offender; any previous convictions and other relevant factors; local community interests or general public concern; any other factors at his/her discretion according to the facts and circumstances of the case.

The provisions of the Vulnerable Witness (Scotland) Act 2004 apply to any child or vulnerable adult cited to appear in any court proceedings.

If there is sufficient evidence, the Procurator Fiscal will then decide what action is appropriate, e.g. to prosecute in court, offer a direct measure or to take no action in the case.

In cases considered by a jury, the Procurator Fiscal may interview witnesses, and gather and review the forensic and other evidence before a decision to prosecute is taken. She/he will then make a report to Crown Counsel - senior High Court prosecutors based at the Crown Office in Edinburgh - to take the decision on whether to prosecute.

Where a Procurator Fiscal decides to take no criminal proceedings in a case, the victim can ask for an explanation of the decision.

4.7 Authority Reporter

The Reporter is an independent official employed by the Scottish Children's Reporter Administration (SCRA). They have the responsibility to receive referrals and make decisions as to whether there are grounds for any child to be referred to a children's hearing (further details of their responsibilities can be found in Section 15).

For grounds of referral see Section 52 of the Children (Scotland) Act 1995.

The Children's Hearings (Scotland) Act 2011 has been given royal assent and was enacted in 2011. Secondary legislation is being drafted. For further information see <http://www.legislation.gov.uk/asp/2011/1/contents/enacted>.

5. Child protection referrals

5.1 General

Incidents of suspected abuse can arise in a variety of ways, including a report by the child, observation of the child and/or carer and through information from another child, person or agency. Concerns might also be expressed by letter, telephone call and/or e-mail and can be with or without the informant's identity.

5.2 Advice

The core agencies (health, social work services and police) encourage professionals, carers and the public to contact them for advice on any concerns they may have regarding children. However, it must be clearly understood that if, in the examination of circumstances during this process, it becomes apparent the matter needs further action, this contact will be deemed a formal referral and the agencies will require all available information to be passed to them.

5.3 Making a child protection referral

A child protection referral is the process by which anyone who knows or suspects that a child has suffered, is suffering or is at risk of abuse (see Section 3), notifies one or more of the core agencies.

It is the role of these agencies to assess the situation, investigate where necessary and ensure the help the child needs is provided, when they need it.

Every person who knows or suspects that a child has suffered, is suffering or is at risk of abuse must make a child protection referral without delay.

No child should be exposed to danger where someone knew of that danger and it is everyone's responsibility to ensure that agencies responsible for the protection of children are informed without delay.

5.4 Action to be taken

For professionals working with children in any capacity, the employing agency or group will have a child protection policy that will comply with these Inter-agency Child Protection Procedures.

Employees or volunteers should always familiarise themselves with their agency's child protection policy. The policy may identify a 'responsible person', 'child protection advisor' or 'designated member of staff' who can be contacted within the organisation for guidance. He/she will listen to concerns and give advice on what action needs to be taken.

In appropriate situations, the employee or volunteer will recommend referring the matter to one of the core agencies.

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 concerns continue, despite the reassurances of a more senior member of staff, a direct referral to one of the core agencies should be made by the member of staff.

5.5 Information required

Where only some information is known, referral should not be delayed.

Prompt referral of concerns to the core agencies can reduce the likelihood of harm to a child significantly. The following information should be passed to the core agencies when making a referral:

- Why there are concerns
- Whether it is believed that the child is in imminent danger
- Whether there are any other children who may also be at risk
- Name, designation and name of agency, along with contact details, of the person making the referral
- The child's full name, age, date of birth and address
- Any specific identifier known (such as a case or reference number)
- Any adults who have care of the child
- Who it is thought may have harmed the child or may pose a risk to them, why this is so and when it may have happened
- The name of the person receiving the referral in the relevant core agency should always be requested and a record of this kept

5.6 What to expect from the core agencies

Where a referral is received by any of the core agencies they will carry out an initial assessment of the information. Where the information indicates a very low level of concern, the matter may be diverted for appropriate action. Where it is deemed to relate to a child protection matter, they will apply the Inter-agency Child Protection Procedures.

The core agencies undertake to:

- Assess jointly the situation and decide how best to progress the matter, with the welfare of the child being paramount
- Treat every referral seriously, gather all of the information available to them, assess and analyse this jointly and make decisions based upon such information
- Identify a professional from one of the core agencies, who will be responsible for

providing feedback to the referrer regarding what action has been taken as a result of their concerns and a timescale for doing so. This is particularly important where the referrer, or their organisation, continues to have ongoing contact with the child and/or family. Where this is the case, the identified professional will also clarify what the ongoing role of the referrer or organisation will be and make clear what information may or may not be passed to the child/family

- Except in cases of immediate urgency, the core agencies will not enter independently into any course of action without consultation with partner agencies

5.7 Initial responses

The initial response of staff to any suspicion of abuse is critical:

- No guarantee of confidentiality can be given to the child or person raising the concern. They will be informed that, as a minimum, the matter must be recorded and will be discussed with other staff with responsibility for child protection
- Initial questioning must be limited to establishing basic facts (see Section 5.8)
- Staff will not introduce personal experiences of abuse or those of others
- The matter must be immediately referred to the member of staff with responsibility for child protection or, in their absence, a senior member of staff
- Where no such person or senior member of staff is available, staff must (without delay) refer the matter directly to one or more of the core agencies
- If suspicions arise because of something a child has said, the member of staff will record the facts as accurately as possible using the child's own words, noting questions asked of the child and responses obtained. This will be signed and dated on the same day and a copy retained
- Staff will record the time and date they pass their concerns to the member of staff with responsibility for child protection/senior staff member
- Staff will record the time and date of any referral made to one of the core agencies, any decisions/advice and the time of any response from the core agency
- The member of staff will ensure the security of any records kept

5.8 Initial questioning

Anyone who receives a report of possible abuse directly from a child or observes circumstances, which cause them concern may try to establish the basic facts before referring the matter further. It is critical that this initial fact finding does not influence what the child says, therefore the following strict guidance is given in regard to the initial questioning of children.

- Only ask sufficient questions to gain basic information
- Take the disclosure seriously and offer support
- Avoid leading questions
- Use open-ended questions

To establish..	You could ask	Don't ask
What	What happened?	Did he/she?
Where	Where did it happen?	Did he/she come to your bedroom?
Who	Who did it?	Did daddy/baby-sitter/John do it?
When	When did it happen?	Did it happen last night?
How/Why	Avoid these questions, they require judgement from the child and may induce self blame	

6. Agency specific procedures

The following represent the procedures that are to be followed within key agencies for dealing with reports of and concerns about abuse and the routes for making and passing on child protection referrals.

6.1 Health staff

Health staff have direct contact with children or involvement with parent(s), carer(s) or other family members in many situations that can give rise to concerns regarding the safety and well-being of children through abuse, lack of provision of effective care or where an individual's circumstances impact negatively on children.

Where health staff suspect that a child is being, has been or is at risk of abuse, they must act on these concerns:

- Concerns should be passed to the Paediatrician on-call for Child Protection. This service is available 24 hours a day
- While it may be appropriate to pass concerns through line managers, they must be clear that they will not act as filters but rather ensure all available information is collated before always passing the matter to the appropriate Paediatrician who will initiate Inter-agency Referral Discussions (IRDs)
- Staff may also believe that it is more appropriate to contact one of the other core agencies dependent upon the circumstances of their concern e.g. immediate concerns for the child's safety, or their own safety or a concern relating to an adult

6.1 (i) Advice

Where health service staff require advice about a possible child protection matter they should contact the Paediatrician on-call for Child Protection or the Child Protection Advisor for their area (see Appendix A for contact details).

6.2 Police

- In cases where the risk to a child is immediate, police officers have powers to take emergency action to protect children [Children (Scotland) Act 1995, Section 61(5), reproduced in Appendix E]
- Circumstances may arise where officers would not be justified in taking emergency action but the cause of concern is serious enough to merit urgent action. In these circumstances, officers will pass their concerns verbally to the Public Protection Unit, or where not available, to the police Duty Inspector, for urgent consideration of initiation of an IRD
- Officers and police staff should contact their local Public Protection Unit for advice regarding child protection matters (see Appendix A for contact details)

Where Public Protection Unit or supervisory officers are not available, staff **must** contact the other core agencies directly to share their concerns.

- Where members of police staff have contact with children, their families/carers or other individuals that give rise to concerns regarding the safety or wellbeing of children - but where the need is not immediate or urgent, the circumstances must still be referred

Force procedures should be followed regarding the submission of a referral.

6.3 Social work and other local authority services (except education)

Local authorities employ a wide range of staff who deal directly with children, their parent(s), carer(s), families and other individuals, in a variety of circumstances.

- Any member of staff who, through contact with children or other individuals, has concerns for the safety or wellbeing of a child or for the level of care being provided for a child, must act on these concerns
- The normal route for this is to contact the duty service or social work service (see Appendix A for contact details). It may be appropriate to express concerns through line management. Line managers must be clear that their responsibility is to ensure all available information is quickly collated and passed on to the social work service. They should not act as filters by deciding whether or not to pass on concerns
- Where a member of staff is unable to contact a line manager or social work service they must, without delay, contact one of the other core agencies directly
- All staff can contact their local social work services for advice about child protection matters (see Appendix A for contact details)

6.4 Education

Members of staff in education establishments are well placed to receive reports of abuse or to observe matters that may cause concerns over a child's health and wellbeing.

All education establishments will have robust structures and procedures in place to deal with staff concerns about the safety, wellbeing and protection of children.

- Each education establishment will have a Designated Member of Staff (DMS) for child protection matters
- Any member of staff with any concern about whether a child has suffered, is suffering or is likely to suffer abuse, will immediately report the concerns to the DMS
- In the absence of the DMS, the staff member with concerns will not delay, but will pass their concerns to a senior manager
- Where the DMS or senior manager is not available, staff will not delay, but will immediately pass their concerns to one of the core agencies

- The member of staff will make a signed and dated record of their concerns, including when the matter was passed to the DMS/senior manager
- The DMS or senior manager will collate all available information and be responsible for ensuring a child protection referral is made to the core agencies
- Education establishments will ensure records of reports of harm/referral are kept securely and not contained within pupil progress records
- If the child changes education establishment, the records/reports/referral of harm must be securely passed to the new establishment and not within the Pupil Progress Record

6.4 (i) Action for the Designated Member of Staff and/or Management Team

Safe and Well (Scottish Executive, 2005) sets out that when a Designated Member of Staff (DMS) and/or Management Team receives information, about concerns for the safety and wellbeing of a child or young person, they must:

- Be familiar with procedures and confident to follow them
- Plan to meet the child's needs quickly
- Think clearly and be prepared to seek the views of others
- Request and share information sensitively
- Record each decision and step taken
- The DMS must never act alone. They should refer the matter to one of the core agencies in order to initiate an IRD.

All staff in school should be aware of what is considered to be abuse or neglect of children and young people. It is essential that staff feel confident to approach the DMS to discuss their concerns and to clarify their thinking when they are not sure.

Children will often disclose or exhibit signals giving rise to concern as the time approaches for them to leave the safety of the education establishment. It is important that these circumstances are not compounded by lack of action.

- Referrals must be made without delay to enable information gathering and discussion to take place at an early stage and before time scales become critical, e.g. before the end of the school day
- Where the child's departure from the education establishment is imminent, and s/he is likely to be exposed to further risk, staff will immediately contact one of the core agencies to discuss a course of action

6.5 Third Sector

Each organisation working with children in any capacity is expected to have a child protection policy and procedures, detailing the steps to be followed by staff who receive a report of abuse or neglect or have cause for concern regarding a child.

Staff should follow these policies and procedures, which should include a point of contact within the organisation for such concerns. It is the responsibility of the Nominated or Responsible Person to collate available information and pass this promptly to one of the core agencies who will initiate an IRD.

Where no clear policy exists for child protection, or where a member of staff is dissatisfied with the reaction of their organisation, they must contact the core agencies directly and convey their concerns.

7. Inter-agency Referral Discussion (IRD)

7.1 General

Information sharing is a key activity of each agency in order to support the assessment of whether a child is at risk of or suffering harm. In order to make decisions, each agency will share with the other core agencies all relevant information. This will include information on the child, key adults who have involvement with the child or any other children who may be at risk.

When this information has been shared, and where one or more of the core agencies assess that a child is at risk or may be at risk of harm, an Inter-agency Referral Discussion (IRD) will take place as the first stage of the child protection process.

An IRD is the first stage in the process of joint information sharing, assessment and decision-making about risk to children. Professionals will consider other children who may be at risk, not only the child who is subject of the referral. This is not a single event, but takes the form of a process or series of discussions, where information is discussed and a co-ordinated response agreed by the core agencies and updated as enquiries progress.

IRDs will take place before any agency proceeds with an investigation, except where emergency measures are taken, and before either a Joint Investigative Interview (JII) or Joint Medical Examination takes place. While it is desirable to have complete information on which to base joint decisions, there may be occasions where the core agencies need to make decisions on the information available to them at the time.

The core agencies are health, police and social work services.

- The core agency receiving the child protection referral will, as a matter of urgency, initiate an IRD
- IRDs may be carried out by telephone but in cases presenting particular challenges, and which are contentious or complex, there may be face-to-face meetings as soon as practicable or, in any case, within 24 hours

7.2 Who participates?

In all cases, all three of the core agencies must participate in the IRD.

The IRD is the central mechanism within the child protection process and only those professionals with appropriate training and experience will participate.

Health

The IRD will be conducted by a senior member of paediatric staff with suitable training and experience.

It is important to restrict calls overnight to those where immediate involvement in the

IRD is essential to decision-making, e.g. the child meets the criteria for immediate Joint Paediatric Forensic Medical (JPF); or the child or sibling may be at risk regarding immediate health issues; or the extent of sexual assault is unclear as referenced in NHS Lothian Child Protection Out of Office Hours Flowchart (see the NHS Lothian Procedures in Appendix D).

Police

The IRD will be conducted within Public Protection Units by a suitably trained and experienced officer of supervisory rank.

Where specialist unit staff are not available or it is out of hours, the IRD should be conducted by an officer of the rank of Inspector or above.

Social Work

The IRD will be conducted by a trained and experienced member of social work staff of supervisory grade or an appropriate Emergency Social Work Service or Social Care Emergency Team staff member.

7.3 Accountability

While the levels of staff who will participate in IRDs is agreed, this does not remove the accountability of senior managers for processes carried out on their behalf.

The level of accountability will be specified in internal core agency procedures.

On the rare occasions that agreement cannot be achieved during an IRD, the matter will be referred to senior managers for discussion and decision.

7.4 Information sharing

Where there is uncertainty as to whether information held by an agency is relevant, it will be shared in the IRD to determine its relevance.

Each agency will consider and share information that indicates any potential risk to professional staff. This might include previous aggressive or violent behaviour, infectious disease or mental health issues.

There is an expectation on the part of the core agencies that each will thoroughly research the information systems available to them and thereafter share information with their partners to enable effective decision making. These systems will include single agency and shared information systems, both paper-based and electronically stored.

These sources of information can be extensive and may vary on a case-by-case basis. The minimum checks to be carried out and shared are stated below.

Health

Community Child Health records: whenever possible, information should come from Health Visitor/School Nurse and GP records. Where appropriate, information from hospital records/info system, mental health records and records of parents/carers, TRAK hospital/

community/maternity electronic systems should be checked during the referral process.

Police

Police National Computer (PNC), Criminal History System (CHS), Information for Family Protection Officers (INFO system), Scottish Intelligence Database (SID), Violent and Sexual Offenders Register (Visor), STORM, UNIFI and PND.

The following historical systems may also provide information:

Memex, Family Protection Unit records, Juvenile Liaison Officer records, Domestic Abuse Liaison Officer records, Missing Persons records.

Social Work

Children and Families records, Community Care/Adult Services records, Criminal Justice including Sex Offender Liaison Officer records. These checks will include electronic and paper records. Where appropriate other local authority services will be checked, e.g. Education, Housing, Environmental Services.

Edinburgh and Lothians Child Protection Register

It is the responsibility of social work to ensure that the Child Protection Register is checked.

7.5 Decision making

IRDs must consider and make decisions on the following:

- Immediate legal measures i.e. Child Protection Order or Exclusion Order, required due to evidence of immediate risk of significant harm to any child, or a Child Assessment Order where there is reasonable cause to suspect a child is suffering or is likely to suffer significant harm and there is a lack of co-operation from parent(s)/carer(s) to enable assessment to be carried out satisfactorily
- What further information is required, who will be responsible for gathering this and whether this will be carried out jointly or by a single agency
- Whether a Joint Investigative Interview (JII) is required and, if so, arrangements for this, including who will carry it out (see Section 9)
- Whether a medical examination is required, the nature and timing of this and, who will perform it (see Section 10)
- What support is required for the child, and who will provide it
- Whether there is evidence of risk to any child other than the subject of the referral
- Whether consent is required from parents/carers, who will obtain this and what information will be passed to parents/carers, even if consent is not being sought
- What feedback will be given to the initial referrer at this stage, and who will provide this

- The initial referrer/agency might continue to have close contact with the child/family and must not be compromised by lack of information
- In considering all of these issues, timescales and the sequence of actions must be decided upon and recorded

7.6 Report to the Child Protection Register (CPR)

Where a child protection concern results in a Child Protection Case Conference (CPCC) and a decision is made to place a child's name on the Child Protection Register:

- The Child Protection Administrator or Statutory Meeting Assistant will notify the Child Protection Administrator in the ELBEG PPP Office as per local arrangements (i.e. workflow on SWIFT or electronic form)
- The date for the first review CPCC will be set via the SWIFT system or generated by the Child Protection Administrator in the ELBEG PPP Office on receipt of notification of the decision of the CPCC

7.7 Notification to other agencies/bodies

Where a child, subject of a child protection referral is accommodated outwith the area, a copy of the referral, any IRD decisions and any other relevant information will be passed to the host local authority.

In certain circumstances it will be necessary for the core agencies to notify other agencies that a child protection referral has been received or an allegation has been made against an individual. These agencies may include Military Welfare Services (see Appendix D), employers where the individual works with children or vulnerable people, and other agencies/individuals as necessary and with reference to the Protection of Vulnerable Groups (Scotland) Act 2007.

Decisions regarding notification to others will be made during the IRD.

All considerations regarding notifying another agency or individual of a referral or allegation will be recorded, along with the reasons for the decision and information shared.

7.8 Recording of IRD

Every stage of IRD will be fully recorded without delay by each agency involved, using the relevant form.

Where a shared electronic information system exists, recording will be undertaken by the core agency initiating the IRD.

Each agency is responsible for ensuring that the information is recorded timeously and is accurate.

7.9 Further discussions

A number of decisions made during the IRD will result in the gathering of further information

and the outcome of particular actions.

These will be fed back and discussed by all the core agencies as part of the IRD process.

All further discussions will be recorded as with earlier IRDs, according to the IRD process.

7.10 Actions from IRD

A number of actions are possible from IRDs and any outcomes will be agreed jointly and explicitly by all core agencies, recording who will be responsible for completing tasks, time scales and sequence of events. These outcomes are not mutually exclusive and more than one outcome may be required as a result of IRD.

No Further Action

Sufficient information may be available to decide that no further action is required at that time by any of the core agencies.

Voluntary support

There may be a need for one or more agency, statutory or voluntary, to provide support to a child and/or family on a voluntary basis.

Single Agency Investigation

Where evidence suggests that this is the best way to proceed, the single agency should conduct further investigations on their own and update the IRD on progress.

Joint Investigation

Where the information suggests that, in the best interests of the child, agencies investigate jointly.

Referral to the Authority Reporter

Where concerns about a child are such that compulsory measures of supervision may be necessary, a referral should be made in writing to the Authority Reporter.

Other Legal Measures

Immediate legal measures, i.e. a Child Protection Order or Exclusion Order, police emergency powers [Section 61(5), Children(Scotland) Act 1995], that are required due to evidence of immediate risk of significant harm to any child, or a Child Assessment Order, where there is reasonable cause to suspect a child is suffering or is likely to suffer significant harm and there is a lack of co-operation from parent(s)/carer(s), to enable assessment to be carried out satisfactorily.

Child Protection Case Conference

Where there are serious professional concerns about the likelihood of harm to a child through abuse and/or neglect, a decision may be taken to convene an initial Child Protection Case Conference. The IRD will not be closed until the decision whether to convene a Child Protection Case Conference has been made.

7.11 Reporting back

At the conclusion of every investigation, whether single agency or joint, all three core agencies will share and access the information gathered and make final decisions regarding the matter.

Consideration will be given at this time to ongoing support or onward referral to other agencies for a child/family, regardless of outcome of any investigation.

The initial referrer must be provided with feedback and the IRD will determine what information will be appropriate and who will feedback to the initial referrer.

These discussions, and any decisions made will be recorded as with earlier IRDs.

7.12 Review and sign off

Every IRD record will be:

- Reviewed within one week of the date of referral and
- Signed off within two weeks of the final outcome of the IRD by the level of senior operational manager dictated in internal agency procedures

These processes will be carried out on an inter-agency basis. However, where issues arise, the core agencies will make joint decisions regarding any action required.

8. Consent

8.1 Parental consent

Part I of The Children (Scotland) Act 1995, *Section 1* sets out parents' legal responsibilities:

- (a) To safeguard and promote the child's health, development and welfare
- (b) To provide, in a manner appropriate to the stage of development of the child:
 - (i) direction
 - (ii) guidance to the child
- (c) If the child is not living with the parent, to maintain personal relations and direct contact with the child on a regular basis
- (d) To act as the child's legal representative, but only as in so far as compliance with this section is practicable and in the interests of the child.

The Act details the rights of a parent, which reflect their parental responsibilities and allow the parent to fulfil their obligations.

There is no legal requirement to obtain consent to investigate a child protection concern, however, wherever possible, professionals engaging with parent(s)/carer(s) should try to gain their full co-operation in any decisions, actions or measures necessary to protect their child from abuse or harm.

On occasion, the consent of the parent(s)/carer(s) to have their child seen regarding a child protection concern may not be sought. This decision would be taken when it is deemed to be in the best interests of the child or young person, including when seeking consent would impede any investigation or harm the child.

On occasion, the parent(s)/carer(s) or others may be suspected or identified as the cause of risk to children. In these circumstances to alert them to planned courses of action might endanger a child further.

For these reasons, consent from parents is not always possible or advisable.

In relation to medical examinations in child protection investigations, explicit, informed parental consent will be required by the examining medical practitioner unless the young person is considered to have capacity to give consent on their own behalf by the medical practitioner (see Section 8.2).

Where a parent(s)/carer(s) is unwilling to give their consent to a medical assessment of the child or young person, and the young person is not considered to have capacity to

give consent on their own behalf, the court may be asked to grant an order, [such as a Child Assessment Order or Child Protection Order (Children Scotland Act 1995)], to allow the child to be medically examined without parental consent.

8.2 Consent of the child

In the progression of a child protection investigation, explicit consent of the child is not required where the investigation is considered to be in the best interests of the child. However, the views and wishes of the child should be taken into account in any action taken.

Where a decision of an IRD is to undertake a joint action, such as a Joint Investigative Interview (JII) (see Section 9), formal consent is not required but will proceed on the tacit consent or assent of the child or young person.

In respect of medical matters, Section 2(4) of the Age of Legal Capacity (Scotland) Act 1991, provides that a child or young person may consent, on their own behalf, to medical procedures and treatments, provided that in the opinion of a qualified medical practitioner they are capable of understanding the nature and possible consequences of the treatment/procedure.

In the following circumstances, the child still has the right to refuse or not comply with the medical examination.

- Where parental consent to medical examination is given
- Where the child is deemed to have the capacity to give consent on their own behalf
- Where a Court Order authorising a medical examination has been granted

8.3 Inter-agency Referral Discussions (IRD)

Consent issues need to be considered in the majority of child protection investigations and it is important that professionals do not make decisions on consent in isolation.

Discussing these matters at an early stage will reduce the likelihood of decisions being made that may compromise investigations or the protection of the child or other children.

8.4 Reference table

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 to be incapable of comprehending.	Required. Where not given, but examination is necessary, consider Child Assessment Order/Child Protection Order.	Not formally sought. Medical practitioner will still seek implied consent.
Medical examination. Where child is deemed by doctor to be capable of comprehending consequences, and of consenting.	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.
Information sharing about the child and significant adults with consent.	Good practice to make aware when, what and with whom information will be shared. This can lead to informed consent to sharing information before any concerns arise.	Good practice to make aware when, what and with whom information will be shared. This can lead to informed consent to sharing information before any concerns arise.
Information sharing about the child and significant adults without consent.	Where there is reasonable cause to believe a child may be at risk of harm, information will be shared. No consent is needed.	Where there is reasonable cause to believe a child may be at risk of harm, information will be shared. No consent is needed.

9. Joint Investigative Interviews (JII)

9.1 General

Guidance on Interviewing Child Witnesses in Scotland, (Scottish Government, 2011) gives practitioners and managers comprehensive guidance on the arrangements and standards expected when child witnesses are to be interviewed.

Professionals involved in interviewing child witnesses should familiarise themselves with this national guidance and ensure that the expectations contained in it are reflected in practice.

An Investigative Interview is a ‘formal, planned interview with a child, carried out by staff trained and competent to conduct it..’ (Scottish Government, 2011)

The decision on the need for a Joint Investigative Interview (JII) of a child witness will be taken by the core agencies, health, police and social work, during the IRD.

9.2 Purpose for interview

The main purposes of the investigative interview are to:

- Learn the child’s account of the circumstances that prompted the enquiry
- Gather information to permit decision-making on whether the child in question, or any other child is in need of protection
- Gather sufficient evidence to suggest whether a crime has been committed against the child or anyone else
- Gather evidence that may lead to a ground of referral to a Children’s Hearing being established

Interviews should always be tailored to the needs of the child and the particular set of circumstances leading to the investigation.

All those involved in the case must clarify and define the purpose of the interview(s) to be conducted and the topics to be explored, but with a clear understanding that the child’s welfare is the paramount concern.

Alongside this shared understanding, the police perspective of the purpose of the investigative interview is to establish whether a crime has been committed, and if so, what evidence is available from the child. The social work perspective of the investigative interview is to gather evidence/information to determine the source and level of risk that the child may face and to support any necessary decisions regarding the child’s needs and any measures required to protect the child.

It is vital that both interviewers enter the interview situation with an open mind and an

agreed view of the approach they intend to take, to assist the child to give any account of the facts and circumstances relevant to the investigation.

There will be a degree of uncertainty as to what will come out of the interview, but by familiarising themselves with all the background information, interviewers should minimise the need to re-interview the child.

9.3 Planning

Where a decision is taken during an IRD on the need for an Investigative Interview, police and social work managers will:

- Identify interviewers to carry out the JII
- Ensure, within the planning of the JII, the availability of recording equipment either at a fixed site or utilising mobile recording equipment
- Agree the arrangements for the interview (time/date, location, additional support needs of the child e.g. an interpreter, and parameters)
- Ensure the interviewers are briefed, with all the detailed information gathered to that point to enable them to develop the interview plan, including any additional needs of the child
- Ensure that the interviewers are given the opportunity to prepare their investigative interview
- Confirm arrangements for the debriefing of interviewers to explore fully and access the information elicited during the interview
- Ensure that a detailed record of all stages is completed, including all decisions made, who was involved in making them and reasons for these decisions. Copies of this record must be kept by police and social work

9.4 Briefing, debriefing and further actions

Briefing and debriefing of interviewers are essential parts of the planning process for an investigative interview and require a supervising officer from either the social work service or police to undertake these processes.

- Once the interview and an agreed joint record of its proceedings have been completed, a debriefing session will take place between the interviewers and the managers of social work and/or police overseeing the investigation
- The debriefing session will be recorded and both agencies will keep records identifying decisions made, by whom and the reasons for them

Although the findings from the interview will be discussed during debriefing, any decisions on further action will be taken by the IRD.

The social work manager and/or police conducting the debriefing session will feed back the

findings of the interview to the IRD, before taking further action.

The IRD will review all available information and consider the need for any further action e.g. the arrangement of a medical examination or a further interview.

9.5 Recording

The visual recording of a JII provides a far superior record of an interview than 'verbatim' note taking. All JIIs therefore must be visually recorded, unless there are specific reasons why this may be inappropriate, e.g. the alleged offence involved video recording or photography of the child/young person.

The visual recording includes all of the pauses, body language and demeanour of the child, the interviewers and any support person present. As well as the information provided by the child that may be of evidential value, the visual recording will also give a clear impression of how evidence was obtained.

As there is a visual recording of the JII, the second interviewer no longer will be required to take a verbatim record of the interview. However, the second interviewer will take written notes, recording salient points and details. This will be required to inform the assessment of the child witness, the level of concern and whether any action needs to be taken.

During the journey to the interview suite, any conversation about the case should be avoided. However, if the child raises issues material to the case, or its circumstances, the conversation should be re-directed to neutral topics. A comprehensive written record of the conversation during the journey must be made at the earliest opportunity.

In addition, this information must be referred to in the recording of the interview.

At the conclusion of the interview, both practitioners will agree the written notes/record taken during the interview.

9.6 The interviewers

Interviewers will be from police and social work services and will be trained to a standard approved by the Association of Chief Police Officers in Scotland (ACPOS) and the Association of Directors of Social Work (ADSW). Their training will comply with the National Curriculum on Joint Investigative Interview Training (JIIT). Locally provided JIIT will be designed and delivered according to the National Curriculum.

The lead interviewer may be from either police or social work, and the roles of lead and second interviewer will be agreed at the briefing, undertaken by either a social work or police manager / supervisor.

It is vital that both interviewers undertake the Investigative Interview with an open mind and a clear view of the approach they intend to take to assist the child to give any account of facts and circumstances relevant to the investigation.

The lead interviewer will be responsible for gathering information during the interview.

The second interviewer will have a clear and active role in monitoring the dialogue of both the child and lead interviewer, and looking for inconsistencies or gaps in the child's account. The second interviewer will also be responsible for taking written notes of the salient points (see Section 9.4).

It may be necessary, on occasion, for the agreed roles to be transferred in the course of the interview, e.g. the child may indicate a strong preference to communicate directly with the second interviewer. In the planning of the interview the interviewers must consider and be prepared to make this adjustment.

9.7 Preparation for interview

In preparation for the conduct of the interview:

- The interviewers should be afforded time together to plan their approach and develop an interview plan
- This plan should be recorded and both agencies must keep records identifying decisions made, by whom, and the reasons for them

9.8 The interview

All investigative interviews with a child witness should include the following broad phases:

- Introductions
- Rapport
- Practice Interview (where appropriate)
- Free narrative
- Questioning
- Closure

Although there are distinct phases to the interview, there may be some overlap and interviewers must be prepared to switch back and forth as appropriate.

The investigative interview provides the child with an opportunity to give their own account of the circumstances, which prompted the attention of the investigating agencies and therefore the best evidence will be the child's free narrative of what happened.

Interviewers are encouraged to use open questions to promote the child's free narrative such as, 'Tell me all about...' or 'Tell me more ...'.

A practice interview is helpful as it provides the child and the interviewers with the opportunity to become familiar with such opening questions. The practice interview would take a neutral subject that has been identified by the interviewers during the rapport phase

to rehearse the use of open questions before moving on to the topic of concern where such open questions will encourage the child's free narrative.

9.9 Consent

Consent is an issue for consideration before commencing a JII (see Section 8).

Consent is not legally required from parents or children before interviewing them or before visually recording the interview. However, it is good practice to seek a child's consent before interviewing them. This is often given as 'assent' by a child rather than formal consent.

Where appropriate, steps should also be taken to keep parents/guardians informed of the unfolding situation. In certain cases, the interviewers may need to see the child without the knowledge or consent of the parent/guardian, for example, where there are strong grounds to suspect that they are involved in the abuse. If this is necessary, a record should be made by both agencies, detailing the reasons for not informing them.

Even where there are compelling reasons to exclude a parent/guardian from knowledge of investigative enquiries, due courtesy and consideration should always be given.

Consent is not required to view a recording of a JII when:

- It is necessary to view a recording of the interview for the purpose of investigation of a criminal complaint, or by the Children's Reporter
- The content of a recording/interview materially affects the conduct or outcome of the investigation, e.g. when aspects of the investigation may have to be revisited or re-done
- There is a court order requiring disclosure

Consent is legally required to view recordings where the reason to view does not form a direct part of the purpose for obtaining the recording such as:

- Competence evaluation - a formal process of monitoring the professional and technical competence of the interviewers to assist professional development, support professional qualification or inform performance assessment
- Complaint - notification from an interested party of dissatisfaction with aspects of the conduct of an investigation or interviews, which may require formal investigation in respect of possible disciplinary or professional misconduct procedures

In order to view the record for purposes beyond the investigation, consent must be sought from a parent or carer, following the completion of the investigative interview, and/or obtained from the child where appropriate.

This should be written consent and the completed form must be retained with the written record of the interview and any other documentation relating to the Investigative Interview. In Scotland a person of 12 years or more is presumed to be of sufficient age and maturity to give consent.

Where consent is sought, (as set out above), interviewers must explain the reasons for this, and how the recording will be used and stored confidentially.

9.10 Competency testing

The Vulnerable Witnesses (Scotland) Act 2004 abolished the need to test the child's ability to distinguish between truth and lies in legal proceeding. It is therefore not required in the conduct of a JII of a child witness.

However, there is a requirement, as with all witnesses, to **assess** the child's understanding and communication ability, which may lead to the identification of special communication needs or other issues.

During the JII interviewers will:

- Make an informal assessment of the child's understanding and communication ability
- Emphasise to the child the importance of giving a true account
- Avoid performing a discreet competence test to establish the child's understanding of truth and lies
- Note any additional information about the child's presentation during the JII that may assist the Procurator Fiscal and/or Children's Reporter

9.11 Other people present at interview

In accordance with the Scottish National Guidance on Interviewing Child Witnesses (2011), personnel should be kept to a minimum to avoid intimidating or inhibiting the child. In most circumstances, it is best for only the two interviewers to be present in the room with the child. However, as per the guidance, there may be a need for an interpreter or facilitator to meet the needs of the child.

In certain cases, a child may wish for, and benefit from, a supportive adult present. This should not be a witness or potential witness, nor should it be someone who has a personal investment in the case. The support person should not be a parent or carer if, for example, the parent/carer is suspected of being directly involved in the abuse or their relationship with the abuser is likely to lead to a conflict of interests.

The presence of a support person might be a hindrance to the child, especially if that adult is someone the child has a particular relationship with. The child may feel uncomfortable about them knowing intimate details of their personal life or events. The interviewers will take the lead in determining the appropriateness of, and the need for, a support person, in conjunction with the child.

If a support person is to be present, interviewers must make them aware that:

- Their role is to support the child, providing comfort and re-assurance
- They must not participate in the interview, e.g. answering questions put to the child or prompting the child

- They should preferably sit out of the line of the child's vision and be prepared to move if the need arises
- They must control their facial expressions and avoid conveying any emotions or intentions towards the child
- It is best that they are only there for the introduction and rapport phase while the child is settled, as determined by the interviewers

Notes:

Under no circumstances should the interview be conducted in the presence of the person alleged or suspected to be the cause of harm to the child.

Where any form of language interpreter is required, this should not be a member of the family.

9.12 Departure from procedures

Interviewers and supervisors will record any departure from these procedures and reasons for so doing, including lack of planning, briefing or debriefing.

Practitioners and managers involved in JIs must always refer to and follow the national guidance, and where there is deviation, this must be recorded by the supervisors/managers concerned.

10. Medical assessment and care of children where child abuse and/or neglect is suspected

10.1 General

In all cases where any form of abuse or neglect of a child is suspected, the need for medical assessment must be discussed during the IRD.

The decision to undertake a medical examination, the nature and timing of that examination **and any decision not to** examine the child must be made by the Paediatrician on-call for Child Protection in discussion with other core agencies and clearly documented.

- Any examination undertaken must be carried out by a doctor or doctor(s) with appropriate skills and competencies for the individual case
- The examination must be comprehensive- gathering information about the child's overall wellbeing, growth and development - not just documentation and interpretation of injuries

Even where the likelihood of finding recent injuries is thought to be small, examination may reveal evidence of previous injury and/or neglect, this is important in establishing any degree of significant harm.

The purposes of the examination can be summarised as:

- Securing any immediate medical treatment required
- Gathering medical and forensic evidence
- Gathering relevant medical, family and social background
- Gathering information on the child's growth, development and emotional state
- Initiating ongoing health care, e.g. treatment of sexually transmitted infections/ pregnancy, mental health care
- Reassuring the child and family

The consultation may also offer an opportunity to gain an impression of the child's emotional wellbeing, the quality of interaction with the parent(s)/carer(s) and the parent's own needs and level of understanding.

10.2 Levels of examination

Medical examinations may be performed at two levels: Comprehensive Medical Assessment (CMA) and Joint Paediatric/Forensic examination (JPF) or specialist paediatric examination (see the flow chart in Section 10.10).

10.2 (i) Comprehensive Medical Assessment (CMA)

CMAs are carried out in situations where it is unclear from the initial information whether abuse or neglect has occurred and alternative accidental or medical explanations may be forthcoming. These examinations are carried out by doctors trained in child health, working either in the community (staff grade and associate specialists), General Practitioners, or hospital based paediatric staff where the child has presented directly to primary care, A&E or hospital paediatric departments.

10.2 (ii) Joint Paediatric/Forensic (JPF) Examination or specialist paediatric examinations

These examinations are carried out where clear evidence of serious injury is reported at the IRD, e.g. non-accidental head injury in an infant, severe injury in an older child or a disclosure of sexual abuse, significant potential harm or a requirement for forensic medical opinion. They are carried out by specialist paediatricians working with Forensic Physicians (FP), or by specialist paediatricians working singly or with another paediatric specialist, e.g. a neurologist, in some situations of physical abuse or neglect where other corroborating evidence exists and the paediatrician has the appropriate skills.

10.3 Timing

The provisional timing of the examination is agreed during the IRD and will, wherever possible, be undertaken locally as soon as possible during working hours. The main factor in determining the timing is the best interests of the child and the need to ensure appropriate facilities and examiners with the necessary skills are available and that the child is appropriately supported.

Where involvement of an FP is required, the police will make contact with the on-call FP through the Force Communications Centre (FCC) to discuss the case and confirm availability.

Wherever possible, examinations after 10 pm will be avoided unless there is an urgent need to conduct an examination (particularly between 10 pm and 8 am). However, the best interests of the child should be paramount and the following criteria will be adopted in urgent cases:

- **Clinical need:** child bleeding, in pain, significant associated injury
- **Forensic need:** evidence from locus or child
- **Need to comply with legal requirements:** where suspect is in custody and where medical evidence is required to progress the investigation
- **Extreme anxiety/distress** on part of child/young person or family

10.4 Location

Examinations must be carried out in child friendly facilities with appropriate equipment and support.

They are usually carried out in the Royal Hospital for Sick Children or St John's Hospital. However, where adolescents report sexual assault, examination may be more appropriately carried out within a specialist examination suite.

10.5 Chaperones

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.

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.

10.6 Recording

- Examinations are documented on a standard pro-forma including body charts to record all injuries
- Consent to examination, taking of forensic samples, provision of reports and photo-documentation are recorded on the standard format and taken in writing from the parent and/or child wherever possible. Alternatively verbal consent is recorded and witnessed by the examining doctor(s). It is important to remember that it is the doctor's responsibility to obtain informed consent
- Genital and anal examinations are recorded using the colposcope on video, CD or DVD format to enable second opinion, defence expert opinion and peer review
- Photo documentation of physical injuries is carried out by the police. Wherever possible this should be done at the time of the examination with the examining doctors ensuring all relevant injuries are captured

10.7 Following examination

- 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 planning for the child, particularly in terms of assessing risk of imminent harm
- Where relevant, appropriate arrangements for postcoital treatment, screening for pregnancy and sexually transmitted infections are made by the examining doctors, in discussion with the young person/parent(s)
- The paediatrician takes responsibility for any further medical investigations and for the collation of the results, together with the examination findings into the subsequent reports

10.8 Reports

Following the paediatric assessment, two reports are produced: one in the form of a letter to the GP by the paediatrician, (and also made available to the Child Protection Case Conference); the other, the Soul and Conscience Report for the Procurator Fiscal. The Soul and Conscience Report is drafted by the FP, amended if necessary, and agreed jointly with the paediatrician and signed by both doctors. This will be available within four weeks of the examination. Both reports may be used by the Reporter in Children's Hearing's proceedings.

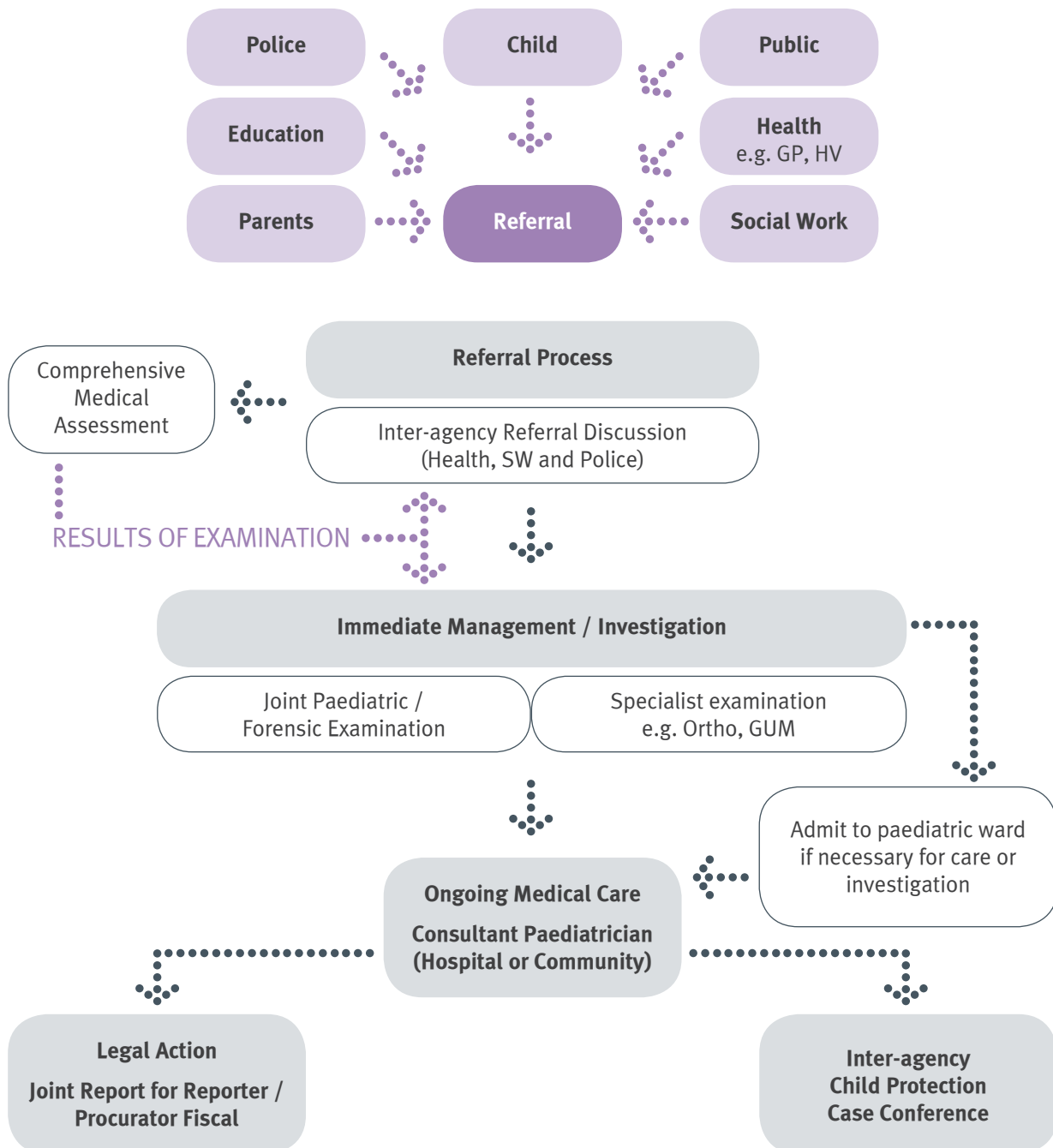
- If a child has been referred to the Authority Reporter, he/she will require a copy of the Soul and Conscience Report. An immediate medical report may be required particularly where a Child Protection Order (CPO) has been taken – good practice is to provide a written report to the Authority Reporter within two working days of the CPO being taken

10.9 Ongoing care

Children seen in the context of child protection investigations frequently have inadequately met health care needs, e.g. immunisation, attendance at ear nose and throat clinic, optician or dental clinics. The investigation and subsequent multi-agency planning offers an important opportunity to initiate care.

- The paediatrician takes responsibility for arranging ongoing health care, including liaison with the school health team, mental health services, hospital outpatient department, etc

10.10 Flowchart for medical assessment of children with suspected abuse or neglect



11. Child Protection Case Conferences (CPCCs)

A Child Protection Case Conference (CPCC) is a formal multi-agency meeting where agencies' assessments, including chronologies and risk assessments are shared and necessary actions are identified through a Child Protection Plan (CPP) to protect a child.

There are four types of CPCC: Pre-birth, Initial, Review and Transfer. Participants should be given a minimum of 5 calendar days' notice of the decision to convene a CPCC wherever possible.

11.1 Purpose of a Child Protection Case Conference

11.1 (i) Pre-birth CPCC

The purpose of a pre-birth CPCC is to decide whether there exist serious professional concerns about the likelihood of harm through abuse or neglect of an unborn child when they are born.

11.1 (ii) Initial CPCC

The purpose of an initial CPCC is to decide whether there are serious professional concerns about the likelihood of harm through abuse or neglect of a child.

This is achieved by:

- Ensuring that all relevant information held by each agency has been shared and analysed on an inter-agency basis
- Reviewing decisions made during Inter-agency Referral Discussions (IRDs) and during any subsequent inquiry/investigation
- Considering all information and initial assessments
- Considering the views of the child/parent(s)/carer(s)

After consideration of the above, the professionals in attendance have a responsibility to contribute to decision making. A key decision is whether the child(ren)'s name(s) will be placed on the Child Protection Register (CPR).

Where the decision is made to do so, the CPCC must then agree a Child Protection Plan (CPP), identify the membership of the Core Group and decide whether to refer the child to the Authority Reporter for consideration of compulsory measures of supervision. This is a formal decision and may follow referral to the Authority Reporter earlier in the child protection process by one of the core agencies, or anyone else.

11.1 (iii) Review CPCC

The purpose of a review CPCC is to review decisions where a child's name has been placed on the Child Protection Register (CPR). They will:

- Review decisions made at initial CPCC
- Review progress of the CPP
- Consider all new information available
- Decide whether the child's name should remain on the CPR

11.1 (iv) Transfer CPCC

The purpose of a transfer CPCC is to consider whether there are serious professional concerns about the likelihood of harm through abuse or neglect of a child whose name has been placed on a CPR and who:

- Moves into the Edinburgh and Lothians area
- Moves out of the Edinburgh and Lothians area
- Moves from one local authority area to another within the Edinburgh and Lothians area (e.g. West Lothian to Midlothian):

and specifically to consider whether, on removal of the child's name from the relinquishing area's CPR, the child's name should be placed on the Edinburgh and Lothians CPR, or continued, in the case of movement within the Edinburgh and Lothians area.

If a child is no longer at risk, their name should be removed from the CPR in their original area and no transfer CPCC is requested as per the National Guidance (2010).

Where a child and their family move from one authority to another and the child's name is on the CPR, a transfer CPCC will be held within 21 calendar days from the date of request for transfer and the case file must go with the child as per National Guidance (2010).

11.2 When to hold a CPCC

11.2 (i) General

- In deciding whether and when to convene a CPCC, professionals will record decisions and reasons
- Where a CPCC has taken place on a Friday or late in the working day, responsibility for notifying Emergency Social Work Service (ESWS) or Social Care Emergency Team (SCET) rests with the allocated social worker. Individual agencies may have their own system/procedures to trigger alerts within their own organisations

11.2 (ii) Pre-birth CPCC

The decision to hold a pre-birth CPCC will be made during the IRD. This should take place as soon as possible after the IRD, but no later than the 28th week of the pregnancy, unless the agencies are unaware of the pregnancy until after 28 weeks, but always within 21 calendar days of the concern being raised to IRD. Where it has not been possible to hold a pre-birth CPCC prior to birth an initial CPCC must take place prior to the baby's discharge from hospital.

Problem substance use is one of a number of reasons to consider convening a pre-birth CPCC and Edinburgh and Lothians Guidelines, Children Affected by Parental Substance Misuse (CAPSM) provide additional guidance. Other factors that might lead to an IRD on an unborn child include:

- The degree of parental mental illness/impairment, which is likely to impact on the child's safety or development
- Domestic abuse, which is likely to impact on the child's safety or development
- Concerns about parental ability to care for themselves and/or to care for the child, e.g. unsupported young parent or parent with a learning disability
- A parent or other person in the household who presents a significant risk to the child's safety or development
- A previous unexplained death of a child whilst in the care of either parent/carer
- A sibling living in the household who is or has been on a Child Protection Register
- A sibling who has previously been removed from the household temporarily or permanently
- Any other concern that the child may be at risk of harm, including a parent previously suspected of fabricating or inducing illness in a child

11.2 (iii) Initial CPCC

- The decision to hold an initial CPCC will be taken on an inter-agency basis during IRD
- An initial CPCC will be held as soon as practicable after the date of a child protection referral when sufficient information has been gathered to enable effective decision making to take place, but in any case within 21 calendar days of the referral to IRD
- An Initial CPCC must not be delayed beyond the time when sufficient information has been gathered, except when it is in the interests of the child to do so (in such cases a record of this decision and the reasons for it will always be kept)

11.2 (iv) Review CPCC

Review CPCCs will be held where:

- The first review CPCC will be decided upon by the Initial CPCC, which will be within three months of the date of the Initial CPCC
- A pre-birth CPCC has taken place and the child's name placed on the CPR, the review CPCC will take place 21 calendar day's after birth, not after registration
- Subsequent review CPCCs will take place six monthly or earlier if circumstances change
- An earlier date has been requested by the Core Group
- It is in response to a significant incident
- Instructed by the Chair of the Child Protection Committee in response to any dispute as per local protocol

11.2 (v) Transfer CPCC

Where the transfer of a child is planned, a transfer CPCC will be held, as per the National Guidance:

- The mechanism for planning a transfer CPCC is an IRD
- IRDs will also enable any further protective measures to be considered and agreed

Where a child has already moved to reside in this area, the child's name will be entered onto the Edinburgh and Lothians CPR (see Section 13) and a transfer CPCC will be arranged within 21 calendar days of the IRD. This will ensure professionals are aware of an ongoing investigation in respect of the child, if their name is checked against the CPR.

11.3 Chair of CPCCs

11.3 (i) General

CPCCs are convened on behalf of the Child Protection Committee (CPC).

- CPCC Chairs will be experienced, qualified and trained
- Chairs will hold a professional qualification in social work, and ideally hold a Child Protection Certificate or equivalent and have undergone role specific training
- The Chair exercises their responsibility as a devolved function of the CPC
- The Chair will not have any direct involvement or supervisory function in relation to any professional who has involvement in the case

11.3 (ii) Review CPCC

- The Chair of the Initial CPCC should chair any review CPCC for that child

11.3 (iii) Transfer CPCC

- Where a child is being transferred into the Edinburgh and Lothians area, the receiving area will chair the Transfer CPCC according to the National Guidance (2010)

11.4 Provision of Reports

More effective decisions can be made by CPCCs where complete information is available to attendees. In recognition of this, and with the expectation that all relevant information will be shared:

- A typed report, including a chronology, detailing involvement with the child and significant adults in the child's life, will be submitted by each agency invited to attend the CPCC where there has been previous or ongoing involvement. Where an agency representative is offering information from another service area they should make this clear
- Where possible a composite report should be produced
- Reports will be submitted ten calendar days prior to the scheduled date of CPCC (except where the notice of invitation or urgent need for CPCC does not permit this)
- Prior to CPCC each agency will share their information with the family and where appropriate the child
- Professionals must be aware that failure to share information available to them, which leads to harm of a child will be viewed as a serious neglect of their duty to protect children
- 'Restricted Access Information' will not be circulated in writing prior to CPCC, although will be shared verbally with those professionals/agencies who need to know
- Restricted Access Information shared or discussed during CPCC 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, contained in reports will be shared openly with the parent(s)/ carer(s) during the CPCC
- Where appropriate, information contained in reports will be shared openly with the child during the CPCC
- The child and parent(s)/carer(s) must be given the opportunity to have their views represented. This is particularly important if they are not attending the CPCC in person

- 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 retain it

11.5 Chronologies

A 'chronology' is a sequential timeline of significant events and issues in the life of a child and family.

All agencies, whether statutory or voluntary, with involvement with the child and/or significant adults in the child's life will produce a chronology of events and interventions to form part of the agency's report to the CPCC.

The detail of these chronologies may differ, dependent on the agency, but will list significant events, including:

- Protective factors/positive achievements
- How the child or parent(s)/carer(s) responded to and interacted with agencies involved

Significant events include:

- Changes to a child's life, e.g. health, education, development, relationships
- Changes of address and dates
- Social and economic circumstances
- New individuals joining the household
- Where appointments are missed or planned/unplanned visits were met with no response
- Where concerns are raised and where events follow these concerns, e.g. home visits, contact attempts, meetings, Child Protection Case Conferences, entry onto/removal from the Child Protection Register or referral to the Authority Reporter
- Individual crises, which may have an impact on the well being of the child, e.g. parental overdose, bereavement, post natal depression, episodes of mental health problems or illness, incidents of domestic abuse, parental separation/divorce, referral for services, etc
- Starting school or nursery
- Passing exams
- Improvements in income, employment, housing, etc
- Missed appointments, including immunisations and other health appointments

The preparation of an agency chronology will enable other professionals to understand that agency's involvement with the child/family and how these events complement and impact on their own agency's involvement.

11.6 Restricted Access Information (RAI)

Restricted Access Information (RAI) is information, which by its nature cannot be shared freely with the child and family/representatives within the full CPCC. It will be shared with professionals present to enable the complete picture to be considered.

Restricted Access Information includes:

Sub judice: Information subject to legal proceedings, the sharing of which may compromise those proceedings.

Third party: Information from or about a third party, which may identify them if shared. Information about an individual, which may not be known to others, including within close family relationships, e.g. medical history, certain previous convictions, intelligence reports.

Risk: Information, which if shared may place any individual(s) at risk.

- Professionals will be required to justify why information is being classed as RAI

11.7 Preparation for CPCC

11.7 (i) Preparation by the Chair

Prior to the CPCC the Chair will:

- Ensure that the CPCC has been organised, key agencies invited and a minute taker appointed
- Ensure reports received are sent, as soon as possible and in any case **two working days** before the date of the CPCC, to the invitees including the parent(s)/ carer(s). Any report sent to the family will be clearly marked on each page as a 'family copy'
- Familiarise themselves with the information contained in reports received
- Consider and rule on requests that a parent/carers and/or child/young person be excluded from the CPCC
- Consider the need for an interpreter or communicator and any other special measures/ facilities that may be required

11.7 (ii) Quorum

For all Case Conferences:

Social work and at least two other agencies must be represented

11.7 (iii) Preparation by Invitees

Prior to Case Conference invitees will:

- Familiarise themselves with the information contained in reports
- Submit to the Chair any request that a parent/ carer and/or/child/young person be excluded from the Case Conference

11.7 (iv) Preparation by Social Worker

Prior to the CPCC the social worker allocated to the child will:

- Prepare the child and parent(s)/carer(s) for the CPCC process and in particular help them consider how their views can be made known and understood
- Seek the views of the child and include these in the assessment and planning and at any subsequent stage, including the CPCC
- Ascertain whether the child wishes to attend the CPCC, taking account of their age and stage of development, and if so, discuss this with the chair prior to CPCC, in order to make appropriate arrangements

11.8 Attendance

11.8 (i) General

Sharing and proper analysis of all available information about the child, their siblings and significant adults in the child's life is key to making correct decisions at a CPCC.

In order to best achieve this:

- All agencies, statutory and voluntary known to have significant involvement in a child's life and the life of significant adults, will be invited to attend the CPCC
- Every agency invited to attend a CPCC is expected to be represented. Where the child is registered with an education establishment, education must be represented. An exception to this will be, when the CPCC is during school holidays, in which event consideration will be given to an early Review CPCC
- All attendees will remain until all decision making is complete. CPCCs usually last between 1 and 2 hours and professionals must allow sufficient time for their attendance and full participation
- Agencies must ensure that their representative(s) is/are fully informed and able to bring all relevant information to the CPCC, including relevant information about parents and significant adults
- A child attending a CPCC will be given the opportunity to have a support person accompany them

- The parent(s)/carer(s) will be invited, other than in exceptional circumstances (see below) to attend
- In exceptional circumstances, professionals may request that parent(s)/carer(s) and/or the child be excluded from the CPCC. Where the Chair of the CPCC is satisfied that exceptional circumstances exist and determines that there is sufficient reason for doing so they may exclude the child or any other person from the CPCC
- Any request to exclude a person from the CPCC will be recorded, as will the decision taken and the reasons for it

Occasions when the child and/or a parent/carers will be excluded will be rare. The likelihood of violence or of serious disruption to the CPCC will influence this decision. The fact that a parent or carer may be a suspected abuser should not automatically preclude their attendance.

11.9 Process of CPCC

11.9 (i) General

The Chair and professionals attending will ensure that the views of the child are made known and acknowledged throughout the process of the CPCC.

The Chair of the CPCC will:

- Introduce themselves to the parent(s)/carer(s) and, where appropriate, the child, **immediately prior** to the CPCC and ensure their understanding of the purpose and process of the CPCC, including the consideration of RAI. They will also clearly explain what will be expected of them and others during the CPCC
- Where RAI has been, or is to be provided, they will explore and discuss this without the child/parent(s) present
- Ensure that any RAI conforms to the criteria
- Ensure that this part of the CPCC is kept to a minimum and that discussion does not continue beyond RAI with the child/parent(s) excluded
- Ask each professional to provide a succinct verbal summary of their agency's previously submitted report(s) relating to their agency's involvement with the child and family, including relevant adults. They should also include an update on any risk reduction measures put in place to cover the period between the IRD and CPCC
- Seek the view of the parent(s)/carer(s), if in attendance, in relation to the information provided
- Lead a discussion on the risks to the child(ren), protective factors and what support can be offered from extended family/community and professionals
- Ensure every CPCC specifically considers the current and future living arrangements of

the child, including a specific consideration as to whether it is safe to discharge a child or baby home from hospital or another safe place

- Obtain the views of each professional in attendance in relation to the risk of harm
- Ensure every CPCC makes decisions as set out in Section 11.10
- Ensure that where a parent/carer has not attended, the decisions of the CPCC are made known to them as soon as practicable after the CPCC
- Where possible, chair any review CPCC and any subsequent initial CPCC for the same child
- Where invitees fail to attend or make provision for delivery of relevant information, fail to submit reports or fail to participate fully in decision making and planning stages of the CPCC, report the circumstances to the invitee's agency

11.10 Decisions and Actions

All CPCCs will reach decisions by consensus. Consensus means 'general or widespread agreement'. It does not mean a majority vote nor does it mean unanimity is required and that one dissenter can control the decision making process.

The role of the Chair is an important one in eliciting key assessment information and supporting the CPCC reaching consensus, based on the facts and professional judgements presented, rather than on understandable anxiety, either about registration or de-registration.

Consensus means that, irrespective of any agency representative's view of the decision, all involved will abide by it. This includes implementing any Child Protection Plan (CPP), which results from a CPCC.

Any agency's judgement that a child's name should be placed on, or removed from, the CPR must be based on a detailed, multi-agency risk assessment, which concludes from the evidence that the child is at significant risk of harm and requires a CPP, or that risk has been reduced to the extent that registration is no longer necessary. Any disagreement should be formally recorded in the minute. An agency's refusal to implement the plan should be reported to the Chair of the CPCC.

Where there is no clear consensus in the discussion, the Chair will use his/her professional judgement to make the final decision, based on an analysis of the issues raised.

Where a Chair of the CPCC has made the final decision, local CPC guidance on independent scrutiny will be followed, as per the National Guidance (2010).

A CPCC, having considered all available information and having reviewed the decisions taken to date, will decide on:

Child Protection Register: Where there are serious professional concerns about the likelihood of harm to a child through abuse or neglect, the CPCC will decide to place the child's name on the Edinburgh and the Lothians Child Protection Register (see Section 13).

Referral to the Authority Reporter: Where concerns about a child are such that compulsory measures of supervision may be necessary, a referral should be made in writing to the Authority Reporter (see Section 14) .

A deterioration in circumstances may lead to a child being referred to the Authority Reporter at a review CPCC.

Immediate Safety of the Child: Every CPCC should specifically consider the current and future living arrangements of the child, including a specific consideration as to whether it is safe to discharge a child or baby home from hospital or other safe place.

Immediate legal measures, i.e. Child Protection Order or Exclusion Order, where there is evidence of immediate risk of significant harm to any child, or a Child Assessment Order, where there is reasonable cause to suspect a child is suffering or is likely to suffer significant harm and there is a lack of co-operation from parent(s)/carer(s) to enable assessment to be carried out satisfactorily. This is most likely to be in response to new information, otherwise an earlier application for legal measures should have been made.

Non registration/De-register: Where a child's name is not placed on or is removed from the CPR, the CPCC will put in place a plan to ensure the continued wellbeing and safety of the child are monitored and supported by an identified Lead Professional.

Where the CPCC decides to place a child's name on the Edinburgh and Lothians Child Protection Register (CPR) the CPCC must:

- Identify a named social worker who will become the Lead Professional
- Identify key professionals to form a multi-agency Core Group and the date of the first Core Group meeting, which will be within **15 calendar days** of the CPCC
- Agree the initial CPP to include the actions to be taken to ensure their wellbeing and safety
- Set **a date for a review** CPCC, which must be within **three months** of the initial CPCC. Thereafter, reviews should take place **six monthly**, or earlier if circumstances change

Where a decision is taken to refer the child to the Authority Reporter:

- The person nominated by the CPCC will submit the referral to the Authority Reporter within ten calendar days of the CPCC. Copies of reports and minutes provided to the CPCC will accompany the referral
- Where a decision is taken not to refer the child to the Authority Reporter, the reason for this must be clearly documented

11.11 Recording

- A minute of each CPCC must be taken. This will include a record of information shared and the evidenced opinions of each professional present, leading to the considered decisions of the CPCC

- To avoid any unnecessary delay in actions and tasks identified, the Chair should produce a record of key decisions and agreed tasks for circulation within **one day** of the meeting. This should be distributed to invitees who were unable to attend as well as CPCC attendees
- The minute will be reviewed and signed by the Chair of the CPCC and sent to all invitees within **15 calendar days** of the date of the CPCC
- Invitees are responsible for ensuring the accuracy of the minute
- Invitees will bring to the attention of the Chair any inaccuracies in the minute, within **15 calendar days** of its circulation. The Chair will decide on whether amendment and re-circulation are required

11.12 Disagreement with Decisions

11.12 (i) Disagreement by Professionals

Whenever possible, the CPCC will reach decisions by consensus. This does not mean unanimity is required. Where a professional disagrees with a decision, this will be noted in the minute.

The Chair will ensure all opinions are fully expressed. However, where a professional cannot agree the contents of the CPP:

- The professional will discuss the matter with their line manager
- The line manager will determine the course of action to be taken and may include further discussion with partner agencies
- Discussion may escalate to more senior level, as required, for agreement to be reached
- Where resolution cannot be agreed, the line manager will refer the matter to the Chair of the CPC
- The Chair of the CPCC will ensure that the protection of the child is the paramount concern and appropriate safety measures within the CPP are in place whilst the matter is being determined and this may include the child's name being placed on the CPR

Where the Chair of the CPCC disagrees with the decision of the CPCC, and all efforts at resolution have been unsuccessful :

- The Chair of the CPCC must refer the matter to the Chair of the CPC
- The Chair of the CPCC will ensure that the protection of the child is paramount concern and appropriate safety measures within the CPP are in place whilst the matter is referred to the Chair of the CPC and this may include the child's name being placed on the CPR

11.12 (ii) Action for Chair of Child Protection Committee

Where the Chair of the Child Protection Committee (CPC) is notified of a significant problem in relation to a decision of a CPCC, s/he will:

- Review all relevant information and reports available
- Review the minute of the CPCC
- Consider consulting other professional colleagues or members of the CPC
- Decide whether the CPCC decision should stand or order the CPCC to reconvene, either with new information or additional attendees or the appointment of a new chair

11.13 Complaints by Parent(s)/Carer(s) and/or Child

11.13 (i) Complaints

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

Where parent(s)/carer(s) and/or a child have a complaint:

- Regarding professional conduct, the matter must be referred to the agency concerned for appropriate response according to internal complaint/ disciplinary procedures
- In respect of the conduct of, or the arrangements for sharing information during, a CPCC, the matter will be referred to individual agencies who must confer with the other agencies involved in formulating a response

12. Core Groups and the Child Protection Plan (CPP)

12.1 The Lead Professional

The Lead Professional will:

- Hold the overview of the CPP
- Be responsible for the details of the child's registration on the CPR
- Act as the investigating social worker, where agreed by IRD, if further referrals are made whilst the child's name remains on the CPR
- Ensure participants receive the agreed CPP within five calendar days of the CPCC
- Ensure that a record of all Core Group meetings is kept, and that any reviewed CPP produced is circulated. Whilst it is the responsibility of the Lead Professional to ensure meetings are recorded, amendment and circulation of the CPP and the arrangements for these tasks will be met jointly by the Core Group members by agreement

12.2 Core Groups

12.2 (i) Function of Core Groups

A Core Group is a group of identified professionals who have a key role to play in the CPP, along with, where appropriate, the parents and child. The Core Group has responsibility for developing, implementing and reviewing the CPP, ensuring the welfare of the child remains paramount.

Core Group members and participants of the CPCC should receive a copy of the agreed CPP within five calendar days of the CPCC.

The Core Group may provide a less formal setting where the child (ren)/parent(s)/carer(s) and others are encouraged to participate actively in the implementation of the CPP.

The Core Group is convened on the direction of the CPCC. It reports back to the CPCC on the progress of the CPP at planned Review CPCCs, or earlier if required.

Where a Core Group identifies a need to make significant changes to the CPP they should notify the CPCC Chair within **three calendar days** to consider the need for a review CPCC.

Situations, which may prompt the Core Group to request an earlier Review CPCC include significant changes in the child's circumstances or where the agreed plan could not be implemented.

12.2 (ii) Purpose

The purpose of the Core Group is to:

- Ensure ongoing assessment of the needs and risks of the child(ren) placed on the CPR
- Agree and implement a CPP, which must include monitoring arrangements, and the frequency the child will be seen by professionals
- Ensure effective continual communication between all agencies involved in implementing the CPP

Where there is no active engagement by parent(s)/carer(s) or young people, the Core Group will refer the matter back to the Chair of the CPCC.

12.2 (iii) Membership

The Core Group should comprise:

- The Lead Professional
- Professionals with active involvement, e.g. health professionals, education professionals, third sector worker, criminal justice social worker, drugs and alcohol worker and where appropriate, police
- Parent(s)/caregiver(s) other significant adults (may be excluded during discussion of RAI)
- The child(ren)/young person where appropriate (may be excluded during discussion of RAI)

As circumstances change, membership of the Core Group will be reviewed to ensure that appropriate key people are involved.

12.2. (iv) Attendance/Conduct

- Members of the Core Group will attend all Core Group meetings and any review CPCC in relation to the child
- Where a Core Group member deviates from the CPP or decision of the Core Group they must inform the Lead Professional who holds an overview of the CPP
- Core Group members will be responsible for disseminating the CPP to other relevant professionals within their agency

12.2 (v) Frequency

The Core Group meetings will:

- Commence on the date agreed by the Initial CPCC, but no later than 15 calendar days of the initial CPCC

- Continue as agreed in the CPP, taking account of changing circumstances, but in any case no less than every eight weeks
- Continue until de-registration of the child from the CPR

12.2 (vi) Chair

- The Core Group will be convened and normally chaired by the Lead Professional. In cases that are complex, contentious or present particular challenges a more senior professional may chair
- Where the Lead Professional is not in attendance, e.g. sick leave, members of the Core Group can still meet and another Core Group member should take the role of chair

12.2 (vii) Recording

- A record of all Core Group meetings will be kept. This will include attendance and any progress or lack of progress of the CPP
- Any amended CPP will be circulated to members of the Core Group and the Chair of the CPCC
- Any material changes to the child and/or family circumstances will be made known by the Core Group to those professionals/ agencies with involvement with the child and/or family

12.3 The Child Protection Plan (CPP)

12.3 (i) General

The inter-agency Core Group is responsible for devising a detailed CPP that must follow registration on the CPR. This is a multi-agency plan to manage the identified risks that a child/young person faces and promote improvements to their safety and wellbeing.

It includes clear actions to be taken in all relevant aspects/circumstances affecting the child/young person's life. It will determine the need for more integrated assessment and work to be carried out with the child and/or family to manage and reduce risk to the child.

It should be adapted according to changing circumstances including heightened or reduced risks.

12.3 (ii) Purpose

The purpose of the CPP is to:

- Safeguard the child(ren) from harm
- Promote the child(ren)'s health and development

- Support the parent(s)/carer(s), the wider family and relevant others, where this is in the best interest of the child(ren), to promote the child's welfare
- Support the child/young person to promote their own personal safety

12.3 (iii) Content

The CPP will identify:

- Key people involved and their responsibility, including the Lead Professional and named practitioners
- Work to be undertaken and tasks to be carried out
- Time scales
- The support and resources required (in particular, access to specialist assistance) and the agreed outcomes for the child/young person
- The process of maintaining and review of any contingency plans
- Strengths and hazards in the child's living circumstances

12.3 (iv) Considerations

In determining the CPP, the Core Group must:

- Seek and consider the views of each child
- Seek and consider the views of the parent(s)/carer(s) where this is consistent with the child's welfare or the safety of others
- Make the CPP available to the family and, where appropriate the child, in the most accessible format to ensure effective communication, taking account of language, disability or other additional needs
- Make every effort to ensure understanding of the CPP by the child(ren)/parent(s)/carer(s) and to enlist their co-operation with its implementation

13. The Child Protection Register (CPR)

Every local authority area in Scotland maintains a register of children in that area deemed to be at an unacceptable level of risk by a CPCC. There is one Child Protection Register (CPR) for children in Edinburgh, East Lothian, Midlothian and West Lothian (The Edinburgh and Lothians CPR).

At the conclusion of a CPCC (see Section 11) it will be explained to the child or young person (where present), parents, carers or representatives, that their details will be placed on the CPR. They should be advised that professionals who come into contact with the child or the family might know about the registration and the known or suspected risk to them.

The purpose of this information is:

- To let professional staff know that there has been an identified risk to the child concerned
- To assist staff to evaluate the current level of risk to the child

Details of registration will be routinely shared with health, police and other local authorities to help protect children.

Information from the CPR is available 24 hours a day, 365 days of the year.

The Edinburgh, Lothian and Borders Executive Group Public Protection Partnership Office (ELBEG PPP Office) maintains the CPR.

Only authorised professionals may make an enquiry of the CPR and reference should be made to agency specific procedures or practice notes for guidance.

During normal working hours, the CPR can be accessed by contacting the ELBEG PPP Office (see Appendix A for contact details).

At other times the CPR can be accessed through ESWS/SCET (see Appendix A for contact details).

14. Provision of information to the Authority Reporter

14.1 General

Where information is received by a local authority that suggests that **compulsory measures of supervision** may be necessary in respect of a child, they **shall**:

- Cause inquiries to be made into the case unless they are satisfied that such inquiries are unnecessary and
- If it appears to them after such inquiries, or after being satisfied that such inquiries are unnecessary, that such measures may be required in respect of the child, give to the Principal Reporter such information about the child as they have been able to discover

Where a constable has reasonable cause to believe that **compulsory measures of supervision** may be necessary in respect of a child they **shall**:

- Give to the Principal Reporter such information as they have been able to discover

Anyone else may refer a child to the Reporter if they believe the child maybe in need of compulsory measures of supervision.

The Reporter is an independent official employed by the Scottish Children's Reporter Administration (SCRA) with the responsibility to receive referrals and make decisions as to whether any child should be referred to a Children's Hearing. For Grounds of Referral to a Children's Hearing see the Children (Scotland) Act, 1995, Section 52 (2) (a)-(i).

14.2 Case Conference Referrals to the Authority Reporter

- Every Child Protection Case Conference (CPCC) has to consider whether to refer a child to the Reporter. Where such a decision is made the referral must be made in writing within ten calendar of the CPCC
- Where the CPCC decides not to make a referral to the Reporter, any individual or agency can still make an independent referral
- Minutes of a CPCC should be sent to the Reporter only if there is either an intention to make a referral or if the child has already been referred and the CPCC report provides further information. Minutes of CPCC should not be sent routinely to Reporters.

14.3 Investigation by the Authority Reporter

(Section 52 (2) Children (Scotland) Act 1995)

Where a Reporter receives a referral they may make such initial investigation as is necessary to determine:

- Whether a child may be in need of compulsory measures of supervision
- Whether there may be sufficient evidence to prove one of the grounds of referral found in section 52 (2) of the Children (Scotland) Act 1995

14.4 Decisions by the Authority Reporter

The following decisions are open to the Reporter:

- To take no further action
- To refer to the local authority for voluntary measures of supervision
- To refer to a children's hearing

The latter decision will only be taken if the Reporter believes:

- A child may be in need of compulsory measures of supervision

and

- There is sufficient evidence to prove a ground of referral found in section 52 (2) of the Children (Scotland) Act 1995

14.5 Children's Hearing

The Children's Hearing may decide:

- To discharge any referral
- To make a supervision requirement with or without conditions
- To continue the matter for further information and issue a warrant if necessary for the immediate protection of the child

The Children's Hearing can only proceed if the grounds of referral have either been accepted and understood by both children and parents or established by a Sheriff (see Children (Scotland) Act 1995, Section 70).

14.6 The Sheriff

If the grounds upon which a child has been referred to a children's hearing are not understood, e.g. the child is too young to understand, or not accepted by either child or parents, the matter may be referred to the Sheriff for proof. The Authority Reporter is

responsible for conducting the proceedings, including leading witnesses in support of the grounds of referral.

Children and parents may be legally represented separately and a Safeguarder may also be appointed.

The provisions of the Vulnerable Witnesses (Scotland) Act 2005 apply to any child or vulnerable adult cited to appear.

In respect of all grounds where a child is alleged to have committed an offence, the standard of proof required will be the criminal standard (beyond all reasonable doubt) and not the civil standard of proof (the balance of probabilities).

The Sheriff will either:

- Find the grounds of referral not established and discharge the referral or
- Establish the grounds and remit the case back to a children's hearing

Any appeal against a final decision of a children's hearing would be heard by the Sheriff.

14.7 Safeguarder

The Safeguarder is an independent person appointed by either a Children's Hearing or Sheriff and acts in the best interests of the child. The Safeguarder provides an independent assessment regarding the child's needs, risks and other relevant circumstances.

15. Allegations against current or previous employees/carers/volunteers

15.1 General

The term ‘agencies’ in this section does not only refer to the core agencies of health, social work services and police, but to all other agencies, groups or individuals who provide services for children and/or families. This includes whether directly or indirectly employed by the core agencies or by way of contract, voluntary work, caring, or in any other capacity.

The terms ‘staff’ and ‘employee’ are used throughout this section and refer to any person who carries out any service, including voluntary work, for children and/or families on behalf of agencies, groups or individuals.

All allegations of suspected abuse against staff must be taken seriously. Allegations may be made against members of staff currently involved with children, but may also be made against staff who are no longer involved in the provision of services. In all circumstances, the matter must be treated seriously and the response must be prompt.

All allegations against employees must be dealt with transparency, but with considerable sensitivity to the management of information. The following inter-agency requirements will be met where an allegation is made against any member of staff:

- A designated senior manager must immediately be informed
- The senior manager may make initial enquiries to establish the broad nature of the allegations. These enquiries should not go beyond trying to establish the basic details of the allegation made
- The senior manager will contact one or more of the core agencies at the outset who, in the IRD, will consider whether the matter constitutes a child protection referral
- Consideration will be given at an early stage whether the employee should be suspended from duty pending the investigation, or whether some other measure (e.g. temporary redeployment) is required. At all times, the paramount consideration will be the protection of children and young people
- It is important that the employee is treated fairly and that his/her rights are respected during the investigative process
- Consideration will be given to the control and management of information to service users and other staff
- Where appropriate a formal referral should be made by the senior manager, in accordance with the Inter-agency Child Protection Procedures, to the core agencies who will initiate an IRD

- The staff member subject of the allegation will not be interviewed concerning the matter prior to a decision being made at IRD, as to whether the matter warrants a child protection investigation

15.2 Historical Abuse

Historical abuse includes all allegations of abuse whether of serious neglect or of a sexual or physical nature, which took place before the victim(s) was/were aged 16 years (or aged 18 in some circumstances) and are made after a significant period has elapsed.

Often the complainant will be an adult, but some cases will apply to older children making allegations of abuse in early childhood.

A “significant period” therefore will usually be a number of years between when the incident occurred and when it is reported, and may be as long as several decades.

- Inter-agency Referral Discussions (IRDs) will decide the action required on receipt of information concerning historical abuse
- The IRD should consider whether there is any potential risk from the alleged perpetrator(s) in relation to any other child or children. This may be in a professional capacity, such as residential or care setting with a person; family setting in the wider community; with other institutional settings; or a combination

Individuals making allegations of historical child abuse may be unwilling to go to the police or have a referral made on their behalf. Their needs must be balanced against the need to protect any child or young person who might currently be exposed to risk from the alleged perpetrator. Whilst support should be provided to the individual, the information that is available must be passed on for consideration by the IRD.

15.3 Recording

Recording allegations of a child protection concern, whether against staff or of an historical nature, must comply with Section 7.8 of these procedures. Sensitivities in relation to allegations against members of staff must be considered, but must not impede the investigation and the protection of children.

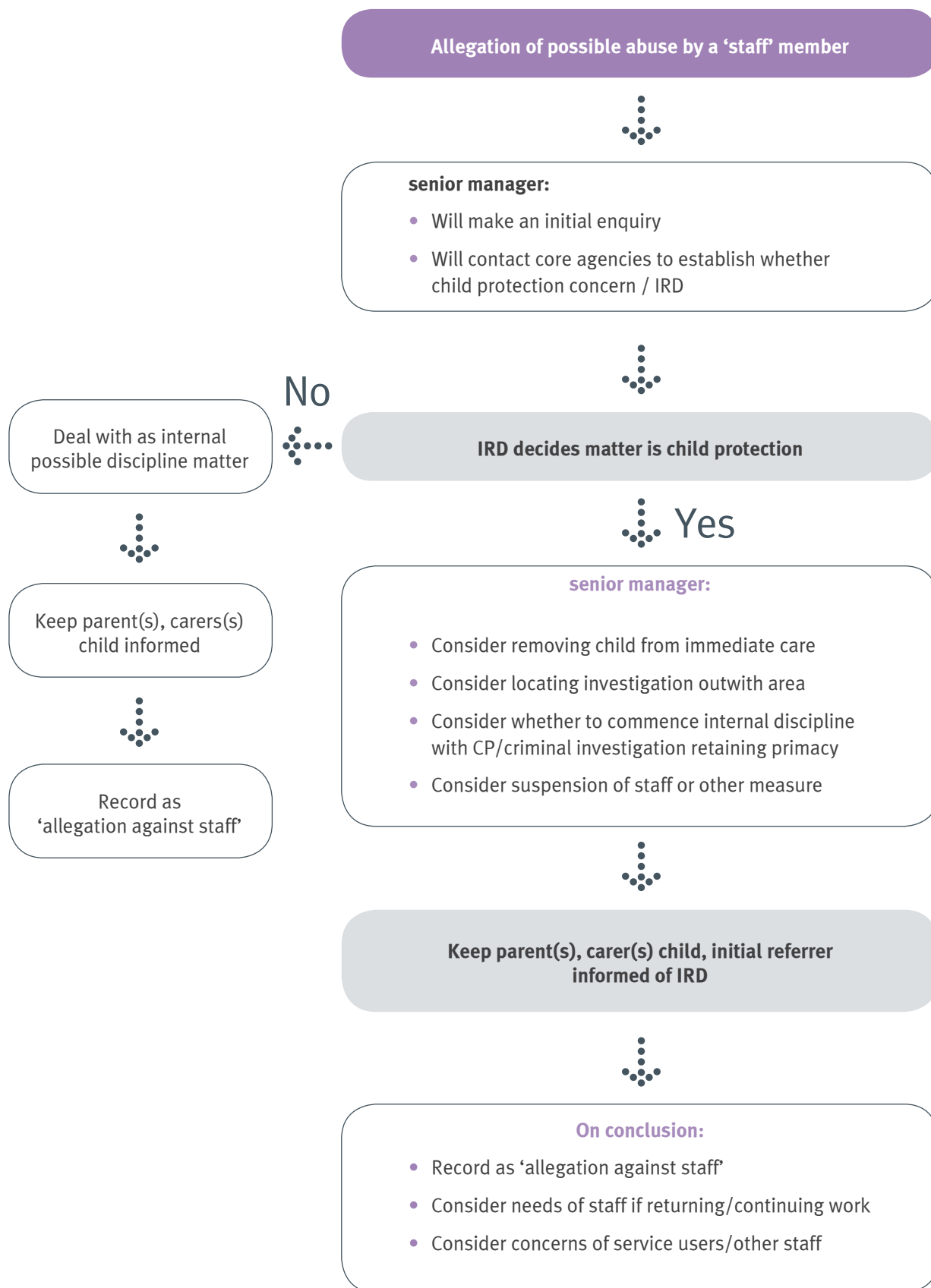
15.4 Management of Staff

Allegations of abuse against employees are a serious matter. Equally, all considerations need to be balanced to ensure that service users are protected, but employees are treated fairly, transparently and with due process.

Where child protection or criminal investigations have ‘No findings’ or the employee is exonerated, it is important that managers give full consideration to the welfare of the member of staff returning to work following suspension or continuing work post-investigation.

Concerns of service users and other staff may also require to be addressed.

15.5 Flowchart: Allegations against Current/Previous Employees/ Carers/Volunteers



Appendix A - Contact Details

East Lothian

Social Work

Children's Services Social Work Team

Randall House, Macmerry Business Park
Macmerry, EH33 1RW
Tel: 01875 824 090

Adult Social Work Services

Access Team, 6-8 Lodge Street, Haddington
East Lothian, EH41 3DX
Tel: 0845 603 1576

Emergency Social Work Service (ESWS)

Out of hours:
Tel: 0800 731 6969

Police

Force Communication Centre (FCC)

Tel: 0131 311 3131
Out of hours ask for the Duty Inspector

Public Protection Unit

Dalkeith Police Station, Divisional Headquarters
Newbattle Road
Dalkeith, EH22 1DY
Tel: 0131 654 5528

Health

Paediatrician On-call for Child Protection

NHS Lothian, (contact from 9-5pm Mon-Fri)
Tel: 0131 536 8107
Out of hours: 0131 536 0000 and ask for the
'Paediatrician On-call for Child Protection'

Designated Nurse for Public Protection

NHS Lothian
Tel: 0131 316 6670

Child Protection Advisor

Musselburgh Primary Care Centre
Inveresk Road
Musselburgh
East Lothian
Tel: 0131 316 6673
Mobile: 0790 987 7672

Scottish Children's Reporter Administration

Authority Reporter
Mid and East Team
1 Fountainhall Road
Edinburgh, EH9 2NL
Tel: 0300 200 1666
Fax: 0300 200 1630

Edinburgh

Social Work

Children and Families Social Care Direct

Chesser House
500 Gorgie Road
Edinburgh
EH11 3YJ
Tel: 0131 200 2327

East Neighbourhood

Craigmillar Social Work Centre, 171 Duddingston
Park South, Edinburgh, EH15 3EG
Tel: 0131 657 8500

North Neighbourhood

Muirhouse Social Work Centre
34 Muirhouse Crescent
Edinburgh
EH4 4QL
Tel: 0131 343 1991

Leith Neighbourhood

Leith Social Work Centre
St John's House
71 Constitution Street
Edinburgh
EH6 7AF
Tel: 0131 553 2121

South Neighbourhood

Captain's Road Social Work Centre,
40 Captains Road
Edinburgh
EH17 8QF
Tel: 0131 529 5300

South West Neighbourhood

Murrayburn Gate Social Work Centre
5 Murrayburn Gate
Edinburgh
EH14 2SS
Tel: 0131 442 4131

West Neighbourhood

Westfield House Social Work Centre
5 Kirk Loan
Edinburgh
EH12 7HD
Tel: 0131 334 9933

Emergency Social Work Service (ESWS)

Out of hours:
Tel: 0800 731 6969

Police

Force Communications Centre (FCC)

Tel: 0131 311 3131

Public Protection Unit

Amethyst Team
Vega House
Lothian and Borders Police
Police Headquarters
Fettes Avenue
Edinburgh, EH4 1RB
Tel: 0131 316 6600

Health

Paediatrician On-call for Child Protection

NHS Lothian (contact from 9-5pm Mon-Fri)
Tel: 0131 536 0467
Out of hours: 0131-536-0000
Ask for the 'Paediatrician On-call' for Child Protection.

Designated Nurse for Public Protection

NHS Lothian
Tel: 0131 316 6670

Child Protection Advisor (South)

Edinburgh

Tel: 0131 316 6673

Mobile: 0777 041 0739

Child Protection Advisor (North)

Edinburgh

Tel: 0131 316 6673

Mobile: 0797 698 9757

Child Protection Advisor

(Acute Division except for St John's Hospital)

Sick Children's Hospital

Rillbank Terrace

Edinburgh

Tel: 0131 536 0170

Mobile: 0791 727 7415

Scottish Children's Reporter Administration

Authority Reporter

Edinburgh Team

1 Fountainhall Road

Edinburgh, EH9 2NL

Tel: 0300 200 1666

Fax: 0300 200 1630

Midlothian

Social Work

Dalkeith Social Work Centre

11 St Andrew Street

Dalkeith, EH22 1AL

Tel: 0131 271 3860

Emergency Social work Service (ESWS)

Out of hours:

Tel: 0800 731 6969

Police

Force Communications Centre (FCC)

Tel: 0131 311 3131

Public Protection Unit

Divisional Headquarters

Newbattle Road

Dalkeith, EH22 1DY

Tel: 0131 654 5528

Health

Paediatrician On-call for Child Protection

Midlothian

(contact from 9-5pm Mon-Fri): 0131 536 8107

Out of hours: 0131 536 0000

Ask for the 'Paediatrician On-call for Child Protection'.

Designated Nurse for Public Protection

NHS Lothian

Tel: 0131 316 6670

Child Protection Advisor

Musselburgh Primary Care Centre

Inveresk Road

Musselburgh

East Lothian

Tel: 0131 316 6673

Mobile: 0790 987 7672

Scottish Children's Reporter Administration

Authority Reporter

East and Mid Team

1 Fountainhall Road

Edinburgh, EH9 2NL

Tel: 0300 200 1666

Fax: 0300 200 1630

West Lothian

Social Work

Bathgate Children and Families Team

69 Whitburn Road

Bathgate, EH48 1HE

Tel: 01506 776 700

Broxburn Children and Families Team

Strathbrock Partnership Centre

189a West Main Street

Broxburn EH52 5LH

Tel: 01506 775 666

Livingston Children and Families Team

New Cheviot House

Almondvale Boulevard

Livingston EH54 6QN

Tel: 01506 282252

Social Care Emergency Team (SCET)

(out of office hours)

Tel: 01506 281028

Police

Force Communications Centre (FCC)

Tel: 0131 311 3131

Public Protection Unit

Civic Centre, Howden South Road

Livingston, EH54 6FF

Tel: 01506 833835

F Division HQ

West Lothian Civic Centre, Howden South Road

Livingston, EH54 6FF

Tel: 01506 431 200

Health

Paediatrician On-call for Child Protection

Community Child Health

St. John's Hospital, Howden

Livingston, West Lothian, EH54 6PP

(contact from 9-5pm Mon-Fri) Tel: 01506 524 412

Out of hours: 0131 536 0000

Ask for the 'Paediatrician On-call for Child Protection'.

Designated Nurse for Public Protection

NHS Lothian

Tel: 0131 316 6670

Child Protection Advisor

St John's Hospital

Howden Road West,

Livingston

West Lothian, EH54 6PP

Tel: 01506 524 414

Mobile: 07769643398

Scottish Children's Reporter Administration

Authority Reporter

West Lothian Team

Civic Centre

Howden South Road

Livingston, EH54 6FF

Tel: 0300 200 1420

Fax: 0300 200 1436

ELBEG

Edinburgh, Lothian and Borders Executive Group Public Protection Partnership Office (ELBEG PPP Office)

Vega House
c/o Lothian and Borders Police
Fettes Avenue
Edinburgh, EH4 1RB
Tel: 0131 316 6689
Fax: 0131 316 6690
e-mail: elbegpppo@lbp.pnn.police.uk

Military Welfare Services

Army Welfare Service (AWS)

Divisional Welfare Support Officer (DWSO)

HQ 2 Div, Building 37, Craigiehall,
South Queensferry, West Lothian, EH30 9TN
Tel: 0131 310 2107 /2108

Divisional Personal Support Officer (DPSO)

HQ 2 Div, Building 37, Craigiehall,
South Queensferry, West Lothian, EH30 9TN
Tel: 0131 310 2618 /2108

Personal Support Team

Dreghorn Barracks, Redford Road
Edinburgh
EH13 9QW
Tel: 0131 310 2845

Lowlands Welfare Support Officer

Dreghorn Barracks, Redford Road
Edinburgh
EH13 9QW
Tel: 0131 310 2845

Highlands Welfare Support Officer

24 Wimberley Way
Inverness
IV2 3XX
Tel: 01463 233 132

Royal Marines

Scotland Welfare Officer

RM Condor
Arbroath
Angus, DD11 3SJ
Tel: 01241 872 201 Ext 2015/6

Team Manager Naval Personal & Family Service & Royal Marines Welfare Service

Northern Area Office
Triton House
1 - 5 Churchill Square
Helensburgh, G84 9HL
Tel: 01436 672 798

Royal Air Force

SSAFA Forces

Help for informal discussion
RAF (UK), Social Work Service, Social Work Team,
Tel: 01334 839 471
Ext. 7444/7656

To notify SSAFA where a child protection plan exists in this country for a child in a service family who are to move overseas

Director of Social Work SSAFA Forces Help

Central Office
19 Queen Elizabeth Street
London, SE1 2LP
Tel: 020 7403 8783
Fax: 020 7403 8815

Appendix B - Glossary of terms and abbreviations

Social Work Services:

The department of the local authority responsible for the delivery of social work services to children, young people and their families.

Health:

The National Health Service including all relevant disciplines, departments and contracted services.

Core Agencies:

Lothian and Borders Police, the local authority social work services and NHS Lothian.

Inter-agency Referral Discussion (IRD):

A tripartite series of discussions between the core agencies, which share relevant information; considers all information referred to it in respect of children/young people who may be at risk of harm; makes decisions and plans responses in relation to such information, and reviews the effectiveness of the implementation of such plans.

ESWS:

Emergency Social Work Service (City of Edinburgh, East and Midlothian) – social work services out of normal working hours.

SCET:

Social Care Emergency Team, West Lothian – social work services out of normal working hours.

FP:

Forensic Medical Examiner – trained medical practitioner providing forensic services.

CPR:

Edinburgh and Lothians Child Protection Register – Register for the local authorities of City of Edinburgh, West Lothian, East Lothian and Midlothian holding names of children deemed, through a child protection case conference, to be at risk of significant harm.

Chief Officers' Group:

The Chief Officers' Group is drawn from core and other key agencies and is responsible for ensuring that the public protection structure and arrangements are operating efficiently to protect the public and mitigate harm.

Critical Services Oversight Group:

As per Chief Officers' Group.

ELBEG - Public Protection:

The Edinburgh Lothians and Borders Executive Group - Public Protection is drawn from senior management from key agencies and provides a strategic oversight of public protection across the ELBEG area and manages the ELBEG PPP Office.

ELBEG PPP Office:

The Edinburgh Lothians and Borders Executive Group Public Protection Partnership Office is a multi-agency funded office. Areas of work include development and review of inter-agency policy and guidance, development of inter-agency training and management of the Child Protection Register.

Getting it right for every child (GIRFEC)

The GIRFEC approach is a Scotland-wide programme of action to improve the wellbeing of all children and young people.

Lead Professional

The Lead Professional is responsible for ensuring an agreed multi-agency Child's Plan or Child Protection Plan is produced to support a child. The Lead Professional role in child protection will typically be taken by the local authority social worker.

The Lead Professional will be the main point of contact with the child, family and professionals to discuss the Child Protection Plan and any changes in circumstances that may affect the plan. They will also ensure that the Child Protection Plan is reviewed by the Core Group, who will collectively consider whether the plan is improving the child's situation.

Abbreviations

ACPOS	Association of Chief Officers in Scotland
ADSW	Association of Directors of Social Work
CAPSM	Children Affected by Parental Substance Misuse
CHS	Criminal History System
CMA	Comprehensive Medical Assessment
COPFS	Crown Office and Procurator Fiscal Service
CPC	Child Protection Committee
CPCC	Child Protection Case Conference
CPP	Child Protection Plan
CPO	Child Protection Order
DMS	Designated Member of Staff
FCC	Force Communications Centre
FP	Forensic Physician
INFO 2	Information Network for Family Protection Officers
IRD	Inter-agency Referral Discussion
JII	Joint Investigative Interview
JIIT	Joint Investigative Interview Training
JPF	Joint Paediatric Forensic-medical examination
PNC	Police National Computer
PND	Police National Database
RAI	Restricted Access Information
SCRA	Scottish Children's Reporters Administration
SID	Scottish Intelligence Database
STORM	System for Tasking and Operations Resource Management
UNIFI	Unified Force Intelligence
VISOR	Violent and Sexual Offenders Register

Appendix C - Alerting signs of child abuse and child protection in specific circumstances

It is important that any such lists are not considered as completely definitive or exhaustive.

The information in such lists has to be used in the context of the child's whole situation and in combination with a range of other information in relation to the child and his/her circumstances.

Some behaviour, e.g. covering arms/legs in hot weather and avoidance of swimming/Physical Education (PE), may be due to sensible precautions against sunburn or cultural issues about dress/changing etc.

There can be an overlap between all the different forms of child abuse, and all or several can coexist.

Physical Abuse

Signs of possible physical abuse:

- Unexplained injuries or burns, particularly if they are recurrent
- Improbable excuses given to explain injuries
- Refusal to discuss injuries
- Untreated injuries, or delay in reporting or seeking treatment for them
- Excessive physical punishment
- Fear of returning home
- Arms and legs kept covered in hot weather
- Avoidance of swimming, Physical Education, etc
- Aggression towards others
- Running away
- Frequent attendance at Accident and Emergency Departments

When considering the possibility of non-accidental injury, it is important to remember that the injuries may have occurred for other reasons. Among the most important:

- Genuine accidental injuries, which are common. The nature and site of the bruising relative to the child's age are important

- Bleeding and clotting disorders
- Mongolian blue spots, which occur naturally in Asian, Afro- Caribbean and Mediterranean children
- Skin disorders, e.g. impetigo
- Rare bone diseases, e.g. brittle bones
- Swelling or dislocation of the eye caused by tumour
- Undiagnosed birth injury, e.g. fractured clavicle

Medical advice must be sought in all cases.

Sexual Abuse

Signs of possible sexual abuse:

Behavioural

- Lack of trust in adults or over familiarity with adults
- Fear of a particular individual
- Social isolation - withdrawal and introversion
- Sleep disturbance
- Running away from home
- Reluctance or refusal to participate in physical activity or to change clothes for activities
- Low self-esteem
- Drug, alcohol or solvent abuse
- Display of sexual knowledge beyond child's years
- Unusual interest in the genitals of adults, children or animals
- Expressing affection in inappropriate ways
- Fear of bathrooms, showers, closed doors
- Abnormal sexualised drawing(s)
- Fear of medical examinations

- Developmental regression
- Poor peer relations
- Over sexualised behaviour
- Eating disorders
- Compulsive masturbation
- Stealing
- Psychosomatic factors
- Sexual promiscuity

Physical / Medical

- Sleeplessness, nightmares, fear of the dark
- Bruises, scratches, bite marks to the thighs or genital areas
- Itch, soreness, discharge, unexplained bleeding from the rectum, vagina or penis
- Pain on passing urine or recurrent urinary infection
- Stained underwear
- Unusual genital odour
- Anxiety/depression
- Eating disorder, e.g. anorexia nervosa or bulimia
- Discomfort/difficulty in walking or sitting
- Pregnancy - particularly when reluctant to name father
- Recurring urinary tract problem, vaginal infection or genital damage
- Venereal disease/sexually transmitted infections
- Soiling or wetting in children who have been trained
- Self-mutilation/suicide attempts

Neglect

Signs of possible neglect:

- Poor hygiene
- Malnutrition and untreated medical concerns
- Inadequate supervision
- Hunger
- Significant lack of growth
- Weight loss
- Hair loss
- Poor skin or muscle tone
- Circulatory disorders

Emotional Abuse

Signs of possible emotional abuse:

- Low self esteem
- Continual self-deprecation
- Sudden speech disorder
- Significant decline in concentration
- Socio-emotional immaturity
- “Neurotic” behaviour (e.g. rocking, head banging)
- Self-mutilation
- Compulsive stealing
- Extremes of passivity or aggression
- Running away
- Indiscriminate friendliness

Domestic Abuse

Domestic abuse (as gender-based abuse), can be perpetrated by partners or ex-partners and can include physical abuse (assault and physical attack involving a range of behaviour), sexual abuse (acts, which degrade and humiliate and are perpetrated against their will, including rape) and mental and emotional abuse (such as threats, verbal abuse, racial abuse, withholding money and other types of controlling behaviour such as isolation from family or friends). Domestic abuse occurs in all social groups, is not caused by stress, unemployment, poverty, alcohol, mental illness or by the victims who experience the abuse. Although most victims are women, men can also suffer domestic abuse, and it can also occur in same-sex relationships.

Children and young people living with domestic abuse are at increased risk of significant harm. Children's experiences of domestic abuse vary widely, and they are often negatively impacted as a result of living in an environment characterised by fear. Children can be used as a tactic of control by perpetrators, including being asked to give information regarding the non-abusive parent, having threats made against them, or being forced to participate in abusive and belittling tactics towards the victim. Children living in a home with domestic abuse are also at greater risk of physical abuse. Children can be affected regardless of whether they are directly witnessing abuse or being abused themselves. Domestic abuse can profoundly disrupt a child's environment, undermining their stability, and damaging their physical, mental, and emotional health.

The impact of domestic abuse on a child will vary, depending on factors including the frequency, severity and length of exposure to the abuse, presence of co-occurring alcohol or drug use, degree of control and isolation, as well as the age of the child. Domestic abuse can also impact on the child's relationship with the non-abusive parent/carer through disrupting the development of healthy attachments, impacting on the non-abusive parent's/carer's mental health and coping skills, and controlling tactics used by the perpetrator (i.e. not letting the non-abusive parent/carer attend medical appointments, preventing the non-abusive parent/carer from showing affection to the child, etc.). It is important that both the child and the adult's safety are considered in tandem.

The best way to keep both children and non-abusive parents/carers safe is to focus on early identification, assessment and intervention through skilled and attentive staff in universal services. It is also important to ensure appropriate referrals for the non-abusive parent are made to enable them to access support and consider various options in relation to their safety.

Domestic abuse is widely under-reported to the police. Given the reticence of victims to come forward, it is crucial that staff are aware of the signs of domestic abuse and routinely make appropriate enquiries.

When undertaking assessment or planning for any child affected by domestic abuse, it is important that practitioners recognise that domestic abuse involves both adults and a child victims. The impact of domestic abuse on a child should be understood as a consequence of the perpetrator choosing to use violence rather than as a result of the non-abusing parent's/carer's actions.

Every effort should be made to work with the non-abusing parent/carer to ensure adequate

and appropriate support and protection are in place to enable them to make choices that are safe for both them and the child. This may involve leaving an abusive situation, however, it is important to recognise that the point of separation from an abusive relationship is often the most dangerous time for both the non-abusive parent/carer and the child, and does not guarantee safety. As such, leaving may not be the safest option available and it is important to establish potential risks involved as well as consider all possible options in relation to safety.

At the same time, staff should maintain a focus on the perpetrator, making referrals to perpetrator programs when appropriate, and monitoring any risk resulting from ongoing abuse. When working with perpetrators it is important to consider any potential service generated risks that could be present and to take into account the non-abusive parent's/carer's safety during meetings and any arranged contacts.

Parental Drug Misuse and Parental Alcohol Misuse (CAPSM)

Drug misuse includes prescription as well as illegal drugs. The risks to and impacts on children of alcohol/drug-misusing parents and carers are known and well-researched.

Alcohol and/or drug misuse during pregnancy can have a significant impact on the health of the unborn child. Parental alcohol and/or drug misuse can also result in sustained abuse, neglect, maltreatment, behavioural problems, disruption in primary care-giving, social isolation and stigma of children.

Alcohol and/or drug-misusing parents/carers often lack the ability to provide structure or discipline in family life. Poor parenting can impede child development through poor attachment and the long-term effects of maltreatment can be complex. The capability of parents/carers to be consistent, warm and emotionally responsive to their children can be undermined.

Addiction staff also need to know when and how to share information to keep children safe, and should understand the contribution they can make to assessing risks, needs and planning. Planning is vital, particularly in the case of unborn children, and will often include input from agencies that do not have a frontline childcare role. The best interests of the child should always be the principal concern.

Disability

Children with disabilities are not only vulnerable to the same types of abuse as other children, they can also be more vulnerable to abuse. Children who are deaf or hard of hearing, or with behavioural disorders, learning disabilities and/or sensory impairments are particularly at risk. Neglect is the most frequently reported form of abuse, followed by emotional abuse.

The definition of disability includes a comprehensive range of physical, emotional, developmental, learning, communication and health care needs. Children with disabilities are defined as children in need under Section 93(4) of the Children (Scotland) Act 1995.

Children with disabilities are more likely to be dependent on support for communication, mobility, manual handling, intimate care, feeding and/or invasive procedures. There may be increased parental stress, multiple carers and care in different settings (including

residential); there may also be reluctance among adults, including practitioners, to believe in their abuse.

Children with disabilities are likely to be less able to protect themselves from abuse. Limited mobility can add to their vulnerability. In addition, the network of carers around the child is likely to be larger than for a child without disabilities, which can be a risk factor in itself. While the majority of parents/carers provide the highest standard of care for their child, in some cases they themselves will be perpetrators of abuse.

Children looked after by parents/carers in the community can have complex health care needs, which include life-threatening conditions. Caring responsibilities, which may involve complex clinical procedures, can lead to considerable pressure on families. Reliance on physical, mechanical and chemical interventions to manage health and behaviour can leave these children particularly vulnerable to harm. The dependence of children with disabilities on medication may leave them exposed to further abuse, for example where medication is incorrectly, or not administered - either deliberately or through lack of knowledge and understanding.

Children with disabilities are often highly dependent on their carers. They may be less resilient and failure to treat even minor ailments can have serious consequences. Practitioners may have an unrealistic view of parents/carers' ability to cope. Parents/carers may be reluctant to admit that they can't cope. To protect children with disabilities, assessments must cover the ability and capacity of parents/carers to cope with the demands being placed on them.

When responding to concerns about a child with disabilities, expertise in child protection and disability should be brought together to ensure the child receives the same standard of service as a child without disabilities. It may be helpful to involve practitioners with experience of working with disabled children, such as speech and language therapists, residential workers or social workers specialising in disability.

Practitioners should be aware of non-verbal communication systems, when they might be useful and how to access them, and should know how to contact suitable interpreters or facilitators. Assumptions should not be made about the inability of a child with disabilities to give credible evidence or withstand the rigours of the court process. Each child should be assessed carefully and supported to participate in the process where this is in their best interests.

The IRD, in planning an investigation, should ensure specialist advice is sought at an early stage. Consideration should be given to the provision of support to the child, including with communication, and this may include communication boards/loop system. The IRD should also identify a suitable location for any interview of the child and, where needed, allow for additional time for the investigation and briefing of staff, as well as time for breaks in line with the child's needs.

Children can also be affected by the disability of those caring for them. Parents/carers/siblings with a disability may have additional support needs relating to physical and or sensory impairments, mental illness, learning disabilities, serious or terminal illness, or degenerative conditions. These may impact on the safety and wellbeing of their children, affecting their education, physical and emotional development.

Non-Engaging Families

Evidence shows that some adults will deliberately evade practitioner interventions aimed at protecting a child. In many cases of child abuse and neglect this is a clear and deliberate strategy adopted by one or more of the adults with responsibility for the care of a child. It is also the case that the nature of child protection work can result in parents/carers behaving in a negative and hostile way towards practitioners.

The terms ‘non-engagement’ and ‘non-compliance’ are used to describe a range of deliberate behaviour and attitudes, such as:

- Failure to enable necessary contact, e.g. missing appointments or refusing to allow access to the child or to the home
- Active non-compliance with the actions set out in the Child’s Plan or Child Protection Plan (CPP)
- Disguised non-compliance, where the parent/carer appears to co-operate without actually carrying out actions or enabling them to be effective
- Threats of violence or other intimidation towards practitioners

Consideration needs to be given to determining which family member(s) may be stopping engagement from taking place and why, e.g. it may be the case that one partner is ‘silencing’ the other and that domestic abuse is a factor.

Service users may find it easier to work with some practitioners than others, e.g. young parents may agree to work with a health visitor/public health nurse, but not a social worker.

When considering non-engagement, practitioners should check that the child protection concerns and necessary actions have been explained clearly, taking into account issues of language, culture and disability, so that parents or carers fully understand the concerns and the impact on themselves and their child.

If there are risk factors associated with the care of children, risk is likely to be increased where any of the responsible adults with caring responsibilities fail to engage or comply with child protection services.

Non-engagement and non-compliance, including disguised compliance, should be taken account of in information collection and assessment. Non-engagement and non-compliance may point to a need for compulsory or emergency measures. In what will often be challenging situations, staff may need access to additional or specialist advice to inform their assessments and plans.

There is a risk of ‘drift’ before non-engagement is identified and action taken. If letters are ignored, or appointments not kept, weeks can pass without practitioner contact with the child. If parents/carers fail to undertake or support necessary actions, this should be monitored and the impact evaluated regularly.

Good records must be kept, including contacts and whether they are successful or not, particularly during periods of high risk when children are not in nursery or school, e.g. Christmas and summer holidays.

Staff need to be clear what action should be taken when contact is not maintained. Where the child is subject to compulsory measures of supervision, the Reporter should be notified if agencies are unable to gain access to the child.

Core groups need to work effectively and collaboratively to deal with and counter non-engagement. Different agencies and practitioners will have different responsibilities. Effective multi-agency approaches provide flexibility so that, e.g. responsibility for certain actions can be given to those practitioners or agencies that are most likely to achieve positive engagement. All services should be ready to take a flexible approach.

Given the nature of child protection work, non-engagement can sometimes involve direct hostility and threats or actual violence towards staff. All agencies should have protocols to deal with this, including practical measures to promote the safety of staff who have direct contact with families. In addition, staff should have the opportunity for debriefing after any incidents.

Families or carers who are directly hostile are very challenging to practitioners. However, services to children should not be withdrawn without putting other protective measures in place.

Children and young people experiencing or affected by mental health problems

Two separate, but not unconnected issues should be considered in identifying, assessing and managing the risks faced by children affected by mental health problems:

- Children and young people who are experiencing mental health problems themselves
- Children and young people whose lives are affected by the mental illness or mental health problems of a parent/carer

Children and young people experiencing mental health problems

The emotional wellbeing of children and young people is just as important as their physical health. Most children grow up mentally healthy, but certain risk factors make some more likely to experience problems than others.

Evidence also suggests that more children and young people have problems with their mental health today than 30 years ago. Traumatic events in themselves will not usually lead to mental health problems, but they may trigger problems in those children and young people whose mental health is not robust.

Changes, such as moving home or changing school, can act as triggers. Teenagers often experience emotional turmoil as their minds and bodies change and develop. Some find it hard to cope and turn to alcohol or drugs. Over the past 15 years, the incidence of self-harm and suicide among young people has increased.

For some young people, mental health problems will severely limit their capacity to participate actively in everyday life and will continue to affect them into adulthood. Some may go on to develop severe difficulties and display behaviour that challenges families and

services, including personality disorders.

A small number of children with mental health problems may pose risks to themselves and others. For some, their vulnerability, suggestibility and risk levels may be heightened as a result of their mental illness. For others, a need to control, coupled with lack of insight into, or regard for, others' feelings and needs may lead to them preying on the vulnerabilities of other children. It is imperative that services work closely together to address these issues and mitigate risks for these children and for others.

Certain risk factors make some children and young people more likely to experience mental health problems than others. These include:

- Having a long-term physical illness
- Having a parent or carer who has had mental health problems, history of offending behaviour or problems with alcohol/drugs
- Experiencing the death of someone close to them
- Having parents who separate or divorce
- Having been severely bullied or physically or sexually abused
- Living in poverty or being homeless
- Having a learning disability
- Experiencing discrimination, perhaps because of their race, nationality, sexuality or religion
- Acting as a carer for a relative
- Having long-standing educational difficulties and
- Forming insecure attachments with their primary carer

Child and Adolescent Mental Health Services (CAMHS) can provide an important resource in helping children and young people overcome the emotional and psychological effects of abuse and neglect. It is important that children and young people's mental health is not seen solely as the preserve of psychiatric services; the causes of mental ill-health are bound up with a range of environmental, social, educational and biological factors. Waiting to access these services should not be a justification for inactivity on the part of other agencies.

Children and young people affected by parental mental health problems

It is not inevitable that living with a parent/carers with mental health issues will have a detrimental impact on a child's development and many adults who experience mental health problems can parent effectively. However, there is evidence to suggest that many

families in this situation are more vulnerable.

A number of features can contribute to the risk experienced by a child or young person living with a parent or carer who has mental health problems.

These include:

- The parent/carer being unable to anticipate the needs of the child or put the needs of the child before their own
- The child becoming involved in the parent/carer's delusional system or obsessive compulsive behaviour
- The child becoming the focus for parental aggression or rejection
- The child witnessing disturbing behaviour arising from the mental illness (often with little or no explanation)
- The child being separated from a mentally ill parent, for example because the latter is hospitalised, and
- The child taking on caring responsibilities inappropriate for his/her age

There are also factors, which may impact on parenting capacity, including:

- Maladaptive coping strategies or misuse of alcohol and/or drugs
- Lack of insight into the impact of the illness (on both the parent/carer and child)
- Poor engagement with services or non-compliance with treatment

This list is not exhaustive. A number of other factors may need to be considered, including the attachment relationship and any instances of domestic abuse. Services involved with the parent/carer should consider the impact of these factors on the child's needs. Where concerns are identified, these should be shared with children's services.

Where parents experience mental health problems, their needs may at times conflict with the needs of their child. Staff should bear in mind the importance of putting the child's interests first. Effective partnership working across services is needed to ensure that children are protected and their short and longer-term needs met appropriately.

Children and young people who display harmful or problematic sexual behaviour

Harmful or problematic sexual behaviour in children and young people can be difficult to identify. It is not always easy to distinguish between what is abusive and/or inappropriate and what constitutes normal adolescent experimentation. Practitioners' ability to determine whether a child's sexual behaviour is developmentally typical, inappropriate or abusive will be based on an understanding of what constitutes healthy sexual behaviour in childhood as well as issues of informed consent, power imbalance and exploitation.

In managing and reducing risk, the diversity of potential behaviour must be taken into account. Children and young people display a wide range of sexual behaviour in terms of: the nature of the behaviour; degree of force; motivation; level of intent; level of sexual arousal; and age and gender of their victim.

Broader developmental issues must also be taken into account, including the age of the young person, their family and background, their intellectual capacities and stage of development. Young people with learning difficulties are a particularly vulnerable and often overlooked group who may need specific types of interventions.

Where abuse of a child or young person is alleged to have been carried out by another child or young person, such behaviour should always be treated seriously and be subject to a discussion between relevant agencies that covers both the victim and the perpetrator. In all cases where a child or young person displays problematic sexual behaviour, immediate consideration should be given to whether action needs to be taken under these Child Protection Procedures, either in order to protect the victim or to tackle concerns about what has caused the child/young person to behave in such a way.

Identifying children and young people with problem sexual behaviour raises a number of dilemmas and issues for practitioners. When children and young people engage in such behaviour throughout childhood it can be developmentally and psychologically damaging to them as well as to others. They will normally require input from youth justice workers as well as health and education services. Other practitioners may also be involved, for example criminal justice workers (including Multi Agency Public Protection Arrangements - MAPPA on some occasions). The interface with child protection processes, and occasionally with adult protection, also needs to be considered.

A risk assessment should be carried out to determine whether the child or young person should remain within the family home and, if necessary, to inform the decision as to what might be an appropriate alternative placement. In the event that an alternative placement is needed, residential staff or foster carers need to be fully informed about the problematic sexual behaviour and a risk management plan drawn up to support the placement. In most instances, a referral should be made to the Authority Reporter so that the need for compulsory measures of supervision can be considered where these are not already in place.

The two key aims of addressing problem sexual behaviour are risk assessment and risk management. They will be best achieved when children and young people learn to manage their sexual behaviour within the broader aim of learning to meet their needs in a socially acceptable and personally satisfying way.

Risk management covers actions taken to reduce opportunities for the problem sexual behaviour to occur. A good risk management process should identify those children and young people who are most likely to commit further sexually abusive behaviour and who therefore need high levels of supervision. It should provide a robust mechanism through which concerns about a young person's problematic behaviour can be shared with relevant agencies so that appropriate risk management measures can be taken.

To manage risk effectively it is essential that:

- Risk management is embedded in the systems around the child and promoted by those who supervise and monitor the child on a daily basis
- Safety plans are drawn up in the relevant environments, e.g. home, schools, communities and residential units

Female Genital Mutilation

Female genital mutilation is a culture-specific abusive practice affecting some communities. It should always trigger child protection concerns. The legal definition of female genital mutilation is 'to excise, infibulate or otherwise mutilate the whole or any part of the labia majora, labia minora, prepuce of the clitoris, clitoris or vagina.

It includes all procedures, which involve the total or partial removal of the external female genital organs for non-medical reasons. There are four types of female genital mutilation ranging from a symbolic jab to the vagina to the partial or total removal of the external female genitalia. The Prohibition of Female Genital Mutilation (Scotland) Act 2005 makes it illegal to perform or arrange to have female genital mutilation carried out in Scotland or abroad. A sentence of 14 years imprisonment can be imposed.

The procedure is usually carried out on children aged between four and ten years. It is a deeply rooted cultural practice in certain African, Asian and Middle Eastern communities. Justifications for female genital mutilation may include:

- Tradition
- Family honour
- Religion
- Increased male sexual pleasure
- Hygiene
- Fear of exclusion from communities

A range of health problems, both immediate and long-term, are associated with the procedure. Short-term effects can include haemorrhage and pain, shock and infection. Longer-term effects include bladder problems, menstrual and sexual difficulties and problems giving birth. The emotional effects of female genital mutilation may include flashbacks, insomnia, anger, difficulties in adolescence, panic attacks and anxiety. In western cultures, the young person may also be disturbed by western opinions of a practice, which they perceive as an intrinsic part of being female.

Female genital mutilation is usually for strong cultural reasons and this must always be kept in mind. Action should be taken in close collaboration with other agencies and should be proportionate and sensitive to the cultural norms and pressures on parents/carers and children. Where possible, workers with knowledge of the culture involved may be able to assist, but the welfare of the child must always be paramount. Nevertheless, female genital

mutilation should always be seen as a cause of significant harm and normal child protection procedures should be invoked.

Some distinctive factors will need consideration:

- Female genital mutilation is usually a single event of physical abuse (albeit with very severe physical and mental consequences)
- There is a risk that a child or young person is likely to be sent abroad to have the procedure performed
- Where a child or young person within a family has been subjected to female genital mutilation, consideration needs to be given to other female siblings or close relatives who may also be at risk
- An IRD must be conducted without delay and will take account of other possible factors such as trafficking and/or forced marriage
- Where other child protection concerns are present they should be part of the risk assessment process. They may include factors such as trafficking or forced marriage
- Legal advice should be obtained where appropriate
- Appropriate interpreters who are totally independent of the child or young person's family should be used

Honour-based violence and forced marriage

Honour-based violence is a spectrum of criminal conduct with threats and abuse at one end and honour killing at the other. Such violence can occur when perpetrators believe that a relative/community member, who may be a child, has shamed the family and/or the community by breaking their honour code. The punishment may include assault, abduction, confinement, threats and murder.

The type of incidents that constitute a transgression include:

- Inappropriate make-up or dress
- Having a boyfriend/girlfriend
- Forming an inter-faith relationship
- Kissing or intimacy in a public place
- Pregnancy outside marriage
- Rejecting a forced marriage

A forced marriage is defined as 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 pressure. A clear distinction must be made between a forced marriage and an arranged marriage.

An arranged marriage is one in which the families of both spouses are primarily responsible for choosing a marriage partner for their child or relative, but the final decision as to whether or not to accept the arrangement lies with the potential spouses. Both spouses give their full and free consent. The tradition of arranged marriage has operated successfully within many communities for generations.

In Scotland, a couple cannot be legally married unless both parties are at least 16 on the day of the wedding and are capable of understanding the nature of a marriage ceremony and of consenting to the marriage. Parental consent is not required.

The consequences of forced marriage can be devastating to the whole family, but especially to the young people affected. They may become estranged from their families and wider communities, lose out on educational opportunities or suffer domestic abuse. Rates of suicide and self-harm are high. Some of the potential indicators of honour-based violence and forced marriage are listed below.

Education

- Absence and persistent absence from education
- Request for extended leave of absence and failure to return from visits to country of origin
- Decline in behaviour, engagement, performance or punctuality
- Being withdrawn from school by those with parental responsibility
- Being prevented from attending extra-curricular activities
- Being prevented from going on to further/higher education

Health

- Self-harm
- Attempted suicide
- Depression
- Eating disorders
- Accompanied to doctors or clinics and prevented from speaking to health practitioner in confidence
- Female genital mutilation

Police

- Reports of domestic abuse, harassment or breaches of the peace at the family home
- Threats to kill and attempts to kill or harm

- Truancy or persistent absence from school

Cases of honour-based violence/forced marriage can involve complex and sensitive issues and care must be taken to make sure that interventions do not worsen the situation, e.g. mediation and involving the family can increase the risks to a child or young person and should not be undertaken as a response to forced marriage or honour-based violence.

Efforts should be made to ensure that families are not alerted to a concern that may result in them removing the child or young person from the country or placing them in further danger.

Concerns may be expressed by a child or young person about going overseas. They may have been told that the purpose is to visit relatives or attend a wedding. On arrival, their documents, passports, money and mobile phones are often taken away from them. These concerns should be taken seriously, although practitioners must also be careful to avoid making assumptions. Such cases may initially be reported to the joint Home Office/Foreign and Commonwealth Office Forced Marriage Unit.

As with all cases of forced marriage, confidentiality and discretion are vitally important. It is not advisable to contact an overseas organisation immediately to make enquiries. If a family becomes aware that enquiries are being made, they may move the child or young person to another location or expedite the forced marriage.

When a child or young person has already been forced to marry, they will sometimes approach children's social work services or the police because they are concerned that they may need to act as a sponsor for their spouse's immigration to the UK. Practitioners should reassure the child or young person that they cannot be required to act as a sponsor until they are 21.

Confronting the family may be extremely risky for the child or young person and result in their being put under increased pressure to support the visa application. These risks need to be discussed with the child or young person.

Cases of forced marriage may initially be reported to social work services as cases of domestic abuse. Spouses forced into marriage may suffer domestic abuse but feel unable to leave due to a lack of family support, economic pressures and other social circumstances. In some cases, they may fear having their own children taken away from them. In all cases, the social worker should discuss the range of options available to the child or young person, including the possibility of taking out a Forced Marriage Protection Order, and the possible risks. The social worker should also consult the Forced Marriage etc. (Protection and Jurisdiction) (Scotland) Act 2011, Multi-Agency Practice Guidelines for further information and resources. In addition, consultation can be sought from the named Lead Officer for Forced Marriage cases in each local authority.

A spouse who is the victim of a forced marriage can initiate nullity or divorce proceedings to end the marriage, but should be made aware that a religious divorce will not end the marriage under UK law.

Practitioners can access the Multi-Agency Practice Guidelines at <http://www.scotland.gov.uk/Publications/2011/12/22165750/4>

Fabricated or Induced Illness

Fabricated or induced illness in children is not a common form of child abuse, but practitioners should nevertheless be able to understand its significance. Although it can affect children of any age, fabricated and induced illness is most commonly identified in younger children.

Where concerns do exist about the fabrication or induction of illness in a child, practitioners must work together, considering all the available evidence, in order to reach an understanding of the reasons for the child's signs and symptoms of illnesses. A careful medical evaluation is always required to consider a range of possible diagnoses and a range of practitioners and disciplines will be required to assess and evaluate the child's needs and family history.

There are three main ways in which a parent/carers can fabricate or induce illness in a child.

These are not mutually exclusive and include:

- Fabrication of signs and symptoms, including fabricating the child's past medical history
- Fabrication of signs and symptoms and falsification of hospital charts, records and specimens of bodily fluids. This may also include falsification of letters and documents
- Induction of illness by a variety of means

For those children who are suffering, or at risk of suffering significant harm, joint working is essential both to protect the child and where necessary to take action, within the criminal justice and child protection systems, against the perpetrators of crimes against children. All agencies and practitioners should:

- Be alert to potential indicators of illness being fabricated or induced in a child
- Be alert to the risk of harm that individual abusers, or potential abusers, may pose to children in whom illness is being fabricated or induced
- Share and help to analyse information so that an informed assessment can be made of the child's needs and circumstances
- Contribute to whatever actions (including the cessation of unnecessary medical tests and treatments) and services are required to safeguard and promote the child's welfare; regularly review the outcomes for the child against specific planned outcomes
- Work co-operatively with parents/carers unless to do so would place the child at increased risk of harm
- Assist in providing relevant evidence in any criminal or civil proceedings, should this course of action be deemed necessary

The majority of cases of fabricated or induced illness in children are confirmed in a hospital setting. The first task for the paediatrician is to find out whether a child's illness and individual symptoms and signs can be accounted for by natural causes. If not, the

possibility that the illness has been fabricated or induced must be considered.

CAMHS may be called in to look at the effects on the child and establish whether the parent/carer suffers from an underlying disorder.

Police must investigate a possible crime. Social workers will co-ordinate the assessment of concerns about the child's welfare or the risk of harm and support to parents/carers during the assessment.

Co-ordinated planning and assessment are essential in the investigation of fabricated or induced illness. Some methods, such as the use of covert video surveillance, should be discussed and agreed by all services involved before being implemented.

Fabrication of illness may not necessarily result in the child experiencing physical harm. However, there may still be concern about them suffering emotional harm and a thorough assessment of the child's needs should be carried out.

Sudden Unexpected Death in Infants and Children

Only a small number of children die during infancy in Scotland. While the majority of such deaths are as a result of natural causes, physical defects or accidents, a small proportion are caused by neglect, violence, malicious administration of substances or by the careless use of drugs.

One of the implications of Section 2 of the Human Rights Act 1998 is that public authorities have a responsibility to investigate the cause of a suspicious or unlawful death. This will help to support the grieving parents and relatives of the child, and it will also enable medical services to understand the cause of death and, if necessary, formulate interventions to prevent future deaths.

There are occasions where the cause of death cannot be established. In such cases pathologists may classify the death as Unascertained, pending investigations or as a Sudden Unexplained Death in Infancy (SUDI). Alternatively, they may choose to record the cause of death as 'Sudden Infant Death Syndrome' (by definition a death due to natural causes which have not been determined).

The six guiding principles, which underpin the work of practitioners dealing with any infant or child death investigations are:

- Sensitivity
- Open mind and balanced approach
- Appropriate response to the circumstances
- An inter-agency response
- Sharing of information
- Preservation of evidence

When the death of a child is reported to the police, a senior investigating officer should

always be appointed to oversee the investigation, whether or not there are any obvious suspicious circumstances.

It is important that the police and hospital/medical staff establish a collaborative approach to any such investigation. While it is appreciated that police and health practitioners have specific duties to perform, they should be sensitive to the nature of the inquiry and respect each other's role. Relevant information-sharing between police and health staff is expected to ensure that a comprehensive picture of what is known jointly is established at the outset and can then be updated throughout the subsequent investigation.

Police forces should consider using suitably trained officers from force public protection units or equivalent for more specialist tasks during such an investigation, such as:

- Interviewing child witnesses
- Obtaining other background information from specialist police databases and other agency records
- Liaising with the relevant local authority social work services to ensure their records are checked, including the Child Protection Register (and previous registrations if possible), and involve them in a strategy discussion, if appropriate

In cases where the child and their family were either not resident in, or had recently moved to the area where the death occurred, the senior investigating officer will ensure that information is sought from other police forces and partner agencies in any area where the child is known to have resided.

Investigations into the death of an infant/child will be particularly challenging. Nevertheless, it is essential that a full and thorough investigation takes place and that it is undertaken in a tactful, sensitive and sympathetic manner.

Practitioners should collaborate to ensure that the fullest possible information is gathered and considered. Chief Officers need to ensure that staff have appropriate support during any investigations, particularly if the circumstances of the case lead to a significant case review.

Practitioners can access the Practitioner's Toolkit at <http://www.sudiscotland.org>

Complex Child Abuse Investigations: Inter-agency Considerations

Each investigation of complex abuse will be different, depending on the characteristics of the situation, its scale and complexity. Although complex abuse in residential settings has been widely reported in recent years, this can also occur within family networks, day care and other provision, such as youth services, sports clubs and voluntary groups, and via the Internet.

Complex abuse investigations require thorough planning, effective inter-agency working and attention to the welfare needs of both child victims and adult survivors. This section aims to provide advice and guidance to practitioners who are faced with these difficult situations.

Where appropriate, definitions relating to various forms of abuse are provided, along with signposts to documents, which will not only support staff but help them understand an area of abuse with which they might be unfamiliar.

Ritual Abuse

Ritual abuse can be defined as organised sexual, physical, psychological abuse, which can be systematic and sustained over a long period of time. It involves the use of rituals, which may or may not be underpinned by a belief system, and often involves more than one abuser.

Ritual abuse usually starts in early childhood and uses patterns of learning and development to sustain the abuse and silence the abused. The abusers concerned may be acting in concert or using an institutional framework or position of authority to abuse children.

Ritual abuse may occur within a family or community, or within institutions such as residential homes and schools. Such abuse is profoundly traumatic for the children involved (Working Together to Safeguard Children, HM Government (2006)).

Ritual abuse can also include unusual or ritualised behaviour by organised groups, sometimes associated with particular belief systems or linked to a belief in spiritual possession.

Abuse by Organised Networks or Multiple Abusers

Several high profile cases, including Cleveland (1987) and Orkney (1991), and investigations within residential schools and care homes have highlighted the complexities involved in investigating alleged organised abuse and supporting children. Complex cases in which a number of children are abused by the same perpetrator or multiple perpetrators may involve the following:

- Networks based on family or community links. Abuse can involve groups of adults within a family or a group of families, friends, neighbours and/or other social networks who act together to abuse children either 'on or offline'
- Abduction. Child abduction may involve internal or external child trafficking and may happen for a number of reasons. Children cannot consent to abduction or trafficking. For further information, see the section on Child Trafficking
- Institutional setting. Abuse can involve children in an institutional setting, e.g. youth organisations, educational establishments and residential homes or looked-after children living away from home being abused by one or more perpetrators, including other young people
- Prostitution. In some cases, children may be recruited or abducted for commercial sexual exploitation

In all of these contexts, where a single complaint about possible abuse is made by, or on behalf of, a child, agencies should consider the possibility that the investigation may reveal information about other children currently, or formerly, living within the same household, community or elsewhere. Allegations of organised abuse are also often made historically.

Disclosures of abuse may come from adult survivors of childhood sexual abuse. In these cases, it is important that links are made with the national strategy for adult survivors of childhood sexual abuse.

Children surviving organised abuse may fear revealing their experiences due to:

- Fear of pornography, photographs and digital images being released
- Threats of harm to other children
- Belief that they are complicit in the abuse
- Belief in the rituals used to silence them
- Fear and distrust of police and social workers
- Fear of their potential involvement in criminal activity
- Belief that their abusers are all-powerful and will punish them for disclosure

In a number of cases, third sector organisations will be working with, or have knowledge of, relevant children and families. It is essential that these organisations have protocols in place, to ensure a consistent approach in their dealings with children and families.

Planning Considerations

Some child protection cases are particularly complex because they can uncover, or be shown to be linked with, other cases of alleged abuse. It is not unusual for such complex investigations to extend beyond the boundaries of individual services. Detailed planning at strategic level is critical to ensure a consistency of approach with clear areas of accountability and responsibility determined from the outset.

Chief Officers should be alerted in such circumstances, including where the concerns involve a child or children outwith the area. Senior managers from social work services and the police should ensure that arrangements for the joint investigation of linked cases are in place, so that children and adults are adequately protected.

The planning of complex investigations needs to be undertaken at both strategic and operational level. The tasks and functions of a strategic management group will vary from case to case, but should normally include the following key functions:

- To establish the terms of reference of the investigation
- To take ownership of the strategic leadership of the investigation
- To agree the staffing of the investigation

Police and social work services should agree arrangements for convening planning meetings, setting up systems for sharing and updating information about the investigation's progress and co-ordinating support. All relevant agencies and services should be involved in these discussions.

Such cases require early involvement of the Procurator Fiscal and the Authority Reporter. Police and social work services should agree a strategy for communicating and liaising with the

media and the public. If a large number of families, parents and carers are involved, the local authority should make special arrangements to keep them informed of events and plans to avoid the spread of unnecessary rumour and alarm.

Parents/carers are usually entitled to the fullest possible information. In these circumstances, particularly where it may be unclear how many families are involved, decisions regarding information-sharing will be particularly complex.

Agencies may need to restrict information provided to families and the public to avoid prejudicing criminal enquiries and this should be considered in the planning process. Parental involvement may need to be limited in order to safeguard the child and the reasons for this should be recorded.

The investigation of complex child abuse may require specialist skills. Investigating team members need expertise in conducting investigations, child protection processes and children's welfare, and they should be committed to working closely together. It may be necessary to involve agencies that are trusted by the child or other witnesses and to obtain specialist advice and support from agencies with particular knowledge of the issues.

When cases involve several children and adults in different households, it will be in the interests of the criminal investigation to prevent suspects from communicating with each other and destroying evidence. This may mean coordinating investigations, interviews and other assessments. Action may need to be taken at a time of day when a family is more likely to be at home, such as early morning or evening, but agencies should avoid unnecessary disruption.

It is good practice for the lead agencies to establish links with neighbouring authorities and agencies to ensure access to necessary resources, including skilled staff and specific facilities such as audio-visual studios, when dealing with complex multiple or organised abuse cases. Any arrangement should identify the roles and responsibilities of different authorities and agencies. It should be borne in mind that where a child has been involved in pornography and constantly filmed or become accustomed to their image being manipulated, recording of interviews may be particularly alarming.

Child Exploitation and/or Trafficking

Child trafficking typically exposes children to continuous and severe risk of significant harm. It involves the recruitment, transportation, transfer, harbouring and/or receipt of a child for purposes of exploitation. This definition holds whether or not there has been any coercion or deception, as children are not considered capable of informed consent to such activity. It applies to activity within a country as well as between countries. The Palermo Protocol broadens the definition of a child to under 18.

Children are trafficked for a number of reasons within and between countries and continents. They may be trafficked for one type of exploitation, but sold into another, making simple categorisation problematic. Forms of exploitation of child victims of trafficking include:

- Child labour, for example, on cannabis farms
- Debt bondage

- Domestic servitude
- Begging
- Benefit fraud
- Drug trafficking/decoys
- Illegal adoptions
- Forced/illegal marriage (for further information, see the section on Honour based violence and forced marriage)
- Sexual abuse
- Sexual exploitation

Tackling child trafficking requires a multi-agency response at all levels. All agencies and practitioners must be aware of the issues pertaining to child trafficking and of the potential indicators of concern. There are two distinctive issues related to child trafficking, which make handling more complex than in many other child protection cases. These are identification and wider legal concerns.

Child trafficking can be difficult to identify. By its very nature, the activity is hidden from view, so practitioners need to be sensitive to the indicators of trafficking when investigating concerns about particular children.

There are no validated risk assessment tools, which can predict the risk of trafficking or definitively identify those who have been trafficked. However, an indicator matrix has been developed, setting out a list of factors often associated with children who have been trafficked or who are at risk. This can be found <http://www.scotland.gov.uk/topics/justice/crimes/humantraffick>

While the presence of any factor does not provide definitive evidence, the indicators do point to the possibility of trafficking, particularly when more than one are present at the same time. The indicators may apply to both UK nationals and/or migrant children and to both boys and girls. Practitioners should keep them in mind when working with children and making an initial assessment. The indicators do not replace child protection investigations and the presence, or otherwise, of trafficking suspicions should not preclude the standard child protection procedure being implemented.

It is essential to take timely and decisive action where child trafficking is suspected because of the high risk of the child being moved. Action should not be postponed until a child realises, agrees or divulges that they have been trafficked. Often, children are threatened with punishment if they speak. Also, they may not be aware that they are victims of trafficking.

Trafficking raises important legal issues, which require the involvement of specific agencies within the UK. As a signatory to the Council of Europe Convention on Action Against Trafficking in Human Beings, the UK has a responsibility to implement a specific mechanism for identifying and recording cases of child trafficking. This formal procedure, known as the National Referral Mechanism, became operational on 1 April 2009. From this date, new arrangements came into force to allow all cases of human trafficking to be referred by frontline agencies for assessment

Trafficking Centre and a linked authority within the UK Border Agency, which handles cases of immigration and asylum.

If an agency or practitioner believes that a child they are in contact with is, or may have been, trafficked they should initially consult the indicator matrix and contact social work services. The child's safety remains the principal consideration and all necessary actions and these Inter-agency Child Protection Procedures will be followed to ensure that they are protected.

In cases where a child may have been trafficked, their carer may be involved in the trafficking or exploitation. Seeking their consent could put the child at further risk or lead to their being moved elsewhere. Unless there is clear evidence that seeking consent would in no way harm the child, referring agencies should not seek the carer's consent.

Appendix D - Military Welfare Services

Army Welfare Service (AWS)

The welfare of army families whose children are considered by a social work service to be at risk is the responsibility of the Army Welfare Service (AWS). The AWS provides a confidential professional welfare support service to all Army personnel and their families through Army Welfare Workers (AWW).

Where a child of an Army family is subject of a child protection referral:

- Social work (Children and Families) will liaise with the AWS Personal Support Team
- The team will be invited to send a representative to any Child Protection Case Conference (CPCC) concerning an Army child

Social work services can also liaise on more general matters with the two Welfare Support Officers (WSO) who between them cover the whole of Scotland. They respond to the Divisional Welfare Support officer (DWSO) who works together with the Divisional Personal Support Officer (DPSO), a qualified social worker, in the Army Headquarters 2nd Division (Appendix A for contact details).

Royal Marines

All welfare matters within the Royal Marines are dealt with by the Royal Marine Welfare Service (RMWS), which is now formally aligned with the Naval Personal and Family Service (NPFS). This is a non-statutory agency, which provides a confidential and professional service to all Royal Marine personnel and their families.

Where a child of a Royal Marine family is subject of a child protection referral:

- Social work (Children and Families Services) will liaise with the Royal Marine Welfare Service
- The team will be invited to send a representative to any CPCC concerning a Royal Marine child

The Royal Marine Welfare Service will negotiate service action on behalf of families. In the event that no-one is available at RM Condor within the Welfare Team, contact should be made with the main NPFS office in Scotland (Appendix A for contact details).

Royal Air Force

The Royal Air Force (RAF) is supported by an independent social work service known as SSAFA Forces Help (The Soldiers, Sailors and Airmen's Families Association). Most stations have trained Personal and Family Support Workers, but small stations are still offered a service from a local designated team. The Officer Commanding Personnel Management Squadron (OC PMS) is the main focus within the RAF system in relation to the welfare of

families on their station.

Where a child of a Royal Air Force family is subject of a child protection referral:

- Social work (Children and Families Services) will liaise with the serviceman/woman's unit, if known or the nearest RAF unit by contacting the OC PMS or SSAFA Forces Help
- The team will be invited to send a representative to any CPCC concerning a Royal Air Force child

Every RAF unit has an officer appointed to this duty and he/she will be familiar with child protection procedures.

For informal discussion contact SSAFA Forces Help
(Appendix A for contact details) – RAF (UK)
Social Work Service, Social Work Team manager
on (01334) 839 471 Ext. 7444. Or Ext. 7656

Service families going or returning from overseas

Where any of the Military Welfare Agencies are aware of child protection issues within a family being considered for overseas service, this will be highlighted during the screening process and action taken to prevent the family's move before child protection issues have been resolved.

It is essential that the local authority social work service exchange information about agencies' involvement with a service family to ensure that no child named on a UK Child Protection Register can be taken abroad and to make sure that parental support is not removed at a critical time.

Therefore where a service's child's name is placed on the Edinburgh and Lothians Child Protection Register:

The Chair of the CPCC will ensure that details are forwarded to the appropriate service families support agency

SSAFA Forces Help provides a statutory social work service and primary health care service for families of all services on overseas stations.

Where there is a Child Protection Plan (CPP) in this country for a child in a service family who are to move overseas, the Case Coordinator will notify SSAFA Forces Help (Appendix A for contact details)

This should be done in writing with full documentation, case summary, case conference notes, etc (Appendix A for contact details).

This information is forwarded to the relevant SSAFA Forces Help Social Worker overseas in order that:

- The case may be entered on the overseas British Forces Child Protection Register
- The practitioners at the overseas base can be alerted and a CPCC arranged and

appropriate support and supervision are provided to the family

Where there is statutory involvement (e.g. a supervision requirement), SSAFA Forces Help will provide regular reports to the relevant local authority.

When a service family with a child in need of protection returns to the UK, SSAFA Forces Help will contact social work (Children and Families) services in the local authority area in which they will reside ensuring that full documentation is provided to assist in the management of the case.

Social work (Children and Families Services) will convene an IRD regarding the child(ren).

Emergency action regarding service families overseas

When it appears that a child is in urgent need of protection, an officer having jurisdiction in relation to the child may order the child to be removed to and detained in a place of safety. If the officer makes an order to transfer the child to the United Kingdom so that care of the child can become the responsibility of the relevant local authority, all necessary action will be arranged and agreed beforehand between the relevant responsible agencies.

Arrangements for dealing with the emergency protection of children of service families abroad were introduced in the Armed Forces Act 1991. These provide for the officer having jurisdiction in relation to a child to make an order to remove the child or keep him or her in accommodation provided by or on behalf of the person who applied for the order.

Appendix E - Legislation and other linked documents

Important Note: The following describes only some of the relevant legal provision, so complete accuracy cannot be guaranteed. Always refer directly to the legislation itself before making reference or taking action.

Primary Legislation

The Children (Scotland) Act 1995

<http://www.legislation.gov.uk/ukpga/1995/36/contents>

Primary legislation that sets out parental roles and responsibilities (sections 1 and 2)

Places a duty on local authorities to

- safeguard and promote the welfare of children in need (section 22)

Places a duty on local authorities to

- make enquiries when information has been received that a child may be in need of compulsory measures of supervision (section 53)
- Establishes conditions for referral to a Children's Hearing for consideration as to whether a child is in need of compulsory measures of supervision (section 52)
- Provides legal measures to protect children by use of orders aimed at protecting children from harm and to assist in establishing whether children may be in need of protection from harm.

These are:

- Child Assessment Order (section 55)
- Child Protection Order (section 57)
- Exclusion Order (section 76)

In cases of emergency where a protection order is not available and the conditions for the making of a Child Protection Order under section 57 are present any person, a local authority or a constable can take steps to protect a child (section 61) – refer to the hyperlink to the act for a full description of powers, timescales and requirements.

The Police (Scotland) Act 1967

<http://www.legislation.gov.uk/ukpga/1967/77/contents>

Establishes the core duties of the police to prevent crime, preserve order and protect life and property. Where a crime has been committed to carry out investigation and report to the

Procurator Fiscal and when required to appear in court for the purposes of giving evidence.

The Criminal Procedure (Scotland) Act 1995 Schedule 1 (as amended)

<http://www.legislation.gov.uk/ukpga/1995/46/schedule/1>

Lists offences against children under 17 years of age in respect of which Section 21 of the Act confers power on a police constable, in certain circumstances, to take people into custody without a warrant if they have committed or the constable has reasonable grounds to believe they have committed the offences. Such offenders are commonly termed 'Schedule 1 offenders'. These offences involve the physical abuse, sexual abuse, sexual exploitation of and cruelty to children. Refer to the hyperlink for a full list of schedule 1 offences.

For the purposes of referral to a Children's Hearing, the offender need not necessarily have been convicted; it is sufficient that:

- The child has been the victim of a schedule 1 offence, or
- The child is likely to become a member of the same household as
 - A person who has committed a schedule 1 offence, or
 - A child in respect of whom a schedule 1 offence has been committed.

Note – the civil burden of proof i.e. the balance of probabilities applies.

Sexual Offences (Scotland) Act 2009

http://www.oqps.gov.uk/legislation/acts/acts2009/asp_20090009_en_1

This Act abolishes a number of common law crimes and repeals various statutory offences. It also creates a number of new statutory offences and provides a definition of consent, which is defined as 'free agreement'.

The act comprises seven Parts and six Schedules:

- Part 1 - Principal offences – Rape etc
- Part 2 - Consent and Reasonable Belief explanations
- Part 3 – Mentally Disordered Persons
- Part 4 – Offences against Children
- Part 5 – Abuse of Trust offences
- Part 6 – Penalties

- Part 7 – Miscellaneous and General Provisions

The Act created a number of protective offences which, criminalise sexual activity with children and mentally disordered persons. Children are divided into two categories

- “young children” (under 13)
- “older children” (13-15)

Section 55 allows for a Scottish resident to be convicted of an offence committed abroad if it would be deemed a criminal offence in Scotland.

Note: The Act became live on 1st December 2010 and any offences, which occurred before this date must be investigated and reported under the legislation applicable at the time of those offences.

The Children and Young Persons (Scotland) Act 1937

<http://www.legislation.gov.uk/ukpga/Edw8and1Geo6/1/37/contents>

Deals with offences of neglect, abandonment, ill treatment and cruelty to children.

Protection from Abuse (Scotland) Act 2001

http://www.oqps.gov.uk/legislation/acts/acts2001/asp_20010014_en_1

Provides legal remedies to women subjected to domestic abuse and can assist attempts to safeguard the interests of children. The primary remedy offered by the Act is that of powers of arrest being attached to an interdict, regardless of the relationship between the abused and the abuser.

Criminal Justice (Scotland) Act 2003

<http://www.legislation.gov.uk/asp/2003/7/contents>

Provides interpretation of what constitutes legally justifiable physical punishment. It is an offence to punish a child in any manner that involves ‘a blow to the head, shaking or the use of an implement’ (section 51). Where any such offence is committed, the defence of reasonable chastisement does not apply.

Sections 52 and 53 relate to reporting restrictions on Children’s Hearings and to the amount of information that the principal Reporter can make available to child victims and relevant persons where the offender is also a child.

Section 16 provides victims the right to be advised of the release dates, etc., of offenders. This may be relevant to children in circumstances where the perpetrator of offences against

them has been given a significant prison sentence.

Prohibition of Female Genital Mutilation (Scotland) Act 2005

<http://www.legislation.gov.uk/asp/2005/8/contents>

It is an offence for a person to carry out specified female genital mutilation procedures on another person or to aid or abet another person to carry out such procedures. This includes making it an offence to send a girl abroad for the purpose of female genital mutilation.

Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005

<http://www.legislation.gov.uk/asp/2005/9/contents>

Legislation covering a number of offences including that of ‘grooming’ a child under the age of 16 for sexual purposes and meeting such a child following prior contact for the purposes of engaging in illegal sexual conduct. This latter offence is often linked to online contact. Under sections 10-12, arranging or facilitating any sexual services from a young person under the age of 18 is an offence, as is attempting to control a young person for the provision of such services, including pornography.

Section 2 - introduction of Risk of Sexual Harm Orders designed to protect children and young people from persons who may not have been convicted of any criminal offence but who have engaged in some level of sexually explicit behaviour or communication in respect of a child under 16. This is a civil matter and the Order would be sought by the Chief Police Officer from the Sheriff. It is not intended as a substitute for criminal process, but rather as a means of protecting children at an earlier stage.

This Act also extends the powers available under the Sexual Offences Act 2003 to allow courts to impose a Risk of Sexual Harm Order at the time of conviction for a sexual offence.

Legislation on managing adults who may pose a risk to children

Police Act 1997

<http://www.legislation.gov.uk/ukpga/1997/50/contents>

Part V of this legislation provides the responsibility and authority for ‘disclosure checks’ on individuals by local authorities or third sector organisations as well as other organisations, depending on the nature of the work being undertaken.

This is further supported by the Police Act 1997 (Criminal Records) (Scotland) Regulations 2006. The legislation allows such bodies to seek to obtain criminal record certificates (known generally as ‘disclosures’) on any person who is likely to undertake direct work with children and other vulnerable groups.

For such purposes, disclosure of previous criminal convictions must be obtained at an ‘enhanced’ level. This means that spent convictions under the terms of the Rehabilitation of Offenders Act 1974 are included, together with any other information considered relevant by

the police and other authorities.

Under the legislation, checks are undertaken on foster carers, employees and any person who, while not holding any form of parental rights in respect of a child, may be entrusted with their regular care.

Protection of Vulnerable Groups (Scotland) Act 2007 (PVG)

http://www.legislation.gov.uk/ssi/2009/39/pdfs/ssi_20090039_en.pdf

The PVG Scheme provides a system governing those who have regular contact with children and protected adults through paid and unpaid work, ensuring that they do not have a known history of harmful behaviour. It replaces the Protection of Children (Scotland) Act 2003.

The scheme is intended to be quick and easy to use, reducing the need for members to complete a detailed application form every time a disclosure check is required, and aims to strike a balance between proportionate protection and robust regulation and make it easier for employers to determine who they need to check in order to protect their service users.

Sexual Offences (Procedure and Evidence) (Scotland) Act 2002

<http://www.legislation.gov.uk/asp/2002/9/contents>

Provides restrictions on when an accused person is allowed to conduct their own defence and thereby cross-examine the defendant. The categories include a range of offences against children, including unlawful sexual intercourse with a girl aged 13-16 and indecent behaviour towards a girl aged 12-16.

The accused is also prohibited from precognition of a child witness under oath and there are specific bail conditions relating to attempting to obtain statements from the complainer.

The extent of the powers under this legislation was extended further in the Vulnerable Witnesses (Scotland) Act 2004 to include non-sexual offences involving children under 12.

Vulnerable Witnesses (Scotland) Act 2004

<http://www.hms0.gov.uk/legislation/scotland/acts2004/20040003.htm>

Removed the requirement for child witnesses to undergo a competence test to ascertain whether they could understand the distinction between telling the truth and lying. Equally important is that under section 6 (which inserts section 288E to the Criminal Procedure (Scotland) Act 1995), an accused cannot conduct his own defence where the child concerned is under 12 and the offence involves sexual assault or violence.

The legislation allows for a range of special measures to support the vulnerable child when giving evidence or being cross-examined. The Act covers criminal cases, civil cases and Children's Hearings court proceedings. Standard special measures available to all child witnesses under 16 are a live TV link, screens in the courtroom and the presence of a supporter.

Further special measures, available on application to the court, include evidence being taken in advance in the form of a prior statement (criminal cases only) or being taken by a commissioner.

Under the act, a person under the age of 16 is a 'vulnerable witness'. The provision of standard special measures will always be considered for them.

Extensive guidance available on the subject (Supporting Child Witnesses Guidance Pack (part 1) Scottish Executive (2003). The 2004 Act underpins the acceptance that oral evidence is no longer the only means by which testimony can be given by children.

Asylum and Immigration (Treatment of Claimants, etc.) Act 2004

<http://www.legislation.gov.uk/ukpga/2004/19/contents>

Section 4 of this legislation relates to the offence of trafficking people for exploitation.

Immigration and asylum issues relating to unaccompanied children are a highly specialised aspect of the legislative framework. The potential for exploitation and vulnerability is high and it is important that specialist legal advice is sought, even in situations, which appear straightforward.

There are complex and contested processes of age-testing, which seek to clarify the ages of unaccompanied children arriving in this country without identifiable information and paperwork. The Scottish Refugee Council can provide initial support and information to help guide workers through these processes.

Anti-social Behaviour (Scotland) Act 2004

<http://www.legislation.gov.uk/asp/2004/8/contents>

This legislation allows for cases of anti-social behaviour to be referred to the Children's Reporter and for parenting orders to be applied to the parents of such children and young people.

Adoption and Children (Scotland) Act 2007

<http://www.legislation.gov.uk/sdsi/2010/9780111007174/schedule/crossheading/adoption-and-children-scotland-act-2007>

The introduction of the Permanence Order may have the most relevance for child protection processes. This order, which can be awarded to local authorities, allows for a greater degree of flexibility regarding a core of more permanent decisions about a child's care. The order allows responsibilities to be shared with carers by the local authority once the Permanence Order is in place and should be part of the single planning process for the child.

Where it has been decided that, in order to safeguard and protect the child's welfare, it is no longer appropriate to consider returning a child to his/her birth family, a Permanence Order may provide the necessary stability without the child being placed within an adoptive

family.

Mental Health (Care and Treatment) (Scotland) Act 2003

<http://www.legislation.gov.uk/asp/2003/13/contents>

This introduced a number of principles, which those discharging functions under the Act are required to observe, including a specific principle for the 'welfare of the child'.

It requires that any functions under the Act in relation to a child with mental disorder should be discharged in a way that best secures the welfare of the child. In particular it is necessary to take into account:

- The wishes and feelings of the child and the views of any carers;
- The carers' needs and circumstances;
- The need to provide carers with information that could help them care for the patient;
- Where the child is or has been subject to compulsory powers, the importance of providing appropriate services to that child; and
- The importance of the function being discharged in a manner that appears to involve the minimum necessary restrictions on the freedom of the child.

The Act is universal and applies to everyone with a mental disorder irrespective of age, but it introduced specific provisions in relation to children and has clear links to the Children (Scotland) Act 1995.

A range of powers and duties is in place for both health boards and local authorities to address the needs of children with mental health problems and with parent(s) who have mental health problems.

Key amongst specific provisions in the Act are:

- The requirement on health boards to provide certain services and accommodation for patients under 18 to help prevent young people being admitted to adult acute wards and improve the provision of specialist child focused services
- The requirement on health boards to provide accommodation and services that will enable mothers with post-natal depression and who are in hospital to care for their child (of less than one year) in hospital, if they so wish
- That all those discharging functions under the Act have a duty to 'mitigate' adverse effect of compulsory measures on parental relations, whether it is the parent or child who has the mental disorder
- That education authorities have a duty to make arrangements for the education of pupils unable to attend school because they are subject to measures authorised by the Act or by other mental health legislation, as a consequence of their mental disorder

Data Protection Act 1998

<http://www.legislation.gov.uk/ukpga/1998/29/contents>

The responsibility of the data controller within any organisation to ensure that the key principles set out in the Act are adhered to by all staff. In the context of child protection those sections of the Act that relate to confidentiality, sharing of information and disclosure of sensitive information are particularly relevant.

Human Rights Act 1998

<http://www.legislation.gov.uk/ukpga/1998/42/contents>

All legislation passed by either the UK or Scottish Parliament should adhere to the principles of the European Convention on Human Rights.

UN Convention on the Rights of the Child

http://www.unicef.org.uk/UNICEFs-Work/Our-mission/UN-Convention/?gclid=CKH7x_Pd16UCFcse4QodehB9jQ

Ratified by the UK Government in 1991, this Convention serves to inform all subsequent child care legislation. The rights of the child to express their views freely in all matters affecting them and to have them taken into account, and the right to have the best interests of the child as a primary consideration in making decisions affecting the child are important aspects of this Convention. Conformity with the standards established by competent authorities is another requirement of the convention.

Equality Act 2010

Restates, streamlines and harmonises equality legislation. It replaces a number of Acts, including the Race Relations Act 1976, the Sex Discrimination Act 1975 and the Disability Discrimination Act 1995. The majority of the Equality Act 2010 came into force on 1 October 2010.

Edinburgh and the Lothians Inter Agency Child Protection Procedures

Edinburgh Lothian and Borders Executive Group
Public Protection Partnership Office

Email: elbegpppo@lbp.pnn.police.uk

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